

Lobbying Strategies for Federal Appropriations: Nursing versus Medical Education

by

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This dissertation is dedicated to my family and friends who believe in my potential and the policy nurses who inspired my career.

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List of Abbreviations

AACN:	American Association of Colleges of Nursing
AAMC:	Association of American Medical Colleges
AHA:	American Hospital Association
AMA:	American Medical Association
ANA:	American Nurses Association
AONE:	American Organization of Nurse Executives
APRN:	Advanced Practice Registered Nurse
BLS:	Bureau of Labor Statistics
CHGME:	Children's Hospital Graduate Medical Education
CRS:	Congressional Research Service
DHHS:	Department of Health and Human Services
DNE:	Division of Nursing Education
DNR:	Division of Nursing Resources
DNP:	Doctorate of Nursing Practice
FNHP:	Federation of Nursing and Health Professions
FTE:	Full Time Equivalent
FY:	Fiscal Year
GME:	Graduate Medical Education
HELP:	Health, Education, Labor and Pensions
HIPPA:	Health Insurance Portability and Accountability Act
HRSA:	Health Resources and Services Administration
IOM:	Institutes of Medicine
JCAHO:	Joint Commission on Accreditation of Healthcare Organizations
LHHS:	Labor, Health and Human Services
NACNE:	National Advisory Council on Nursing Education
NACNEP:	National Advisory Council for Nursing Education and Practice
NIH:	National Institutes of Health
NOHSN:	National Organization of Hospital Schools of Nursing
NSSRN:	National Sample Survey of Registered Nurses
NTA:	Nurse Training Act
PAC:	Political Action Committee
PHS:	Public Health Service
PHSA:	Public Health Service Act
PI:	Principal Investigator
RN:	Registered Nurse
SEIU:	Service Employees International Union
SCHIP:	State Children's Health Insurance Program
TDM:	Total Design Method

Abstract

The aims of this comparative exploratory descriptive qualitative study were to learn which lobbying strategies of interest groups are used and which of these strategies influence federal appropriators' decisions. This study compared the lobbying strategies used to advocate for the Title VIII Nursing Workforce Development programs with those employed to advocate for Children's Hospital Graduate Medical Education (CHGME). The CHGME program was selected as the comparison program for Title VIII because both programs are federally funded through the Labor Health and Human Services appropriations bill, authorized under the Public Health Service Act, and support a single healthcare discipline. Given the 483% increase in funding between Fiscal Year (FY) 2000 and FY 2001, it is clear the CHGME program has been able to significantly increase federal dollars. The Title VIII programs have not been able to secure the same level of appropriations or a dramatic funding increase.

Twenty-seven interviews were conducted with nursing lobbyists (n=10), CHGME lobbyists (n=7), and Congressional appropriations staff (n=10). The constant comparative method of analysis, a component of grounded theory method, was used to analyze the data. Open coding was used to generate the main themes and axial coding was used to relate concepts to each other. For example, comments by the nursing lobbyists were compared to those of the CHGME lobbyists and in turn with the lobbyists responses related to those made by the Congressional staff.

Results indicated that while nursing used similar strategies to those who advocate for CHGME, their level of investment in these strategies was significantly less. Moreover, nursing lacks specific components of inside and outside advocacy strategies such as grass tops advocacy and grassroots intensity, which impacts the profession's ability to secure higher levels of funding for the Title VIII programs. A conceptual framework, future research and implications for the profession are offered.

CHAPTER ONE

Introduction

Research Purpose

As the nation looks toward reforming the broken healthcare system, focus must be given to strengthening the Registered Nurse (RN) workforce. Yet, as the American Association of Colleges of Nursing ([AACN], 2008a) stated, “the ongoing shortage of nurses is contributing to the breakdown of the nation’s ability to ensure access to safe, quality, and affordable healthcare. Unfortunately, the demand for RNs continues to outpace the supply of new nurses entering the healthcare system each year” (¶ 2). The 2003 landmark study by Institute of Medicine (IOM), *Crossing the Quality Chasm*, reported that poor RN staffing levels harm patient safety. Moreover, the Agency for Healthcare Research and Quality (AHRQ) released a meta-analysis in 2007 that found the shortage of RNs, coupled with an increased workload, threatens the quality of patient care (AHRQ, 2007). In order to improve patient safety and healthcare quality, the nursing workforce must be expanded. A historical and successful method to help reverse the nursing shortage and improve healthcare accessibility is a federal investment in nursing education (Kalisch & Kalisch, 1982).

As the largest source of federal funding for nursing education, the Title VIII Nursing Workforce Development programs (42 U.S.C. 296 et seq.) have supported nearly five generations of future nurses and faculty. Yet in the past 10 years, during one of our nation’s largest nursing shortages, inadequate funding has been provided by the federal

government to address the workforce crisis. The last five fiscal years (FY) have proven to be particularly damaging to nursing education as level funding for the Title VIII programs has decreased their purchasing power and each year nearly 20% less students are supported by the programs (Division of Nursing, 2008a). While other federal programs have also experienced stagnant appropriations, their funding levels still receive a significantly higher amount than nursing, despite the documented nursing shortage. One program of particular interest that has a similar focus and source of funding is the Children Hospital Graduate Medical Education (CHGME), which out paces funding for nursing education by 50%. One explanation for this vast funding difference is the lobbying strategies used to secure higher levels of appropriations in which certain interest groups have more success than others (Humphries, 1991; McConnell (1966) as cited in Hall & Deardorff, 2006; White, 2005).

The aims of this comparative exploratory descriptive qualitative study are to gain insight into effective lobbying strategies of interest groups and which of these strategies influence federal appropriators' decisions. This study compared the lobbying strategies used to advocate for the Title VIII Nursing Workforce Development programs with those employed to advocate for CHGME in an effort to determine differences in advocacy strategies. The CHGME program was selected as the comparison for Title VIII because both programs are federally funded through the Labor Health and Human Services (LHHS) appropriations bill, authorized under the Public Health Service Act (PHSA), and support a single healthcare discipline. However, CHGME has been able to significantly increase federal appropriations as seen in the 483% increase between FY 2000 and FY 2001 (Health Resources and Services Administration (HRSA), 2008). The Title VIII

programs have not been able to secure the same level of appropriations or a dramatic funding increase. Between FY 2005 and FY 2008, CHGME funding was double that of Title VIII (HRSA). This difference in funding is especially notable as the CHGME program is narrowly focused on physician residencies in free-standing children's hospitals and the Title VIII programs are intended to address all aspects of the nursing shortage (recruitment, retention, practice, and education).

Twenty-seven interviews were conducted with nursing lobbyists, CHGME lobbyists, and Congressional appropriations staff. The Congressional staff were included in this study to determine which advocacy strategies were deemed effective and which strategies influenced an appropriator's decision. The ultimate objective of this study was to understand effective advocacy strategies to enhance lobbying efforts for the Title VIII Nursing Workforce Development programs. With this knowledge, the potential to increase funding for Title VIII may grow, which in turn would help reverse the nursing and nurse faculty shortage and improve access to safe, quality healthcare—tenets of the healthcare reform discussions.

An Overview of Healthcare Reform in America: System in Crisis

Massive and overarching healthcare reform in the United States has not occurred since the advent of Medicare and Medicaid in the early 1960s. During the 1970s, the Nixon, Ford, and Carter administrations proposed to slow rising healthcare costs and offer universal coverage, but their efforts faded over the next decade (Daschle, Greenberger, & Lambrew, 2008). The Reagan administration in the 1980s focused on the growing power of Health Maintenance Organizations and Preferred Provider Organizations. In the 1990s, the Clinton administration offered a “managed competition”

plan that allowed private insurers and healthcare providers to vie over potential consumers (Daschle, Greenberger, & Lambrew). Under the Clinton administration, major healthcare reform seemed certain. Yet, due to a number of contributing factors nothing came of the efforts put forth by Clinton and his Democratic supporters in Congress.

While great successes for healthcare have been made, such as Senator Edward Kennedy (D-MA) and former Senator Nancy Kassebaum's (R-KS) Health Insurance Portability and Accountability Act (HIPPA) in 1996 and State Children's Health Insurance Program (SCHIP) in 1997 (Daschle, Greenberger, & Lambrew, 2008), no all-encompassing change has occurred. Under the current Obama administration, many Americans and political pundits alike believe this will be the decade that healthcare reform finally occurs.

Today, as in the past, the overwhelming need to drastically transform the healthcare delivery system is not only well documented, but is also plainly visible to the millions of individuals who require its services on a daily basis. When President Clinton's plan of universal healthcare coverage did not come to fruition in the early 1990s, the American public was left with a default plan, which focused more on economics than providing healthcare services (Curtin, 2007). The healthcare system was driven by market-based strategies that chose to "optimize profit through gaining competitive advantage" (Curtin, p.105). Demands by the consumers (business and government) to lower costs and adhere to a structured business plan took precedence over the public's ideal of health care as a humanitarian service (Curtin). The shift received significant attention from healthcare stakeholders. In 1995, the American Hospital Association (AHA) referred to the changes as the "worst disaster to hit U.S. hospitals"

explaining that patient errors, malpractice suits, and union activities all increased under this flawed model. (Curtin).

Early in the new millennium, experts at the IOM (2001) stated that the healthcare delivery system was in crisis, citing it could not meet the needs of its consumers; nor would the system be able to fulfill increasing demands in the future. Landmark studies, such as *To Err is Human: Building a Safer Health System* (IOM, 2002), reported that adverse medical outcomes were on the rise. At the time, it was estimated the number of deaths from medical errors ranged from 44,000 to 98,000 each year (IOM). The publication *Keeping Patients Safe: Transforming the work Environment of Nurses* (IOM, 2003) reported that acutely ill patients, frequent staff and patient turnover, and the healthcare work environment were factors that affected patient safety and the ability of nurses to provide safe patient care.

Quality became a dire concern amongst healthcare stakeholders, but the broken system would only grow more critical as financial burdens and coverage shortcomings played a role in the demise of the nation's current system. Today, the cost of private health insurance has increased to the extent that individuals personally pay more for decreased benefits. More concerning however, is the staggering number of Americans who remain uninsured. It is currently estimated that 46 million Americans are uninsured (Kaiser Family Foundation, 2008). This serves to reinforce the dismal condition of the American healthcare delivery system (IOM, 2002).

Racial and ethnic disparities as well as the under and overuse of medical services, only widen the gap between effective, efficient, and quality care in the nation's delivery system. Not surprisingly, when the crisis is critically analyzed, it is not only the

American consumers who are suffering, but also the healthcare providers who are left faltering through the regulatory, payment, and legal barriers that affect their ability to provide the level of care that patients deserve (IOM, 2002).

These findings deliver the shocking message— change must occur. However, changes of this magnitude cannot occur or survive within the confines of healthcare institutions alone. The debate on how to repair the broken system currently rages in and around the Capitol beltway. Policy experts, members of Congress, the Administration, and public stakeholders are seriously focused on the difficult task of reforming the “system in crisis.”

Nursing’s Impact on Access to Quality Healthcare

Three overarching barriers have been identified as the most significant topics to address during healthcare reform: access, quality, and cost (S. Hinck, Senate Finance Committee, personal communication, September 30, 2008). Questions regarding the healthcare workforce, pay-for-performance, reimbursement, and innovative healthcare research fall within each of these three critical categories. For the nursing profession, addressing the dwindling workforce is paramount. By ensuring a robust pipeline of RNs, barriers to access and quality within the healthcare system can be overcome. Simply stated, without a strong nursing workforce, attempts to provide access to healthcare is futile. If there are not enough healthcare providers, in particular Advanced Practice Registered Nurses (APRNs) and RNs, holding an insurance card will be meaningless. Unfortunately, America is facing a decade long nursing shortage that is not projected to improve in the coming years.

The National Nursing Shortage

During the early and mid 1990s, managed care plans reduced rising healthcare costs through such tactics as budget cuts and hiring freezes targeted at nursing positions (AACN, 1999). The media reported on stories of nurses being laid-off from their positions and many left the profession concerned over job security. The public's skepticism of the nursing workforce's stability transferred to nursing school enrollments. According to AACN, enrollment in entry-level baccalaureate nursing programs fell by 6.6% in 1997 and 5.5% in 1998, marking a four-year downward trend in program enrollments (AACN).

However in 1998, the stability of the nursing workforce changed dramatically. Lower graduation rates, RN layoffs, and nurses leaving the profession coupled with the need for nurses in new healthcare venues and positions quickly created a demand. It was at this time, Burheaus (1998) first reported on the national nursing shortage. Unfortunately, time has not solved the problem. Today, there are 116,000 vacant nursing positions nationwide, which translates to an 8.1% vacancy rate (AHA, 2007). This vacancy only accounts for acute care settings. Nurses are in high demand in other healthcare fields such as public and community health, long-term care, and emergency preparedness.

The nursing shortage is only expected to intensify as experienced nurses begin to retire and the demand for nursing services increases. The U.S. Bureau of Labor and Statistics (BLS) (2007) project that one million new and replacement nurses will be needed by the year 2016. Analysts at HRSA (2006), project that by 2015 all 50 states will experience varying levels of RN shortages. Access to quality health care provided by

professional RNs remains bleak given the current status and future trend. There are a number of contributing factors that impede the growth and sustainability of the RN workforce.

An Overview of the Nursing Workforce

Population

The nursing workforce is the largest profession in the healthcare delivery system. According to the National Sample Survey of Registered Nurses (NSSRN), administered by HRSA (2007), 2.9 million individuals held a RN license in 2004. Of those nurses, 2.4 million currently work in nursing and 1.7 million nurses reported that they were working full-time (HRSA). While the nursing population far exceeds other health professions (in 2007, the U.S. BLS reported 900,000 physicians working in medicine), the workforce remains depleted.

Diversity

Nursing is still a predominately white, female profession. In 1973, men were a small sector of the nursing population with only 200,000, or 2% of the population, practicing. Today, men now comprise 8.6% of the nursing workforce (U.S. BLS, 2006). The 6.6% growth over 33 years is a positive improvement, but does not represent a major shift in nursing's diversity. Similar to the male population, the racial and ethnic diversity in nursing has increased over the last 30 years. HRSA (2007) reports that 10.7% of the nursing workforce identifies themselves as an ethnic or racial minority. However, this increase has not kept pace with the general census. According to the U.S. Census Bureau (2007), the nation's minority population totaled 100.7 million in 2007 or 30% of the nation's total population. Specifically, the RN population is represented by 81.8% White,

non-Hispanic; 1.7% Hispanic or Latino; 4.2% Black or African America, non-Hispanic; 3.1% Asian or Native Hawaiian, or Pacific Islander, non-Hispanic; 7.5% unidentified race and/or ethnicity (HRSA).

Educational Preparation

An individual can enter the nursing profession through multiple paths. Diploma (hospital based training), associate, and baccalaureate programs all exist as a method to obtain a registered nurse license. Over the decades, the profession has seen a decrease in the number of nurses trained at the diploma level. According to the NSSRN, between the years of 1980 and 2004, the percentage of nurses who received their education from diploma programs decreased from 63.2% to 25.2% (HRSA, 2007). This proves to be a positive trend as the profession looks toward educating the next generation of qualified, highly-educated nurses. The percentage of nurses who are educated at the associate degree level continues to climb. In the same time frame (1980-2004), associate degree prepared nurses surged from 18.6% of the nursing population to 42.2% (HRSA). This increase in associate degree prepared nurses may be due in part to the need to educate nurses faster and cheaper during a time of shortage. Associate degree programs run approximately two years and cost significantly less than baccalaureate programs.

However, the call for nurses to be prepared at the baccalaureate level has grown in conjunction with the demand for highly skilled nursing services. Patients admitted into the hospital present with multiple co-morbidities such as obesity, diabetes, and hypertension, which has fundamentally changed nursing care (AACN, 2008b). Therefore, national organizations such as AACN, the Association of Nurse Executives (AONE), the American Nurses Association (ANA), and the National Advisory Council on Nursing

Education and Practice (NACNEP), have all released statements supporting the baccalaureate nursing degree as the level of education required to enter into practice (AACN). It does appear; however, that the level of nurses with advanced degrees is growing.

Nurses who obtained their baccalaureate or graduate degree in nursing has increase in the last two and a half decades. The percentage of nurses who received their initial education in a baccalaureate or higher program increased from 17.4% to 31.0% between the years of 1980 and 2004 (HRSA, 2007). Between the years 1996 and 2000, the growth in nurses who received their education through a baccalaureate degree or higher increased at a faster rate (17.3%) than nurses who graduated from associate degree programs (12.7%) (HRSA).

An Overview of the Factors Contributing to the Nursing Shortage

The nursing workforce shortage and its multifaceted causes have contributed to the diminishing level of health care in America. As noted, the 2003 landmark study by IOM, *Crossing the Quality Chasm*, reported that poor RN staffing levels harm patient safety. Additionally, the Agency for Healthcare Research and Quality (AHRQ) released a meta-analysis in 2007 that found the shortage of RNs, coupled with an increased workload, threatens the quality of patient care (AHRQ, 2007). The quality of patient care is also impacted by the level of education nurses receive. According to Aiken, Clarke, Sloane, Lake, and Cheney (2008), when more baccalaureate prepared nurses are on a patient-care unit, mortality and failure-to rescue rates decrease. These findings have been confirmed through numerous research studies (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Friese, Lake, Aiken, Silber &

Sochalski, 2008). Unfortunately, only 34.2% of the nursing population currently holds a baccalaureate degree (HRSA, 2007).

All federal and public reports (Bureaus, 1998; Buerhaus, Staiger, & Auerbach, 2009; HRSA, 2006; U.S. BLS, 2007) suggest that the shortage will indeed worsen in the coming years if drastic action is not taken to reverse the trend. The complex contributing factors need direct and immediate attention.

An Aging Workforce

The nursing population continues to age. With decreased enrollments during the 1990s, the influx of younger nurses into the profession dropped. According to HRSA (2007), a 4% decline was seen in the number of nurses under the age of 30 between 2000 and 2004. During the same time frame, the percentage of nurses over the age of 54 increased to 25.2% (20.3% of RNs were over the age of 54 in 2000) (HRSA, 2007). Currently, the average age of RNs is 46.8 years of age compared to 45.2 in 2000 and 44.3 in 1996 (HRSA).

Slow Growth in the RN Workforce

According to HRSA (2007), the growth of the nursing population has plummeted. The NSSRN is collected every four years. At every four year interval since 1980, the RN population has increased. However, while there was a 7.9% increase between the years of 2000 and 2004, this is comparatively low to other intervals. For example, between 1992 and 1996, the RN population increased by 14.2% (HRSA).

Job Dissatisfaction

One commonly cited factor contributing to the nursing shortage is job dissatisfaction or burnout, which is causing nurses to leave the profession. Due to the

unprecedented shortage, nurses have been forced to work under staffing quotas and have taken responsibility for more patients. Ultimately, this causes increased emotional distress and job dissatisfaction for many RNs (Aiken, Clarke, Sloane, Sochalski, & Sibley, 2002). Studies have shown that nurses are not satisfied with their working conditions. The Federation of Nurses and Health Professionals' (FNHP) (2001) survey found that 56% of the nurses questioned wanted a less stressful and physically demanding job and 43% stated that increasing nurse staffing levels would be the ultimate factor in improving their jobs. Additionally, the same survey found that 22% of the nurses were concerned about their schedules and hours (FNHP). According to Buerhaus and colleagues (2005), who also investigated the work perceptions of nurses, the shortage is a catalyst for increased stress (98%), lowered patient care quality (93%), and nurses leaving the profession (93%).

Moreover, and of unequivocal importance, the increased stress and dissatisfaction created by the shortage impacts patient care. Nurses have been and are currently required to care for more patients. The Joint Commission, formally the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), (2002) found that since 1996 low nursing staff levels were contributing to an alarming 24% of patient deaths (JCAHO). More recent reports suggest that 75% of RNs believe the nursing shortage presents a major problem for the quality of their work, the quality of patient care, and the amount of time nurses can spend with patients (Buerhaus et al., 2005).

RN Turnover

High nurse turnover and increased vacancy rates are affecting patient care (Buerhaus et al., 2005). Of particular concern is the number of newly licensed RNs

changing positions or leaving after their first year as a nurse. Of the newly licensed RNs participating in Kovner and colleagues' (2007) study, 13% stated that they left their first nursing job within a year and 37% reported that they were ready to leave their current position.

Nursing Education

One remaining factor contributing to the shortage has the potential to cripple the ability to significantly increase the nursing workforce—the nursing education crisis. In the United States, the nursing educational system appears to be thriving. For the seventh consecutive year, enrollments in baccalaureate and graduate nursing programs have increased (Fang, Tracy, & Bednash, 2008b). Between the academic years of 2006 and 2007, enrollments increased by 5.4% (Fang, Tracy, & Bednash). However this trend is slowing. Between academic years 2007 and 2008, the increase in enrollments was only 2.2% (Fang, Tracy, & Bednash, 2009a)

Media coverage has clearly communicated to the public the need for qualified nurses and the public has taken notice. Given the current state of the economy, the rate of unemployment, and positions being sent overseas, nursing has become an attractive and lucrative career or second career choice for many. In addition to individuals entering generic baccalaureate nursing programs, schools created accelerated baccalaureate degree programs, which allow individuals already holding a bachelors degree to finish a nursing degree in 12-18 months. In 2008, a total of 11,018 students were enrolled in accelerated baccalaureate degree programs, up 9.8% from 2007 and an astounding 44.7% from 2004 when AACN began tracking the programs (Fang, Tracy, & Bednash, 2009a). The graduation rates from these programs have also increased dramatically over the last three

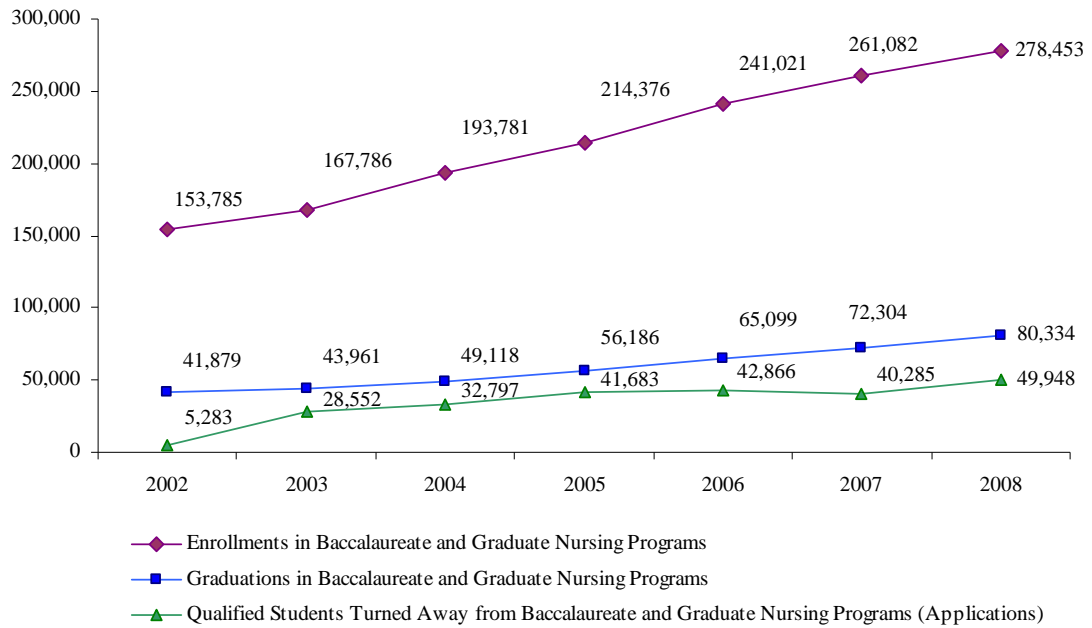
years. Between 2004 and 2007, the percentage increase of new graduates from the accelerated programs was 64.7% (Fang, Tracy, & Bednash).

The considerable interest in nursing education is a real and welcomed trend given the severe nursing shortage. However, the remarkable strides nursing schools have made to increase enrollments and graduations quickly fade when compared to the unprecedented number of students turned away from nursing programs. In academic year 2007-2008, it was reported that 49,948 qualified applicants were turned away from baccalaureate and graduate nursing programs (Fang, Tracy, & Bednash, 2009a). Since 2002, the number of eligible applicants being turned away from nursing schools has drastically increased (see Figure 1.1). While enrollments and graduations are increasing, they do not meet the demand. According to HRSA (2006), nursing schools need to increase graduations by 90% each year to meet the demand. More recent projections report that nursing schools must graduate 30,000 additional nurses each year, 30% over the current graduate rate (Council on Physician and Nurse Supply, 2008).

Similar to the numerous factors contributing to the national RN shortage, the crisis in the nursing educational system is also complex. Among the reasons for not accepting all qualified applicants in 2008 was an insufficient number of clinical sites, overall budget cuts or an insufficient budget, insufficient classroom space, and insufficient clinical preceptors (Fang, Tracy, & Bednash, 2009a) (see Table 1.1). However, the most concerning factor contributing to the problems within the nursing educational system is the lack of qualified nursing faculty (see Table 1.1 & 1.2).

Figure 1.1

Historical Trends of Nursing School Enrollments, Graduations, and Qualified Applicants Turned Away: 2002-2008



From: Fang, D., Tracy, A., Bednash, G.D. (2009a). 2008-2008 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington, DC: American Association of Colleges of Nursing.

Table 1.1

Reason for Not Accepting all Applications by Type of Program

Table 39. Reasons for Not Accepting All Qualified Applications by Type of Program.

REASON	BACCALAUREATE		MASTER'S						DOCTORAL					
	GENERIC		RN		NP		CNS		OTHER MAJORS		RESEARCH		DNP	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
SCHOOLS REPORTING =	331		42		83		18		59		23		33	
Insufficient Number of Faculty	207	62.5	26	61.9	43	51.8	8	44.4	28	47.5	7	30.4	14	42.4
Insufficient Clinical Sites	178	53.8	11	26.2	37	44.6	6	33.3	18	30.5	0	0.0	5	15.2
Overall Budget Cuts/ Insufficient Budget	49	14.8	8	19.0	14	16.9	2	11.1	8	13.6	2	8.7	3	9.1
Insufficient Classroom Space	140	42.3	11	26.2	8	9.6	3	16.7	8	13.6	0	0.0	2	6.1
Insufficient Clinical Preceptors	84	25.4	9	21.4	30	36.1	6	33.3	14	23.7	1	4.3	4	12.1
Other	63	19.0	12	28.6	12	14.5	7	38.9	19	32.2	7	30.4	8	24.2
Not Reported/Not Adequately Specified	{17}		{23}		{18}		{12}		{36}		{11}		{10}	

From: Fang, D., Tracy, A., Bednash, G.D. (2009a). 2008-2009 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington, DC: American Association of Colleges of Nursing.

Table 1.2

Reason for Insufficient Numbers of Faculty by Type of Program

Table 40. Reasons for Insufficient Number of Faculty by Type of Program.

REASON	BACCALAUREATE		MASTER'S						DOCTORAL					
	GENERIC		RN		NP		CNS		OTHER MAJORS		RESEARCH		DNP	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
SCHOOLS REPORTING =	206		26		43		8		28		7		14	
Insufficient Funds to Hire New Faculty	130	63.1	13	50.0	20	46.5	4	50.0	18	64.3	5	71.4	9	64.3
Inability to Recruit Faculty Due to Competition for Jobs with Other Marketplaces	160	77.7	18	69.2	29	67.4	6	75.0	18	64.3	3	42.9	9	64.3
Qualified Applicants Unavailable in the Geographic Area	80	38.8	7	26.9	13	30.2	5	62.5	12	42.9	0	0.0	3	21.4
Faculty Retirement	59	28.6	6	23.1	10	23.3	2	25.0	2	7.1	2	28.6	1	7.1
Faculty Resignation	62	30.1	4	15.4	10	23.3	1	12.5	3	10.7	0	0.0	0	0.0
Other	14	6.8	2	7.7	3	7.0	0		2	7.1	0	0.0	0	0.0
Not Reported/Not Adequately Specified	{1}		{0}		{0}		{0}		{0}		{0}		{0}	

From: Fang, D., Tracy, A., Bednash, G.D. (2009a). 2008-2009 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington, DC: American Association of Colleges of Nursing.

The Nurse Faculty Shortage

Throughout the last three decades, nursing school enrollments have dictated the size of the nurse faculty workforce. During the 1970s, women began to choose careers outside of traditional female professions such as nursing (Buerhaus, 2009). As a result, nursing programs began to experience decreased enrollments, which forced schools to decrease their faculty rosters in the 1980s (Brendtro & Hegge, 2000). According to Hinshaw (2001), “When enrollment rebounded in the early 1990s, many programs were not able to recruit full-time faculty, since faculty had found other opportunities and positions in nursing” (¶ 14). Since schools of nursing had a difficult time finding full-time faculty, more part-time, master’s prepared faculty were hired as a convenient and temporary solution (DeYoung, Bliss, & Tracy, 2002). Anticipating that this pattern would likely repeat itself in the 1990s, experts predicted a nurse faculty shortage (AACN, 1999, DeYoung, Bliss, & Tracy).

According to AACN (1999), media reports in the late 1990s of RN layoffs sparked decrease enrollments in nursing programs as potential candidates, concerned over job stability, sought other career options. Enrollments in entry-level baccalaureate nursing programs fell by 6.6% in 1997 and 5.5% in 1998, marking a four-year downward trend (AACN). Subsequently, schools of nursing had to freeze faculty positions as a method to counter lower tuition revenue (Hinshaw, 2001). However, this trend did not last.

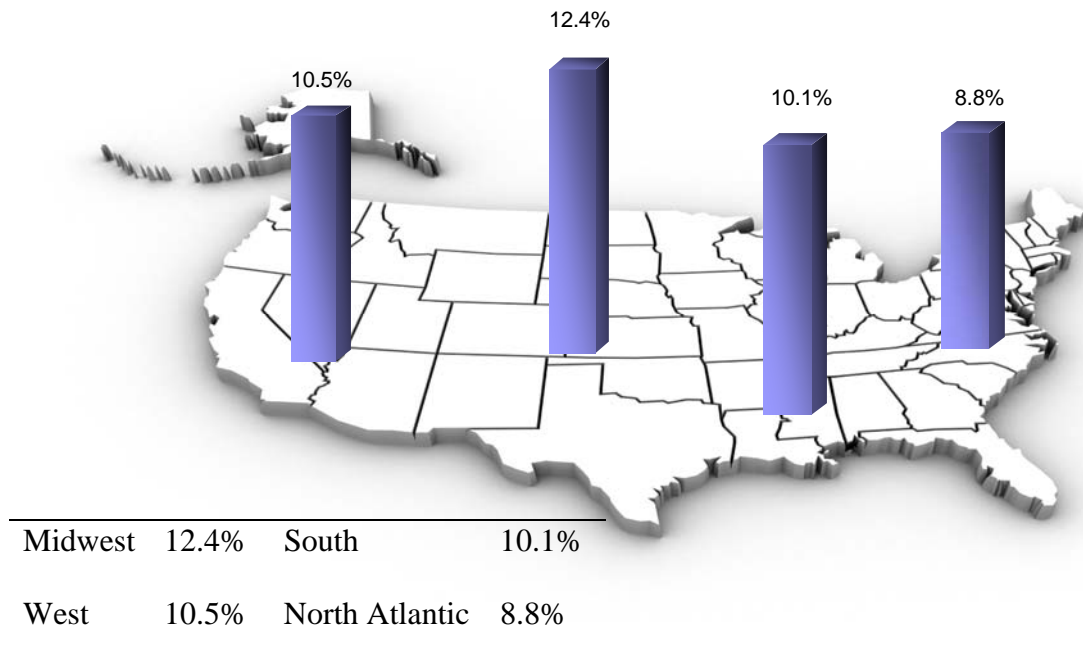
The continual ebb and flow of workforce shortages cycled once again in the late 1990s and early 2000s as the demand for RNs became great. At this time, the nursing shortage intensified as the need for healthcare services grew and the supply of nurses

dwindled (Buerhaus, 1998). Reports of the nursing shortage spread widely. The media, and shortly thereafter the public, began to understand that the profession was a stable and desirable career path. The bleak enrollment numbers of the 1990s quickly changed in 2002, and a wave of applicants flooded nursing programs. While enrollments began to surge, nursing schools were not immediately concerned with having a potentially inadequate faculty workforce. AACN conducted an informal poll of 159 member deans and found that more than half (59.1%) did not report experiencing a nurse faculty shortage (AACN, 1999). Still, 40.8% of schools reported difficulties increasing school enrollments because of faculty recruitment barriers. The experts held a slightly different view and projected a nurse faculty shortage that would have a severe impact on the ability to educate the next generation of nurses needed to meet the demand (AACN; Anderson, 1998a; Hinshaw, 2001).

Today, the faculty shortage continues and has grown critical. Of the 449 schools responding to AACN's (2008b) *Member Survey on Vacant Faculty Positions for Academic Year 2008-2009*, 62.8% reported faculty vacancies. Of those schools, the vacancy rate was 10.4% or 814 faculty positions left unfilled. Regionally, nurse faculty vacancy rates are higher in the Midwest (12.4%) compared to the North Atlantic, Southern, and Western regions of the country (see Figure 1.2). The 2008 national faculty vacancy rate is 7.6% (AACN, 2008b).

Figure 1.2

Vacancy Rate by Region in Schools Reporting Vacancies for Academic Years 2008-2009



From: American Association of Colleges of Nursing (2008b, July). Member Survey on Vacant Faculty Positions for Academic Year 2008-2009. Washington, DC.

The nurse faculty shortage is a result of the enrollment trends in past 10 years and the subsequent consequences for schools of nursing (i.e. hiring freezes). Yet, explanations for why the shortage has continued for a decade are complex. At a time when faculty is needed most, a lack of qualified faculty, a reliance on part-time faculty, an aging workforce, the current cadre of doctoral students, and a decreased interest in academic careers all play a significant role in nursing's ability to reverse the trend.

Lack of Qualified Faculty

The academic norm requiring doctorally prepared faculty to educate baccalaureate and graduate students was established later in nursing than other disciplines (Hinshaw, 2001). In 1979, only 16.1% of faculty in baccalaureate and graduate programs held a

doctoral degree (Fang, Tracy, & Bednash, 2009a). While noteworthy strides have been made in nursing education to increase this number, the percentage of faculty with doctoral degrees has dropped in recent years. In 2002, a reported 51.3% of faculty were educated with the terminal degree (see Figure 1.3). Currently, only 45.4% now hold doctoral degrees. Over the last decade, the attempts to address the nurse faculty shortage proved to be unsuccessful as the underlying issue was never addressed; the need for full-time, doctoral prepared faculty.

Lack of Full-Time Faculty

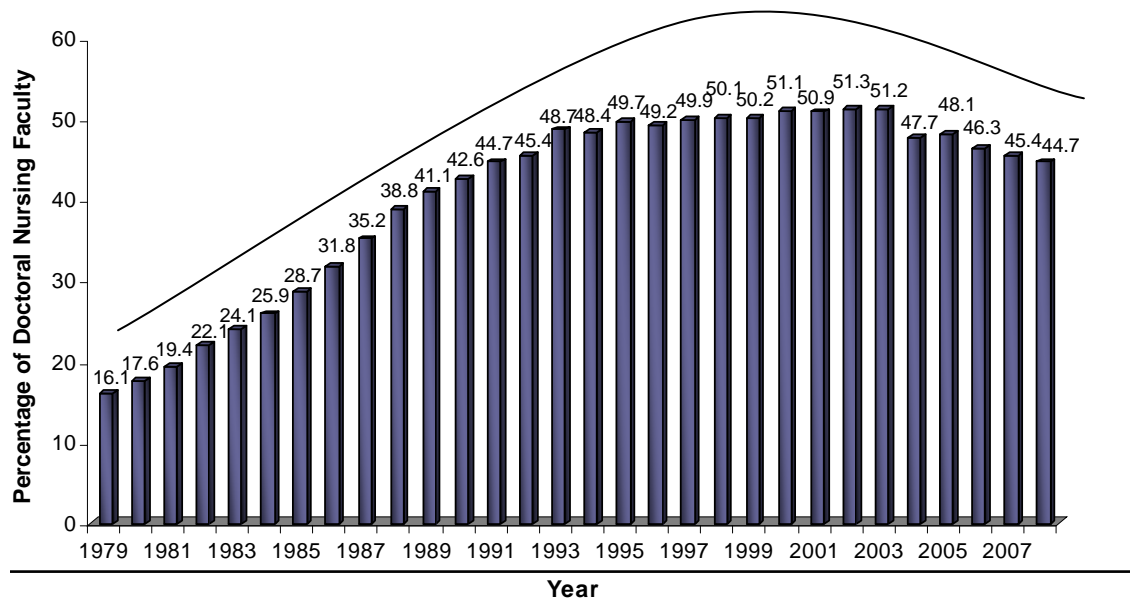
When entry-level baccalaureate enrollments skyrocketed from 62,821 in 1999 to 102,089 in 2004, schools quickly felt the effects of the nurse faculty shortage (Berlin, Stennet, & Bednash, 2004; Fang, Tracy, & Bednash, 2009a). Once again, the use of part-time master's prepared faculty was the "quick fix." As shown in Figure 1.4, between the years 2000 and 2004, the number of part-time nursing faculty increased by 35.8%. Since 2000, the number of part-time faculty has grown by 142%. In the past four years, the use of part-time faculty has grown by an alarming 78% (see Figure 1.5). Today, the number of part-time faculty out numbers full-time nursing faculty.

As DeYoung, Bliss, and Tracy (2002) note, "Over reliance on part-time faculty, however, is problematic. It not only causes the smaller core of full-time faculty to carry the burden of curricular and administrative duties, but it also means that there are not as many people available to carry out the mission of the university" (p. 315). Figure 1.5 clearly denotes an increasing trend in the use of part-time faculty, which is likely to continue as other contributing factors impact the ability to alleviate the nursing faculty shortage. Imminent retirements and an insufficient pool of doctorally prepared nurses to

take full-time positions will significantly hamper attempts to build an adequate nurse faculty workforce.

Figure 1.3

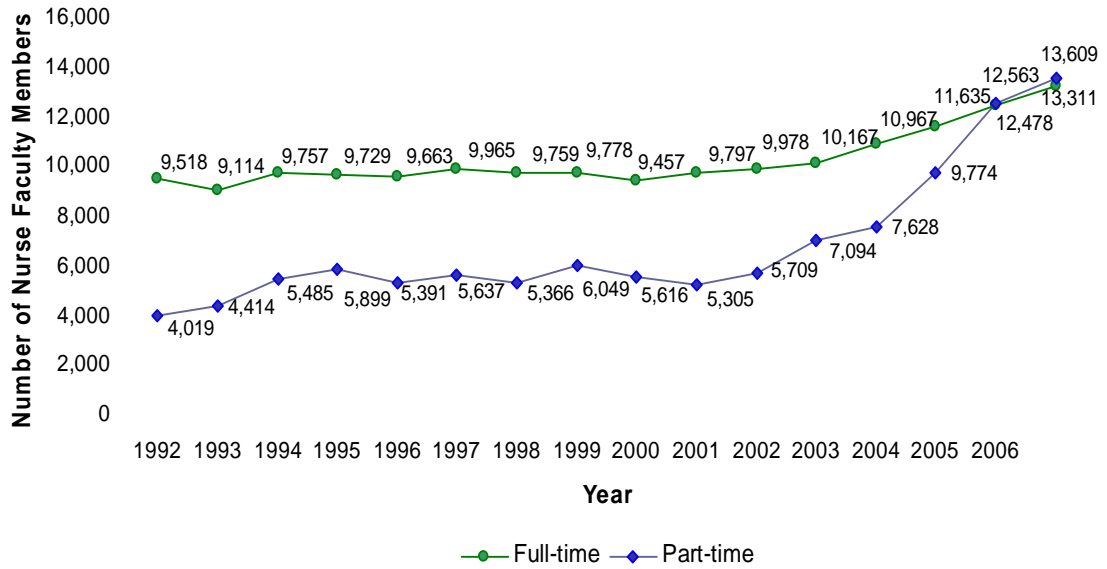
Percentage of Doctorally Prepared Faculty in Baccalaureate and Graduate Nursing Programs: 1979-2008



From: Fang, D., Tracy, A., Bednash, G.D. (2009). 2008-2009 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington, DC: American Association of Colleges of Nursing.

Figure 1.4

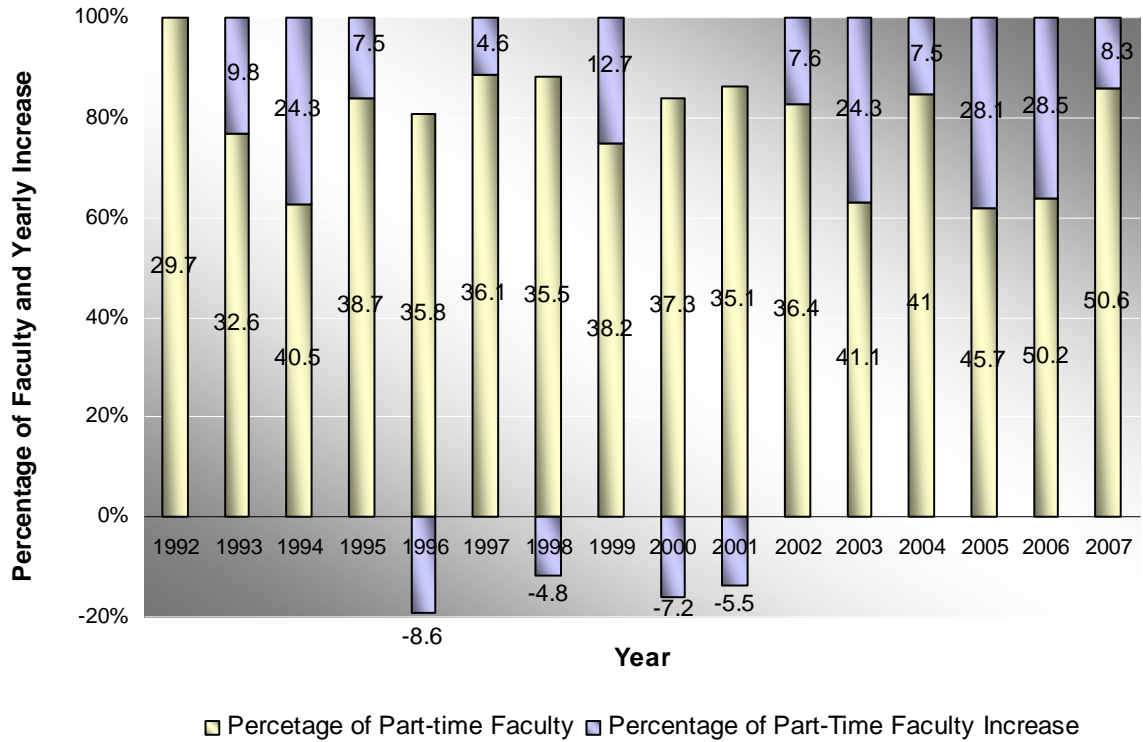
Number of Part-time Nursing Faculty vs. Full-time Nursing Faculty: 1992-2007



From: Salaries of Instructional and Administrative Nursing Faculty in Baccalaureate and Graduate Programs in Nursing. Years: 1993-2007. Washington, DC. American Association of Colleges of Nursing.

Figure 1.5

Percentage of Part-time Faculty and Yearly Trends: 1992-2007



From: Salaries of Instructional and Administrative Nursing Faculty in Baccalaureate and Graduate Programs in Nursing. Years: 1993-2007. Washington, DC. American Association of Colleges of Nursing.

An Aging Faculty

Current nursing faculty are quickly approaching retirement. In 2008, the average age of doctorally prepared faculty was 55.6 (Fang, Tracy, & Bednash, 2009b). More specifically, those doctorally prepared faculty holding the ranks of professor, associate professor, and assistant professor were 59.1, 56.1, and 51.7, respectively. Master's prepared faculty present a similar situation as the average age is 54.7 years (Average age by rank: professors 58.9; associate professors 55.2; and assistant professors 50.1) (Fang, Tracy, & Bednash). More troubling is that the proportion of older nurse faculty continues to climb. In 1993, the proportion of faculty over the age of 50 was 50.7%, which increased to 70.3% in 2001 (Berlin & Sechrist, 2002). An aging faculty is compounded by an insufficient number of younger faculty entering academia. The percentage of faculty under the age of 50 dropped from 49.3% in 1993 to 29.7% in 2001 (Berlin & Sechrist).

As the faculty ages, retirement become a chief concern. With the average age of retirement being 62.5 years and knowing faculty retire in this age bracket (less than 3% of nursing faculty over the age of 65 years), a wave of vacant positions will be available in the next 10 years (Berlin & Sechrist, 2002). As Berlin and Sechrist projected, from 2003 through 2012, between 200-300 doctorally-prepared faculty will be eligible for retirement each year. Between 2012 and 2018, the annual number of master's prepared faculty that will be eligible for retirement ranges from 220-280. The faculty shortage will reach its peak this year according to Berlin and Sechrist, with 2009 being the modal year reported for retirements. If this 2002 projection remains true, the implications on the nursing shortage are considerable. Additional vacant faculty positions will continue to

limit the number of nursing school enrollments, and the national nursing shortage will further jeopardize patient care.

Complicating the problem further is the age of students entering doctoral nursing programs. In 2002, the median age of nurses receiving their doctoral degree was 47.3 years (AACN, 2005). The majority of the graduates (50.8%) were between the ages of 45-55 years of age, and 12.8% were over the age of 55. Unfortunately, the average age of doctoral students and graduates has not decreased in recent years. According to AACN (2008d), in 2007, the median age of doctoral students was 47 and the mean was 46.08. Of those nurses that did graduate with their doctoral degree in 2006, the median age was 46.8 years (Robert Wood Johnson Foundation [RWJ], 2007). Unlike other disciplines, nursing traditionally has older doctoral students because of the belief within the profession that the student should have clinical practice before moving from a baccalaureate to graduate degree (DeYoung, Bliss, & Tracy, 2002).

While other disciplines enter the role of assistant professors in their third decade of life, nursing students typically enter in the fourth decade (Anderson, 1998a). In 2006, the national median age of research doctoral awardees in the social sciences was 33.1 years of age (RWJ, 2007). As mentioned, this compares to median age of 46.8 years for doctoral nursing graduates. Considering the average age of faculty retirement is 62.5, the length of an academic career for doctorally prepared nurses is shortened significantly compared to faculty in other disciplines (Anderson; Hinshaw & Ketefian, 1996). The average academic career of a doctorally-prepared nurse faculty member is 13.7 years shorter than those in other disciplines. The need to attract younger nurses into doctoral programs is a necessary strategy to alleviate the faculty shortage.

Time to Degree Completion

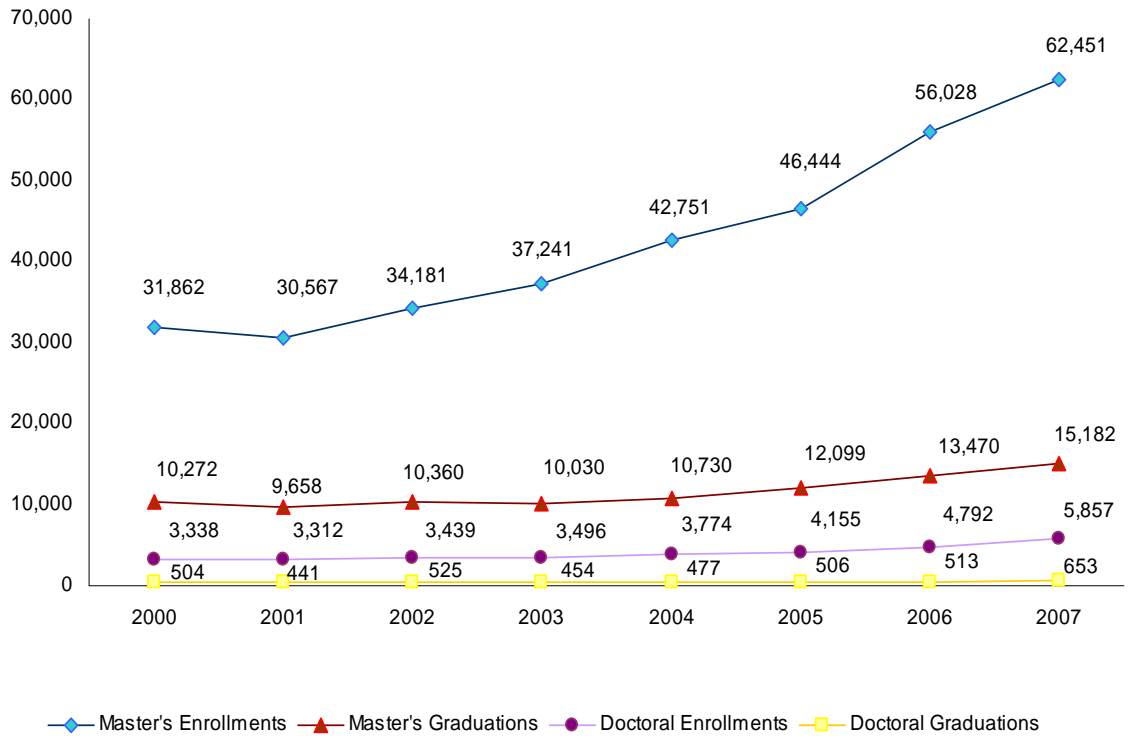
Age may also be a factor inhibiting nurses from completing their degree in a timely fashion. As established, the nursing population is still predominately female, which may contribute to a delayed entry into advanced education. Family obligations are one potential explanation for the decision to pursue a doctoral degree later in life. Given the high cost of doctoral education, financial constraints may also be a contributing factor. Additionally, the need for students to have a clinical background could lengthen the time before entering a doctoral program as well. These issues could also play a significant role in the increased length of time to degree completion. On average, nurses complete their doctoral degree in 8.8 years, 1.3 years longer than other research doctoral degrees (National Opinion Research Center, 2004). Nurses also wait 2.1 years longer than other professions before moving from master's to doctoral degree. Not only do nurses take longer to complete the terminal degree, few choose to do so.

Enrollments and Graduations from Advanced Nursing Degrees Programs

While enrollments in and graduations from master's programs have steadily increased, enrollments in and graduations from doctoral nursing programs have been slow to rise over the last eight years (see Figure 1.6). Given that the greatest demand is for doctorally prepared nurse educators, this stagnate trend further decreases the potential pool of faculty. More concerning is that graduations from doctoral programs have remained relatively flat since 2000. AACN reported that enrollments in research-focused doctoral nursing programs increased by only 0.1% between the 2006-2007 and 2007-2008 academic years (Fang, Tracy, & Bednash, 2009a).

Figure 1.6

**Enrollments and Graduations from Master's and Doctoral Nursing Programs:
2000-2007**



Note: Doctoral data includes both research focused and doctor of nursing practice students.
 From: Fang, D., Tracy, A., Bednash, G.D. (2009). 2008-2009 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing. Washington, DC: American Association of Colleges of Nursing.

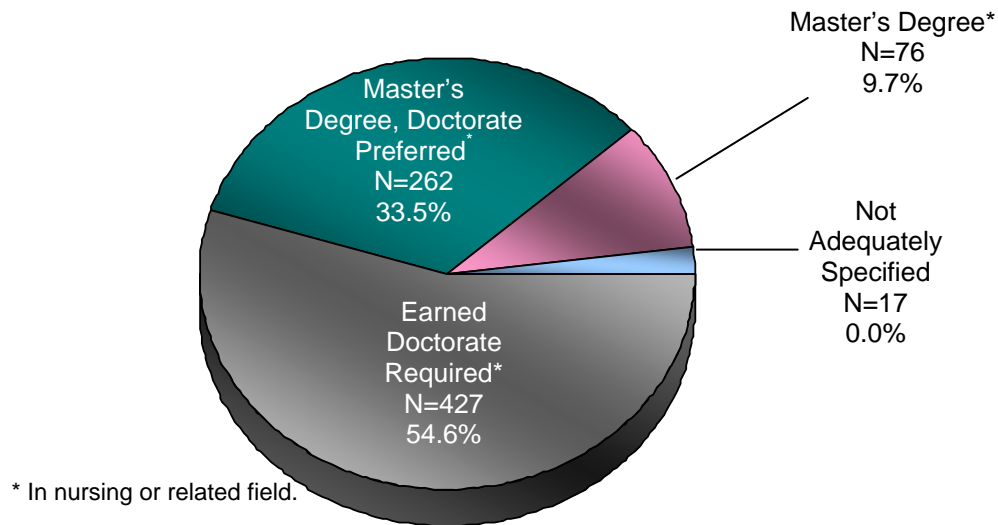
The enrollment and graduation trend is only part of the problem. According to AACN (2009) approximately half of the students (50.7%) who received their research focused doctorate plan to teach in a school of nursing upon graduation (Fang, Tracy, & Bednash, 2009a). This constitutes 281 new faculty members out of the potential 555 who received their research focused doctorate in 2008. For those nurses who received their Doctor of Nursing practice (DNP), the number pursuing an academic career is even less. Only 30.8% of these students plan to seek a faculty position after graduation (Fang, Tracy, & Bednash). Therefore, the harsh reality is only 42.7% of the nation's faculty vacancies (814) can be filled by last year's doctoral nursing graduates. Even more concerning is the fact that many of these doctoral graduates are already faculty members in schools of nursing which does not help to decrease the demand.

Considering the data more closely, 427 positions or 54.6% of all vacant faculty positions require a doctorally prepared nurse (AACN, 2008b) (see Figure 1.7). While other factors need to be explored, such as the vacancies in schools that did not respond to the AACN's 2008 survey and doctoral students who are already in faculty roles, this data suggests that approximately 25% of the vacant positions requiring a doctoral degree will remain unfilled. Each year the problem perpetuates as too few nurses graduate with a doctoral degree. As faculty retire, more positions will become available, but the graduating class is unlikely to address the need. The vacant faculty positions from the preceding year, retirements, and new appointments will inhibit the ability to truly address the shortage.

Figure 1.7

Selected Characteristics of Vacant Faculty Positions for Academic Years 2008-2009

Degree Requirements for vacant faculty positions (Valid N=764)



From: American Association of Colleges of Nursing (2008a, July). Member Survey on Vacant Faculty Positions for Academic Year 2008-2009. Washington, DC.

Decreased Interest in an Academic Career

With only half of new doctoral nursing graduates choosing a career in academia, the question becomes, “why is an academic career not appealing?” The current nursing shortage has offered nurses with graduate degrees multiple opportunities, which may be one reason for nurses not choosing a career in education (Berlin & Sechrist, 2002; Hinshaw, 2001). Yet, one of the more probable explanations is salary differentials (Berlin & Sechrist; Hinshaw; Jaklevic & Lover, 2000; Ryan & Irvine, 1994). Compensation in the clinical or administrative field is significantly more lucrative than a career in academia. The 2008 median salary for a Head of Nursing or Chief Nurse Officer is \$171,325 (Salary.com, 2008) (see Table 3). Comparatively, the 2008 median salary for a full professor who has a doctoral degree is \$109,367 (Fang, Tracy, & Bednash, 2009b).

For nursing faculty, this difference equates to 36.2% (\$61,958) less pay than nurses in clinical or administrative positions. As demonstrated in Table 1.3, all clinical/administrative positions have higher compensation than faculty positions.

Table 1.3

Comparison of Median and 75th Percentile Faculty Salaries to Clinical/Administrative Nursing Positions

School of Nursing Faculty Positions	Median		75th Percentile	
	Master's	Doctoral	Master's	Doctoral
Professor	\$82,133	\$109,367	\$97,795	\$128,128
Associate Professor	\$72,074	\$89,222	\$81,596	\$99,859
Assistant Professor	\$65,998	\$78,222	\$73,333	\$85,556
Instructor	\$62,333	\$73,333	\$69,667	\$79,444

Note: Based on calendar year not academic year.

From: American Association of Colleges of Nursing (2008). *2007-2008 Salaries of Instructional and Administrative Nursing Faculty in Baccalaureate and Graduate Programs in Nursing*. Washington, DC.

Clinical/Administrative Positions	Median	75th Percentile
Head of Nursing	\$171,325	\$199,986
Chief Nurse Anesthetist	\$165,256	\$177,297
Nurse Anesthetist	\$142,212	\$152,263
Nursing Director	\$105,503	\$121,420
Certified Nurse Midwife	\$87,020	\$93,733
Head Nurse	\$84,648	\$93,437
Nurse Practitioner (Specialty Care)	\$85,371	\$95,840
Nurse Practitioner	\$80,599	\$87,206
Clinical Nurse Specialist	\$78,916	\$85,936

From: Salary.com (2008). *HR Reported data as of August 2008*. Retrieved August 19, 2008.

When compensation is higher in the clinical setting, the incentive to choose a faculty position can be particularly difficult if graduate nursing students have high educational debt when they leave their master's or doctoral program (AACN, 2008c;

DeYoung, Bliss, & Tracy, 2002). According to an AACN (2009) survey on federal funding, nursing students (n=1,501) reported that educational loans for their combined baccalaureate and graduate debt was, on average, \$64,077. The average education debt of a master's degree was \$44,393 and that of baccalaureate degree was \$30,375 (AACN, 2009).

The strikingly high salary differential also may play a role in deterring nurses from obtaining a doctoral degree. As stated in AACN's 2005 white paper on the faculty shortage, "Potential students calculate whether it profits them to seek doctoral study and enter academia when they can earn better salaries in non-academic master's-level positions" (p. 8).

Higher Expectations for Nurse Faculty

Another factor that may deter a doctorally prepared nurse from choosing a career in academia is the high expectations that are associated with the collegiate title. The heavy workload of college professors offer their own set of responsibilities and stressors (Berberet & McMillion, 2002). As Hinshaw (2001) described, the "tri-partite" role of faculty includes teaching, research, and service. A professor must also serve as an advisor and mentor to students, spend time updating curricula, create new courses, and remain current in the discipline. These responsibilities can be overwhelming and intense. Berberet and McMillion found that "73% of faculty respondents expressed frustration at 'never having time to complete a piece of work'" (p.2). Unfortunately for nursing, dissatisfaction for the faculty role is higher among younger professors. As Berlin and Sechrist (2003) found, 54.7% of junior faculty (assistant professor, instructor, and

lecturer) were dissatisfied with their workload, nearly twice that of more senior faculty (29.5%).

One of the unique aspects of the faculty role is remaining current on the latest methodologies and technologies. For doctorally prepared nurse faculty, the tri-partite role limits the ability of nurses to expand their practice expertise (Hinshaw, 2001). With clinical faculty assuming the role of teaching students in the practice setting, doctoral faculty have limited access to the new advances developing in health care. Unless the faculty member's research is directly linked to clinical practice, the ability to remain current on new nursing skills is a challenge. An interesting trend within the new cadre of recent graduates from nursing doctoral programs is the desire to focus on their research rather than teaching (Anderson, 1998b; Brendtro & Hegge, 2000; DeYoung, Bliss, & Young, 2002). "Some nursing faculty members have taught undergraduates before obtaining their PhDs and associate that level of teaching with the absence of the PhD" (Anderson, p. 53). Should this trend continue, the ability to educate the next generation of nurses will suffer. If doctorally prepared faculty focus more on research and graduate education, the reliance on master's prepared, part-time faculty will persist, and the faculty shortage will never truly be resolved.

Solving the Nurse Faculty Shortage

For the past decade numerous long and short term solutions have been offered. As established above, many nursing programs turned to the hiring of part-time faculty to fill the void. Yet, as demonstrated in the 1980s and 1990s, this was not an effective solution and actually caused additional strain on the nursing education system in future years. The most direct and needed solution is focusing on retention of both junior and senior faculty.

Junior faculty must be provided with the appropriate mentoring, institutional encouragement, and professional development to retain their commitment to the faculty role (AACN, 2005). Much like junior faculty, senior nurse educators should be offered additional resources and attention (Hinshaw, 2001). Moreover, senior faculty who have reached the age of retirement may be interested in a part-time appointment if this option were available to them (AACN).

To recruit nurses into a career in academia, time and effort must also be invested in current baccalaureate and graduate nursing students. As indicated above, nursing students choose to pursue higher education much later in life. To combat this trend, nursing students must be recruited earlier in their career (Hinshaw, 2001). Currently, 63 schools of nursing across the country offer a “fast-track” baccalaureate-to-doctoral nursing program (Fang, Tracy, & Bednash, 2009a). By moving nursing students quickly through these programs, the opportunity for a longer academic career is possible.

Additionally, current graduate students need to be “sold” on the faculty role. According to AACN, 14.6% of research-focused doctoral students and 31.9% of DNP students do not know what type of position they would like to take after graduation (Fang, Tracy, & Bednash, 2009a). More attention must be given to mentoring potential faculty candidates during their doctoral education.

Ultimately, much like the clinical nurse shortage, the nurse faculty shortage cannot be solved without a long-term investment in the education of the new workforce. A lack of financial support for nursing education programs, their students, and faculty is at the crux of the current nursing crisis. Substantial increases in federal funding are arguably the most viable solution to both the nursing and nurse faculty shortage. The

Nursing Workforce Development Programs authorized under Title VIII of the Public Health Service Act (P.L. 107-205) have long supported nursing education, but as will be described, the lack of funding for these programs inhibits the profession from making positive strides to meet the demands for new RNs and nurse faculty and in turn negatively impacts quality patient care.

CHAPTER TWO

Review of Relevant Literature

Nursing Workforce Development Programs (Title VIII of the Public Health Service Act)

Setting the Stage for Federal Nursing Education Funding

The Public Health Service

As Kalisch and Kalisch (1982) noted, “One can trace the roots of the federal focus on nursing education as far back as the establishment of the Public Health Service (PHS) in 1798” (p.167). It was during the administration of President John Adams, who signed legislation that would pave the way for the U.S. Public Health Service and eventually the Division of Nursing. While it would not be until 1902 that the name formally became the U.S. Public Health Service, the use of healthcare professionals to provide public services spans the centuries (Kalisch & Kalisch).

Nurses played a limited role in the U.S. Public Health Service during the first 120 years. However, when the United States became involved in World War I, nurses were deployed by the Public Health Service to military camps, and tasked with the duty of ensuring the health conditions in surrounding civilian populations (Kalisch & Kalisch, 1982). Nurses were responsible for investigating communicable diseases, teaching communities proper sanitation, and inspecting the health of children. When World War I ended, public demand for the services U.S. Public Health Service nurses provided was great.

“In general, the public health expenditures of the 1920s proved that public health nursing could be a purchasable commodity: the public health nursing programs, which had grown up in the first quarter of the 20th century, had helped to lower the mortality rate, to increase life expectancy and reduce significantly the morbidity rate from tuberculosis, typhoid fever, smallpox, malaria, and most infant diseases” (Kalisch & Kalisch, p. 170).

During the Great Depression; however, federal funding for public health service projects was cut drastically due to the depleted national economy. It was not until the New Deal in 1933 that the U.S. reinvested in social welfare and in turn nursing. Congress enacted the Federal Emergency Relief Administration and funding was allocated for the use of nursing services. Additionally, the Civil Works Administration hired over 10,000 nurses to assist with public health campaigns (Kalisch & Kalisch, 1982). At this time, federal involvement in nursing education was associated with providing support for postgraduate training for public health nurses. While nursing funding remained relatively small, the nursing shortage during World War II increased the federal government’s investment (Kalisch & Kalisch).

U.S. Cadet Nurse Corps

The 1940s marked a historical turning point for federal nursing education policy. Nursing leaders, understanding World War II would create a demand for RNs, formed the Nursing Council for National Defense to ensure a nursing workforce that could assist America during the war (Kalisch & Kalisch, 1982). The PHS provided the council funding to conduct a national nursing survey and prepare nursing education facilities for the immediate influx of students. Congress responded by appropriating funds to provide basic nursing education and postgraduate or refresher courses in nursing. This program was administered through the Public Health Nursing section of the Division of States

Relations of the PHS and was the first time the federal government authorized funds (\$1.2 million) for basic nursing education (Kalisch & Kalisch). This funding covered tuition, subsidies, and some support for advanced programs, but no new nursing education programs could be created (Kalisch & Kalisch).

More comprehensive funding for nursing education came with the establishment of the U.S. Cadet Nurse Corps in 1943. Nurses, mainly from the hospital settings, were being drafted into the military. The conscription of nurses into the military placed a significant strain on civilian hospitals, marking the first American nursing shortage. Proposals to shorten nursing education and move individuals through programs faster to meet the demand were strongly opposed by nursing leaders who feared a “massive collapse of the already meager educational standards” (Kalisch & Kalisch, 1982, p. 173). However, the nursing workforce demands of the war grew too great and nursing leaders accepted the need to create an accelerated nursing education program. The proposed U.S. Cadet Nurse Program, offered individuals the opportunity to enroll in either a 24 or 30-month nursing program. The students would receive free tuition, a monthly stipend, and uniforms, all supplied by the federal government, which would cost \$60-70 million per year for 65,000 nurses (Kalisch & Kalisch).

Congresswoman Frances Payne Bolton (R-OH) introduced the U.S. Nurse Cadet Program in 1943 and President Roosevelt signed it into law on June 15, 1943. This investment by the federal government marked the “largest experiment in federally subsidized education in the history of the United States up to that time” (Kalisch & Kalisch, 1982, p. 174). The program was under the authority of the PHS Surgeon General who created a Division of Nursing Education (DNE) to administer the U.S. Cadet Nurse

Corps. A powerful media campaign in the form of newspapers and radio ads, posters, billboards, movies, and even celebrity events made the Cadet program a success.

Unfortunately, federal support for nursing education was seen as a war effort. Congress phased out the U.S. Cadet Nurse Corps and the DNE. As a result, a drastic decrease was seen in the number of nursing school enrollments and hospitals faced severe nurse shortages (Kalisch & Kalisch, 1982). The war's end and less support from the federal government caused nursing leaders to examine the status of nursing education. The profession struggled with faculty shortages and grew increasingly concerned that nursing's academic standards had been diminished under the U.S. Cadet Nurse Corps. At this time, 97% of nursing programs were hospital based diploma programs, which had a stronger focus on service to the hospital than to the standards of nursing education (Kalisch & Kalisch). Studies were developed to determine current state of nursing education. One particular study released in 1948 was sponsored by the Carnegie Corporation and the Russell Sage Foundation and titled *Nursing for the Future* (Kalisch & Kalisch). Among the recommendations was the importance of closing sub-par nursing programs and opening them within colleges and universities. The need to have a highly educated nursing workforce was validated by the American Medical Association's (AMA) concern over the quality of nursing care. In 1948, the AMA created the *Committee on Nursing Problems* and developed a report that stressed the increased emphasis on nursing education at the baccalaureate level (Kalisch & Kalisch).

Despite these reports, no major federal support was given to legislation that focused on strengthening the quality of nursing education. The Emergency Health Professions Training Act of 1949 that would have support nursing scholarships failed to

move forward in Congress. While it passed in the Senate, the National Organization of Hospital Schools of Nursing (NOHSN) swayed House of Representative members not to vote in favor of the bill. NOHSN claimed it would allow the Surgeon General to control hospital based nursing programs (Kalisch & Kalisch, 1982).

However, according to Kalisch and Kalisch (1982), support for nursing education was seen in numerous post-war efforts on Capitol Hill. In many forms, federal aid for nursing education came with larger healthcare reform packages. Some legislation was rejected by conservative Congresses, but "...their recurring appearance before each session of Congress indicated that they had acquired a permanent base of support" (Kalisch & Kalisch, p. 180).

Federal Nursing Activity in the 1950s

The end of World War II, the U.S. Cadet Nurse Corps, and the DNE in the 1940s, marked a shift in the way nursing was viewed at the federal level. Significant progress in the field of nursing was seen in efforts to promote nursing at the Public Health Service. In 1946, the Division of Nursing was created within the Office of the Surgeon General to oversee nursing activities within the PHS. The division had no federal administrative authority and no viable budget so it was quickly phased out of the Surgeon General's office. It was not until 1949 that the concept behind the Division of Nursing was resurrected when the PHS was reorganized. Along with dentistry and sanitary engineering, a nursing division was created within the Bureau of State Services. Pearl McIver was promoted from Chief Nurse Officer of the PHS to the Director, given the title of Assistant Surgeon General, and served as an Associate Bureau Chief. Yet this division did not last at the Office of the Surgeon General and its functions were taken over by the

Division of Nursing Resources (DNR) at the Bureau of Medical Services. Throughout the early 1950s, the DNR was able to maintain its services on a meager budget (\$90,000) by focusing on research and publications that surveyed the quality and quantity of the nursing workforce (Kalisch & Kalisch).

In the early 1950s there was general consensus that the need for nurses had grown; however, there was not agreement on the level of education nurses needed to practice. The disagreement centered on the need to simply produce more nurses or nurses with more advanced training. The nursing community saw both as equally important. The push for nursing programs to be housed in collegiate universities was a difficult. Few existed and without external support at the federal level, the ability to create a movement toward baccalaureate education would be difficult (Kalisch & Kalisch, 1982). Attempts to secure federal funding for nursing education was met with strong resistance from hospital based programs and the three different legislative proposals offered, one sponsored by Representative Francis Payne Bolton, in 1951 failed. In 1953 nursing champion Representative Bolton tried again to pass legislation that would support nursing schools, but this bill also failed to move forward in Congress. The only federal support for nursing from 1948 to 1956 was through the National Mental Health Act of 1946 that provided funding for psychiatric nursing education (Kalisch & Kalisch).

Federal funding for nursing education (beyond the mental health program) came under the Health Amendments Act of 1956, which authorized traineeships for nurses pursuing a career in education or administration. The traineeships received \$2 million in its first year and supported the higher education of 3,800 nurses (Kalisch & Kalisch, 1982). Nursing education would require significantly more than \$2 million if the

profession would be able to meet the growing demand for RNs. In the late 1950s and early 1960s, nursing leaders, understanding the emerging need for nurses in the healthcare system, worked to develop a strategy that would eventually secure consistent federal funding for nursing education over the next five decades.

The Creation of Modern Day Nursing Education Funding: The Nurse Training Act (NTA) of 1964

During the late 1950s and early 1960s the U.S. faced the second significant nursing shortage as US hospitals reported exceedingly high RN vacancy rates (Buerhaus, Staiger, Auerbach, 2009). Comparatively, measurements of RN FTE (full-time equivalent) vacancy rates in the early 1960s far surpassed the current vacancy rate (8.1%) by nearly 15%. In 1961, the reported vacancy rate soared to 23.2% (Yett, 1975). The shortage was driven by expanding positions for nurses in the hospital setting. As Kalisch and Kalisch (1982) noted:

“In the 1940s, hospitals had about one professional nurse for every fifteen beds and one practical nurse, or other auxiliary, for every ten beds. By the 1960s, one professional nurse was required for every five beds and one auxiliary for every three beds. Health care was given to a greater variety of people, and the primary focus of care had shifted from the home to the institution” (p. 186).

Much like today, the devastating shortage of the 1960s impacted hospitals' ability to provide high quality nursing care. Non-professional personnel engaged in direct patient care without proper supervision by licensed RNs leading to harmful errors. Negligence further irritated the problem (Yett, 1966). Considerable attention was paid to the impact of the nursing shortage on patient care. Historical accounts note that in addition to hospital, medical, nursing, and public health journals documenting the problem, mass circulation in public media (eg. magazines and Sunday newspapers) all reported the frightening conditions (Yett). The nursing shortage was on the national agenda. As cited

by Yett, “Gradually, and inevitably, an awareness of this situation has become a part of what John Kenneth Galbraith so aptly has described as our ‘conventional wisdom’” (p. 190).

In an attempt to reverse the negative trend, hospitals lobbied Congress to enact legislation that would subsidize nursing education and ultimately address the long-run demand for nurses (Buerhaus et al., 2009). While such programs as the Cadet Nurse Corps and the Nurse Traineeship program had existed to support the expansion of the workforce, there was a new demand (Yett, 1966). The nurse vacancy rate surged each decade starting with 5% in the 1940s to 10-15% in the 1950s and eventually 20% in the early 1960s. Congress needed to act before the shortage could increase and continue to compromise patient care.

The impetus for overarching and comprehensive legislation to address the nursing workforce shortage came in 1963 after the release of the Surgeon General’s report “*Toward Quality in Nursing, Needs and Goals*” (Congressional Research Service [CRS], 2005). This report validated the need for additional nurses and recommended that the supply be increased to 850,000 practicing RNs by the year 1970 (CRS). This constituted an additional 300,000 nurses, or an increase of 55%, compared to the number of practicing RNs at the time of the report. Additional recommendations included increasing the number of nursing school graduates by 75% to meet the goal for nurses by 1970, increasing the number nurses with graduate degrees by 194%, increasing the number of baccalaureates by 100%, and increasing the number of licensed practical nurses by 50% (Kalisch & Kalisch, 1982).

The resulting legislation was the Nurse Training Act (NTA) of 1964 (P.L. 88-581), which established Title VIII of the Public Health Service Act (PHSA). When the legislation was approved it authorized a maximum of \$238 million for five programs over five years with an additional \$4.6 million for the administration of the programs (Kalisch & Kalisch, 1982) (see Table 2.1). President Johnson signed the programs into law on September 4, 1964 and \$9.92 million was provided in its first year (Division of Nursing, 2008b). “On signing the act, President Johnson observed that the Nurse Training Act of 1964 was the most significant nursing legislation in the history of the country” (Kalisch & Kalisch, p. 188). Further, “...he believed that it would enable the nation to attract more qualified young people to this ‘great and noble calling’” (Kalisch & Kalisch, 1977, p. 855).

Table 2.1

Title VIII Programs and Authorization Levels

Programs	Authorization	Purpose
Nursing Student Loans	\$85 million	Those who received the awards agreed to work five years after graduation and would be forgiven half of their loan.
Professional Nurse Traineeship	\$50 million	Continuation of existing professional nurse traineeship programs.
Construction Grants	\$90 million	Construction and improvement of nursing facilities. \$55 million for diploma and associate degree programs. \$35 million for baccalaureate programs.
Project Grants	\$17 million	Improvements to teaching methodologies and other special projects.
Formula Grants to Diploma Schools	\$41 million	Improvements to hospital based nursing programs such as the quality of instruction.

From: Kalisch, B.K, & Kalisch, P.A. (1982). Politics of Nursing. J.B. Lippincott Company: Philadelphia. Scott, J.M. (1967). Three years with the Nurse Training Act. The American Journal of Nursing, 67(10), 2107-2109.

The Division of Nursing was tasked with the administration of the programs and created the Nursing Education and Training Branch within the division to implement the new authorities (Kalisch & Kalisch, 1982). The law was comprised of five basic programs: 1) student loans, 2) professional nurse traineeship, 3) construction grants, 4) project grants, and 5) formula grants to diploma schools (Scott, 1967) (see Table 2.1). The student loan program offered long-term low-interest loans to nursing students who agreed to work as a professional nurse after graduation for five years. If the nurse worked in a healthcare setting, one half of the loans would be cancelled at a rate of 10% each year. The ultimate goal of the program was to increase the number of nurses practicing by helping to finance their education (Scott). Within the second year of authorization, applications for the student loans tripled surging from 3,645 in 1965 to 17,218 in 1967 (Kalisch & Kalisch). Between the years of 1964 and 1967, the program had provided aid to over 32,000 nursing students (Scott).

The Professional Nurse Traineeship program, which began in 1954, was expanded to include long-term and short-term traineeships for graduate nurses who were pursuing their education in a clinical specialty track (Scott, 1967). Prior to the NTA, the traineeship program was dedicated solely to nurses whose career path led to a faculty or administrative position. Over a three-year period, the program supported 17,000 RNs.

To meet the goal of increasing graduations by 75% in six years, Congress understood that nursing school capacity would also need to be increased. This meant expanding and renovating the actual nursing school facilities as well as building new programs. Scott (1967) reported that nursing schools in the 1960s were overcrowded and the buildings were obsolete, inhibiting the adoption of new teaching methods and

curriculum. The construction grants authorized under the NTA between 1964-1967 awarded 62 schools funding for expansion and renovation, which resulted in the ability to enroll 2,600 nursing students (Scott). Additionally, nine grants for the development of new nursing schools were awarded between the same time period (Scott). All of the schools supported by the construction grants needed to be accredited by the National League for Nursing, which at the time, precluded diploma programs from receiving funding (Kalisch & Kalisch, 1982).

Project grants awarded under the passage of the NTA allowed for innovation in nursing curricula. Scott (1967) reported that between 1964 and 1967, a total of 116 project grants were awarded and benefited 33,000 students. The ability to educate nurses “outside of the box” provided the opportunity for clinical courses to be taken out of traditional hospital setting and moved into the community. Students studying maternal and child health for example had the chance to learn nursing care in the family’s home enhancing their understanding of various social and economic circumstances. The grant money also facilitated the use of multimedia technology to create instructional videos for nursing students.

Finally, the formula grants to diploma schools were created under the NTA to support the high cost hospitals incurred running diploma programs (Scott, 1967). The funds provided partial reimbursement for the cost associated with educating nurses. While the guidelines were flexible and the diploma schools were not required to report how the funding was used, Scott’s work found that the money went towards expanding libraries and purchasing teaching materials. During the first three years of the NTA, 414 diploma programs were supported (Scott). At the time, many diploma programs felt the

NTA focused too heavily on support for collegiate nursing education. Since diploma programs were not accredited by a national accrediting body (the National League for Nursing), they were not eligible for construction grants. An amendment was proposed to the NTA that would allow grants to be awarded to regional or state accrediting bodies. The amendment failed to move forward with great opposition from the American Nurses Association and the National League for Nursing (Kalisch & Kalisch, 1982).

While nursing experts of the 1960s affirmed that the NTA would significantly help alleviate the nursing shortage, some analysts suggested that the funding and programs could not meet the goals set by the Surgeon General's report. Yett's (1966) analysis of the NTA revealed that the Surgeon General's Consultant Group on Nursing, who wrote the 1963 report, did not accurately predict that the nursing educational system could increase the nursing population to 850,000. According to the report

“...a feasible goal for 1970 is to increase the supply of professional nurses in practice to about 680,000” and that to meet this goal schools of nursing must produce 53,000 graduates a year by 1969 (including 13,000 baccalaureate, and an additional 3,000 at the master's level) (US Public Health Service, 1963 as cited in Yett, 1966).

Clearly, this prediction contradicted the proposed increase of 850,000 RNs by 1970, leaving a shortage of approximately 170,000 nurses or a 20% deficit in the nursing workforce (Yett). Moreover, the ability to fully reverse the nursing shortage and prepare enough nurses to meet the government's projection was further complicated by inadequate classroom space. As Kalisch and Kalisch described in their 1977 unpublished study for the Division of Nursing, “It soon became obvious that unless the shortage of classroom and other training space in hospital schools of nursing and junior college

nursing programs was corrected, it would stand in the way of the nation's goal of having 680,000 nurses in active practice by 1970 (p. 834).”

Despite this projection, the nursing shortage of the 1960s slowly dwindled as it remained on the legislative agenda. When the original NTA authorization was set to expire in 1969, a program review committee was established to evaluate the five authorities. The committee found significant strides made in the program's ability to reverse the national nursing shortage through the substantial improvements in nursing education. However, the committee did find that additional areas outside of nursing needed support and recommended that the NTA be expanded to include funding for planning, recruitment, and research (Kalisch & Kalisch, 1982).

Based on the committee's recommendation and the need to consider other health education programs, congressional hearings were held on the NTA and legislation for other health professionals. An omnibus bill, the Health Manpower Act of 1968, was drafted and reauthorized many health profession education programs including NTA. Unfortunately, the bill weakened the accreditation standards of the programs, which was due in part to the large role associate degree programs played in nursing education. However, the scholarship provisions under the NTA were strengthened and more grants were authorized (Kalisch & Kalisch, 1982).

Amendments to Title VIII in the 1970s and 1980s

In the 1970s and 1980s, the Title VIII programs saw a number of amendments and reauthorizations. Of notable interest was the Nurse Training Act of 1971 (P.L. 92-158) and 1975 (P.L. 94-63). This legislation proposed the largest expenditure for nursing education in the nation's history, authorizing \$855 million for three FYs (Kalisch &

Kalisch, 1982). For the first time, basic support grants for all types of nursing education programs were authorized through the NTA of 1971 (Kalisch & Kalisch, 1977). These support grants, otherwise known as capitation grants, were the major component of the NTA of 1971. They were "... based on the well established need to maintain the quality of education in schools of nursing by establishing a firm core of financial support" (Kalisch & Kalisch, 1977, p. 1135). Capitation grants provided formula grants based on enrollment rates in schools of nursing (AACN, 2008e). The grants were awarded to schools that could demonstrate increased enrollments over the previous year. Schools could in turn use the funding to hire faculty, recruit students, enhance clinical laboratories, expand school of nursing buildings, or for other learning equipment (AACN). For collegiate schools of nursing, Congress provided "...\$400 for each full-time baccalaureate student enrolled in the last two years of a nursing program, and approximately \$275 for each student enrolled in an associate degree or diploma program" (AACN, ¶ 3). Capitation grants received significant funding support from Congress and in FY 1977 and FY 1978 the program was appropriated \$55 million (AACN).

The capitation grant program, while endorsed by the liberal Congress, was not supported by the conservative Nixon administration. Reluctantly, President Nixon signed the Nursing Training Act into law in 1971 (Kalisch & Kalisch, 1982). Yet, continual debates between the Administration and Congress over the appropriate funding levels for nursing education lead President Nixon to veto a number of bills that would have created higher levels of funding. Congress was able to pass a continual resolution in 1972 and 1973, but President Nixon impounded \$73 million nursing appropriations that were later recovered through a federal court case (Kalisch & Kalisch). By 1974, the Nixon

administration wanted to drastically cut funding for federal nursing education. The \$160 million appropriated to Title VIII in 1973 was cut in the President's Budget request to \$49 million (Kalisch & Kalisch, 1982). However, Congress was able to secure funding for Title VIII above the President's request and \$139 million was finally appropriated for the NTA programs in FY 1974 (Division of Nursing, 2008a).

During the early 1970s, conflicting views on the level of funding for nursing education was not the only problem for the profession as the restructuring of the Public Health Service decreased the authority of nursing within the federal government. The Nixon administration moved the Bureau of Health Manpower Education, which housed the Division of Nursing from the Office of the Surgeon General to the Office of the Assistant Secretary for Health (Kalisch and Kalisch, 1982). Once belonging to the prestigious National Institutes of Health (NIH), the bureau along with the Division of Nursing was transferred to the newly created Health Resources Administration. The Title VIII programs were decentralized and the Division of Nursing staff was cut from 155 in 1972 to 55 in 1975 (Kalisch & Kalisch).

As Kalisch and Kalisch (1982) reported, "On January 4, 1975, these developments reached their logical climax when President Gerald Ford vetoed the Nurse Training Act of 1974, which had made few changes in the 1971 act; he claimed it was too expensive" (p. 195). As would prove to be the case in future years, Congress continued to appropriate funding for Title VIII despite the authorities expiration date. The Ford Administration sought to phase out the nurse scholarship and loan programs claiming that nursing students were eligible for other federal loans (Kalisch & Kalisch). In an attempt to negotiate with the Administration, Congress drafted the Nurse Training Act of 1975.

The bill reduced funding for the Title VIII programs and extended them for the fiscal years of 1976, 1977, and 1978. The most notable difference in the NTA of 1975 was the creation of the Advanced Nurse Training Program that would provide funding for the expansion of master's and doctoral nursing education. President Ford vetoed the bill, but Congress was able to override his veto.

While the passage and veto override of the 1975 NTA was a great success for nursing, the late 1970s and early 1980s would prove to be a tremulous time for nursing to secure appropriate funding levels. In 1978, debates continued to rage between the Administration and Congress regarding support for nursing education. President Carter held a similar view to Presidents Nixon and Ford that; 1) nursing students could be supported through other federal programs, 2) the NTA had helped reverse the nursing shortage, and 3) the spending levels were excessive; therefore, continuing to fund the programs under NTA was not necessary (Kalisch & Kalisch, 1982). In President Ford's FY 1978 budget, he provided no funding for nurse training "...and foreboded the probable end of the Division of Nursing had his administration continued" (Kalisch & Kalisch, 1977, p. 1225).

In 1978, Congress passed an extension to the NTA that would continue funding for an additional two years. However, when the bill reached President Carter's desk for approval, it was pocket-vetoed on November 11, 1978 (Kalisch & Kalisch, 1982). This tactic angered the nursing community. In 1979, Congress was able to fund the Title VIII programs for one additional year and called for national studies to determine if the federal government should continue to provide institutional support, if there was an actual nursing shortage, if the government should subsidize all of a nursing student's loan, and

how should Congress address the unequal distribution of nurses and the increase in nursing specialization (CRS, 2005). Another bill, the Nurse Training Act of 1979, was developed and passed by Congress with the provision that these questions would be answered in a study by the IOM. A preliminary report to Congress and the Department of Health and Human Services was to be presented in 1980 with the full report released in 1981. Given the provision of a study, the Carter administration signed the NTA of 1979 into law on September 29, 1979 (Kalisch & Kalisch, 1979).

The IOM report, *Nursing and Nursing Education: Policies and Private Actions*, found that federal support for the “overall supply of nurses was not needed, but that generalist education programs should continue to help sustain the nursing supply” (CRS, 2005, p. CRS-2). The report recommended that alleviating the nursing shortage in certain geographic areas should be done by federal, state, and private contributions (CRS). Given the results of this report, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), made significant changes to the Title VIII programs by authorizing and extending some programs until 1984, but repealing others. The Nurse Education Amendments of 1985 (P.L. 99-92) further cut the Title VIII authorities. Construction grants, capitation grants, financial distress grants (to prevent nursing school closures), and scholarships at schools of nursing were all eliminated. The laws passed in 1981 and 1982 repealed most of the programs that were established in the 1960s and 1970s (CRS).

The Health Omnibus Program Extension of 1988 (P.L. 100-607) was the last reauthorization of the Title VIII programs in the 1980s. Through the bill Congress redirected the funding emphasis from capitation and construction grants to traineeships for advanced practice nursing education, long-term care nursing demonstration projects,

and home health care as well as nursing homes (CRS, 2005). The 1988 reauthorization also created the National Advisory Council on Nursing Education (NACNE), which was charged with evaluating the effectiveness of the Title VIII programs.

Amendments to Title VIII: 1990 to Today

Between 1990 and today, only three major legislative efforts have been made to reauthorize the Title VIII programs, despite the decade long national nursing shortage. As can be seen in Table 2.2, continual and consistent amendments or reauthorizations to Title VIII helped to address the nursing workforce needs from 1964 to 1988. In the early 1990s however, Congress' diligence to addressing the various nursing shortages through Title VIII adjustments became less of a priority.

The first law to reauthorize Title VIII in the 1990s was the Nurse Education and Practice Improvement Amendments (P.L. 102-408) in 1992. This law established career ladder programs to assist nursing assistants and licensed practical nurses to advance their nursing education. The program would be formally titled the Nurse Education, Practice, and Retention Grants in 1998 (CRS, 2005). The Health Professions Education Partnership Act of 1998 (P.L. 105-392) supported scholarship and grant programs for advanced and basic nursing education. The law also created a provision where preferences would be given to institutions that helped meet the "nursing needs to medically underserved populations" (CRS, p. CRS-3). Additionally, NACNE was officially changed to the National Advisory Council on Nursing Education and Practice (NACNEP) extending their function to include policy advice and recommendations to Congress and the Secretary of Health and Human Services regarding nursing education, practice, and the workforce (CRS).

Seven years ago, the national nursing shortage reached a public media peak. The Johnson and Johnson Company began their *Discover Nursing* campaign that was widely viewed through television commercials, Internet campaigns, as well as other media venues. The focus was to encourage individuals to choose a nursing career. Paired with local and national reports of widespread nursing shortages as well as the 2001 IOM report *Crossing the Quality Chasm: A New Health System for the 21st Century*, there was no question that the nursing shortage needed significant attention from the federal government. National nursing organizations clamored for action from Congress to react. After two long years of heated debate regarding what should be included in the amendments to the Title VIII programs, nursing organizations were able to come to an agreement on their priorities.

Table 2.2

Reauthorization and Amendments to Title VIII

Public Law	Amendment or Reauthorization Date	Number of Years between Amendment or Reauthorization
P.L. 88-581	1964	-
P.L. 89-290	1965	1
P.L. 89-751	1966	1
P.L. 90-490	1968	2
P.L. 92-52	1970	2
P.L. 92-158	1971	1
P.L. 94-63	1975	4
P.L. 94-484	1976	1
P.L. 96-76	1979	3
P.L. 97-35	1981	2
P.L. 99-92	1985	4
P.L. 100-607	1988	3
P.L. 102-408	1992	4
P.L. 105-392	1998	6
P.L. 107-205	2002	4

Congressional Research Service. (2005). Nursing Workforce Programs in Title VIII of the Public Health Service Act. (Order Code RL32805). Washington, DC: The Library of Congress.

Headed by such Congressional nursing champions as Senators Barbara Mikulski (D-MD), John Kerry (D-MA), and Edward Kennedy (D-MA), as well as Representatives Lois Capps, RN (D-CA), Carolyn McCarthy, Licensed Vocational Nurse (D-NY) and Michael Bilirakis (R-FL) the Nurse Reinvestment Act of 2002 (P.L. 107-205) was passed by Congress and signed into law by President George W. Bush. The law created three new authorities under Title VIII, the Nurse Faculty Loan Program, Comprehensive Geriatric Education, and Public Service Announcements. Additionally, the law extended and revised the Basic Nurse Education and Practice Grants, the Loan Repayment Program, and the Nurse Education, Practice and Retention grants (CRS, 2005). The Public Service Announcements, created under this reauthorization, have yet to be funded.

An Overview of the Current Title VIII Programs

Today, the Title VIII Nursing Workforce Development programs represent the largest source of federal funding for nursing education. Since inception in 1964, the programs have supported the supply and distribution of nurses to meet the nation's healthcare needs. These programs have been successful in addressing the education, practice, retention, and recruitment problems that have spurred national nursing shortages. Below is an overview of each currently funded Title VIII authority.

Advanced Education Nursing Grants

The Advanced Education Nursing (AEN) grants (Sec. 811) are rooted and modeled after the early traineeship programs of the 1960s and 1970s. Created for nurses pursuing advanced clinical and administrative graduate nursing degrees as well as the development and enhancement of graduate nursing programs, the AEN grants offer three distinct funding opportunities. First, the AEN grants specifically, provide schools of

nursing, academic health centers, and other nonprofit entities funding to improve the education and practice of nurse practitioners, nurse-midwives, nurse anesthetists, nurse educators, nurse administrators, public health nurses, and clinical nurse specialists (P.L. 107-205). In FY 2008, the AEN grants supported the graduate education of 4,470 nurses (Division of Nursing, 2008c). Second, the AEN traineeships offer full or partial support for graduate nursing students for such expenses as tuition, books, program fees, and reasonable living expenses (P.L. 107-205). In FY 2008, the traineeships supported 7,941 nursing students (Division of Nursing, 2008c). Finally, the Nurse Anesthetist Traineeships (NAT) provides assistance to students in nurse anesthetist programs. Similar to the AEN traineeships, the NAT offers full or partial support for the educational expenses related to the student's program (ex. tuition, books, program fees). One hundred percent of the applications received for FY 2008 were approved and funded, which supported 1,243 students (Division of Nursing, 2008b).

Workforce Diversity Grants

Workforce Diversity Grants (Sec. 821) provide educational assistance for individuals from disadvantaged backgrounds, including racial and ethnic minorities under-represented among RNs, to become nurses. This program awards grants to schools of nursing, nurse-managed health centers, academic health centers, state or local governments, and nonprofit entities that provide programs which support efforts to increase diversity within nursing education (P.L. 107-205). In FY 2008, 19,362 nursing students were supported through this program (Division of Nursing, 2008c).

Nurse Education, Practice, and Retention Grants

Nurse Education, Practice, and Retention Grants (Sec. 831) offer assistance to schools of nursing, academic health centers, nurse-managed health centers, state and local governments, and health care facilities to strengthen programs that provide nursing education, practice, and workforce retention programs (P.L. 107-205). Specifically, the education grants are offered to entities that "...expand enrollments in baccalaureate nursing programs; develop internship and residency programs to enhance mentoring and specialty training; and provide for new technology in education, including distance learning" (AACN, 2008f, p.3). Practice Grants expand practice arrangements in non-institutional settings to improve primary health care in medically underserved communities; provide care for underserved populations such as the elderly, provide skills to practice in existing and emerging health systems; and develop cultural competencies (P.L. 107-205). Retention Grants offer two distinct components: a career ladder program and a patient care delivery program. The Career Ladder program supports educational efforts that allow individuals the opportunity to enter the nursing profession or advance within it. The Patient Care Delivery Systems component offers funding to programs that enhance the incorporation of best nursing practices. This may include efforts to increase collaboration and improve communication among nurses and other health care professionals, increase nurse involvement in the organizational and clinical decision-making processes of a healthcare facility. In FY 2008, this program supported over 7,700 nurses and nursing students (Division of Nursing 2008c).

The Nursing Student Loan Program

The Nursing Student Loan (NSL) Program (Sec. 835) is one of the original Title VIII programs from the 1960s. As a part of the 1964 Nurse Training Act, the program was established to address workforce shortages. Today, the program is a revolving fund and has not been allocated additional appropriations since 1983. The nursing student must be accepted or enrolled in a nursing program (at any degree level) and pursuing coursework either full or part-time. The loans provide a maximum of \$13,000 at a 5% interest rate and preference is given to those with financial need. For the first two years of schooling, the student may be eligible for \$2,500 non-taxable loans and \$4,000 during his or her last two years of education (P.L. 107-205). The student has a total of ten years to repay the loans.

Nurse Loan Repayment and Scholarship Programs

Nurse Loan Repayment and Scholarship Programs (Sec. 846) assist nurses and nursing students (at any degree level) with the cost of their educational debt, if they agree to work for at least two years in a healthcare facility that has a critical shortage of nurses. The Loan Repayment portion of the program repays up to 85% of nursing student loans. The nurse must have obtained a diploma, associate, baccalaureate, or graduate degree in nursing to be eligible for the loan repayment. In FY 2008, a total of 5,875 applications were reviewed; however, only 7.4% were funded providing support to 435 students (Division of Nursing, 2008c).

The Scholarship component offers individuals who are enrolled or accepted for enrollment as full or part-time nursing students the opportunity to apply for scholarship funds. In FY 2008, only 169 students (Division of Nursing, 2008c).

The Nurse Faculty Loan Program

In response to the severe nurse faculty shortage, the Nurse Faculty Loan Program (NFLP) (Sec.846A) was established through the 2002 Title VIII reauthorization. Through the program, schools of nursing can apply for a student loan fund. To be eligible, the student must be enrolled in a graduate nursing degree program on a full-time basis. This decision was made to facilitate the entry of nurse faculty into the pipeline faster. However, it is the discretion of the Secretary to allow part-time students to receive funding under this program. Due to the overwhelming number of part-time students, for the first time since its establishment, the Secretary will allow part-time graduate students to receive funding in FY 2009. If a student is a NFLP recipient, he or she must agree to teach at a school of nursing in exchange for cancellation of up to 85% of their educational loans, plus interest, over a four-year period at a rate of 20% per year for three years and 25% in the final year (P.L. 107-205). In FY 2008, the program supported the education of 729 future faculty members and graduated 401 nurse faculty members (Division of Nursing, 2008c).

Comprehensive Geriatric Education Grants

Comprehensive Geriatric Education Grants (Sec. 855) are awarded to an eligible entity such as a school of nursing or health care facility. Recipients of the grants help educate nursing staff to provide better health care services for the elderly. These grants may be used to train RNs who will provide direct care to older Americans, develop and disseminate geriatric curriculum, train faculty members, and provide continuing education (P.L. 107-205).

Status of a Title VIII Reauthorization

It has been six years since Congress has amended the Title VIII programs through a reauthorization. At the onset of the second session in the 110th Congress, reports from the Senate Health, Education, Labor, and Pensions (HELP) Committee suggested that a Title VIII reauthorization was a priority for the Committee (AACN, 2008f). On January 24, 2008, Senator Mikulski, who helped spear head the Title VIII reauthorization in 2002, contacted nursing community leaders and requested a single document be drafted that detailed priorities for a Title VIII reauthorization bill. Headed by the American Association of Colleges of Nursing, a Title VIII Reauthorization task force was created to develop the consensus document requested by Senator Mikulski's office. Under a tight deadline of three weeks, the nursing community worked to create properties that could be agreed upon by all organizations.

During the first week, AACN requested that each nursing organization provide a list of priorities to be voted upon by the task force. These priorities and supporting rationale were categorized and presented to the task force for review. In the second week, the task force decided which recommendations were acceptable for a Title VIII reauthorization. It was agreed upon by the community that the current Title VIII programs meet the needs of the nursing workforce, but they are sorely under funded. Most importantly, the group agreed that no specific nursing groups (ex. pediatric nurse practitioners or school nurses) should receive a funding "carve out" in a Title VIII reauthorization, which was the root of the contentious disagreements between the community during the 1998 and 2002 reauthorization. In the final week, AACN

developed the consensus document that provided an overview of the need for a reauthorization and offered rationale for each guiding principle.

The document included five principles:

1. Overarching Principle: Increase Funding for Title VIII- all other principles were contingent upon increased funding levels.
2. Guiding Principle: Increase Support for Nurse Faculty Education
3. Guiding Principle: Strengthen Specific Resources for the Education of Advanced Practice Nurses and Advanced Education Nursing
4. Guiding Principle: Increase Efforts to Develop and Retain a Diverse and Professional Nursing Workforce for the Transforming Health Care Delivery System
5. Guiding Principle: Increase Efforts of HRSA and the Division of Nursing to Release Timely and More Comprehensive Data on the Nursing Workforce (see Appendix A)

“When Senator Edward Kennedy (D-MA), Chairman of the HELP Committee, became ill, the ability to advance legislation slowed, and the 110th Congress ended with out a Title VIII reauthorization” (AACN, 2008f, p. 8). Should Congress consider a Title VIII reauthorization in the 111th Congress, the Conesus Document developed was agreed upon and signed by 37 national nursing and health care associations (see Appendix A).

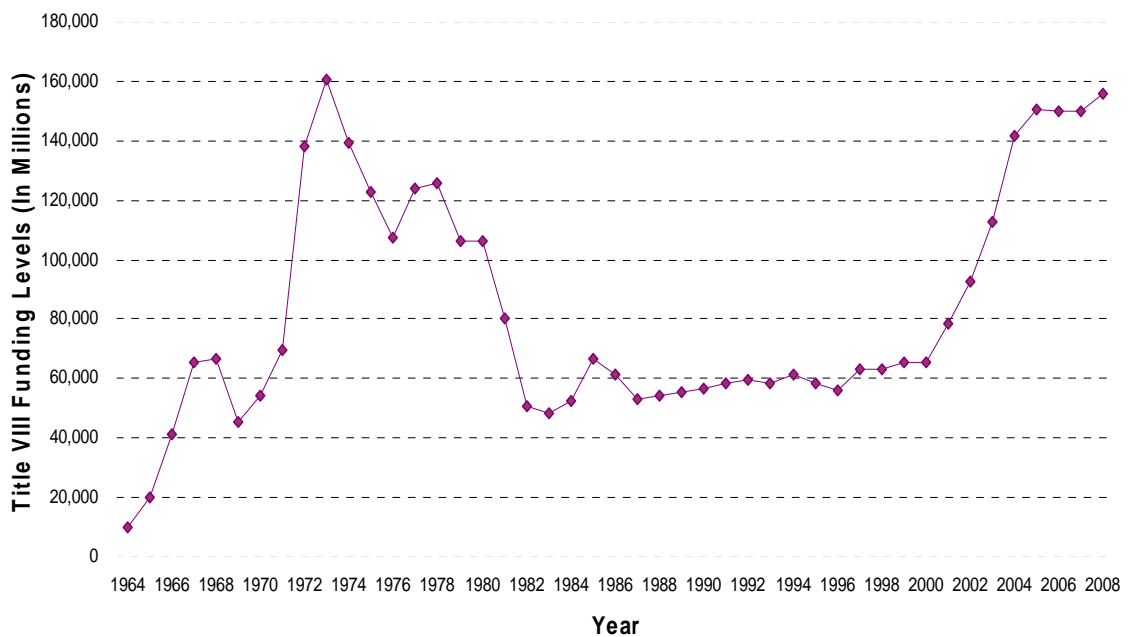
Legislative Standstill: Title VIII Funding.

The reauthorization of Title VIII in 2002 marked a significant reverse in the stagnant funding for nursing education during the last two decades. Between FY 1982 and 2000, Title VIII did not received significant funding increases as the range of

appropriations stayed within \$48 and \$65 million with the average funding level being \$58 million (see Figure 2.1 and Table 2.3). As a result of the Nurse Reinvestment Act being signed into law, funding increased from \$78.74 million to \$92.74 million between FY 2001 and 2002, nearly an 18% increase (see Table 2.1). Given the publicity surrounding the national nursing and nurse faculty shortages, considerable increases to Title VIII funding were seen in FY 2003 and 2004 with a \$20 million increase in 2003 and a \$29 million increase in 2004 (see Figure 2.1 and Table 2.3).

Figure 2.1

Title VIII Funding: FY 1964-2008



From: Health Resources and Services Administration (HRSA), Division of Nursing, 2008.

Table 2.3 Title VIII Funding FY 1964-2008

FY Year	Funding Level
1964	\$9,921,000.00
1965	\$19,779,000.00
1966	\$41,462,000.00
1967	\$65,672,000.00
1968	\$66,755,000.00
1969	\$45,523,000.00
1970	\$54,383,000.00
1971	\$69,385,000.00
1972	\$137,975,000.00
1973	\$160,605,000.00
1974	\$139,457,000.00
1975	\$122,709,000.00
1976	\$107,500,000.00
1977	\$124,000,000.00
1978	\$125,500,000.00
1979	\$106,250,000.00
1980	\$106,250,000.00
1981	\$80,113,000.00
1982	\$50,835,000.00
1983	\$48,523,000.00
1984	\$52,466,000.00
1985	\$66,700,000.00
1986	\$61,152,000.00
1987	\$53,300,000.00
1988	\$54,046,000.00
1989	\$55,547,000.00
1990	\$56,636,000.00
1991	\$58,524,000.00
1992	\$59,572,000.00
1993	\$58,487,000.00
1994	\$61,487,000.00
1995	\$58,640,000.00
1996	\$56,187,000.00
1997	\$63,188,000.00
1998	\$63,102,000.00
1999	\$65,555,000.00
2000	\$65,562,000.00
2001	\$78,740,000.00
2002	\$92,740,000.00
2003	\$112,760,000.00
2004	\$141,920,000.00
2005	\$150,670,000.00
2006	\$149,680,000.00
2007	\$149,680,000.00
2008	\$156,050,000.00

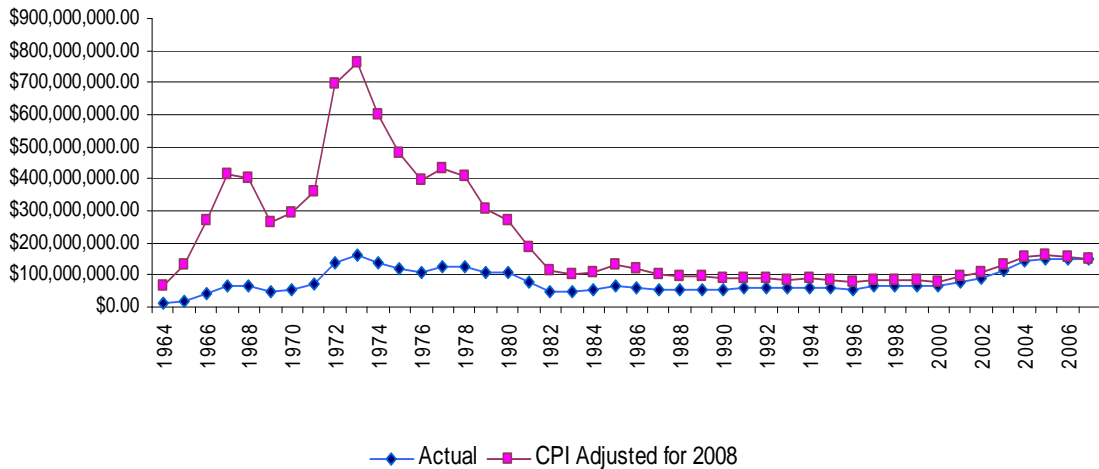
From: Health Resources and Services Administration (HRSA), Division of Nursing, 2008.

However, in recent years, funding for Title VIII has been dormant. From FY 2005-2008, the funding level remained close to \$150 million (see Table 2.3). Increased funding for nursing education does not appear to be on the legislative agenda as it did in the 1970s during a similar, critical nursing shortage. As can be seen in table 2.3, Congress provided \$160.61 million to Title VIII; the largest appropriation of funds Title VIII has ever received. Adjusting for inflation, this amount would be a commitment of over \$763 million today. In FY 2008, Title VIII received \$156.05 million (see Figure 2.2).

“Compounding the impact of this low appropriation level is the stagnant nature of Title VIII funding in the face of escalating education costs. In FY 2006 and 2007, \$149.68 million was appropriated to Title VIII. This allocation supported 91,189 nursing students and nurses in 2006 while only 71,729 in 2007, due in part to increased tuition costs and inflation” (see Table 2.4) (AACN, 2008g).

Figure 2.2

Historical Funding for Title VIII: Consumer Price Index Inflation



From American Association of Colleges of Nursing. (2008f). Support Increased Funding for Title VIII Nursing Workforce Development Programs. Washington, DC.

Table 2.4

Nurses and Nursing Students Supported by Title VIII FY 2006-2008

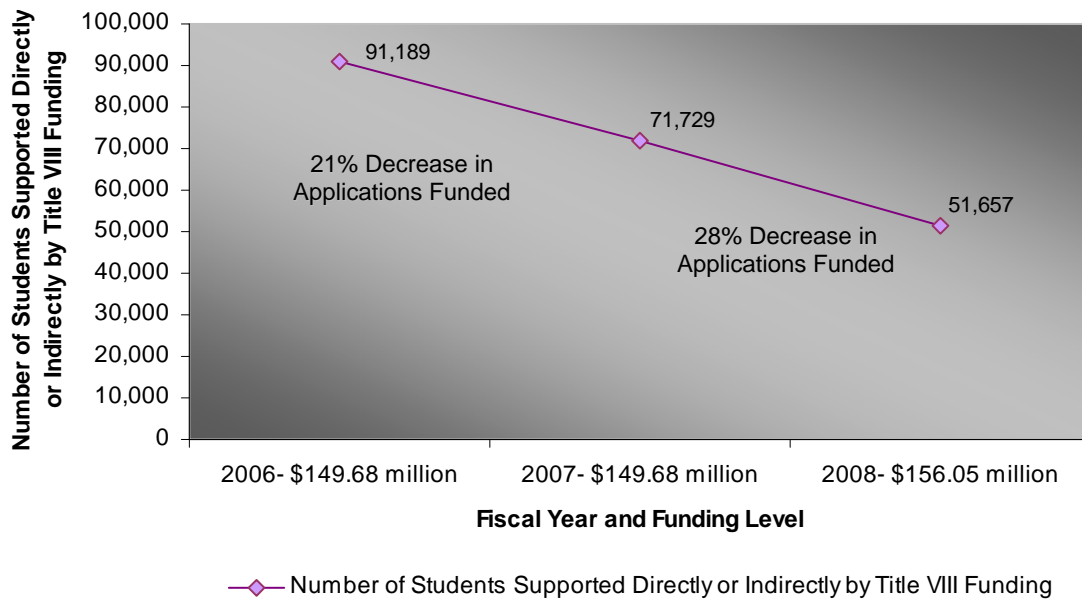
Fiscal Year	Appropriations (millions)	Students or Nurses Supported
2006	\$149.68	91,189°
2007	\$149.68	71,729°
2008	\$156.05	51,657

Division of Nursing. (2008a). FY 2008 grants. Provided via electronic mail. December 09, 2008.

The same scenario was seen between FYs 2007 and 2008. Despite a \$6.37 million increase in funding for Title VIII, the economic purchasing power drastically decreased the number of students who were supported by Title VIII funding (See Figure 2.3).

Figure 2.3

The Effects of Level Funding on the Number of Students Supported by Title VIII



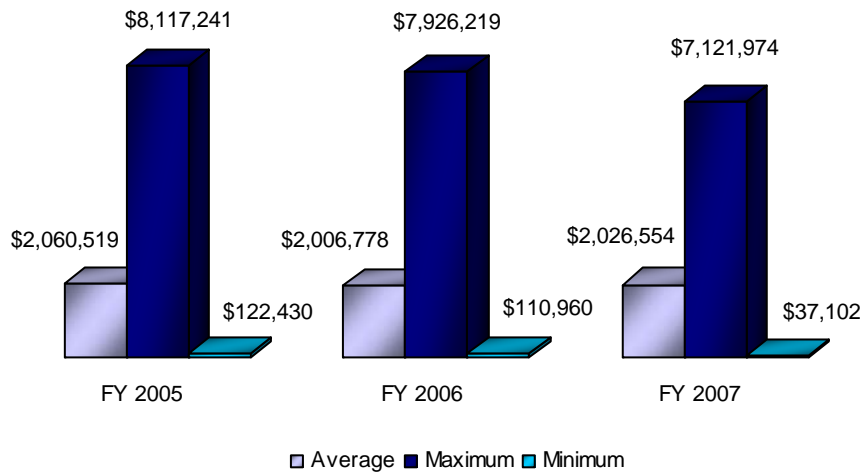
AACN. (2009). Title VIII Nursing Workforce Development Programs: Supporting the Next Generation of Nurses and Nurse Faculty. Presentation to the nursing community. (January 28, 2009).

Level Title VIII funding also caused states to see a decrease in their purchasing power. “Between FY 2005-FY2006, 54% of the states experienced a decrease in Title VIII funding and 46% saw a decline in funding between FY 2006-2007. During FY 2006, states lost on average \$537,282 and \$425,591 in FY 2007” (AACN, 2008h) (see Figure 2.4 and Appendix B).

Between the years FY 2005 and 2006, Title VIII funding decreased by nearly one million dollars. This dip in funding was due to a 1.0% cut in discretionary spending for programs authorized under the FY 2006 LHHS appropriations bill (AACN, 2008i). Pressures to finish a spending bill during an election year, lead Congress to pass a Continuing Resolution (CR) in FY 2007, which provided Title VIII funding with that same allocation as FY 2006.

Figure 2.4

Title VIII Data by State



From American Association of Colleges of Nursing (2008f). Nursing Workforce Development Programs: Supporting the next generation of nurses and the faculty who educate them. Washington, DC.

When the Democratic Party took control of both the House of Representatives and Senate after the 2006 election, partisan politics inhibited further action on providing

funding increases for Title VIII. For the first time since his presidency began, President George W. Bush called for significant cuts to Title VIII funding. The President's FY 2008 Budget Request called for a 30% reduction in funding for the Nursing Workforce Development Programs. Specifically, the Administration called for the complete elimination of the Advanced Education Nursing Grants citing that they did not meet their prescribed mission (AACN, 2007). If Congress had accepted his proposal, funding for Title VIII programs would have decreased from \$149.68 million to \$104.78 million in FY 2008.

However, the now Democratic Congress considered the President's FY 2008 budget request "dead in the water" when it reached the Capitol (AACN, 2007). Chairman of the House Appropriations Committee and LHHS Appropriations Subcommittee David Obey (D-WI) was committed to increasing funding for all LHHS programs. Both the House and the Senate LHHS Appropriations bills included significant increases for Title VIII. The House provided \$165.62 million and the Senate provided \$169.68 million. During House and Senate negotiations for FY 2008, Title VIII funding would have received \$167.65 million in the final conference agreement. However, the partisan battle between Congress and the Administration halted further progress on the bill. When Congress passed the FY 2008 LHHS Appropriations bill, President Bush vetoed it with the rationale that he would not sign any appropriations bill over his FY 2008 budget request (AACN, 2008j). Congress attempted to override the Presidential veto, but was short two votes (AACN). After the failed override attempt, Congress adjusted the funding levels by an across the board recession of 1.747%, which then provided Title VIII with \$156.05 million.

FY 2009 marked the second year in a row that the President's budget proposal requested a 30% reduction in funding for Title VIII. Of greatest concern was the complete elimination of funding for the AEN grant programs. Again, the President cited that the AEN program proved to be ineffective when reviewed the PART or Program Assessment Rating Tool. His justification noted that "...less than 10 percent of students enrolled end up practicing in underserved areas and the number of minorities is less than 5 percent" (Department of Health and Human Services, n.d., p. 100). Therefore, since the AEN grants "...demonstrated no substantial impact of health professionals in underserved areas and [in response, the FY 2009 budget], direct resources to nursing programs that will provide direct patient care in areas where nurses are critically needed through scholarship and loan repayment programs" (Department of Health and Human Services, n.d., p. 100). As the President's justification noted, much of the funding that was pulled from the AEN program was redistributed to the Nurse Loan Repayment and Scholarship Program and the Nurse Faculty Loan Program (see Table 2.5). The Loan Repayment and Scholarship program received \$43.74 million, \$13.23 million over the FY 2008 level. The NFLP received \$9.32, an 18.6% increase over FY 2008. While increases were seen in some Title VIII programs under the President's FY 2009 Budget Request, overall funding would have decreased significantly from \$156.05 million in FY 2008 to \$109.85 million in FY 2009.

When the House and Senate deliberated the FY 2009 appropriations level for Title VIII, both chambers increased funding for the programs. The House LHHS Appropriations Subcommittee offered \$174.41 million, the highest level of funding Title VIII would have ever received, an 11.6% increase over FY 2008. Of particular interest to

the shortage of nurse faculty, the subcommittee provided \$12 million to the NFLP (see Table 2.5).

“Unfortunately, when the LHHS appropriations bill was taken up in the full committee on June 26, 2008, Representative David Obey... halted the appropriations process when Committee Republicans attempted to include provisions to expand offshore drilling in the Interior Appropriations bill. Chairman Obey did not reschedule the full committee hearing for FY 2009 and decided instead to work on a Continuing Resolution” (AACN, 2008f, p. 4).

The Senate was able to complete their FY 2009 LHHS Appropriations bill and provided \$167.65 million for Title VIII programs (see Table 2.5). Yet, the political climate between the Republican Administration and the Democratic Congress lead to a “legislative gridlock” and Title VIII received level funding for FY 2009 when the President signed the *Consolidated Security, Disaster Assistance and Continuing Appropriations Act of 2009* (H.R. 2638) on September 30, 2008. However, this bill was passed to fund the government until the end of the fiscal year. When the final FY 2009 LHHS appropriations bill passed \$171.03 million was provided to Title VIII (see Table 2.5).

Table 2.5

Title VIII Funding: FY 2008-2009

PROGRAM	Final FY 2008 (12/26/07)	President's FY 2009 Budget * (2/4/08)	FY 2009 House Subcommittee Mark Up (6/19/08)	% Change (vs. FY 2008)	FY 2009 Senate Full Committee Mark Up (6/26/08)	% Change (vs. FY 2008)	FY 2009
Nursing Workforce Development (Title VIII)	\$156.05 mil	\$109.85 mil	\$174.41 mil	11.8%	\$167.65 mil	7.4%	\$171.03 mil
-Advanced Education Nursing	\$61.88 mil	\$0 mil	\$61.88 mil	0%	\$62.98 mil	1.8%	\$64.44 mil
-Nursing Workforce Diversity	\$15.83 mil	\$16.11 mil	\$16.11 mil	1.8%	\$16.11 mil	1.8%	\$16.11 mil
-Nurse Education, Practice, and Retention	\$36.64 mil	\$37.29 mil	\$37.29 mil	1.8%	\$37.29 mil	1.8%	\$37.29 mil
-Loan Repayment and Scholarship Programs	\$30.51 mil	\$43.74 mil	\$43.74 mil	43.4%	\$40.00 mil	31.1%	\$37.13 mil
-Nurse Faculty Loan Program	\$7.86 mil	\$9.32 mil	\$12.00 mil	52.7%	\$7.89 mil	0.3%	\$11.50 mil
-Comprehensive Geriatric Education	\$3.33 mil	\$3.39 mil	\$3.39 mil	1.8%	\$3.39 mil	1.8%	\$4.57 mil

From American Association of Colleges of Nursing (2008f, October). Government Affairs Report: October 2008. Report presented at the meeting of the American Association of Colleges of Nursing, Washington, DC.

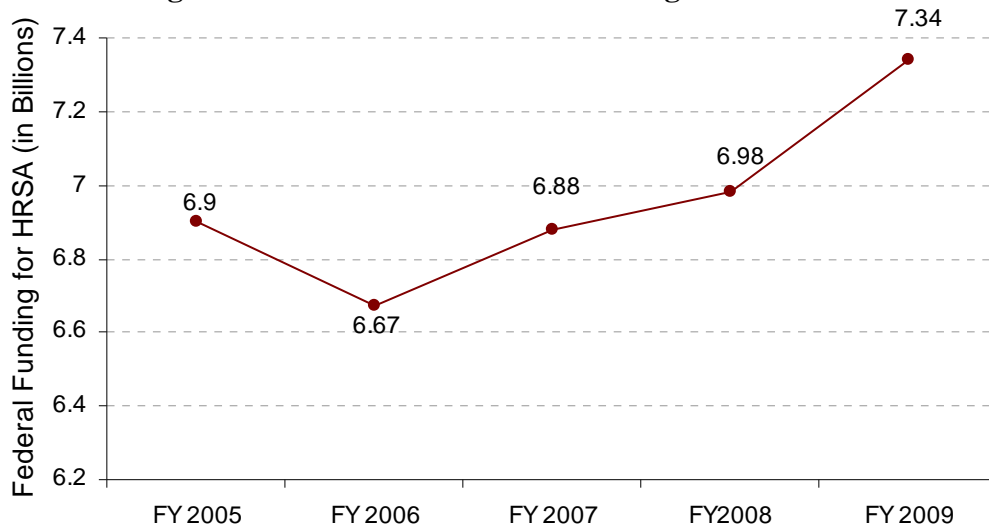
Understanding Stagnant Funding for Title VIII

Overall Funding for the Health Resources and Services Administration

Much like nursing education, the programs providing financial support to healthcare and health professionals (supported under the PHSA and administered by HRSA), have remained level over the last five FYs (see Figure 2.5). Under President Bush's administration many programs received drastic cuts, leaving Congress with the task of restoring funding. For example in FY 2006, funding for the Health Professions Education Programs (Title VII, PHSA) was cut from \$299.57 million to \$10 million in the President's budget. Congress then restored the funding to approximately half of the FY 2005 funding level, \$145.20 million (AACN, 2008i). Level funding for all programs under HRSA has made it difficult for the Title VIII Nursing Workforce Development Programs to receive a substantial increase, despite the documented need. A number of political barriers account for the stagnant funding.

Figure 2.5

Federal Funding for HRSA Administration and Programs: FY 2005-2009



From American Association of Colleges of Nursing (2008i). *Historic HRSA Funding: Fiscal Years (FY) 2005-2009*.

Understanding the Political Barriers Leading to Stagnant Funding

Divided Government and Legislative Gridlock

Various rationale help to support, but not fully explain, the reasons why the programs funded under HRSA have remained limited over the last five years. Political scholars have studied the dynamics of a divided government for decades. A divided government is one in which the Administration and Congress belong to different political parties (Mayhew, 1991). Ripley (1983) reported that a divided government slows legislation on domestic matters in particular. If domestic legislation (issues such as education and health) is passed, it is often inconsequential. Fiscal decisions also slow in a divided government (Mayhew).

When the Administration and Congress are controlled by varying parties, lawmaking is often expected to decline or remain stagnant (Mayhew, 1991). “Deadlock,” “stalemate,” or “gridlock” are only some of the terms used to describe this political state. Gridlock is defined as “the absence of policy change in equilibrium in spite of the existence of a legislative majority that favors change” (Krehbiel, 1998, p. 26). As mentioned above, the term gridlock is often associated with a divided government (Binder, 1999; Clinton & Lipinski, 2006; Coleman, 1999; Mayhew, 1991). While the circumstance of a divided government and legislative gridlock certainly provide an explanation for why Title VIII has remained level funded over the last two fiscal years, (in which a Democratic majority controlled the Congress and the Administration was Republican) it does not explain the three previous fiscal years. Moreover, gridlock can occur in both partisan and bipartisan political climates. As Krehbiel described “gridlock

is common but not constant” (p.5) and would argue that large bipartisan coalitions in Congress play a role in legislative gridlock.

Funding Competition

Demand and competition for federal funding also plays a significant role in supporting domestic programs, such as Title VIII and other HRSA programs, which receive discretionary spending. The Wars in Iraq and Afghanistan has required an overwhelming amount of financial support from the Federal government over the last five fiscal years and will continue to do so in the future. Additionally, the national deficit creates a political climate where the task of allocating appropriations is difficult for Congressional Appropriators, particularly when Congress enforces the PAY-GO rule, or pay-as-you-go. In this climate, funding must not increase the federal deficit and must be offset by savings from other programs (Office of Management and Budget, 2008). Moreover, the sheer number of federal programs that require discretionary spending is enormous. There are 12 appropriations bill that support 15 executive cabinet departments and a countless number of discretionary spending programs. The Health and Human Services department has 17 discretionary program lines that fund nearly 200 programs (Department of Health and Human Services [DHHS], 2007). HRSA funds 27 of them. As a result, the Nursing Workforce Development programs compete for funding with numerous other domestic programs. Therefore, the advocacy that takes place to secure increased funding for nursing must compete with all national interest groups seeking discretionary spending—over 800 in health and education alone (M. Mabee, email communication, November 20, 2008). Existing theories, described below, suggest that certain effective lobbying strategies help to overcome barriers to stagnant funding.

Overcoming Barriers to Stagnant Funding: Understanding Effective Lobbying Strategies

Inside and Outside Strategies

Inside and outside strategies are considered effective lobbying strategies when implemented correctly. Inside strategies “involve quietly persuading a member of Congress in a meeting with interest group lobbyists, to act in a particular way” (Wilcox & Kim, 2005, p. 130). They are considered superior in relation to efficient information processing and rely on the reputation of the lobbyist (Beyers, 2004). While varying opinions exist on whether inside strategies are effective, mainly because of the difficulty to truly measure them accurately, Wilcox and Kim note that they are most successful when they are not noticed. Examples of insider strategies include, providing contributions to political campaigns, offering electoral support, hiring professional lobbyists with access to key legislators, or offering important data or technical assistance on legislation (Wilcox & Kim).

As Wilcox and Kim (2005) note, outside strategies “involve contact between a group’s members and the offices of legislators” (p. 137). The most widely noted form of outside strategies is grassroots lobbying. Grassroots can include a coordinated call or email campaign, participating in a lobby day, or protests (Kollman, 1998; Wilcox & Kim). One of the most effective forms of grassroots lobbying are lobby days (Wilcox & Kim). Lobby days occur when professional associations fly their members to Washington, DC to meet with a member of Congress or their staff to advocate on behalf a particular issue. Other outside strategies include generating a media campaign for a particular issue to place pressure on legislators (Schlozman & Tierney, 1986; Walker, 1983). The effectiveness of outside strategies are often measured by the quality and

quantity of output by the constituents (Kollman, 1998; Thrall, 2006; Wilcox & Kim, 2005).

Exchange Theory

Exchange theories suggest that lobbyists and legislators engage in unspoken agreements or a trade (Austen Smith, 1996; Morton & Cameron, 1992). As the theory suggests, the trade between a member of Congress and a lobbyist is an implicit trade that mutually benefits both parties. This type of trade is typically identified as political campaign contributions to a member of Congress for their vote on a particular issue or a contribution to a Political Action Committee (PAC) in exchange for a vote. The exchange is established and maintained when long-term investments by interests group are made in members of Congress and are repeated (Snyder, 1992).

Exchange theories have been mostly describes as “votebuying.” Extensive research had been completed on the influence of PAC contributions and roll-call votes. (Warwo, 2001; Wright, 1996). However, as Hall and Deardoff (2006) explain, exchange theories may not necessarily describe effective lobbying strategies because interest groups tend to provide PAC contributions to members of Congress who already agree with their issue.

Others have viewed exchange theories as “buying” a member of Congress’ time (Stratmann, 1998). This suggests that PAC contributions are made to a particular member of Congress so lobbyists can discuss a specific issue with the hope of gaining their “vote.” Yet as Hall and Deardoff (2006) note, members of Congress receive PAC contributions from multiple interests groups and their “discretionary time is frustratingly scarce” (p. 71).

Persuasion Models

As Hansen (1991) describes persuasion models, interest groups have access to information about their constituent views which can persuade legislators. Persuasion models also suggest that the relevance of the message is critical in the attempt to persuade a member of Congress (McGuire, 1989; Perloff, 2003). McGuire's model of persuasion suggests that persuasion is only effective if the individual comprehends the message. When competing with multiple messages, Congressional staff must decide which message to pay attention to.

Legislative Subsidy Theory

According to Hall and Deardoff (2006), legislative subsidy suggests that "legislators are interested in issues on which they wish to make 'progress'" (p. 73). Legislative subsidy is a "...matching grant of costly policy information, political intelligence, and labor to the enterprises of strategically selected legislators" (Hall and Deardorff, p. 69). Progress on an issue could be associated with a legislator moving closer to a preferred policy, a legislator increasing the probability of change, or a legislator delaying the enactment of a bad policy.

Viewing lobbying as a subsidy, Hall and Deardoff (2006) suggest that participation or "effort" of a member of Congress will increase when lobbying efforts increase. The goal of this strategy is for lobbyists to assist their allies in Congress to achieve common objectives rather than attempting to change the minds of legislators who are not like-minded. Hall and Deardorff's model also suggests that in addition to lobbying their allies, lobbyists seldom lobby uncommitteds since it is uncertain whether they will favor the lobbyist's position. Additionally, when lobbyists increase their efforts,

their allies also increase their efforts for the group's agenda. Similarly, legislators often grant access to like-minded interest groups (Hall & Deardorff).

The Power of Interest Groups

The power of interest groups and the constituents they mobilize plays an extremely large role in the ability to move legislation or increase appropriations for particular programs. The influence of interest groups has intrigued numerous political scholars for decades. In the late 1960s, McConnell (1966), suggested that the involvement of interest groups in politics was a “most serious and perplexing problem” (McConnell, 1966, p. 25, as cited in Hall & Deardorff, 2006). McConnell further explained that while some interest groups have been able to capitalize on opportunity and achieve success, others have “...been unable to seize the opportunity at all (p. 25 as cited in Hall & Deardorff). Seizing political opportunity can be achieved through political lobbying (Hall & Deardorff). However, what lobbying strategies by interest groups are considered effective?

Many would argue that multiple contributing factors are involved and not one strategy determines success. As noted, Snyder (1992) suggested that lobbyists make long term investments in certain members of Congress by establishing trust and a reputation (as cited in Hall & Deardorff). Others would argue that PAC spending helps influence politicians' decisions (Brownars & Lott, 1997; Herrnson, Shaiko, & Wilcox, 2005; Humphries, 1991; Wawro, 2001,). Yet, some non-profit organizations without a PAC are as effective as those that spend millions to influence politicians' votes (Berry & Arons, 2003). Through tactics such as testifying at hearings, encouraging members to write or call their legislators, or releasing research reports to members of Congress, non-profits

have been able to gain credibility with legislators (Berry & Arons). Kenneth Goldstien (1999) suggested that lobbyists are also skilled strategists who learn how to frame the issue to influence federal legislators and are effective at mobilizing their membership.

Appropriations Advocacy

Scholars have also investigated the ability of interest groups to contribute to the appropriations process (White, 2005). While Congress relies on agency budget offices to provide accurate information about specific programs, during various administrations, appropriators worried that pressure from the Office of Management and Budget precluded them from obtaining this information and interest groups are viewed as an alternative resource (White). White reported the comments of a subcommittee clerk that suggested this premise “...there are huge numbers of groups, they spend their whole day tracking issues, and they are very responsive to us. Often they have information faster than the State Department” (pg. 174). White argues that strategies such as PAC contributions, hiring lobbyists who specialize in the appropriations process, and developing partnerships or relationship with appropriators are effective methods to influence the appropriations process.

Olson’s Theory of Collective Action

Another way to consider effective lobbying would be to examine the theory of collective action or how organizations/individuals mobilize to achieve a particular goal. According to Olson (1965), the assumption that groups of individuals with common interests will usually work to further those interests is false and based on flawed logic. In his classic book *The Logic of Collective Action: Public Goods and the Theory of Groups*, Olson shows that for large groups, the opposite is often the case. Because the interest is

common, every one in the group benefits if the interest is advanced. This creates an incentive for rational individuals to avoid bearing any of the costs or burdens associated with the actions required to achieve the benefit. This behavior is referred to as the “free rider” problem of collective action and is particularly an issue in large groups. Unlike in a small group, members of a large group will not likely notice if some folks let others do all the work or pay a larger price. Meanwhile, the benefits are enjoyed by all, despite lack of participation (Olson, 1965).

Because members of large groups place different values, monetary or otherwise, on the collective good the group is seeking, the incentive to “free ride” varies. When the available amount of such a good is fixed, less of the good is available to each member of the group, especially when the group is large. This contributes to the problems of large groups since there is less reward to go around. Some individuals may be more willing to pay for the benefit than others to varying degrees. However, the costs to them will continue to rise as fewer people believe the benefit to be worth the cost, resulting in the decision to “free ride” rather than to contribute financially or otherwise. Additionally, groups that organize have associated costs which increase as the group size grows larger. Costs are not always monetary, for instance, costs are frequently associated with accommodating differing viewpoints. Organizational costs are added to the cost of getting the desired collective benefit. Not surprisingly, the more expensive it becomes, the harder it is to obtain the benefit (Olson, 1965).

As a result of the above mentioned problems associated with large groups, Olson (1965) asserts that they often require either coercion or incentives in addition to the reward of the collective good in order to mobilize. Coercion or incentives must be

selective—contributors are treated differently from those that do not. It is not difficult to see that it is much easier to organize a small group than a large one due to lower costs and greater collective benefits for members (Olson, 1965). Therefore, the theory of collective action has direct implications on effective lobbying strategies.

Constituent Engagement

Constituent engagement, an outside strategy, is also seen as an effective lobbying strategy, particularly as it relates to grassroots advocacy. Research has shown that an organization with a large constituent base in a particular district or state can “gain the ear” of their member of Congress simply because their members are registered voters (Wright, 1996). As Goldstein (1999) suggests, “grassroots communications demonstrate to legislators that traceability has been established” (p. 39). Traceability suggests that a large constituent voice has been registered with the member of Congress through calls, emails, or other methods.

Goldstein (1999) suggests a number of methods to increase constituent engagement. First, Goldstien (1999) notes that “citizens contact their legislators when someone asks them to and shows them how” (p. 50). Second, Goldstein would also suggest that interest groups should target members who are most likely to respond to a request if asked to participate. These individuals include citizens with higher levels of education and stronger connections to political life because they tend to have more influence and are more likely to respond to a request (Goldstein).

Other scholars have suggested the importance of an implied cost. Tversky and Kahneman (1981), suggest that in order to elicit a more intense response is to impress upon the individual constituent that they would suffer a personal cost. Additionally, some

researchers suggest that in order to elicit greater grassroots intensity, interest groups have to raise the cost of not participating (Goldstein, 1999; Rosenstone & Hansen 1993).

Goldstein states that, “professional sanctions to those with whom they have a business relationship and social sanctions to those with whom they have a social relationship can be brandished” (p. 50).

Summary

As Hall and Deardorff (2006) argue,

“The empirical literature on lobbying is large and often contradictory. At the same time, the relevant theoretical literature is eclectic and gives uncertain guidance to further empirical research. The juxtaposition of the empirical and the theoretical, in turn gives rise to several anomalies. Such anomalies, Kuhn (1962) has argued, can be theoretically useful. They prompt us to revisit basic assumptions and rethink core concepts” (p.80).

The limited success of nursing interest groups to secure high levels of funding for the Title VIII Nursing Workforce Development programs over the last five years, even the last decade, prompts an investigation into the basic assumptions of effective lobbying strategies. Since it is difficult to isolate any one political barrier (divided government, legislative gridlock, funding competition, or the power of interest groups) that inhibits Title VIII from receiving necessary increases, this study sought to discover the most effective lobbying strategies by interviewing key players in the appropriations process. Congressional appropriations staff who advise federal appropriators, the advocates who are able to secure high levels of funding for domestic discretionary funding programs, and advocates from the nursing community were questioned to determine successful and counter productive strategies. To achieve this end, a HRSA program that has a similar mission to Title VIII, but a higher level of funding was isolated. The organizations which

lobby for this program were interviewed to determine how their successful lobby strategies compare to those of nursing.

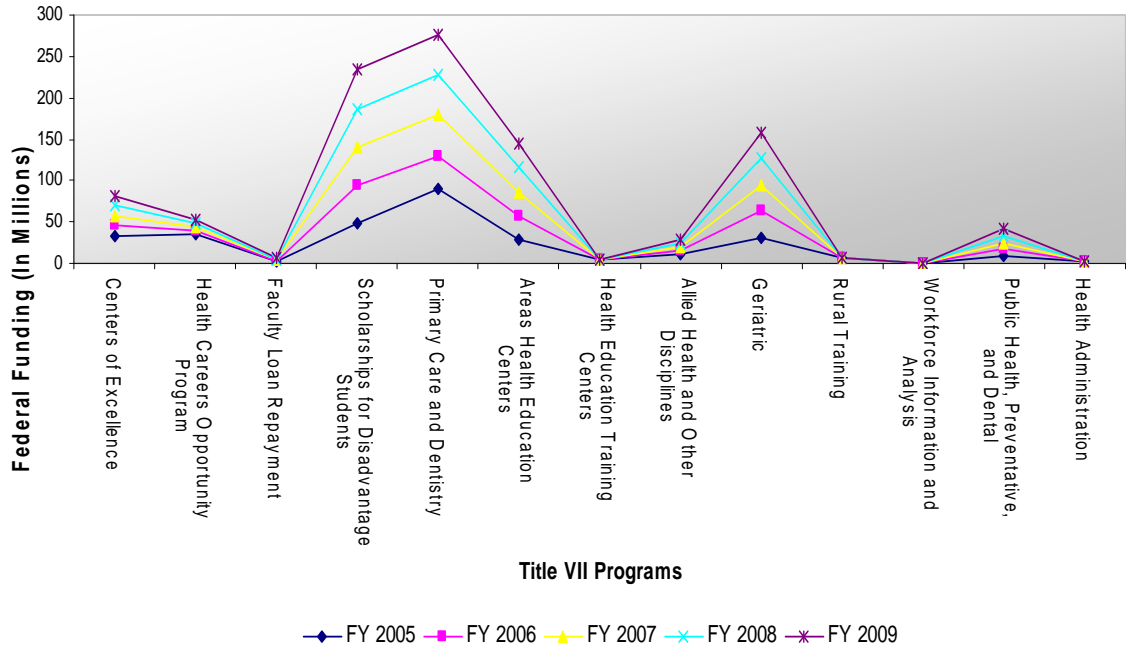
Comparing Nursing and Health Professions Education Funding Programs (Title VII)

Like nursing, educational funding for other health professionals has remained low under the HRSA budget. For example, the Allied Health Program under Title VII of the PHSA went from receiving \$11.75 million in FY 2005 to \$4.0 million in FYs 2006-2008, a 66.3% decrease in funding (Association of American Medical Colleges [AAMC], 2008). Funding for Primary Care Medicine and Dentistry (also funded under Title VII) decreased by 54% between years FY 2005 (\$88.82 million) and FY 2006 (\$40.85 million) (AAMC). After FY 2005, funding for training professionals in rural areas was completely eliminated (AAMC). As seen in Figure 2.6, each of the programs under Title VII, decreased consistently or remained level funded.

Given that the Title VII programs have remained on par with the funding for Title VIII (i.e. sustained decreases or remained level funded), a single program cannot be isolated to compare the strategies taken by either advocacy groups to increase funding. The political barriers mentioned above have appeared to affect almost all of programs funded under HRSA. In order to identify a program that helps educate health professionals and has secured a higher level of funding than Title VIII, a review of the HRSA programs was conducted. Four programs under HRSA have large funding allocations, Ryan White HIV/AIDS Activities (~\$2 billion), Health Centers (~\$2 billion), Maternal and Child Health Block Grants (~\$700 million), and CHGME (~\$300 million). However, only one program, CHGME, is used to educate health professions (DHHS, 2007).

Figure 2.6

Federal Funding for Title VII Health Professions Programs: FY 2005-2009



From: Association of American Medical Colleges (2008). Title VIII Health Professions Programs. FY 2008 Funding, Washington, DC.

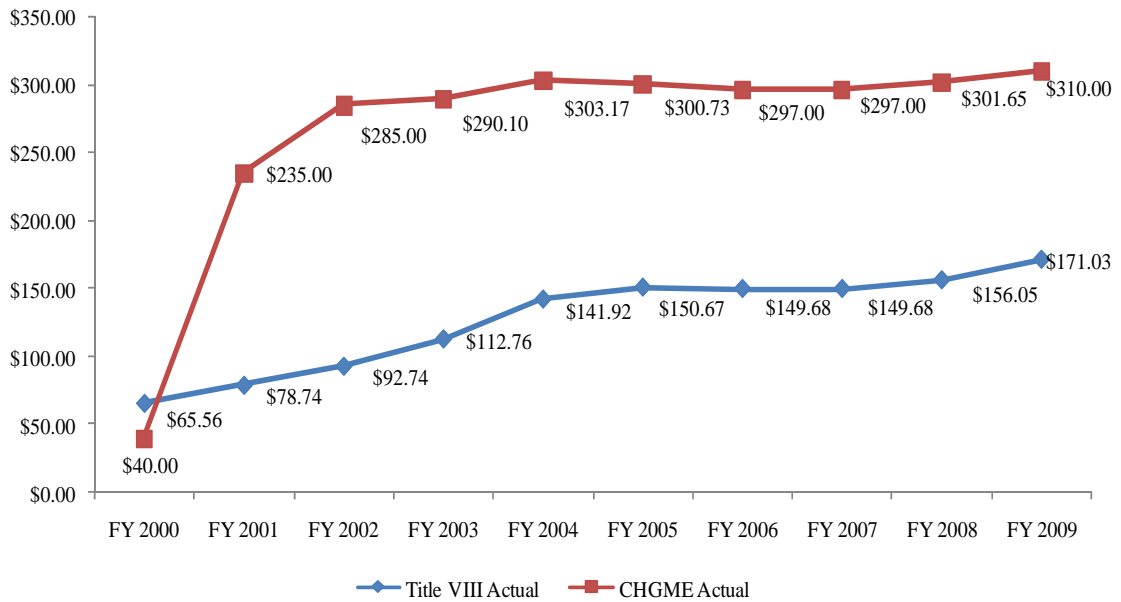
Children’s Hospital Graduate Medical Education

The CHGME program, authorized under Section 340E of the PSA, supports the education of physician residents in free-standing children’s teaching hospitals (AAMC, 2008). The program was created in 1999 to help children’s hospitals support residents because their low Medicare patient volume did not allow them to secure significant direct or indirect Graduate Medical Education (GME) payments (GME is funded through Medicare under the Social Security Act) (AAMC). While CHGME was funded at a low level (\$40 million) in FY 2000, the funding increased by 483% in FY 2001. Funding

increases for both CHGME and Title VIII remained fairly level during the Bush era (FY 2002-FY 2009). (see Figure 2.7).

Figure 2.7

Federal Funding for Title VIII and CHGME: FY 2000-FY 2009



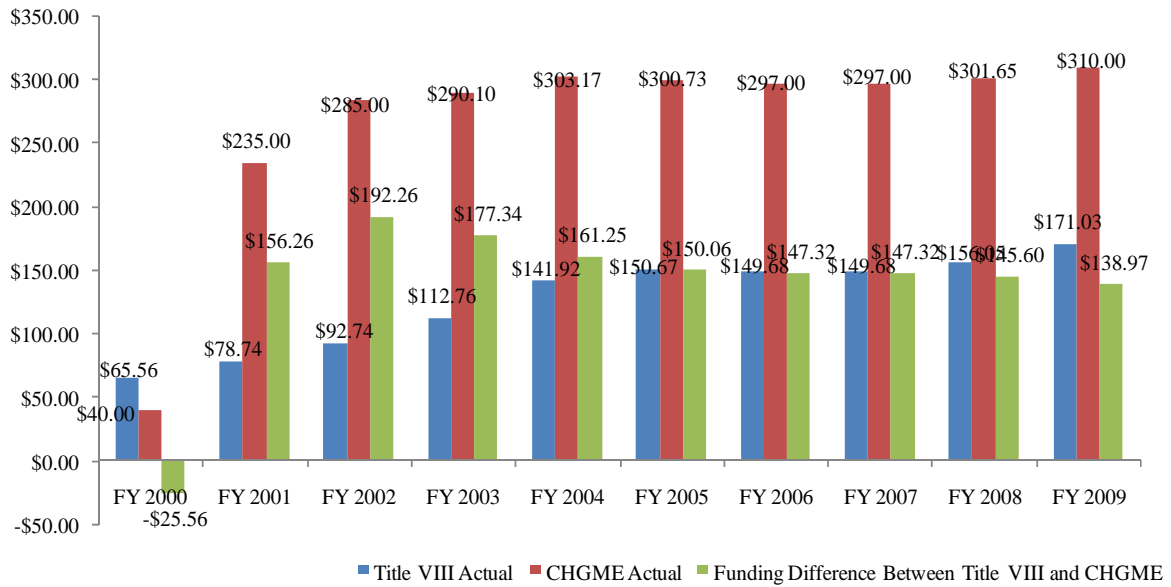
From: HRSA, (2008). *Fiscal Year 2008 Justification of Estimates for Appropriations Committees: Children’s Hospitals Graduate Medical Education Payment Program*.

While increases have been moderate for both programs between FY 2002-2009, CHGME received \$301.6 million compared to \$156.05 million for Title VIII in FY 2008. This funding difference is striking as the Title VIII programs support six authorities that cover all aspects of the nursing shortage (recruitment, retention, practice, and education) and CHGME is intended for a narrow subset of the medical community, physician residents in free-standing children’s teaching hospitals. This also is particularly notable when considering CHGME funding is in addition to the funding physicians receive under Title VII and the nearly \$9 billion that is spent each year on GME (Lisk, 2008).

As seen in Figure 2.8, between FY 2005 and FY 2007, the difference in funding spent on CHGME nearly equaled the amount spent on Title VIII. Considering the funding level for physician education is on average, 50.88% more than it is for nursing (see Figure 2.9), three factors need to be investigated. First, what types of strategies are used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME respectively? Second, what do nursing lobbyist, CHGME lobbyists, and Congressional appropriations staff consider effective strategies to secure federal funding? Third, what are the major difference in strategies used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME?

Figure 2.8

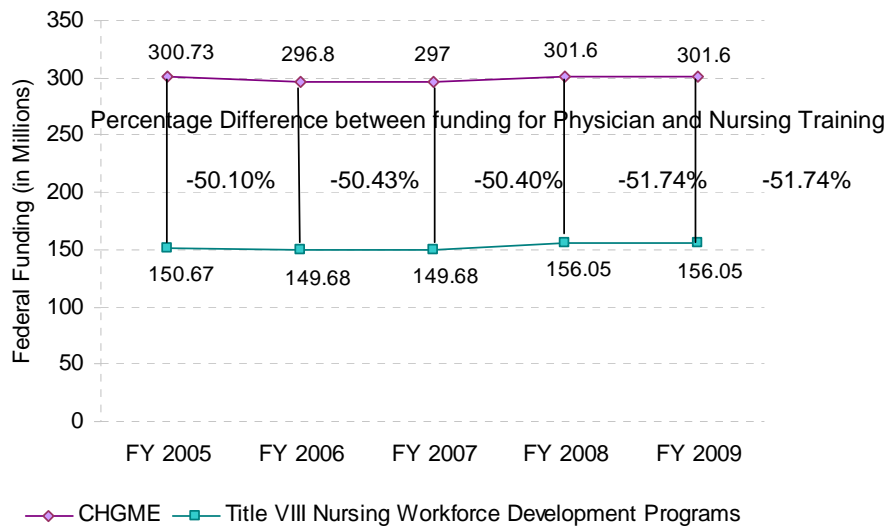
Comparing Funding for Title VIII and CHGME: FY 2000-FY 2009



From: HRSA, (2008). *Fiscal Year 2008 Justification of Estimates for Appropriations Committees: Children's Hospitals Graduate Medical Education Payment Program.*

Figure 2.9

Comparison of CHGME vs. Title VIII Funding FY 2005-2009



From: HRSA, (2008). *Fiscal Year 2008 Justification of Estimates for Appropriations Committees: Children's Hospitals Graduate Medical Education Payment Program.*

Conclusion

Federal funding for nursing education has been limited over the past five fiscal years due to a number of political barriers. At a time when there is a dire need to educate the next generation of nurses and nurse faculty to reverse the shortage, it is necessary to understand the strategies that yield success in achieving high funding levels. This study investigated what factors influence federal appropriations. First, lobbyists who actively advocate for CHGME were interviewed to gain insight into the strategies taken to secure federal appropriations. Concurrently, lobbyists who actively advocate for Title VIII appropriations were interviewed to determine what strategies, if any, overlap, and what measures are not being taken. Second, key staff for federal appropriators were interviewed to obtain an understanding of how decisions are made and what lobbying strategies are effective in influencing their decision. This study intended to determine

what lobbying strategies are effective so that Title VIII advocacy can be targeted and tailored to meet the political environment and ultimately secure the funds necessary to help reverse the shortage.

Hypothesis and Assumptions

Research Questions

1. What types of strategies are used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME respectively?
2. What do nursing lobbyist, CHGME lobbyists, and Congressional appropriations staff consider effective strategies to secure federal funding for Title VIII and CHGME?
3. What are the major difference in strategies used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME?

Research Aim

The aims of this comparative exploratory descriptive qualitative study were to gain insight into effective lobbying strategies of interest groups and which of these strategies influence federal Appropriators decisions. The ultimate objective of this study was to understand effective advocacy strategies to enhance lobbying efforts for the Title VIII Nursing Workforce Development Programs. With this knowledge, the potential to increase funding for Title VIII may grow, which in turn could help reverse the nursing and nurse faculty shortage and improve access to safe, quality healthcare.

CHAPTER THREE

Methods and Procedures

Research Design

Research Designs and Methods

Design

This was a comparative, exploratory, descriptive, qualitative study conducted to gain insight into effective lobbying strategies of interest groups and which of these strategies influence federal appropriators' decisions. The design was chosen based on Sandelowski's (2000) work on qualitative descriptive studies. As Sandelowski suggests, the goal of qualitative exploratory descriptive studies is to provide a comprehensive summary of events in everyday terms. When straight descriptions of phenomena are desired, qualitative descriptive studies are the method of choice (Sandelowski).

Sample

The sample for this study included lobbyists from national nursing organizations who advocate for Title VIII and lobbyists from national organizations that advocate for CHGME. Legislative staff for LHHS appropriators were also included in this study.

There are approximately 50 nursing organizations that lobby on behalf of Title VIII, however 15 have registered lobbyists (OpenSecrets, 2008). Therefore, participants were recruited from these organizations. There are approximately 10 national organizations that lobby on behalf of CHGME, similarly the participants were recruited

from this pool (OpenSecrets). As a criteria for participation, the lobbyists had at least one year of experience and were registered. Choosing registered lobbyists ensured that they abided by the federal ethical regulations and disclose to the government which issues as well as which members they lobby.

The Congressional staff population for this study included 37 appropriations staffers (17 from the House LHHS Appropriations Subcommittee, 16 from the Senate LHHS Appropriations Subcommittee and 4 Subcommittee staffers). The inclusion criterion for this subset of participants was individuals who currently hold a legislative staff position in a Congressional office and cover healthcare appropriations for a member of either the House or Senate LHHS Appropriations Subcommittee. These individuals included legislative assistants, legislative directors, chief of staffs, or committee staff. An equal sampling of participants from both parties were recruited for a comprehensive assessment of the factors that influence appropriations decisions.

Appropriations staffers were chosen for this study because they address federal funding decisions on a daily basis and are seen as the experts on the issues. As Romzek and Utter (1997) stated, “Congressional legislative staff, those individuals who work directly for elected members of Congress, oftentimes represent a thread of continuity, institution memory, and expertise within the institution” (p. 1252). Moreover, the Library of Congress once noted, “Virtually nothing is done in Congress so exclusively by Members of Congress themselves that staff have no impact on the outcome” (Rundquist, Schneider, & Pauls, 1992, as cited in Romzek & Utter, p. 1252). “Congressional staff occupy positions of substantial influence in our national policy making process”

(Romzek & Utter, 1996, p. 415). Therefore, their perspectives were both appropriate and insightful.

A convenience sample was used for this study. Since the populations of interest had limited numbers of potential participants all 15 Title VIII lobbyists, 10 CHGME lobbyists, and 37 LHHS appropriations staffers were recruited.

Recruitment

Participants were recruited through personal telephone contact by the principal investigator (PI). For this study, a modified version of Dillman's (1978) Total Design Method (TDM) was used to obtain a higher response rate. As Dillman (1978) suggests, the TDM is "...based on convincing people first that a problem exists that is of importance to a group with which they identify, and second that their help is needed to find a solution" (p.162). Therefore, the participants were introduced to the intent of the study and to the PI. When interviewing the nursing and CHGME lobbyists as well as legislative staff, it was explained that their expertise was being sought to understand effective appropriations advocacy strategies. For both groups, this established the importance of their participation and demonstrated how their answers could be used to help improve lobbying strategies.

More specifically for the legislative staff, it was explained that the PI was interested in understanding how appropriations decisions are made for health professions education programs. The PI stressed the importance that as legislative or subcommittee staff for LHHS appropriators, their knowledge is essential to understanding effective lobbying strategies that influence funding decisions. Additionally, the use of more

general the statements such as “health professions education” as opposed to Title VIII or CHGME decreased initial potential bias.

Following this introduction, the next recruitment step included asking the participants if they meet the inclusion criteria. Upon meeting the criteria, a short description of the study was given that included the time commitment, procedure, (open-ended questions) and explanation of privacy.

Additional considerations of Dillman’s (1978) method were used during the initial phone conversation to increase participation. According to Dillman (1978), three basic factors exist that can encourage response; (1) rewarding the respondent, (2) reducing the cost to the respondent and (3) establishing trust. Since the PI is a nursing lobbyist, Congressional staff were not able to accept a reward for participating in the study due to the lobbying ethics rules. However, to elicit a higher response rate from the staff, the PI sought to reduce the cost to the participant. The Congressional staff were informed that the face-to-face interview would take approximately 20 to 30 minutes and would be done at their convenience. Additionally, if a face-to-face interview was not feasible for the participant, a telephone interview was offered. The PI also attempted to establish trust with the Congressional participants to elicit a higher response rate. To establish trust with the legislative staff, the participants were told that the PI has experience working on Capitol Hill, understands the appropriation process, and can sympathize with the intense nature of their work and the limited time they have for additional commitments.

In order to establish trust with the lobbyist participants, the PI explained that they had been contacted because of their success and skill in securing funding for Title VIII or CHGME. Specifically for nursing, the lobbyists were told that their insights are needed to

help secure a common goal. For the CHGME lobbyists, it was disclosed that the PI is a lobbyist for the nursing community, but had no intention of attempting to use their answers to inhibit funding for CHGME. The PI stressed that the intent of the interview was to learn best practices.

All participants were told that the PI is a lobbyist. This information was critical during data collection and analysis because the PI understood the terminology used and references to the appropriations process. Generally, the PI's role as a lobbyist was beneficial to this study as it was not necessary to stop the participants and ask for further explanation on certain topics raised in the interview.

It was explained to all participants that the information they provided would be kept confidential to help obtain a higher response rate. The PI explained that the study was submitted for IRB approval and was exempt from further review. The participant was provided a copy of the IRB exemption form (see Appendix C). Their anonymity was not compromised throughout the study and in the eventual dissemination of the findings.

Multiple attempts were made to contact the participants. If direct contact was not made initially, a message was left for the participant. The message provided a brief description of the study and how the participant could return the call. If the PI had not heard from the potential participant within three days, a second phone call was placed and a message was left. If no response was obtained after an additional three days, a third attempt was made by telephone. One final attempt, to recruit the participant was through email contact if an address was available. Email requests to participate provided the greatest response rate. After a two week time period, no further attempts were made to contact the participant. Of the 15 nursing lobbyists contacted, 10 participated, two never

responded and three declined. Seven CHGME lobbyists agreed to participate and three declined. Four Congressional staff declined to participated, seven Congressional staff never responded, and 10 Congressional staff agreed to participate. As will be described below, after 10 interviews were conducted with the Congressional staff saturation was reached and the remaining 16 Congressional staff members were not contacted.

Sample Size

For all three groups of participants, (nursing lobbyist, CHGME lobbyists, and legislative staff) a final sample size was determined by saturation of the data. To achieve saturation, the third step in Morse' (2007) intraproject sampling was used in which data collection is ceased when no new information is obtained. Simultaneous data collection and analysis was used to determine saturation. Ultimately, saturation was achieved during the interviews with the CHGME lobbyists when three lobbyists identified one organization as the lead for CHGME appropriations advocacy and therefore offered no new data. After 10 interviews were conducted with both the nursing lobbyists and Congressional staff, saturation was reached as no new themes emerged. The final sample size (N=27) comprised of 10 nursing lobbyists, 7 CHGME lobbyists, and 10 Congressional staff members.

Data Collection Measures

Procedure

The study was submitted to the Health Sciences Institutional Review Board Institutional Review Board (IRB) for approval and was deemed exempt from ongoing IRB review, per the following federal exemption category (EXEMPTION #2 of the 45 CFR 46.101.(b)) (see Appendix C):

“Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.”

The PI conducted all of the 27 interviews. Each face-to face interview was conducted at the lobbyist's place of work, or if they preferred, over the phone. Interviews with the legislative staff were conducted at the Congressional office, another location deemed appropriate (e.g. cafeteria), or by telephone. All seven interviews with the CHGME lobbyists were conducted over the phone. Seven interviews were conducted over the phone with the nursing lobbyists and three were conducted in person. Similarly, seven of the interviews conducted with the Congressional staff were over the phone and three were in person.

The participants were asked if their interview could be tape recorded for data analysis. It was explained to the participants that if they were unwilling to have their interview recorded, notes could be taken. The majority of the participants approved the use of a tape recorder. For the participants who preferred not to be recorded (n=9), data was collected by taking extensive notes.

Qualitative Data Collection

Qualitative data was collected using an interview guide (see Appendix D & E). At the onset of each interview, the participant was assigned a number based on their participant category in order to keep his or her information confidential. For example, a nursing lobbyist was labeled as NL1, a CHGME lobbyist was labeled as CHGMEL1, and a Congressional staffer was labeled as CS1. The interview guide for the lobbyists focused

on the lobbying strategies used to secure federal appropriations for their respective program (Title VIII or CHGME) (see Appendix D).

The questions for the Congressional staff focused on effective lobbying strategies and (Questions 1-6, see Appendix E) the lobbying strategies used for CHGME and Title VIII (Questions 7-11, see Appendix E).

After the interview, the participant was thanked for his or her participation and reminded that his or her answers would be kept confidential (see Appendix F). For security purposes, all data was stored on the PI's personal computer. The participant ID number was used on all the data transcripts. While a reference sheet was kept for the purposes of follow-up questions that included the participant name, contact information, and their ID number, the sheet was destroyed after data analysis was completed. The participant was given the PI's contact information should they have any questions or think of additional information that might be pertinent to the investigation.

Data Management and Analysis

Data analysis was guided by three research questions: (1) what types of strategies are used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME respectively? (2) what do nursing lobbyist, CHGME lobbyists, and Congressional appropriations staff consider effective strategies to secure federal funding for Title VIII and CHGME? (3) what are the major difference in strategies used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME?

The data collection and analysis occurred simultaneously. Within 48 hours of the interview, the data was transcribed verbatim into a word processing document and memos were taken and placed in an Excel file for analysis purposes. The Excel file

provided a means to constantly input data related to the three research questions and compare emerging themes. The PI then examined the document for accuracy by comparing the audiotape and document or the notes and the document. The constant comparative method of analysis, a component of grounded theory method, was employed to analyze each interview. According to grounded theory, there are three approaches to coding the data, open, axial, and selective coding (Creswell, 2003).

For the purpose of this study, open and axial coding were used. Open coding generated the main categories or themes contained in the data. First, the whole transcript was reviewed for a general impression of the data. Second, as mentioned above, memos were taken to comment on general impressions, follow-up questions, relevance of the data to the three research questions, emerging themes, and important points to raise or questions to ask in future interviews.

Next, the PI performed a line-by-line examination of the responses from the lobbyists and Congressional staff. Specifically, the PI searched the data for the emerging themes and consistent terminology related to effective lobbying strategies noted in the original memos. Axial coding was used to relate concepts to each other and compare the responses, particularly between the CHGME and nursing lobbyist, as well as with the lobbyists and the Congressional staff. During this process, the data was reviewed for a second time to deduce how the themes related and clustered together. The clusters were generated based on the three research questions. The PI cross referenced all participant responses to determine what themes were perceived by the participants as effective lobbying strategies and were common across the three groups of participants. These themes were also cross referenced to the current literature on effective lobbying strategies

presented in chapter 2 (inside and outside strategies). Additionally, ongoing comparison of the data was done to obtain emerging themes that “maximize the similarities and differences of the information” (Creswell, 2003, p.14).

The categorization process was used when analyzing the strategies data. Three major categories were developed: (1) highly (2) moderately, and (3) not. A theme was considered “highly used” or “highly effective” if the majority of the participants in each group reported the theme. A theme was considered “moderately used” or “moderately effective” if it was mentioned by a few participants in each participant group. A theme was considered “not used” or “not effective” if it was not mentioned by the participants in each group.

To ensure validity, the PI used Creswell’s (2003) recommendations for determining accuracy of qualitative data. Specifically, rich, thick description during the explanation of the findings was used to avoid biases. Additionally, the PI used colleague validation by discussing with the dissertation committee chair participant responses to validate general impressions, avoid bias, and enhance understanding of the data. The colleague validation also enhanced the simultaneous data analysis by helping to develop the conceptual framework.

CHAPTER FOUR

Results

The aims of this comparative exploratory descriptive qualitative study were to gain insight into effective lobbying strategies of interest groups and which of these strategies influence federal appropriators' decisions. This study compared the lobbying strategies used to advocate for the Title VIII Nursing Workforce Development programs with those employed to advocate for CHGME in an effort to determine differences in advocacy strategies. The CHGME program was selected as the comparison program for Title VIII because both programs are federally funded through the LHHS appropriations bill, authorized under the PHSA, and support a single healthcare discipline. However, CHGME has been able to significantly increase federal appropriations given the 483% increase between FY 2000 and FY 2001. The Title VIII programs have not been able to secure the same level of appropriations or a dramatic funding increase. Between FY 2005 and FY 2008, CHGME funding was double that of Title VIII. This difference in funding is especially notable as the CHGME program is narrowly focused on physician residencies in free-standing children's hospitals and the Title VIII programs are intended to address all aspects of the nursing shortage (recruitment, retention, and education).

Twenty-seven interviews were conducted with nursing lobbyists, CHGME lobbyists, and Congressional appropriations staff. The Congressional staff were included in this study to determine which advocacy strategies were deemed effective and which

strategies influenced an appropriator's decision. The ultimate objective of this study was to understand effective advocacy strategies to enhance lobbying efforts for Title VIII Nursing Workforce Development Programs. Specifically, this study sought to provide insight on three research questions to determine how nursing could achieve higher levels of funding for Title VIII. First, what types of strategies are used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME respectively? Second, what do nursing lobbyist, CHGME lobbyists, and Congressional appropriations staff consider effective strategies to secure federal funding for Title VIII and CHGME? Third, what are the major difference in strategies used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME?

Demographics of the Participants

Demographics of Nursing Lobbyist Participants

Ten registered lobbyists representing national nursing organizations, which actively advocate on behalf of the Title VIII, participated in the study. These lobbyists represented national organizations with a focus on advanced nursing practice (n=4), specialty or generic nursing practice (n=5), and nursing education (n=1). The average number of years the nursing lobbyists had been advocating for Title VIII was 6.35 years with the maximum being 11 years and the minimum being one year. Seventy percent of the lobbyists were female (n=7) and 30% were male (n=3) (see Table 4.1).

Table 4.1**Demographic Characteristics of Nursing Lobbyists**

Nursing Lobbyist	Number of Years Advocating for Title VIII (N=10)	Gender (N=10)	Organization Type (N=10)
NL1	9	Male	Advanced Practice
NL2	9	Female	Advanced Practice
NL3	2	Female	Advanced Practice
NL4	1	Female	Advanced Practice
NL5	9	Male	Advanced Practice
NL6	7	Male	Specialty or Generic Nursing Practice
NL7	8.5	Female	Specialty or Generic Nursing Practice
NL8	11	Female	Nursing Education
NL9	2	Female	Specialty or Generic Nursing Practice
NL10	5	Female	Specialty or Generic Nursing Practice

Demographics of CHGME Lobbyist Participants

Seven registered lobbyists representing national medical/physician or hospital associations which lobbied on behalf of CHGME participated in the study. The average number of years the CHGME lobbyists had been advocating for the program was 6.4 years with the maximum being 12 years and the minimum being 2 years. The majority of the lobbyists were female (n=5) (see Table 4.2). As noted in chapter 2, saturation was achieved while interviewing the CHGME lobbyists when three lobbyists identified one organization as the lead for CHGME appropriations advocacy. Current lobbyists from the core organization declined an interview; therefore, four interviews were conducted with

lobbyists who had recently worked or currently consult for the core organization. The interviews conducted with lobbyists from the supporting organizations included a physician, medical education, and hospital association.

Table 4.2

Demographic Characteristics of CHGME Lobbyists

CHGME Lobbyist	Number of Years Advocating for CHGME (N=7)	Gender (N=7)	Organization Type (N=7)
CHGMEL1	10	Female	Core
CHGMEL2	4	Male	Core
CHGMEL3	2	Female	Supporting-Physician
CHGMEL4	2	Female	Supporting-Education
CHGMEL5	5	Female	Supporting- Hospital
CHGMEL6	10	Male	Core
CHGMEL7	12	Female	Core

Demographics of Congressional Staff Participants

Ten Congressional staffers for members of Congress who serve on the House or Senate LHHS Appropriations Subcommittees participated in the study. While there was an equal representation by political party (Democratic (n=5) and Republican (n=5)), there were slightly more males than females (Female (n= 4) and Male (n=6)) and the majority of the staff interviewed work in the House of Representatives (n=7) (see Table 4.3).

Table 4.3**Demographic Characteristics of Congressional Staff**

	House vs. Senate (N=10)	Gender (N=10)	Political Party (N=10)
CS1	House	Female	Democrat
CS2	House	Male	Democrat
CS3	Senate	Female	Republican
CS4	Senate	Female	Democrat
CS5	House	Male	Democrat
CS6	House	Male	Republican
CS7	House	Female	Republican
CS8	House	Male	Republican
CS9	House	Male	Republican
CS10	House	Male	Democrat

Research Question 1

What types of strategies are used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME respectively?

The nursing and CHGME lobbyist were asked to provide the types of strategies used to secure federal funding for Title VIII and CHGME respectively. These strategies included: (1) deciding the appropriations “ask,” (2) strategies used to secure federal funding, (3) strategy differences by chamber of Congress and political party, and (4) level of funding spent on the advocacy strategies. The use of each of these strategies is reported below. A theme was considered “highly used” if the majority of the participants, in each of the two groups (nursing lobbyists and CHGME lobbyists) mentioned that it was frequently used. A theme was considered “moderately used” if it was mentioned by a few participants as a strategy used. A theme was considered “not used” if it was not mentioned by the participants in each group.

1. Deciding the Appropriations “Ask”

Lobbyist descriptions of how an appropriations “ask” or request for a particular federal program was decided for the upcoming fiscal year revealed four common themes: (1.1) coalition collaboration, (1.2), consultation with Congressional champions, (1.3) laugh test/political reality, and (1.4) use of data. These themes are described below. Table 4.4 depicts the level to which the nursing and CHGME lobbyists used these themes in creating their appropriations “ask.”

Table 4.4

Strategies Used to Develop an Appropriations “Ask”

	Nursing	CHGME	Nursing	CHGME	Nursing	CHGME
	Highly Used		Moderately Used		Not Used	
Coalition Collaboration	X	X				
Consultation with Congressional Champions			X	X		
Laugh Test/Political Reality			X	X		
Use of Data		X			X	

1.1 Coalition Collaboration

Coalition work has been described in multiple ways, but as Shaw (2001) suggested it is typically the combination of “two or more organizations in pursuit of at least one mutual objective” (p.81). Coalitions unite around a common goal. Both the nursing and CHGME lobbyists noted that coalition collaboration was a heavily used strategy when developing their appropriations “ask.” The nursing lobbyists relied on the “Nursing Community,” which is a forum for professional nursing and related organizations, to collaborate on a wide spectrum of health care and nursing issues including practice, education, and research. The nursing lobbyists identified this coalition as a way to build consensus among the nursing organizations that may advocate for Title VIII funding, but who may not necessarily have Washington, DC representation or a lobbyist.

Nursing Lobbyist- “The ‘ask’ is born out of collaboration with a combination of nursing groups within the nursing community, an effort led by a very astute, and well connected lobbyist.”

Nursing Lobbyist- “So we work with a coalition of other organizations who have parallel interests in nurse education and workforce development, to develop and recommend a cogent, coherent request. It largely occurs in the three months leading up to the issuance of the administration’s budget for the following fiscal year.”

The CHGME lobbyists who worked for the supporting organizations cited that they supported the request that was developed by the core organization.

CHGME Lobbyist- “We support the ask developed by the [core organization].”

CHGME Lobbyist- “We follow the [core organization].”

Both the nursing and CHGME lobbyists felt that this was an important strategy to use when developing an appropriations “ask.”

1.2 Consultation with Congressional Champions

As White (2005) identified, the need to secure Congressional champions for appropriations advocacy is considered an important strategy. Both the nursing and CHGME lobbyists identified the importance of working with Congressional champions on Capitol Hill to determine a feasible appropriations request for Title VIII and CHGME.

Nursing Lobbyist- “Weight is placed on the champions in Congress and what they recommend and to see what is a reasonable request. It is important to talk to the staff in the offices of the Congressional champions. The request has to be ‘doable.’”

CHGME Lobbyist- “The second part was in consultation with key Congressional supporters to determine the budget climate of that particular year. In consultation with key members of Congress saying ‘here is what inflation adjustment would amount to if we are going to continue to achieve equity.’ And we would provide that calculation. We had conversations as to what level they felt comfortable with and sometimes they felt comfortable with going with what was the new goal [for CHGME] and sometimes they felt comfortable going with less.”

The lobbyists reported that support from Congressional champions in both the House and Senate is critical to advance their request on Capitol Hill. It is the Congressional champions who will help promote the request and secure support from other legislators. As described by the nursing lobbyists, the Congressional champions help to determine what is a politically feasible “ask” or what will pass the “laugh test,” which was also identified as a theme by the nursing and CHGME lobbyists.

1.3 Laugh Test/Political Reality

Coinciding with the “consultation with Congressional champions” theme was the “laugh test” or in more concrete terms “political reality.” The lobbyists stressed the importance of developing an “ask” that is appropriate for the current political climate, specifically related to the budget and appropriations process. The lobbyists noted that one must understand the political reality of the appropriations process, commenting specifically on the number of discretionary funding programs and the lack of federal dollars to address each program adequately.

Nursing Lobbyist- “Nursing has to take into consideration the realistic aspect of how much money there is for discretionary funding.”

Nursing Lobbyist- “Importance is placed on a reasonable ‘ask’ within the confines of the political environment.”

CHGME Lobbyist- “Then we would discuss with the key members of Congress if that was realistic. Realistic being something that people wouldn’t blanch at it if they saw it.”

1.4 Use of Data

The CHGME lobbyists placed great importance on using data to develop an appropriations “ask.” In developing the CHGME “ask,” the core organization commissioned a data-driven study to determine funding for multiple fiscal years. It was

explained that while the authorization language for CHGME is written as “such sums as necessary,” the study provides the guidelines for funding levels.

CHGME Lobbyist- “They look at what would be a level of CHGME funding that would bring equity with what adult teaching hospitals have under the Medicare formula.”

CHGME Lobbyist- “Our authorization was ‘such sums as necessary.’ We had been asking for \$330 million. That amount, if I recall, was basically decided because we approximated through data analysis that that would have given us equitable funding with other hospitals through Medicare GME. So essentially if you took all of the GME slots at all of the children’s hospitals who are eligible in the country, gave them as much funding as what you would have got through Medicare GME, added it all up and then in the aggregate it would have been about \$330 million.”

CHGME Lobbyist- “We worked out a formula with the Lewin group that provided equity or parity for GME slots to the ones at children’s hospitals.”

However, the nursing lobbyists reported they did not use data to develop a concrete appropriations “ask.” They indicated that many of the data points were not available to help create an easily justifiable request largely due to outdated statistics on the nursing shortage. It was cited that the “Nursing Community” had attempted to use the available data to make these projections, but many of the national sources and projections were three to four years old.

Nursing Lobbyist- But the frustration has been that [the data] has not always been linked to the quantity of nurses that the profession feels are needed...it would be nice at some point, to have it be linked more closely to the real demand for nurses. One of the challenges there has been that the Department of Labor has not until just recently, even tracked, the numbers of Advanced Practice Registered Nurses from the nursing category. That may help our efforts with Title VIII justifications.”

2. Strategies Used to Secure Federal Funding

In determining what strategies were used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME respectively, they were asked to

identify specific strategies that were implemented. Nine major themes were identified by the lobbyists' responses regarding appropriations advocacy strategies. These included: (2.1) "shoe leather lobbying," (2.2) grassroots lobbying, (2.3) one-pagers, (2.4) sign-on letters, (2.5) Dear Colleague letters, (2.6) testimony, (2.7) member education, (2.8) fly-ins or lobby days, and (2.9) grass tops lobbying (see Table 4.5). The lobbyists reported the use of multiple strategies to achieve increased federal funding. The use of each of these strategies is described below and the level of use is depicted in Table 4.5.

Table 4.5
Strategies Used to Secure Federal Funding

	Nursing	CHGME	Nursing	CHGME	Nursing	CHGME
	Heavily Used		Moderately Used		Not Used	
Shoe Leather Lobbying	X	X				
Grassroots Lobbying	X	X				
One-Pagers	X	X				
Sign-on Letters	X	X				
Dear Colleague Letters	X	X				
Testimony			X	X		
Member Education			X			X
Fly-ins/Lobby Days		X	X			
Grass tops Lobbying		X			X	

2.1 “Shoe Leather Lobbying”

“Shoe leather lobbying” is making visits with Congressional staff or the actual members of Congress to discuss the importance of a funding request and asking the member of Congress to support the request. This was a highly implemented strategy by all lobbyists to secure federal funding.

Nursing Lobbyist- *“One is what I would just call shoe leather lobbying. Walking the halls and meeting with staff about a particular request.”*

Nursing Lobbyist- *“...have direct conversations with the key appropriations staff, the actual members, as well as outside organizations working in coalitions.”*

CHGME Lobbyist- *“We made appropriations visits with the LHHS subcommittees.”*

The lobbyists identified this method as a means of developing new and existing relationships with the Congressional appropriations staff. This included identifying sympathetic individuals and cultivating relationships, and collaboration support.

Nursing Lobbyist- *“Identifying those individuals in the House and the Senate who are sympathetic to the nursing profession and then cultivating those relationships and working with their staff to see what makes them comfortable or uncomfortable. You can only ask for what a member will support. So it is a collaborative between the groups asking and the individual [Member of Congress] who is asked to carry that flag for nursing in the appropriations cycle.”*

2.2 Grassroots Lobbying

Grassroots lobbying involves “using interest group members (or the general public) to pressure Congressional lawmakers to support a group’s agenda” (Wilcox & Kim, 2005, p. 136). Grassroots can be in the form of letter-writing campaigns, coordinated calls to Capitol Hill, or face-to-face meetings with members of Congress or their staff (Wilcox & Kim). The importance of grassroots, or activating the organizations’ membership to advocate on behalf of Title VIII or CHGME, was identified as a highly

implemented strategy to secure federal funding. Action alerts, through the use of an online advocacy tool, such as Capwiz™, were cited as critical vehicles for lobbyists to mobilize their grassroots networks. In recent years, on-line advocacy programs have simplified grassroots activities by allowing constituents to directly email their member of Congress with a form letter written by an organization.

Nursing Lobbyist- “We try to encourage grassroots from our membership.”

Nursing Lobbyist- “We utilize Capwiz™ to mobilize members to request the same funding ‘ask.’”

CHGME Lobbyist- “We worked through hospitals continually throughout the year to be educating appropriators of the subcommittee and they would make requests.”

CHGME Lobbyist- “When we first started advocating for the program we used extensive grassroots. Hundreds of letters and calls to the members of Congress.”

2.3 One-Pagers

A “one-pager” is literally a one-page document that clearly and concisely articulates a problem, the solution, and what is the request of a member of Congress. Providing Congressional staff with a “one-pager” on the importance of the Title VIII or CHGME program was a highly implemented strategy by the nursing and CHGME lobbyists.

Nursing Lobbyist- “...putting our request into the congressional user friendly format which usually consists of a summary and highlights in a page the request with additional background documentation.”

CHGME Lobbyist- “We would create one pagers that we revised each year and addressed the success of the program.”

The lobbyists noted that the “one-pager” must provide the staff member with a justification for the request and relate the data to the relevant member’s district or state. This data was substantiated by the Congressional appropriations staff who stated that the

most helpful type of advocacy materials were a one or two-page document that is concise, clearly articulates the “ask,” and has sufficient background or data regarding the issue. The staff also noted that the materials are best when they are linked directly to the impact the program will have in the state.

Congressional Staff (D)- “Materials are helpful when they are concise. It is best to send a one or two pager electronically so I can save it for the long-term. I once had a lobbyist come for a visit who worked on the Hill and brought me a ½ inch loose leaf binder with tabbed sections, that thing was going straight into the trash. There is no place to store something like that on the Hill. One-two pagers are the best with the “ask” clearly identified. If I am interested about an issue, I will ask for more.”

Congressional Staff (R)- “I need one page that is de-cluttered. Also with text large enough to read. Ideally, 3-4 bullet points with the request. Folders get thrown out. I will keep the piece of paper with request. There is no room to store it all.”

2.4 Sign-on Letters

Coalition sign-on letters highlight a problem, the solution, and request a particular “ask” of a member of Congress or Congressional committee. These letters are then signed by national organizations or interest groups who support the request. For appropriations advocacy, these letters typically request a certain level of funding and are sent to the House and Senate Appropriations Committee or subcommittee of jurisdiction, for example the LHHS Appropriations Subcommittee would receive the letters for Title VIII and CHGME. The lobbyists noted that sign-on letters were a highly used strategy to raise awareness of the Title VIII and CHGME programs during the appropriations cycle. The CHGME lobbyists who supported the core organization’s efforts, stated the sign-on letter was organized by the core association for CHGME advocacy. For nursing, the letters were developed by the “Nursing Community.”

2.5 Dear Colleague Letters

A Dear Colleague letter traditionally is championed by both a Democrat and Republican member of Congress who requests that the appropriations subcommittee provide a certain level of funding for a particular program. The goal of a Dear Colleague letter is to obtain a high number of signatures from members of Congress to demonstrate support for the program. These letters are addressed to the Chairman and Ranking Member of the House and Senate LHHS Appropriations Subcommittee to request a certain level of funding. This strategy was also a highly used by both the nursing and CHGME lobbyists.

Nursing Lobbyist- “We work with the House Nursing Caucus to help gain signatures for the ‘Dear Colleague’ that requests other members of Congress to support the Title VIII’ ask’. This is also done in the Senate with the Senate nursing champions. At this time, lobbyists will do specific outreach and work with state colleagues to request that members of Congress sign both the House and Senate ‘Dear Colleague.’ It is important to gain a diversity of signatures, bipartisan support, and new member support.”

CHGME Lobbyist- “We would get a bipartisan set of members in the House and also in the Senate to craft a letter to their colleagues on the Appropriations Committee. Usually the request is to fully fund the Children’s Hospital GME program, and then we and the member hospitals worked our delegation to get them to sign onto that letter, to show broad based support for the program. That’s one strategy that has been relatively effective in the past.”

2.6 Testimony

Providing written or oral testimony to the House and Senate LHHS Appropriations subcommittees that requests a certain funding level for a particular program was a moderately used strategy by the lobbyist. Written testimony can be submitted by any national organization or interested party. National organizations or interested parties must submit a formal request to orally testify before the appropriations subcommittees and then must be selected by the appropriations subcommittee.

Nursing Lobbyist- “We provide written testimony to the subcommittee.”

CHGME Lobbyist- “We would request to testify before the subcommittee on the program.”

2.7 Member Education

While the CHGME lobbyists did not identify the use of member education (explaining the purpose of the program and why funding is important), the nursing lobbyists pointed to the use of association-level member education to secure federal funding. Nursing lobbyists noted that more education is needed regarding the Title VIII programs, as it is hard for constituents to lobby for an issue with which they are not familiar.

Nursing Lobbyist- “We educate members on Title VIII programs. The vast majority of them are not Title VIII recipients so they do not know what they do or what it means.”

Nursing Lobbyist- “We educate our specific nurse workforce interest area in our organization, so that they can be effective advocates for this type of funding.”

2.8 Fly-Ins or Lobby Day

When interest groups bring their members to Washington DC to visit a member of Congress they are called “lobby days” (Wilcox & Kim, 2005). Fly-Ins or lobby days were a frequently implemented strategy by the CHGME lobbyists, but a moderately used strategy for the nursing lobbyists.

Nursing Lobbyist- “We make nurse workforce development funding part of our spring fly-in advocacy meeting during which we have several hundred of our members come to Capitol Hill and talk about this as our issue.”

CHGME Lobbyist- “We had three different lobbying days a year. We would bring in the families, the VIPs like the CEO, Trustees. The lobbying days linked with different stages of the appropriations process.”

The CHGME lobbyist noted the use of multiple advocates (children, families, VIPs—direct and indirect beneficiaries of the program’s funding). The nursing lobbyists noted the need to engage nursing students (direct beneficiaries of Title VIII funding). Currently, nursing organizations will have their members make visits to Capitol Hill who are not necessarily the recipients of Title VIII funding.

Nursing Lobbyist- “I would like to see us actually do a better job at getting the students directly involved in this because they have a direct benefit by increased resources.”

It was noted by a Congressional staffer that personal testimony on the importance of a program is critical.

Congressional Staffer (D)- “But generally I don’t think any piece of paper can tell it better than an actual story or talking to somebody. I think it’s really important to get the organization here as much as possible. And like I said it’s often difficult for these organizations that really need the appropriations to come out here because its expensive to...it’s an investment to make the trip to DC.”

Nursing Lobbyist- “We plan a lobby day where over 600 members come to town and it is one of three asks. [Title VIII] is a top priority for our organization.”

One of the issues identified by nursing lobbyists under this theme was the lack of funding for these events.

Nursing Lobbyist- “We typically do have fly-ins specifically for Title VIII appropriations. However, if the timing works and our members are in town, then we will ask that they advocate for increase funding levels. Unfortunately, we do not have the resources to have more than one fly-in a year.”

2.9 Grass tops

Grass tops are defined as citizens who have the “...greatest probability of influencing a legislator” (Goldstein, 1999, p. 61). The CHGME lobbyist described grass tops as using influential individuals from within the organization’s membership to help carry the message for a particular appropriations request. While this strategy was not used by nursing lobbyists, the CHGME lobbyists from the core organization noted grass tops

advocacy as a highly implemented strategy during the appropriations process. For CHGME, this would include high level donors who contributed to a legislator's political campaign such as a chief executive officer (CEO) of a hospital.

CHGME Lobbyist- "...Their chief executive officers, their trustees, through people affiliated with the hospital who had personal or working relationships with the key members of Congress."

CHGME Lobbyist- "We identified those high level donors to the folks that make the decisions. Everyone does it, there's nothing dirty about it. Those people have relationships with the decision makers. We educated them on the necessity of the program, and they would put in phone calls, schedule meetings, and make the case for why children's hospitals deserve to have a separate line in graduate medical education because we sure were not doing too well. We were getting 1/200th the GME, what adult teaching hospitals were getting for doing the exact same thing."

3. Strategy Differences by Chamber of Congress and Political Party

Overall appropriations strategy for Title VIII or CHGME did not differ by Congressional Chamber, according to the nursing and CHGME lobbyists. However, it was noted by a majority of the nursing lobbyists that the tactics or approach may differ especially related to the varying size of the Congressional chambers. Since the Senate is a smaller chamber, personal connections were cited as more important than the larger House of Representatives, where briefings were identified as a way to reach this Congressional staff audience. Additionally, it was noted that the tactics differed in relation to the area the Member represented. In the Senate, the member represents the state so the messaging can be much broader; however, in the House, a Congressional district may be small with few nursing contacts to lobby their representative.

Nursing Lobbyist- "In the Senate, it is a much smaller group...The Senate is a smaller body and it works a little bit differently."

Nursing Lobbyist- “With the House there are more people so we will focus on briefings. Because the Senate is smaller, we focus on more one-on-one discussions.”

Nursing Lobbyist- “A different tactic might be used. Messaging might be slightly different given the fact that a Senator represents an entire state. So you could, from a grassroots standpoint, use a lot more people to reach a Senator so a broader message sometimes works with the Senator. Whereas as in a particular Congressman’s district there may be only one person, one member, or one institution that will sway them on these funding issues. So you really have to use that one person. The tactics that you might use will be slightly different, but the strategy will remain the same.”

It was also noted by nursing lobbyists that timing affects the tactics. The House is the first chamber to move forward in the appropriations process so advocacy would start in this chamber. The CHGME lobbyists did not identify different tactics for the House and Senate.

Both the nursing and CHGME lobbyists felt that their issue was bipartisan and different strategies were not implemented based on the member of Congress’ political party.

Nursing Lobbyist- “The nursing issues are really bipartisan or nonpartisan, so sometimes there are certain facts about the programs that will resonate with one side or another, but for the most part, we really treat these as nonpartisan issues.”

CHGME Lobbyists- “Well whoever is in power, you’re going to put more emphasis there, but with the appropriations committee being relatively bipartisan, you know we work the bipartisan angle. You know you can’t ignore one party over the other even if they’re the minority.”

Nursing Lobbyist- “One nice thing about health care is that it is for the most part kind of a nonpartisan issue. For the most part there are payment policies that are geared to one party or another, but largely in the appropriations side of things you’re not dealing with that. I think that whether you’re a Democrat or a Republican you want to know that the money is being spent on Title VIII are dollars well spent and that it is effective.”

CHGME Lobbyist- “We were very cognizant of the support for the program being bipartisan.”

However, both nursing lobbyists and CHGME lobbyists noted that political party influenced their messaging so that it would be consistent with the party's philosophy.

Two themes emerged regarding how the lobbyists constructed their message—"fiscal conservatism" and "social awareness." Although "fiscal conservatism" was more often cited in relation to the Republican Party and "social conscience" was related to the Democratic Party, the nursing lobbyists noted that this might vary depending on the member of Congress, despite their political party.

Fiscal conservatism, associated more often with the Republican Party, was identified as a major theme which influenced how the lobbyists crafted their appropriations message. This messages relied on hard data and economic arguments. The importance of stressing the return on investment for the Title VIII or CHGME dollars was important for Republicans mostly, but also their Democratic colleagues.

Nursing Lobbyist- "The thing is that Republicans are more fiscally conservative and have attitudes towards not funding certain projects because they think they may be the responsibility of the state or the individual."

CHGME Lobbyist- "Republicans are more about equity, value, and return on value."

Nursing Lobbyist- "The strategy is the same, but the tone is different. Republicans are more fiscally conservative. Therefore there will be a different set of arguments. You will need to be more specific and explain how the programs work in their district or state. You will need to make them feel comfortable with the 'ask' and who it is supporting. The Republicans typically believe that the individual should pay for their education and the schools should be able to bring about the answers to the nursing shortage."

Nursing Lobbyist- "Republicans like to be able to see the business case and the value of this type of spending. Ultimately everybody is for nurses, except for those from whom this money will come and it will either come from some form of taxes or it will come from somebody in the form of less spending on a program they care about. So it has to be a demonstrated value proposition here."

CHGME Lobbyist- “So the Republicans were in power in 1999 when the program was first authorized, and going up there and making the case that you know this is a necessity, its not a hand out, we are simply looking for equity. It is an equity issue, and using that economic argument, the equity argument, that resonated. You know we’re not going to go up there and say “oh it’s for the children” That is not an effective argument, so we really relied on hard data and made those economic arguments, and the argument that ‘we cannot sustain our training programs....we are funding these training programs out of our operations and we are going to have to cut back’ and so I would say, yes it does depend on who’s in power. You have to find the arguments that resonate the strongest with the party that is in power.”

Nursing Lobbyist- “With the Republicans, cost is always an issue so we try to play up the real cost problem of having a shortage, make it more personal to them. Everyone knows you need nurses in the system, but make it personal to the care they would they receive in their state or district. A little more convincing for the Republicans is needed when it is tied to money. Explaining what you get for the money. For Democrats you have to explain that as well.”

Social awareness was identified as a message for the Democratic Party. This theme related to the “public good.” For example, the funding is “for the children” or “for nurses.”

Nursing Lobbyist- “Democrats are much more socially aware and are much more eager to sign discretionary programs as nursing is one. They seem to be more liberal in their ability to address these issues. A good example is the first ‘ask’ of the Nursing Community this year was \$215 million. The Nursing Community, having dealt with Republican administrations in the past, has always been much more conservative in their ‘ask.’ And this ‘ask’ of \$215 is a perfect example of that. Having dealt with Republicans, we were pleasantly surprised when the President in his budget put forward a 9.6% increase. This was beyond our wildest expectations. But again, I think it is reflective of the political philosophies of the various parties. The Democrats are much more willing to address discretionary programs with larger amounts of money.”

Nursing Lobbyist- “For the Democrats the hurdles are a little less high. Democrats have a strong affinity for the role government should play in the development of the nursing workforce. It has to be a blend of the two philosophies.”

Nursing Lobbyist- “Democratic representatives are more inclined to see the interest in nurse workforce development in terms of coalition support and coalition development.”

CHGME Lobbyist- “For the Dems [Democrats] it is the children. So you have to modify the message.”

4. Level of Funding Spent on the Advocacy Strategies

The CHGME lobbyists reported a higher level of funding spent on CHGME than the nursing lobbyists. Overall, the organization’s contributions to appropriations lobbying varied by association type and by issue (Title VIII vs. CHGME). Six of the ten nursing lobbyists reported the approximate dollar amount spent each year on lobbying for Title VIII. The average amount reported was \$75,000 with the minimum being \$50,000 and the maximum being \$100,000. The other four nursing lobbyists projected that it was a percentage of their total advocacy work. The percentage ranged from less than 25% to 50% with 32.5% being the average percentage of time spent on Title VIII advocacy. For nursing, variance in advocacy spending was identified by the type of organization. Two of the advanced practice nursing organizations and the nursing education organization reported that \$100,000 was spent annually on Title VIII appropriations advocacy. Two generic or specialty nursing practice organizations and one advanced practice organization reported \$50,000 was spent annually on appropriations advocacy for Title VIII (see Table 4.6).

The three CHGME lobbyists representing the core organization reported an approximate annual spending amount for appropriations advocacy. While one CHGME lobbyist reported \$1,000,000, the other two reported \$500,000 and other sums in the hundreds of thousands. One CHGME lobbyist from the core organization could not venture an approximation. The three CHGME lobbyists who identified themselves as working for a supporting organization all commented that “little” or “very little” was spent on CHGME lobbying (see Table 4.7).

Table 4.6**Nursing Appropriations Advocacy Financing by Organizational Type**

Nursing Lobbyist	Actual Dollars	Percentage of Efforts (%)	Organization Type (n=10)
NL1		30	Advanced Practice
NL2	\$50,000		Advanced Practice
NL3	\$100,000		Advanced Practice
NL4		>25	Advanced Practice
NL5	\$100,000		Advanced Practice
NL6		50	Specialty or Generic Nursing Practice
NL7	\$50,000		Specialty or Generic Nursing Practice
NL8	\$100,000		Nursing Education
NL9	\$50,000		Specialty or Generic Nursing Practice
NL10		25	Specialty or Generic Nursing Practice

Table 4.7**CHGME Appropriations Advocacy Financing by Organizational Type**

CHGME Lobbyist	Actual Dollars	Effort Level	Organization Type (n=5)
CHGMEL1	\$1,000,000		Core
CHGMEL2	\$500,000		Core
CHGMEL3		Little	Supporting
CHGMEL4		Very Little	Supporting
CHGMEL5		Little	Supporting
CHGMEL6	Hundreds of Thousands		Core
CHGMEL7	Could Not Provide a Guess	None Reported	Core

Research Question 2:

What do nursing lobbyist, CHGME lobbyists, and Congressional appropriations staff consider effective strategies to secure federal funding for Title VIII and CHGME?

Effective advocacy strategies are critical to securing high levels of federal funding. Ten themes emerged when the lobbyists and Congressional staff were asked to identify the most effective strategies for securing federal funding. They included: (1) use of grassroots lobbying, (2) relationships with Congressional staff, (3) unified lobbying, (4) understanding the process, (5) providing a reasonable “ask,” (6) being prepared, (7) appropriate demeanor with staff, (8) get to the point, (9) use of grass tops lobbying, and (10) financial investment in appropriations advocacy (see Table 4.9). A theme was considered “highly effective” if the majority of the participants, in each of the three groups (nursing lobbyists, CHGME lobbyists, and Congressional staff), stressed its effectiveness. A theme was considered “moderately effective” if it was mentioned as effective by a few participants in each group. A theme was considered “not effective” if it was not mentioned as an effective strategy by the participants in each group. Further details on the effectiveness of these strategies are described below.

Table 4.8

Most Effective Strategies to Secure Federal Funding

	Nursing	CHGME	Staff	Nursing	CHGME	Staff	Nursing	CHGME	Staff
	Very Effective			Moderately Effective			Not Effective		
Use of Grassroots	X	X	X						
Relationship with Congressional Staff	X	X	X						
Unified Lobbying	X	X	X						
Understanding the Process	X	X	X						
Reasonable "Ask"	X	X	X						
Be Prepared		X	X	X					
Appropriate Demeanor with the Staff			X	X	X				
Get to the Point			X				X	X	
Use of Grass tops		X	X				X		
Financial Investment in Appropriations Advocacy	X	X							X

1. Use of Grassroots Lobbying

The use of grassroots was considered a highly effective strategy by both the Title VIII and CHGME lobbyists. The Congressional staff also validated the importance of grassroots advocacy in relation to visits with constituents (see Table 4.9).

Congressional Staff (R)- “Some organizations fly-in their members. Hospitals will bring in their CEO, President, or their patients. It is better when the message is communicated by the constituent. Some professional organizations will fly-in physicians or nursing deans.”

Congressional Staffer (R)- “Having a constituent with a really compelling story from the district is important so that they can tell the member [of Congress] directly what works well.”

Congressional Staffer (R)- “The constituent will have a compelling story. They can tell you how the money will help the state.”

Congressional staffer (D)- “Come with a constituent.”

However, while nursing noted that grassroots advocacy was an effective strategy, they struggled to mobilize an effective grassroots campaign according to the nursing lobbyists and the Congressional staff.

Nursing Lobbyist- “I think that nurses out in the field don’t understand and don’t appreciate the power of their voices and that lobbying is a part of being an advocate. It is not something that is necessarily dirty or something nurses shouldn’t do.”

Nursing Lobbyist- “I think it would be an interesting test to use the coalitions that are in place to coordinate grassroots efforts together so that we have a Title VIII day where all of our organizations are sending grassroots input to the Hill. I just think our voice needs to be louder and more coordinated than those of us who are here in DC trying to scream. I also think that the coalitions that are in place ought to do some thinking about how we might be able to work together to sensitize the nursing community out in the field on why this is so important and not a bad thing, but a good thing.”

Congressional Staff (D)- “The one thing I have found to be nursing’s problem is that they have never figured out how to use their numbers. If they could instill in nurses at the baccalaureate level the importance of policy, you [principal investigator] would not have to be asking these questions.”

Further insight provided by the nursing lobbyists suggested that a major problem in nursing's ability to mobilize nurse constituents was that they become discouraged and lack hope that a funding increase will occur. It was mentioned that these constituents become frustrated that the funding for Title VIII is consistently low despite the many efforts to increase funding.

Nursing Lobbyist-“They cannot lose confidence in the nursing community. The nursing community works every year to secure higher levels of funding and will continue to work the issue. However, the DC representation cannot fight the battle on their own, members of Congress need the request to be tied to their district or their state, this is where constituent input is vital. In the last few years, there have been many factors inhibiting the increase in Title VIII, but we have to celebrate the small successes. While we were level funded for many years, we were never cut.”

Nursing Lobbyist- “Another issue that we often see is that our grassroots networks begin to become burned out or become cynical. It is very easy to say, ‘every year my organization requests that I write my member of Congress for the same or slightly higher funding level over last year.’ When people see that you are not making significant strides in reaching your appropriations request, they get frustrated. It is so important for nurses to know that we have to fight every year for Title VIII appropriations.”

It is interesting to note that a few of the CHGME lobbyists stated that while grassroots lobbying was effective in the beginning phases of advocacy for CHGME, the usefulness of the strategy is difficult to ascertain when a funding increase is not critical.

CHGME Lobbyist- “Grassroots letters, while extremely helpful in the start, I am not sure they make a difference during the ongoing advocacy. We are not working on a crisis so the volumes of letters may not be necessary.”

2. Relationship with Congressional Staff

Both the nursing and CHGME lobbyists considered relationships with Congressional staff to be a highly effective strategy. The importance of these relationships was corroborated by the Congressional staff (see Table 4.9).

Congressional Staff (R)- “Personal relationships. They are people you know. They go a long way. Often they are people you know who then became a lobbyist for the state issues.”

Congressional Staff (D)- “If you come once a year, with out following up, I am going to forget about you. However, the follow-up should not be intrusive. Offer to help me on other issues of interest. Don’t always come just asking for things. May be you could help write questions for a hearing or track what is going on in another committee.”

Congressional Staff (D)- “Know the office you’re visiting, know it well. If you can get any information ahead of time, know the staffer themselves, like who they used to work for or something, it will help clue you into something more personal at your initial contact, and that is always helpful.”

Congressional Staff (R)- “You have to have a relationship with the member [of Congress] or with the staff and with both sides of the aisle.”

Congressional Staff (R)- “The staff will develop connections with the constituents and their lobbyists. That is important.”

Nursing Lobbyist- “I’ve also seen a lot of people who don’t take the time to get to know the members and the staff of the committees and build a relationship. They just send a letter or add their organization’s name to the end of a larger letter and think that that’s sufficient. And I disagree. I think that you have to be engaged personally to be able to make the case for how this funding decision impacts their state and home district.”

The CHGME lobbyists, specifically noted the use of grass top advocates in Congressional staff relationship development. These individuals usually have provided political contribution to the member of Congress. Political contributions, a broadly cited strategy in the literature on lobbying, help develop personal relationships with a member of Congress (Goldstein, 1999; Savage, 1999; Wilcox & Kim; 2005; White, 2005; Wright, 1996).

3. Unified Lobbying

“Unified lobbying” or a “unified voice” consists of both coalition work and developing a cohesive message that each organization can support. The nursing lobbyists,

CHGME lobbyists, and the Congressional staff all considered this as a highly effective strategy (see Table 4.9).

Nursing Lobbyist- “I would say the most important thing is that you can’t do it alone. It has to be a collaborative effort and the bigger the collaboration the better chance you have. Unless some how you are particularly wealthy or you are somehow related to some of these people in the House or the Senate.”

Nursing Lobbyist- “There is strength in numbers. Coalition work is so important because more than one organization has a stake in funding for the program. There is always more power in numbers than if it is just you alone.”

CHGME Lobbyist- “One of the most important things is to have allies on the Hill and in the community and coordinate your activities as much as possible with those on the Hill and in the community. You’re most effective when what you are asking for will benefit everybody. You have to make them aware of how you fit into the larger picture.”

Congressional Staff (R)- “Everyone in the state has to get behind the ‘ask’ for the Senator to take notice. It is especially important when unlikely partners come together.”

Congressional Staffer (R)- “It is best when the ‘ask’ comes from people in the state or district working together. For example if they need seed money for a project and they have strong constituent support.”

While unified lobbying was considered an effective strategy, the nursing lobbyists revealed that nursing struggled to unify their lobbying activities and speak with “one public voice.”

Nursing Lobbyist-“Nursing in particular needs to be the unified voice. We need to find a way to let the important things that we can all agree on rise to the top and let the things that we don’t agree on, sit themselves to the middle or to the bottom. But other groups with healthcare interests have perfected the art of speaking with one voice, speaking publicly with one voice. We can speak to each other with as many voices as we want, but we need to have one public voice, and we don’t. People need to stick their necks out and start to unify the group and a put a brand and a website and all the other things that certain people have proposed doing.”

Most concerning to the nursing lobbyists was a lack of respect and unwillingness to collaborate by certain nursing lobbyists that prohibited a unified voice. They described

some lobbyists to be competitive and divisive. One nursing lobbyist noted that individuals in the community have “thrown others under the bus” for personal gain.

Nursing Lobbyist- “Also, nursing is not always cohesive, and individual organizations are advocating for their particular program that impact their members instead of really pushing for overall funding for all nursing education. I think sometimes we’re even competing against each other, instead of all of us going for the greater good.”

Nursing Lobbyist- “The only thing that jumps out at me is when you’re working in a coalition. I think coalition work is extremely important and it really adds a depth to your argument. But when you’re willing to throw members of the coalition under the bus for your own personal gain, I think that you lose a lot of ground.”

Nursing Lobbyist- “There is a long history in the nursing community of certain lobbyists causing problems and in-fighting, which is not beneficial to nursing as a whole. I have worked in other organizations where I have not experienced that same level of competition. Different players have moved in and out, but the level has remained the same...or is somewhat improved. There are some old school nursing lobbyists that have been doing this for a long time and do not play as nicely.”

Nursing Lobbyist- “I think on the negative side, although I haven’t really experienced it in my history with nursing lobbying, there was a time when the groups were extremely divisive and competitive and I think that those would be strategies that would be absolutely harmful.”

Shaw (2001) noted that, “the need to compromise on tactics, as well as on style and substance, makes some groups wary of joining coalitions” (p. 82). This appears to be a problem within nursing as the nursing lobbyists cited the inability to agree on the Title VIII “ask.”

Nursing Lobbyist- “A big one [ineffective strategy] has been lack of coordination between the nursing community. A lot of in-fighting about what the number should be...more than...less than... The difficulty is in getting the nursing community together. Although this has been much better under new leadership.

Nursing Lobbyist- “Inconsistency among the various organization on what we should ask for [has been a problem]. I would not say in the most recent years, but prior to that I would say there were situations where there was inconsistency in the voice.”

The nursing lobbyists clearly expressed concern over the lack of unity in the nursing community. However, as noted above, some of the lobbyists feel that this has been improving in recent years.

4. Understanding the Process

The need to understand the appropriations process as well as key deadlines was identified as a critical component of lobbying and a highly effective strategy noted by the lobbyists (see Table 4.9). This included the importance of understanding key dates and times during the appropriations cycle. This information was supported by the Congressional staff.

Congressional Staff (D)- “Lobbyists need to know when to deliver it [appropriations request]. They need to understand the timing and when requests are due. They should weigh in on budget requests as well. October and November OMB are considering their number. Work with the budget committee and appropriations committee.”

Congressional Staff (D)- “Make sure you are coming to me at the right time. February and March is when I should see you if you have an appropriations request.”

Congressional Staffer (D)- “I really do not like the lobbyists who come in and know nothing about the impact the program is having on the community. A lot of times it’s those same lobbyists who don’t know deadlines. They beat around the bush in terms of what are we doing and harass us all the time about where are we in the process. If you’re really knowledgeable about the timeline you know when you can prod.”

Nursing Lobbyist- “I would also say understanding the process and understanding who you’re asking from and what their constraints are. I think staff and members [of Congress] are fairly limited in what they can actually achieve. Giving them realistic requests allows them the ability to do what it is that you want. More importantly, it allows them to have success and enables them to come back to you the next year and continue to work with you. Also you can’t give up on it [advocacy], you can’t ignore it. Even for one part of the part of the process, let alone an entire year. You have to stay on it, because if people aren’t advocating for it, it becomes very easy for Congress and the Administration to ignore it.”

CHGME Lobbyist- “You need to work it from all angles. I think lobbyists tend to be this way by nature. You can go into a committee room and you can tell the difference between a hill staffer and a lobbyist and a journalist by what they’re wearing and the expression on their face. Lobbyists, I think, are sort of generally just uptight people, which is kind of a good thing, because if you’re trying to be successful in the appropriations game, you’ve got to know the process, you’ve got to start in the very beginning and you’ve got to work it until the very end. And you’ve got to work every member, every subcommittee, as much as you can.”

It was also noted by nursing lobbyists that the leadership of national associations should also understand the process, as timing is a critical factor in the lobbyists’ ability to act. If the leadership is not engaged in the process, it can be difficult to move forward with appropriations advocacy.

Nursing Lobbyist- “But I think that in a lot of cases, the appropriations process is really difficult to understand, especially to somebody who is not up here doing it every day. I remember my first appropriations cycle, I was a staff assistant doing work for a different organization and I really didn’t get it until I had gone all the way through one. I think that the leadership in organizations don’t necessarily know what’s going on and don’t necessarily know when key times and dates are coming up. They don’t know when certain things need to happen, and so the lobbyist has to make sure that those things are flagged and make sure there’s appropriate time devoted to appropriations. The leadership can’t take you in another direction or pull your priorities off track because they don’t understand the process or the importance of it.”

5. Reasonable “Ask”

Developing and providing Congress a reasonable “ask” was also considered by all the participants as a highly effective strategy to achieve federal funding (see Table 4.9). As described above, the “ask” must be based in fiscal reality and provide sufficient rationale.

Congressional Staff (D)- “A reasonable ask is important when you are in a tight budget cycle. When you ask for the program to be doubled, you can’t take that to your member [of Congress] so it becomes and non issue for you.”

However, as can be seen by the quotes from nursing lobbyists below, a difference exists in how the “ask” should be created. One nursing lobbyist noted that the “ask” should be based in reality and have the support of Congressional champions. The second nursing lobbyist did not feel that the appropriations request should be at the discretion of Congressional nursing champions.

Nursing Lobbyist- “Yes, I’ve seen people recommend funding levels that they pull out of the sky. Completely lacking of rationale or justification and they are not based in reality. They don’t do the outreach to our champions in Congress to see if they would even be comfortable in backing us.”

Nursing Lobbyist- “The request [for funding] has been modest and, the expectation has been modest. There was, as I recall, in the fairly recent past, a sense that nurse organizations should go to Capitol Hill and ask legislators ‘how much will you support for nursing education?’ and simply request that amount. Certainly it is in that legislator’s interest to give the smallest number possible that would satisfy the questioner so that they would have the least work, and be able to turn their attention to other things. That type of tactic is frankly no longer satisfactory to meet the public health need for nursing care in the system. I think short term thinking and short term strategies have yielded short term outcomes. I’d say going to the Hill, and asking them how much they’ll give you is ineffective. Just as if you walked up to somebody and said I will do something nice for you, how much will you pay me for it, and they’re going to give you the lowest possible number to satisfy your interest, if not zero.”

The difference in the statements above regarding how the Title VIII “ask” should be developed reinforces nursing’s inability to support a unified lobbying strategy. A difference in the tactics, as Shaw (2001) discussed, makes an organization wary of joining coalition work. This creates further division in the nursing community.

6. Being Prepared

The CHGME lobbyists and the Congressional staff considered “being prepared” as a highly effective strategy while the nursing lobbyists believed it was a moderately effective strategy (see Table 4.9). “Being prepared” includes knowing how the dollars

appropriated to the program were spent, how the funding will impact the state or district, the political climate, and the impact of additional appropriations.

Congressional Staffer (R)- “The best lobbyists know the Senator’s history. They know the areas of interest and can make a justification in refunding a particular [program] or the progress that is being made on a project. The constituents don’t know the political landscape like the lobbyists.”

Congressional Staff (R)- “You can quickly identify the experienced or veteran lobbyists. They are well versed in the specifics and know just what to say and when to say it. You can tell the ones who use to be Hill staff they anticipate your questions and have the answers.”

Nursing Lobbyist- “Do your homework. Identify why it is in the interest of a legislator to help you. Know the answer to the question ‘why should this matter to me in my own state or district?’ ‘What difference will this make?’ Know the answer to the question, ‘who will oppose this and why?’ If it doesn’t matter at home, it is not going to matter.”

Nursing Lobbyist- “I would say wherever possible, ground your request in real empirical data that shows value for the dollar spent. If you do that you will be one of the few people that are doing that on the Hill. I think often times either organizations don’t take the time or that information isn’t available, so that you’re asking for money in a vacuum. It’s just important to make sure you’re always collecting the data on what you’ve done with the money and then funnel that back into the lobbying effort for next year to say, ‘here’s what we achieved, here was our goal, we haven’t met the goal yet, and here’s what we need to reach our goal.’ I think legislators are logical like that, and then they can make a good assessment on if this is a good value. But that’s a very difficult task.”

Nursing Lobbyist- “I would say be prepared, understand the programs. Understand the past funding level. I think one of the biggest problem groups and lobbyists encounter is when there is a vast overreach that is outside the realm of possibility for a staffer or a Committee or Congress to provide. Seeking 100% increase for a particular program without a national emergency behind it is not a realist way to do it.”

Nursing Lobbyist- “I think that one thing is being an honest broker. Having the kind of information that elected officials need and making sure that it is accurate to the best of your ability. I mean you need data for justification.”

CHGME Lobbyist- “Understand the political climate and the climate around appropriations. You don’t want to go in there naïve, you want to acknowledge that the budget is bad, it’s very tight. So you don’t want to go in and ask for an exorbitant amount and look completely out of touch with political reality. And

have a well crafted ask. You can't just go in and put in your request and let it linger out there, you have to continue to pound the pavement.”

CHGME Lobbyist- “Do your homework regarding the programs and understand how the program operates in the real world. You have to be the credible voice for the program.”

One CHGME lobbyist described “being prepared” as building a rock solid case that had flawless rationale and evidence-based arguments stating why the funding is necessary. It was stated that if you do not have a rock solid case then you are “wasting your time.”

CHGME Lobbyist- “You have to be prepared to work extremely hard. If that answer was true in 1999 when Congress was operating under a surplus budget, it should hold more true in 2009 when the federal government is running astronomical deficit. You have to be prepared to work extremely hard and do everything. This issue is doing everything you can possibly do. You have to be ambitious and ask for what is worthwhile, but you also have to be prepared to be realistic. You have to be prepared to not take ‘no’ for an answer, and that is a tricky business. Sometimes ‘no’ means absolutely ‘no’ and sometimes ‘no’ means you have to have further conversations with the member of Congress. And we have found when you have a ‘no’ from a Congressional staffer you should never accept it until you have affirmation from the member of Congress. Appropriations lobbying is infinitely more difficult than it was ten years ago.”

The majority of the Congressional staff referred to “being prepared” as responsiveness to a request and providing expert information.

Congressional Staff (D)- “I do rely on professional organizations for their expertise and I have my favorites. The ones that are the most responsive and give me the best answers. For nursing, ANA and AACN get it right. In medicine it is the pediatric groups who do it well. March of Dimes is an exemplar and Trust for America’s Health. It is also important that the professional organizations keep in touch with you outside of the appropriations process.”

Congressional Staff (D)- “The good lobbyists can sometimes get to the source of information before I can. That’s really helpful. I try to work with the individuals at the organizations as much as possible. Not only because you can tell they know the issue better, but it’s important to get know your constituent and establish that connection.”

Congressional Staff (R)- “The best folks are the people we can always get a hold of. We can always get a hold of the lobbyist, but can’t always get to the dean of the school. Access is their biggest issue. Staff determines the projects funded. For example if you need to scale back the program request, you are going to go to someone in DC. The district people do not always have the knowledge like the lobbyist.”

Congressional Staff (R)- “I once received a personal thank you note that was delivered to the office. It was the best kind of follow-up I had received. But in general, you want to follow-up during the interim as well. It is easy to forget someone when appropriations is not the entire year.”

7. Appropriate Demeanor with Staff

The Congressional staff pointed to appropriate demeanor as a highly effective strategy while the nursing and CHGME lobbyists only reported this strategy moderately. The Congressional staff commented that lobbyists should not only act professionally, but they should also give deference to the individual constituent during joint meetings with the staff.

Congressional Staffer (D)- “I don’t like it when lobbyist get confrontational. Sometimes, you just don’t ‘click’ with them. Lobbyist who are arrogant or condescending or have an attitude towards you are bad. I also hate the people who act like I do not know anything even though I have been doing this for 12 years. I don’t want to work with the lobbyists I can’t trust. I like the lobbyists who are honest and reliable and don’t say crazy stuff.”

Congressional Staffer (D)- “Another thing is just your disposition with the staffer, and your ability to be friendly. It’s more helpful. I hate it when a lobbyist comes in with individuals from the state and the lobbyist dominates the conversation. Even if that person is boring, give deference to that individual. Because that’s really who the meeting is about, that’s who we want to hear from. Then if the lobbyist follows up and says ‘I know it was their first time, maybe they were a little nervous, but I wanted to follow up and provide some more detail,’ that’s the way you should do it as a lobbyist.”

While the nursing and CHGME lobbyists cited appropriate demeanor with the staff as moderately effective, they did report the importance of acting professionally with staff.

Nursing Lobbyist-“Some lobbyists and organizations can take on a threatening persona. They think that ‘we deserve this money, and if you don’t give us this money we won’t support you.’ I find that totally ineffective on the Hill. The Hill is all about begging and pleading. You have to humble yourself to say ‘let us help you.’”

Additionally, it was mentioned that the lobbyists should not “make enemies” with the staff or member of Congress, which was also corroborated by a Congressional staff member.

CHGME Lobbyist- “You always want to work with the appropriations committee. You do not want to work against them or get on their bad side. That is a very bad thing.”

Nursing Lobbyist- “Someone was actually just telling me last night about a cancer organization that did ads in the state of North Dakota against the whole delegation there. It was something having to do with NIH funding. The delegation was furious because they had already explained why they couldn’t vote for a particular provision, and when they didn’t the organization took out this nasty ad. Your relationships with Congress last a long time so if someone doesn’t do something right by you once, you just have to find another opportunity for them to do right the right thing. Playing those nasty games and criticizing offices I think it comes back to bite lobbyists and organizations more than it helps. Nobody’s gotten far from them.”

Congressional Staff (R)- “Don’t blast the member of Congress if you do not get what you want. That is a sure way to sour the member [of Congress] to that particular group. Don’t blast anyone. You want to foster relationships with them not destroy them. There are just some lobbyists who have not learned how to play well in the sand box.”

8. Get to the Point

One theme that was mentioned as an effective strategy by the Congressional staff but not the lobbyists was the need to “get to the point.” The Congressional staff are inundated with appropriations meetings. One staff commented that, on average, she held 17 meetings a day for appropriations requests alone. Therefore, the staff believed that an effective strategy was presenting a compelling case quickly.

Congressional Staff (D)- “Have brevity and as little materials as possible. No binders or journals.”

Congressional Staff (D)- “Don’t waste my time.”

Congressional Staff (D)- “You need to dive into it and get to the ‘ask.’”

Congressional Staff (D)- “Develop your case quickly and get to the point that helps me and provides an orderly flow to the meeting.”

9. Use of Grass tops

The major distinction to emerge between the nursing lobbyists and the other participants (CHGME lobbyists and Congressional staff) was the use of grass tops advocacy. This strategy was not mentioned by the nursing lobbyists during any of ten interviews. Grass tops advocacy, as noted above, is the use of influential constituents, such as hospital CEOs or hospital board members, who have a personal connection with the member of Congress to assist in an appropriations request.

CHGME Lobbyist “...meetings that cracked open the door... really blew it open was because somebody with credibility and an existing relationship came in and sat down and said, ‘look, Joe Representative, you know me, I’m not going to blow smoke, I’m telling you this is a significant issue, this is why it’s a problem and this is why we need you to get on board and support us.’ Those kind of conversations really helped open the door that then allowed us to use our grassroots. Taking in the grass tops along with the hospital representatives, maybe bringing in the CEO along with the government relations representative, with the chairman of the hospital board and having a sit down with a key Senator. So I’m going to say at the outset it was the grass tops meeting that got the program authorized.”

CHGME Lobbyist “Grass tops are significant. Having a personal meeting with the Chairman or Ranking Member of the Appropriations Committee. The meetings were not focused on lobbyist to staff, but hospital to member of Congress. The champions we had were the people who made the difference. It was a personal ‘ask’ to the member of Congress.”

CHGME Lobbyist “I think the grass tops strategies, CEOs or a physician leader from the hospital back home. These include visits to the hospitals by the members of Congress. The member can follow a resident and see how the funding is being used.”

Congressional Staff (D)-“I’ve found that a lot of the big organizations, whether it be the national organization of hospitals...they often hire lobbyists that used to be big shots on the Hill or big shots in the administration. Regardless of how effective of a lobbyist they are, their name is able to carry the cause, and often times they can meet with the Senator themselves and are able to get to the Chief of Staff, and those types of influences. That’s where the rubber meets the road. If you don’t have a champion who can move the cause up the ladder, it’s unfortunate.”

10. Financial Investment in Appropriations Advocacy

The final theme to emerge as an effective strategy was the investment in appropriations advocacy. While the Congressional staff did not mention this strategy, it was cited and a highly effective strategy by both the nursing and CHGME lobbyists. However, an important difference emerged during the data analysis— CHGME had sufficient resources while nursing did not. As noted above, the CHGME reported that they hosted three lobby days a year and commented that a study was commissioned by the Lewin group to determine the level at which CHGME should be fully funded. Both of these strategies are significant financial investments. The nursing lobbyists cited a lack of financial investment in advocacy as a barrier to achieving increased funding for Title VIII. It was mentioned that without this investment an organization could not be expected to have “their voice heard.” Another lobbyist commented “you get what you pay for.”

Nursing Lobbyist- “And I would also say organizations’ investment in government affairs overall. Organizations can choose what they do with their budget. In the past 15 years, organization’s investments in government affairs, not just nursing organizations, but broadly has increased. It has been amazing how every year organizations say I want my voice heard in Washington. How do I do that? What do I need to do? In nursing, there are a lot of groups that have high hopes, but are not willing to put their resources towards those efforts so the biggest barrier are those organizations that want a place in the discussion and a place in the debate over these issues but don’t put forth the time or effort to have professionals do this work. So organizations I think need to make an investment into putting forth part of their budget to government affairs and hiring policy professionals who can represent them both on Capitol Hill and can educate them

and their members about advocacy. I think a lack of that by a certain portion of the nursing community has been one of the biggest barriers. I can also say that...that may be a group may not have the ability to afford to do that, which is understandable, but I think that they have to be willing to understand that their voice will be heard less and that is just the nature of the democratic process and of advocacy in any area let alone nursing.”

Nursing Lobbyist- “And the money issue... I wish I could figure out. I think we all need PACs, but that is not going to happen on our end.”

Nursing Lobbyist- “We have limited recourses at the organization. There are too few staff and even fewer tools that would be helpful in our advocacy efforts. We don’t have a PAC so that is a barrier to access. Most of all, advocacy is not a high priority for our Board of Directors and our Executive Director. They do not want to invest resources in advocacy, so you get what you pay for.”

Nursing Lobbyist- I also think that our resources in general, given they are so much less than other communities, hampers our ability to be fully effective within the policy and lobbying industry.”

In summary, themes one through five were considered highly effective by all participants interviewed. Themes six and seven were reported as highly effective by both the CHGME lobbyists and Congressional staff, but only moderately effective by nursing lobbyists. The Congressional staff were the only participants to consider theme eight as highly effective. Unlike the CHGME lobbyists and Congressional staff, the nursing lobbyists did not mention theme nine. Finally, both the nursing lobbyists and the CHGME lobbyists cited the importance of an investment in appropriations advocacy. This was not mentioned by the Congressional staff.

Research Question 3:

What are the major difference in strategies used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME?

Based on the data presented under research questions one and two, it was concluded that eight significant differences exist in appropriations advocacy by the Title VIII and CHGME lobbyists. The following eight strategies were identified as: (1) a lack of grass tops advocacy, (2) a lack of grassroots intensity, (3) the absence of a unified lobbying strategy, (4) the absence of a data-driven “ask,” (5) a lack of consistent visits with Congressional staff and offering district visits, (6) a lack of a financial investment in appropriations advocacy, (7) an absence of an easily framed message, and (8) a lack of influential players.

1. A Lack of Grass Top Advocacy

Nursing did not report the use of grass tops advocacy. However, both the CHGME lobbyists and Congressional staff considered it to be a highly effective strategy. Since the nursing lobbyists did not report the use or importance of this strategy, it is difficult to determine if grass tops nursing advocates exist or if it is difficult for nursing lobbyists to determine who these individuals are.

2. A Lack of Grassroots Intensity

All the participants interviewed commented on the effectiveness of grassroots advocacy. However, Congressional staff and nursing lobbyists noted the difficulty in mobilizing nursing constituents. This was not cited by the CHGME lobbyists. The CHGME lobbyists explained their grassroots advocacy efforts were successful because they involved multiple beneficiaries of the CHGME program—the physician residents, the patients, and the hospital. The nursing lobbyists stated the difficulty in obtaining

sufficient resources for grassroots efforts to ensure Title VIII beneficiaries such, as nursing students, visit with or write to their members of Congress. The lack of grassroots intensity was also described by the nursing lobbyists as nurses not understanding its importance, frustration with incremental increases for Title VIII, lack of knowledge about the programs, and not knowing they should participate.

3. The Absence of a Unified Lobbying Strategy

The nursing lobbyists reported that a unified lobbying strategy was important and noted the “unified voice” had improved in recent years. Nevertheless, the majority of the lobbyists reported that nursing still struggled to come to agreement. When the responses from the nursing lobbyists were analyzed, differing opinions emerged, particularly related to how the Title VIII appropriations ‘ask’ was developed. The CHGME community was successful in achieving unity. The supporting CHGME lobbyists relied on the core organization to make the decisions regarding advocacy strategies for CHGME appropriations. As Shaw (2001) noted, “coalitions require individual groups to cede control of strategy and tactics” (p. 82). While one lobbyist stated that the “Nursing Community” coalition was under the leadership of one lobbyist, the other lobbyists did not comment on a single leader for the coalition, which may contribute to the lack of unity. A lack of unity was seen as an ineffective strategy by the Congressional staff; however, the staff did not report that nursing was not unified, simply that unity was necessary.

4. The Absence of a Data-Driven “Ask”

A data driven “ask” was reported as providing a justifiable and rational explanation for why a particular funding level was needed. The Congressional staff

stressed the importance of a reasonable “ask” that was based on data. However, the prominent difference between the nursing lobbyists’ “ask” and that of the CHGME lobbyists was the lack of data to justify the request. The CHGME lobbyists noted that their “ask” was developed by the Lewin group and based on equity or parity with the Medicare Graduate Medical Education funding. This request is easily explained. However, the nursing lobbyists noted that due to a lack of comprehensive data, they could not develop a data-driven “ask.” Therefore, the nursing request was typically developed by consulting with the Congressional champions, which one nursing lobbyist stated as not meeting the actual need for Title VIII because the Congressional champions supported conservative requests.

Another difference related to the data-driven “ask” was the level of funding requested by the CHGME and nursing lobbyists. The CHGME lobbyists requested \$330 million, which provides parity to the Medicare Graduate Medical Education funding. This is an exact amount based on concrete data. Since the nursing lobbyists rely on the Congressional champions to “approve” their “ask” and they stated that it should be based in fiscal reality, it has remained, on average, \$200 million for the last six fiscal years (as noted by the nursing lobbyists). The request of \$200 million, does not coincide with the need for Title VIII. Congress provided \$160.61 million to Title VIII in FY 1973; the largest appropriation of funds Title VIII received prior to FY 2009. Adjusting for inflation, this amount would be a commitment of over \$763 million today. Nursing’s request of \$200 million is approximately 25% of the \$763 million. The conservative nature of nursing’s request as well as the lack of data to support the current need is a barrier that inhibits nursing from increasing federal appropriations for Title VIII.

5. A Lack of Consistent Visits with Congressional Staff and Offering District Visits

When the Congressional staff were asked to provide differences in strategies used by the Title VIII and CHGME lobbyists, they noted that the local children's hospitals consistently lobbied their office on behalf of CHGME. The Congressional staff reported a wide variety of nursing organizations that lobbied on behalf of Title VIII, yet only four staff members could identify specific nursing organizations. All four staff members who reported actual nursing organizations (3 Democrats and 1 Republican) noted that AACN and ANA consistently visited their offices on Title VIII. The American Organization of Nurse Executives, the American Association of Nurse Anesthetists, APRN groups, state boards of nursing, the nurse managed health clinics, and Service Employees International Union (SEIU) were reported as organizations that had visited the staff's offices. Two Republican staffers stated they had not been lobbied on behalf of Title VIII. Moreover, it was noted by one Congressional staff member, "*every nursing group comes in for a visit [separately], nursing should lobby together.*" This Congressional staff's comment refers back to nursing's inability to unify their lobbying strategy and suggests that nursing should lobby for Title VIII together. Additionally, this Congressional staff member commented that,

"...the small nursing organizations don't get it. They come in with multiple asks, they are all over the place, they are asking for support on legislation. Don't bother appropriations staffers with legislative asks!"

District visits was the second strategy reported by Congressional staff as a strategy used by the CHGME lobbyists, but not the nursing lobbyists. The Congressional staff noted that while they were in the district or state, they were invited on hospital tours to meet with the patients from the children's hospital as well as the physician residents

who were support directly by the funding. The staff reported that this was memorable experience because they could see how the funding was being used to care for children. The Congressional staff and the nursing lobbyists did not state that they offered visits to schools of nursing, hospitals, or other clinical sites to see the benefit of Title VIII dollars. Much like the visits to children's hospitals, these visits would help emphasize the importance of Title VIII funding. However, it should be noted that this strategy has been applied inconsistently in the past by nursing organizations.

6. A Lack of a Financial Investment in Appropriations Advocacy

As indicated above, nursing's investment in Title VIII appropriations advocacy does not equal the amount spent by the CHGME lobbyists. The amount of money spent on appropriations advocacy was based on assumptions made by the lobbyists. However, the CHGME lobbyists' estimations far exceeded the nursing lobbyists. Between \$500,000 and \$1,000,000 was reported by on CHGME organizations. This amount nearly equaled the total sum reported by all the nursing lobbyists interviewed. This lack of financial investment toward Title VIII advocacy by the nursing community is a mitigating factor for why nursing also struggles to implement other effective strategies such as a grassroots and a data driven "ask."

As a follow-up question regarding funding spent on advocacy, the PI contacted one CHGME lobbyist and one nursing lobbyist to determine how many lobbyists were employed at their respected association. To compare like entities, the medical education lobbyist and the nursing education lobbyist were contacted. The medical education lobbyists noted that eight registered lobbyists were employed at the association. The nursing education lobbyists stated that two registered lobbyists were employed at the

association. Medical education lobbyists outnumber nursing education lobbyists four to one or there is 300% more medical education lobbyists than nursing education lobbyists. It should also be noted that when comparing these associations' memberships there are over 500 more nursing schools than medical schools. The number of lobbyists impacts an association's ability to cover multiple issues effectively.

7. Absence of an Easily Framed Message

When the study was developed, the FY 2009 appropriations process had not been completed and the FY 2008 levels for Title VIII (\$156.05 million) and CHGME (\$301.6 million) were used in the interview guide. The Congressional staff were asked to offer their insights on why CHGME had a higher funding level than Title VIII. Half of the staff interviewed did not realize the vast funding difference between Title VIII and CHGME.

Congressional Staff (R)- "I am shocked to hear this. I am not sure why there is such a large distinction."

Congressional Staff (D)- "Wow, I didn't even know that... That's unreal."

However, the main theme to emerge when this data was analyzed suggested that the CHGME lobbyists more effectively framed their message. The Congressional staff stated that CHGME is for the children, which is why they may be more compelled to fund the program. They could easily understand the need to provide funding to train pediatricians who will care for children.

Congressional Staff (D)- "The benefits are easier to see because it is children's health."

Congressional Staff (R)- "Maybe it is because we want to help the children under any circumstance."

Congressional Staff (D)- "I think also it seems kids are such an easy topic with us, items that focus on kids. Everybody loves kids. It's easy to frame that argument in

terms of ‘we’re just helping the kids.’ And everyone loves a children’s hospital, it’s all decorated and able to bring warm fuzzies to people.”

Congressional Staff (R)- “We had the opportunity to visit children’s hospitals in the district. CHGME is easy. The money is used to keep one-pound babies alive.”

Congressional Staff (D)- “You can understand CHGME...it is for the physicians who take care of the children.”

Congressional Staff (D)- “Maybe it’s just me, but how can you say no to the children.”

In contrast, the Congressional staff stated that Title VIII was more difficult to understand because the programs were so diverse. The Title VIII programs support advanced practice registered nurses, entry-level nurses, recruitment and retention efforts, nurse faculty, and geriatric nursing programs. This becomes confusing for the Congressional staff because various nursing organizations will lobby for one aspect of the Title VIII programs. For example, as the nursing lobbyists described, the advanced practice groups will stress the importance of how Title VIII is important for the subset of nursing. Therefore, the message is not clear how the Title VIII dollars are spent and it is difficult for the Congressional staff to understand exactly where the money is directed and the results of the funding. This diversity in messaging refers back to nursing’s inability to unify their lobbying strategies.

Congressional Staff (D)- “I think it’s [Title VIII] so massive and you have so many different types of nurses and you have such a big nursing shortage. It is not as easy to solve as children’s hospital. Issues are so limited with those hospitals, I mean one children’s hospital has something like 90% bed list, then they’re able to train 90% of the physicians. So I think it [CHGME] seems more targeted, while the Title VIII programs are massive, and people can’t see the immediate result of the funding. I think that’s where the difficulty in messaging lies.”

Congressional Staff (D)- “It’s hard for a Congressional staffer to understand all that it’s under Title VIII. You have loans and scholarships and then some funding goes to the schools and to the hospitals.”

Congressional Staff (D)- “The diversity of the nursing issues makes it harder to advocate for.”

The messaging for CHGME is clearly framed to suggest that the money is used “for the children.” Nursing, on the other hand, has not framed the message for Title VIII in a way that Congressional staff will easily identify with and feel compelled to support. This messaging related directly to the importance of “being memorable” as one Congressional staff stated. Considering the number of appropriations visits, lobbyists must find a way to stand out amongst the masses.

Congressional Staff (R)- “You have to figure out a way to be memorable. I have 17 meetings a day so it is hard for me to remember you. You need something that stands out. A way to connect with the staff and build a relationship. You have to bring in the constituents.”

When the Congressional staff visit the children’s hospitals, they remember the children. This is lacking in nursing. The Congressional staff do not have a person or individual, like the children, to link the Title VIII programs to.

8. A Lack of Influential Players

The Congressional staff noted that nursing lacked influential players, which may be one reason CHGME received a higher level of appropriations than Title VIII. Such large organizations as the American Hospital Association and American Medical Association lobby on behalf of CHGME because it funds hospitals and in turn funds physician residents. The Congressional staff did not associate nursing as having powerful and influential players advocating with them.

Congressional Staff (D)- “CHGME funding is providing funding to the hospitals to train pediatricians. So you have big players in the game. The American Hospital Association and the American Medical Association are two major industries that lobby on behalf of it because they get the money. Traditionally, the physicians have done a better job at getting the government to pay for their training.”

Moreover, because these organizations are considered influential and powerful, they are able to hire “big shot” lobbyists.

Congressional Staff (D)- “It has to be their lobbyists. I’ve found that a lot of the big organizations, whether it be the national organization or hospitals. they often hire lobbyists that used to be big shots on the Hill or big shots in the administration. Regardless of how effective of a lobbyist they are, their name is able to carry the cause, and often times they can meet with the Senator themselves and able to get to the Chief of Staff, and those types of influences, and that’s where the rubber meets the road. If you don’t have a champion who can move the cause up the ladder, it’s unfortunate.”

Conclusion

The aims of this comparative exploratory descriptive qualitative study were to gain insight into effective lobbying strategies of interest groups and which of these strategies influence federal Appropriators decisions. This study compared the lobbying strategies used to advocate for the Title VIII Nursing Workforce Development programs with those used to advocate for CHGME in an effort to determine differences in advocacy strategies. Twenty-seven interviews were conducted with nursing lobbyists (n=10), CHGME lobbyists (n=7), and Congressional appropriations staff (n=10). The Congressional staff were included in this study to determine which advocacy strategies were deemed effective and which strategies influenced an appropriator’s decision.

The data revealed that the nursing and CHGME lobbyists used similar strategies to secure federal funding for their respective programs. Of the five strategies reported to develop an appropriations “ask,” only one differed. The CHGME reported the use of data, while the nursing lobbyists did not. Three out of the eight strategies differed in regards to what strategies were used to secure federal funding. First, the CHGME did not mention the use of member education, while the nursing lobbyists reported moderate use.

Second, the CHGME lobbyists reported that lobby days were highly used while nursing only moderately reported this strategy. Third, the major strategy that was highly used by the CHGME lobbyists, but not used by the nursing lobbyists, was grass tops advocacy. Finally, the CHGME lobbyists reported higher amounts of funding spent on appropriations advocacy than the nursing lobbyists.

The second research question was what nursing lobbyist, CHGME lobbyists, and Congressional appropriations staff consider effective strategies to secure federal funding for Title VIII and CHGME? Five out of the ten effective strategies reported by participants differed. First, the CHGME lobbyists and Congressional staff considered “being prepared” as a highly effective strategy, while the nursing lobbyists reported it as moderately effective. Second, the Congressional staff believed “appropriate demeanor with staff” to be a highly effective strategy, while the nursing and CHGME lobbyists considered it to be moderately effective. Third, the Congressional staff considered the need to “get to the point” as effective. The nursing and CHGME lobbyists did not mention this strategy. Fourth, the Congressional staff and the CHGME lobbyists found grass tops advocacy to be highly effective, but it was not mentioned by the nursing lobbyists. Finally, both the nursing lobbyists and the CHGME lobbyists found a fiscal investment in appropriations advocacy as an effective strategy, but it was not mentioned by the Congressional staff. Additionally, it should be noted that the grassroots and unified lobbying strategies, while reported effective by the nursing lobbyist were not necessarily used effectively. Specifically, the nursing lobbyists noted a lack of a “public voice” and an inability to mobilize their memberships to contact their member of Congress.

The third research question provided the key conclusions for this study—what are the major difference in strategies used by nursing and CHGME lobbyists to secure federal funding for Title VIII and CHGME? The results for this question suggest that nursing lacked important aspects used by the CHGME lobbyists to secure federal funding. These included: (1) a lack of grass tops advocacy, (2) a lack of grassroots intensity, (3) the absence of a unified lobbying strategy, (4) the absence of a data-driven “ask,” (5) a lack of consistent visits with Congressional staff and offering district visits, (6) a lack of a financial investment in appropriations advocacy, (7) absence of an easily framed message, and (8) a lack of influential players.

CHAPTER FIVE

Discussion

The aims of this comparative exploratory descriptive qualitative study were to gain insight into effective lobbying strategies of interest groups and which of these strategies influence federal Appropriators decisions. Twenty-seven interviews were conducted with nursing lobbyists, CHGME lobbyists, and Congressional appropriations staff. The ultimate objective of this study was to understand effective advocacy strategies to enhance lobbying efforts for Title VIII Nursing Workforce Development programs.

Compared to the existing literature on effective lobbying strategies, it was concluded that while nursing uses similar strategies to those who advocate for CHGME, their level of investment in these strategies was significantly less. Moreover, nursing lacks specific components of inside and outside advocacy strategies such as grass tops advocacy and grassroots intensity, which impacts the profession's ability to secure higher levels of funding for the Title VIII programs. Below, based on the first aim, the results are presented to demonstrate how they support existing literature. Next, based on the second aim, the results of this study are framed by existing lobbying theories to provide recommendations for ways to improve nursing advocacy. Study limitations and a conceptual framework are also presented below. Finally, future research and implications for the profession are offered.

Aim 1: Effective Lobbying Strategies of Interest Groups

Nine major themes were identified by the lobbyists and Congressional staff as effective lobbying strategies. These included: (1) use of grassroots lobbying, (2) relationships with Congressional staff, (3) unified lobbying, (4) understanding the process, (5) providing a reasonable “ask,” (6) being prepared, (7) appropriate demeanor with staff, (8) get to the point, (9) use of grass tops lobbying, and (10) financial investment in appropriations advocacy. These findings are consistent with current literature on classic “inside” and “outside” lobbying strategies as describe below. Most of the themes were inside strategies (themes two, four, five, six, seven, eight, nine, and ten) Theme one is an outside strategy. Theme three can be considered both an inside and outside strategy.

Inside Strategies

As noted in chapter 2, inside strategies “involve quietly persuading a member of Congress in a meeting with interest group lobbyists, to act in a particular way” (Wilcox & Kim, 2005, p. 130). They are considered superior in relation to efficient information processing and rely on the reputation of the lobbyist (Beyers, 2004). Inside strategies are difficult to measure accurately and thus opinion varies on their effectiveness. However, Wilcox and Kim noted that they are most successful when they are not noticed.

Examples of inside strategies include, providing contributions to political campaigns, offering electoral support (“getting the vote out” or running advertisements), hiring professional lobbyists with access to key legislators, or offering important data or technical assistance on legislation. The majority of the strategies identified by the nursing and CHGME lobbyists as well as the Congressional staff were inside strategies.

Since inside strategies rely on personal connections with or access to members of Congress or their staff, five specific themes identified in this study confirm the existing literature on inside strategies (Beyers, 2004; Wilcox & Kim, 2005). These include: relationships with the Congressional staff, appropriate demeanor with staff, get to the point, providing a reasonable “ask,” and using grass tops. Relationships with Congressional staff and the use of grass tops were directly discussed in the literature, while appropriate demeanor, get to the point, and provide a reasonable “ask” are implied. Lobbyists who do not behave appropriately will not gain access to the member of Congress or their staff. Similarly, as the Congressional staff in this study noted, they appreciate lobbyists who can “get to the point.” Pleasing the Congressional staff helps to develop a positive relationship.

Offering staff important data or technical assistance on legislation is also considered an inside strategy. Therefore, understanding the process and being prepared, two themes identified in this study, would be considered inside strategies. In order for lobbyists to provide technical assistance on legislation, they must understand the process, especially the timing. Additionally, “being prepared” and “get to the point” emphasizes to the importance of providing critical data.

This study found that a financial investment in appropriations advocacy is an effective strategy. This theme would be considered an inside strategy because it impacts a lobbyists’ ability to develop relationships and collect important data.

Outside Strategies

As Wilcox and Kim (2005) note, outside strategies “involve contact between a group’s members and the offices of legislators” (p. 137). The most widely used form of

outside strategies includes grassroots lobbying which was identified by all the participants in this study as an effective strategy. Grassroots can include a coordinated call or email campaign, participating in a lobby day, or protests. The effectiveness of outside strategies is often measured by the quality and quantity of output by the constituents (Kollman, 1998; Thrall, 2006; Wilcox & Kim, 2005).

One theme identified in this study that could be considered both an inside and outside strategy is “unified lobbying.” The efforts of a unified coalition must incorporate both inside and outside strategies. Unified lobbying will be discussed more thoroughly in the next section. In summary, the findings of this study, supported by the body of literature on inside and outside strategies, suggest that a combination of strategies is most effective.

Aim 2: Strategies that Influence Federal Appropriators Decisions

The major findings of this study suggest that nursing does not employ eight key strategies that the participants deemed effective and influence federal appropriators’ decisions. These include: (1) a lack of grass tops advocacy, (2) a lack of grassroots intensity, (3) the absence of a unified lobbying strategy, (4) the absence of a data-driven “ask,” (5) a lack of consistent visits with Congressional staff and offering district visits, (6) a lack of a financial investment in appropriations advocacy, (7) an absence of an easily framed message, and (8) a lack of influential players. These findings are consistent with existing theories and the current literature on lobbying and interest groups. Below, the findings will be applied to these theories and findings from existing literature. A conceptual framework will be presented to shape the results of this study.

Exchange Theory

Exchange theories (Austen Smith, 1996) would suggest that nursing's lack of grass tops advocacy and a lack of financial investment in appropriations advocacy inhibits increased appropriations for Title VIII. Specifically, exchange theories suggest that lobbyists and legislators engage in unspoken agreements or trade. This type of trade is typically identified as political campaign contributions to a member of Congress for their vote on a particular issue (Austen Smith; Morton & Cameron, 1992), but can include time such as volunteering for a political campaign. The nursing lobbyists did not mention the use of grass tops advocacy as it related to the use of influential individuals who contributed to a member of Congress' political campaign. As the theory suggests, the trade between a member of Congress and lobbyist or grass tops advocate is an implicit trade. Therefore, exchange theory would suggest that grass tops nursing advocates need to offer political contributions and time to members of Congress in return for the understanding that they will support increased funding for Title VIII. In particular, grass tops advocates should engage in developing relationships with federal appropriators. Since the nursing lobbyists did not mention the use of grass tops advocacy, it is difficult to ascertain whether grass tops advocates exist in nursing, if it is hard for the nursing lobbyists to determine who they are, or if influential nurses have not cultivated grass top level relationships.

Persuasion Models

Models that view lobbying as persuasion (Hansen, 1991; McGuire, 1989; Wright, 1996,) would suggest that nursing's lack of grassroots intensity, consistent visits with Congressional staff and offering district visits (to nursing schools or hospitals when a

member is home), a data-driven ask, an easily framed message, and a unified lobbying strategy inhibits their ability to increase federal appropriations for the Title VIII Nursing Workforce Development programs.

As Hansen (1991) describes persuasion models, interest groups have access to information about their constituent views which can persuade legislators. The ability of nursing to persuade members of Congress in relation to constituent views proves to be difficult because grassroots intensity is lacking. If legislators do not hear from their constituents on an issue they are unlikely to act. Similarly, if appropriations staff are not consistently visited by nursing lobbyists, they will not be persuaded that funding for Title VIII is important. Additionally, if Congressional staff are not invited to nursing schools, hospitals, or other clinical settings in the state or district, they will not be persuaded by the constituents of Title VIII. Nursing advocates must engage in these types of activities.

Persuasion models also suggest that the relevance of the message is critical in the attempt to persuade a member of Congress (McGuire, 1989; Perloff, 2003). According to persuasion models, nursing's lack of a data-driven "ask" inhibits the ability to increase funding for Title VIII. As the nursing lobbyists suggested in this study, they did not have current data on the intensity of the nursing shortage that could accurately describe to the members of Congress the need for Title VIII funding. This hindered attempts to create a data-driven "ask." Without a compelling argument that is relevant and emphasizes the need for funding, members of Congress are unlikely to increase funding. Based on the persuasion model, nursing lobbyists should consider financing a study to determine what level of funding Title VIII needs to address the nursing and nurse faculty shortages, even if it is a percentage or portion of the total funds needed.

McGuire's (1989) model of persuasion suggests that persuasion is only effective if the individual comprehends the message. When competing with multiple messages, Congressional staff must decide which message to pay attention to. Therefore, if Congressional staff only pay attention to the relevant messages, nursing's lack of an easily framed message regarding Title VIII may inhibit increases in funding for the programs. Therefore, nursing lobbyists should consider developing a consistent message that is relevant to the political climate, possibly framed around the current healthcare reform debates.

Similarly, the lack of a unified lobbying strategy also inhibits nursing's ability to persuade members of Congress to support Title VIII. The nursing lobbyists noted that each organization advocates for their specific programs under Title VIII. The Congressional staff reinforced this message by commenting that the Title VIII programs are too diverse and it is difficult to understand their mission. As McGuire's (1989) persuasion model suggests, a message is only effective if it is comprehended. Conflicting messages about the Title VIII is obviously not a unified lobbying strategy and thus the message is less likely to be comprehended by the staff. This in turn inhibits the ability of nursing to persuade the members of Congress and their staff that Title VIII is critical to fund. Nursing organizations and their lobbyists should strengthen existing coalitions such as the "Nursing Community" to help unify a Title VIII appropriations advocacy strategy.

Legislative Subsidy Theory

According to Hall and Deardoff (2006), legislative subsidy suggests that "legislators are interested in issues on which they wish to make "progress" (p.73). Progress on an issue could be associated with a legislator moving closer to a preferred

policy, a legislator increasing the probability of change, or a legislator delaying the enactment of a bad policy. Viewing lobbying as a subsidy, Hall and Deardoff suggest that participation or “effort” of a member of Congress will increase when lobbying efforts increase. Nursing’s lack of consistent visits with Congressional appropriations staff and lack of grassroots intensity inhibits a member of Congress’ effort to support Title VIII. As mentioned above, nursing lobbyists must work to grow a strong grassroots network for their organization and use this network to consistently make visits to Capitol Hill.

Constituent Engagement

Research has shown that an organization with a large constituent base in a particular district or state can “gain the ear” of their member of Congress simply because their members are registered voters (Wright, 1996). As Goldstein (1999) suggests, “grassroots communications demonstrate to legislators that traceability has been established” (p. 39). Traceability suggests that a large constituent voice has been registered with the member of Congress through calls, emails, or other methods. The nursing lobbyists noted that new on-line advocacy tools exist. However, they commented that it is difficult to mobilize constituents to contact Congress, which was suggested as a barrier to increase Title VIII appropriations.

To overcome this barrier, researchers would suggest a number of solutions. First, as Goldstein (1999) noted, “citizens contact their legislators when someone asks them to and shows them how.” As the nursing lobbyists noted, more member education is needed within their organization’s membership on the importance of Title VIII funding and the mission of these programs. It was confirmed by the nursing lobbyists that nursing constituents, including practicing nurses, students, faculty, and deans, are “asked” to

respond to the messages requesting they contact their member of Congress, but the problem may lie in the need for the constituents to be “shown how” and have the impression that their personal message is necessary to impact change.

Second, Goldstein (1999) would suggest that interest groups should target members who are most likely to respond to a request to participate if asked. These individuals include citizens with higher levels of education and stronger connections to political life because they tend to have more influence and are more likely to respond to a request (Goldstein). The barrier for nursing, may be identifying nursing constituents who have a strong connection to a political life. Nursing research suggests a perceived lack of involvement or “political apathy” has hindered nurse participation in shaping healthcare policy especially compared to other healthcare professionals (Des Jardin, 2001; Winter & Lockhart, 1997).

The third potential solution to elicit a more intense response is to impress upon the individual constituent that they would suffer a personal cost (Tversky & Kahneman, 1981). If the nursing constituents felt that a lack of increased funding for Title VIII would impact them personally, they may be more likely to respond. This finding refers back to the nursing lobbyists and Congressional staff comments that more students should be engaged in advocating for nursing education. Moreover, nursing schools, faculty members, hospitals, and other clinical settings are also direct beneficiaries of Title VIII and consequently should be more heavily engaged in grassroots advocacy.

When considering the importance of engaging direct Title VIII beneficiaries, the PI questioned the actual intensity of nursing’s grassroots. The PI contacted the nursing education lobbyist to determine the number of messages sent by their membership as it

includes direct Title VIII beneficiaries- nursing schools, students, and faculty. While not all requests for action were directly related to Title VIII, they were related to nursing education policy in some way. It was reported by the nursing education lobbyist that since the beginning of 2009, seven messages were sent for their membership to act and only 1,403 members responded to the alerts, approximately 0.5% of the membership. The concept that personal impact is important to achieving grassroots success was obvious in the recent efforts to prevent the elimination of Title VIII funding under the *American Recovery and Reinvestment Act*. As noted by the nursing education lobbyist, during this time approximately 1,000 messages were sent to Capitol Hill— a significant portion (71%) of the total advocacy messages.

The lack of grassroots intensity by the nursing profession may suggest that in addition to education on how to respond, the nurse must feel compelled to respond because of a personal connection to the issue, and have hope that his or her response will make a difference. Moreover, nursing organizations need to inform their members when their voices have made a difference such as in the case when the stimulus funding was potentially eliminated. Hearing confirmation that their voice matters may make them more likely to respond to future requests to contact their legislators.

A final solution to elicit greater grassroots intensity in the nursing community is raising the cost of not participating (Goldstein, 1999; Rosenstone & Hansen 1993). Goldstein states that, “professional sanctions to those with whom they have a business relationship and social sanctions to those with whom they have a social relationship can be brandished” (p. 50). Nursing lobbyist must maximize their relationships with

individual nurses within their membership to elicit responses as well as request that these members ask their professional and social relationships to act.

Olson's Theory of Collective Action

According to Olson (1965), the assumption that groups of individuals with common interests will usually work to further those interests is false and based on flawed logic. In his classic book *The Logic of Collective Action: Public Goods and the Theory of Groups*. Olson shows that for large groups, the opposite is often the case. Because the interest is common, every one in the group benefits if the interest is advanced. This creates an incentive for rational individuals to avoid bearing any of the costs or burdens associated with the actions required to get the benefit. This behavior is referred to as the "free rider" problem of collective action and is particularly an issue in large groups.

Unlike in a small group, members of a large group will not likely notice if some individuals let others do all the work or pay a larger price. Meanwhile, the benefits are enjoyed by all, despite lack of participation (Olson, 1965). This lack of participation is considered a "free ride." Nursing's inability to unify may be in part to its size. There are over 100 nursing organizations and approximately 50 belong to the "Nursing Community." Therefore, due to the number of actors in nursing advocacy, the belief that others will do the work may actually inhibit the ability to achieve higher levels of funding for Title VIII.

Additionally, Olsen (1965) suggests groups that organize have associated costs which increase as the group size grows larger. Costs are not always monetary, for instance, costs are frequently associated with accommodating differing viewpoints. Organizational costs are added to the cost of getting the desired collective benefit. Not

surprisingly, the more expensive it becomes, the harder it is to obtain the benefit (Olson). Nursing's inability to agree on the "ask" for Title VIII and providing different messages when presenting the importance of Title VIII suggests that nursing cannot accommodate differing viewpoints which also inhibits their ability to advocate in unison and increase funding for Title VIII.

As a result of the problems associated with large groups, Olson (1965) asserts that they often require either coercion or incentives in addition to the reward of the collective good in order to mobilize. Coercion or incentives must be selective—contributors are treated differently from those that do not. The organizations involved in the "Nursing Community" must understand the importance of collective good and be provided incentives for their participation. This may include recognition on "Nursing Community" documents or having input on the development of these documents.

Coalition Trust

Interest groups tend to work together in coalitions because of the complexity of the federal government, the number of voices competing for various priorities, and the number of legislators. This makes it difficult to pass legislation (Borwne 1988; Lommis 1986). The benefits of coalition work allow the group's leaders to divide work and combine their resources (Hula, 2005). While the nursing lobbyists state the importance of coalition work and talked about the "Nursing Community," they felt that it has only been in recent years that the nursing community has worked well together. As indicated by the nursing lobbyists' responses, trust was a factor preventing a unified lobbying strategy.

People assess the trustworthiness of others based on reputation, performance, and appearance (Sztompka, 1999). Interest group leaders can observe and evaluate these

attributes because they have worked in the past with these individuals and have seen each other's activities. Experience with certain individuals allows a person to evaluate the trustworthiness of individuals. Trust may be the reason the nursing lobbyists are wary of engaging in coalition work. They expressed that they have been "thrown under the bus" by other nursing lobbyists and some nursing lobbyist are extremely divisive and competitive. These activities by other nursing lobbyists decrease trust and the willingness to work collectively. As Hula (2005) notes, "violations of trust in a coalition do not go unnoticed" (p.237). Hula reported a quote from a long-time Washington representative expressing this point. "It's [a case of] one association being viewed as trying to pull the wool over the eyes of the other associations...pull a fast one on the rest of us..." (p. 237).

It appears from the data that nursing lacks this trust of other individual members in the nursing community. As Hula (2005) stated, "Interpersonal trust is crucial to coalition building, because coalitions are not built out of thousands of group members marching lockstep, arm in arm. Rather coalitions are built out of groups' officers, staff members, lobbyists or executives" (p. 237). For nursing to overcome the lack of a unified lobbying strategy, Hula would suggest that coalition trust must occur at three levels. First, the organizational participants must trust each other. Second, if an organization identifies other members of the coalition as trustworthy, they are more likely to trust the work of the coalition. Finally, the coalition and its members need to have a positive reputation. Based on the data, it can be inferred that the nursing lobbyists believed the level of trust within the "Nursing Community" has improved in recent years, partly due to new leadership.

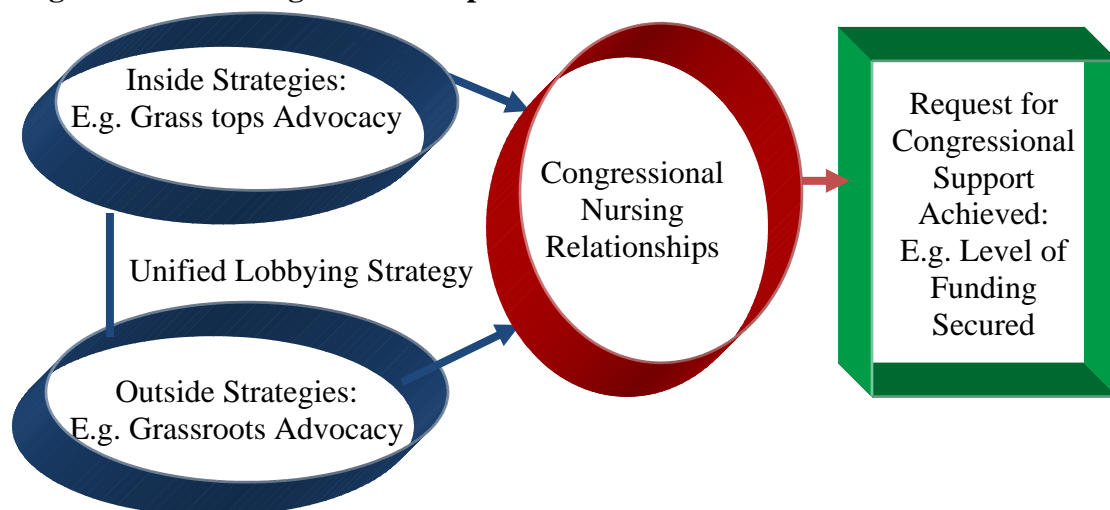
It should also be noted that Shaw (2001) suggests a coalition will not be united if it is not comprised of the right combination of individuals. While nursing is moving toward the right combination of individuals, certain lobbyists can hold back unity. The nursing lobbyists expressed the point of view that unity has improved and will continue to improve by creating a unique unified voice and an organization that is willing to “stick their necks out and start to unify the group.”

Conceptual Framework: Proposed Congressional Nursing Relationship Model

Based on the results of this study and the body of literature regarding lobbying and interest groups, a conceptual framework was developed to help structure the findings. The model of “Congressional Nursing Relationships” suggests that both inside and outside strategies, when linked by a unified lobbying strategy, are effective in influencing an appropriators’ decision. However, the relationships with members of Congress or their staff are critical in the ultimate goal of achieving Congressional support for a particular request. If one element of the model is missing, the likelihood of success is weakened (see Figure 5.1).

Figure 5.1

Congressional Nursing Relationship Model



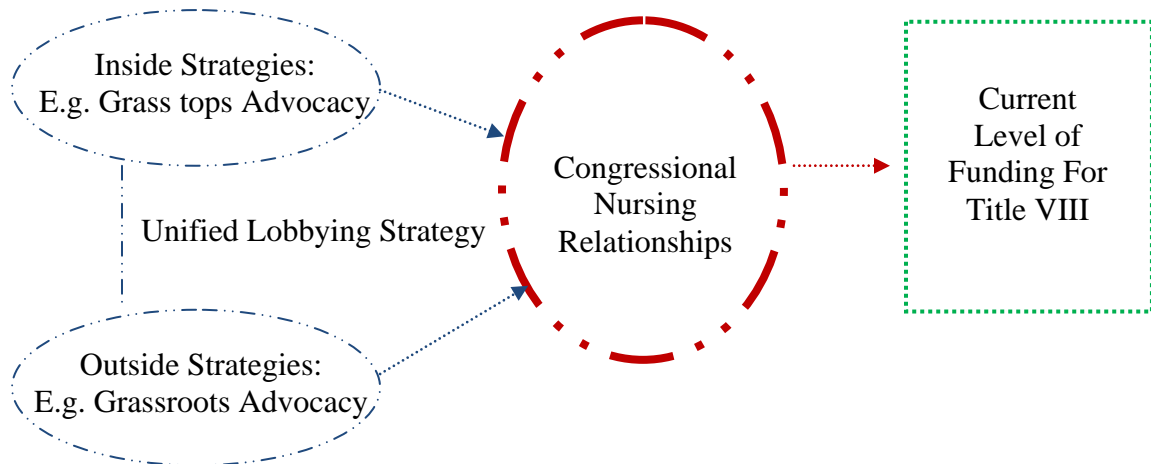
The main focus of the model is the Congressional relationships, which were seen as a key factor in this study. As the Congressional staff and lobbyists who were interviewed for this study noted, personal relationships are an effective lobbying strategy, but are also critical in the lobbyist's ability to implement inside and outside lobbying strategies. The Congressional staff provided specific characteristics of lobbyists who are effective advocates. For example the staff stressed the importance of a lobbyist demeanor, "get to the point," and a lobbyist who is knowledgeable of the process and can offer expert information.

This model creates a representation that inside and outside strategies, bonded by a unified lobbying strategy, can affect the development of Congressional relationships. If these Congressional relationships are strong they can help ensure a request for Congressional support is achieved. In an ideal scenario, a Congressional request is achieved when all of these factors are present. Therefore, the model has provided thick consistent lines to represent the importance of each component. Implementing this model for nursing's current ability to achieve success in their Congressional request for increased Title VIII funding, Figure 5.2 demonstrates that inside and outside strategies as well as the unified lobbying strategy are weak (represented by dotted lines). This in turn impacts the strength of their Congressional relationships and predicts why nursing has not been able to achieve substantial funding increases for Title VIII. It should also be noted that while the strength of the components represented in Figure 5.2 are weak, the model still represents the fact that nursing has been able achieve incremental, if not sufficient, increases for Title VIII. Further research would need to be conducted to test the

importance of this conceptual framework, but the model offers an explanation for the results of this study.

Figure 5.2

Congressional Nursing Relationship Model: Applied to Demonstrate Nursing's Inability to Achieve Increased Title VIII Funding



Study Limitations

Three limitations to this study were identified. These limitations included the time frame of the study, the PI's role as a lobbyist, and the unavailability of exact data on expenditures for appropriations advocacy.

Time Frame of the Study

A limitation of this study was the time frame in which the data was collected. The interviews for this study were conducted over a two-month period. During this time frame, Congress was intensely involved in discussions regarding healthcare reform and the FY 2010 appropriations cycle, which affected the accessibility of both the appropriations staff and the lobbyists for Title VIII and CHGME. This presented challenges in contacting participants. However the recruitment plan enabled the PI to recruit 27 participants and reach saturation.

Many of the Congressional staff who participated in the study held the role of both the LHHS appropriations staff as well as the healthcare legislative aid. Therefore, the staff held a significantly high level of responsibility and workload due to the intensity of the issues being addressed in Congress. While some Congressional staff declined to participate in the study, it took several attempts to schedule interviews with many who agreed to participate. One tactic used to elicit staff participation was the firm commitment made to the staff by the PI that the interview would not last longer than 20 minutes.

The Title VIII and CHGME lobbyists expressed similar time constraints due to the level of Congressional activity. While it was easier to schedule interviews with the nursing lobbyists, the PI provided the highest level of flexibility when scheduling and rescheduling a session. However, the PI did experience some difficulty scheduling interviews with the CHGME lobbyists and had to reschedule the interviews multiple times. However, the PI remained flexible when rescheduling the interviews.

The PI's role as a Lobbyist

Initially, there was concern that that the lobbyists may be unwilling to participate in this study due to the fact that the PI is a lobbyist for a nursing organization. However, the participants provided detailed responses during the interviews and no participants refused to answer questions. Additionally, the PI used colleague validation to ensure no bias when analyzing the data. There was no indication that the PI's role as a lobbyist limited the quality of the data.

Unavailability of Exact Data on Expenditures for Appropriations Advocacy

Another limitation in this study was the unavailability of exact data on expenditures for appropriations advocacy. The lobbyists interviewed expressed difficulty

in providing an exact number because multiple costs are associated with appropriations advocacy activities such as, preparing lobbying materials, preparing grassroots alerts, visiting with appropriations staff, in addition to a portion of the lobbyists' salary.

However, data was obtained on estimations and percentages of work.

Implications for Future Research and Practice

Future Research

Based on the findings of this study and the conceptual framework, a number of questions emerged that should be considered in future research. First, testing the first component of the conceptual framework (inside and outside strategies), future research could be conducted to compare the amount of money spent by nursing and other health professions on advocacy towards a particular Congressional request and if that request was achieved. This question could help to discover whether nursing's lack of investment in appropriations advocacy, which impacts both the effectiveness of inside and outside strategies, is inhibiting the success of Congressional requests. Specifically, this study could investigate how the funds are obtained and how they are allocated to various inside and outside advocacy strategies. These results could potentially provide a benchmark for nursing to determine how their advocacy spending compares to other healthcare disciplines and how they should invest limited resources.

Second, because the results of this study concluded that nursing lacks grass top advocacy, it would be important to investigate who are considered grass tops advocates in other healthcare disciplines and their level of influence with members of Congress or their staff. This study would test the component of the conceptual framework that links inside strategies and Congressional relationships. More specifically, this study would

seek to determine when grass tops advocates are used and how they are identified by national organizations. The results could provide insight on how nursing organizations can better identify grass tops advocates and how to effectively use them in the context of moving forward on a nursing issue.

Third, it would be important to investigate who nursing considers Congressional champions and how these champions compare to those of other healthcare disciplines. This type of study would test the Congressional relationship component of the conceptual framework. When a discipline has Congressional champions, it suggests a relationship exists between the lobbyist and the member of Congress or their staff. As Hall and Deardoff (2006) suggested, lobbyists will lobby their allies and their strongest allies. However, are nursing's allies on par with those of other disciplines? It would need to be determined how often these Congressional champions are visited, how much funding is provided to the champion's PAC, and if the member supported the discipline's Congressional requests. These data points could be collected by investigating the voting record of Congressional champions on nursing and other healthcare disciplines issues, their co-sponsorship of key legislation, or Congressional floor statements. Additional data points would include whether the Congressional champion held a high level committee position such as the chair or another leadership position. The results of this study could provide insight on which members of Congress nursing should seek as Congressional champions or how to enhance the relationship between Congressional champions and nursing lobbyists.

Fourth, considering nursing's lack of grassroots intensity, despite the enormous number of nurses, it would be important to investigate how nursing can better mobilize

their efforts. This would test the outside strategy component of the model as it relates to Congressional relationships and achieving a Congressional request. Determining the current level of advocacy efforts of various nursing organizations and who comprises their membership may offer insight on the best type of nurses to target. Using methods such as social network analysis, it could be determined who are influential members of the nursing community and how these individuals could sway other nurses to respond to requests such as contacting their members of Congress.

Practice Implications

The results of this study offer a number of implications for practice, particularly related to nursing activism. The practice implications provided below offer suggestions for nursing education and investments in nursing advocacy.

Due to the lack of grassroots and grass tops advocacy in nursing, nurses must be taught early on in their career the importance of activism. This includes how personal relationships with members of Congress and their staff can help move an agenda forward. Contributing to a legislator's political campaign or PAC, volunteering for a legislator's election campaign, or offering their nursing expertise to a Congressional staffer are only some of the ways nurses can begin to develop these relationships.

In the most recent versions of the AACN Baccalaureate Essentials (AACN, 2008k) and AACN Essentials for Doctoral Education for Advanced Nursing Practice (AACN, 2006), Essential V focuses on Healthcare Policy. The intent of the healthcare policy component is to teach students the entire scope of the policy process including advocacy, legislation, and regulation. To assist schools' implementation of the new AACN Baccalaureate Essentials, a tool kit was created offering suggestions for

healthcare policy education such as participating in a state or national lobby day or attending congressional hearings (AACN, 2008). These suggestions relate directly to teaching nursing students the importance of advocacy.

The responsibility of implementing these activities, particularly participating in a lobby day, must be shared by the nursing schools and the national nursing associations. While internships exist for nursing students, nurse faculty, or other interested nurses to participate in a lobby day such as the Nurse in Washington Internship or the George Mason Washington Health Policy Summer Institute, these are not exclusively for nursing students and they do not target Title VIII recipients. A concerted effort must be undertaken by the nursing schools and national nursing organizations to identify Title VIII recipients to participate in a lobby day that is centered on requesting an increased funding level for Title VIII. As indicated by the nursing lobbyists, funding for these types of events is limited. Yet the Congressional staff noted they prefer to visit with nursing constituents, which only stresses the importance of a “fly-in” or lobby day for nursing students. Pooling resources or virtual lobby days are some suggestions for nursing organizations and schools to enhance the feasibility of these critical advocacy events.

Another implication for practice is the investment by national nursing organizations in government affairs work. If nursing is truly interested in advancing specific agenda items in Congress, they must invest heavily in both inside and outside strategies. This includes increasing the number and quality of nursing lobbyists hired. The results of this study indicated that there are leaders of national nursing organizations who do not understand the Congressional process or importance of advocacy work. Therefore, it is difficult to impress upon these leaders the need for lobbyists. For nursing

to be on par with such groups as medicine or hospitals administrators, they cannot rely on a small pool of lobbyists. While nursing's resources are significantly less than those of physicians or hospitals administrators, an evaluation of nursing's current resources and priorities must be considered and weighed against their desire to see Congressional action occur for major nursing priorities.

Finally, to overcome nursing's lack of grassroots intensity, nurses must join professional nursing organizations. It is estimated that 80% of nurses do not belong to any professional association at all. Approximately 13% belong to one of the specialty organizations (Mason, Leavitt, & Chaffee, 2002). The ANA, the largest and most broad base organization representing the profession has only 5% of the nursing population as its members (Mason, Leavitt, & Chaffee). Nursing organizations provide the tools for nurses to easily contact their members of Congress. They know the message and how to deliver it. Additionally, with increased membership in national nursing organizations, the organizations will potentially be able to increase their investment in government affairs work because more resources are available (e.g. membership dues).

Conclusion

Comparing the strategies used by nursing and CHGME lobbyists, this study sought to gain insight into effective lobbying strategies and which of these strategies influence federal appropriators decisions. It was concluded that while nursing uses similar strategies to those who advocate for CHGME, their level of investment in these strategies are significantly less. Moreover, nursing lacks specific components of inside and outside advocacy strategies such as grass tops advocacy and grassroots intensity, which impacts the profession's ability to secure higher levels of funding for the Title VIII

Nursing Workforce Development programs. Based on the findings of this study, a conceptual framework was created that suggests inside and outside strategies, bonded by a unified lobbying strategy, can affect the development of Congressional relationships. If these Congressional relationships are strong they can help ensure a request for Congressional support is achieved. This framework provides guidance for future research such as investigations into nursing's grassroots and grass tops advocacy. The study also provides implications for practice as it relates to current nursing lobbying efforts and the education of nurses regarding the importance of political activity.

Appendix A

Nursing Community Consensus Document

Reauthorization Priorities for Title VIII, Public Health Service Act (42 U.S.C. 296 et seq.)

We the undersigned organizations firmly believe that the priorities listed below should be incorporated during the reauthorization of the Nursing Workforce Development programs, authorized under Title VIII of the Public Health Service Act (PHSA) (42 U.S.C. 296 et seq.).

Introduction

The Nursing Shortage – A Critical Component of Health Care Reform

America's health care delivery system is in desperate need of reform. The health system and health policy have become increasingly complex and ineffective in recent years — unable to meet the needs of today's consumers much less the increasing demands of the future.¹ According to experts at the Institute of Medicine (IOM), the state of the American health care system is in crisis.²

One alarming factor contributing to the nation's weakened health care infrastructure is the inability to meet the high demand for Registered Nurses (RN). For ten years, the United States has experienced a significant shortage of RNs, which has dramatically impacted the quality of care provided to our nation's health care consumers.³ This shortage is expected to intensify as the baby boomer population retires and the need for health care expands. The Health Resources and Services Administration (HRSA) projects that the nation's nursing shortage will grow to more than one million nurses by the year 2020.⁴ Unless action is taken now, this shortage will increase over the next twelve years, further jeopardizing access to quality care.

As the country moves toward health care reform, nurses will play a pivotal role in developing and utilizing health care technology, quality indicators, health care outcomes, and preventative care. During this reform all aspects of the health care system will need to be transformed, including the nation's public health infrastructure. Public health nurses, the largest group of public health providers, will play a significant role in helping the nation focus on prevention.

¹ Institute of Medicine (2002). *To Err is Human: Building a Safer Health System*. Washington, DC: The National Academies Press.

² Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: The National Academies Press.

³ Buerhaus, P.I., Donelan, K., Ulrich, B.T., Kirby, L., Norman, L., and Dittus, R. (2006). State of the Registered Nurse Workforce in the United States. *Nursing Economics*. 24(1), 6-12.

⁴ Health Resources and Services Administration (2004). *What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?* Accessed February 19, 2008, from <http://bhpr.hrsa.gov/healthworkforce/reports/behindrnprojections/index.htm>

Currently, RNs comprise the largest group of health professionals with approximately 2.4 million providers⁵ offering essential care to patients in a variety of settings, including hospitals, long-term care facilities, community or public health areas, schools, workplaces, and home care. In addition, nurses receive graduate degrees that allow them to practice autonomously as advanced practice nurses; become nurse faculty, nurse researchers, nurse administrators, and public health nurses; and work in the policy area to help shape health care delivery. Nurses are involved in every aspect of health care, and if the nursing workforce is not strengthened, the health care system will continue to suffer. Therefore, reform must include solutions to the nursing shortage that consider all aspects of the crisis: education, practice, retention, and recruitment.

Education

Nationwide attention to the nursing shortage has sparked the interest of thousands of men and women across the country to pursue a nursing career. However, nursing schools are struggling to overcome a variety of barriers that preclude them from further expanding student capacity and increasing the nursing workforce. These include an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints.⁶ Each year, thousands of potential nursing students have been denied the opportunity to pursue a nursing education, despite the high demand for RNs. These barriers within nursing's educational system have complicated the nursing shortage beyond a simple "supply and demand" model. Of the many concerns within nursing education, the shortage of nurse faculty is the most dire as it inhibits the profession from educating the next generation of nurses.

Furthermore, the nurse faculty shortage is not only affecting civilian health care facilities, but also the military. Much like the civilian sector, the military is facing difficulties in recruiting and retaining nurses. Neither the Army nor the Air Force has met its active service nurse recruitment goals since the 1990s.⁷ In 2006, the Air Force, Army, and Navy experienced overall nurse vacancy rates of 15 percent, 8 percent, and 9.6 percent, respectively.⁷ In order to address the current shortage, all branches of the military are offering incentives to nurses to encourage them to join the Armed Services. Since the military recruits nurses from the nation's existing schools of nursing, they face significant supply issues because nursing schools cannot educate enough nurses to meet the demand for either the military or civilian sector.

Practice

Nurses provide vital services — assessing, monitoring, and evaluating the status of patients, implementing life-saving interventions, coordinating care delivery, and educating patients and their families. Patients spend the greatest amount of time with RNs and depend upon

⁵ Health Resources and Services Administration (2004). *National Sample Survey of Registered Nurses*. Accessed February 19, 2008 from

<http://bhpr.hrsa.gov/healthworkforce/reports/rnpopulation/preliminaryfindings.htm>

⁶ American Association of Colleges of Nursing. (2008). *2007-2008 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington, DC.

⁷ Armed Services Nurse Vacancy Rate: Electronic Mail Communications from the Branches of the Armed Services Nurse Corps.

them for their moment-to-moment care and recovery. However, the ongoing shortage of registered nurses in the workforce leaves too few nurses to provide adequate care in an increasingly complex health care system. The Institute of Medicine has called for substantial changes in the work environment of nurses in order to protect patients, including changes in how nurse staffing levels are established and mandatory limits on nurses' work hours.⁸ Despite the growing body of evidence that better nurse staff levels result in safer patient care, nurses in some health care facilities are overburdened with up to 12 patients to care for per shift. Long work hours pose one of the most serious threats to patient safety, because fatigue slows reaction time, diminishes attention to detail, and contributes to errors.⁸

Retention

The stress of being a nurse often makes it difficult to retain both the new and experienced nurses in our health care system. More than 75 percent of RNs believe the nursing shortage presents a major problem for the quality of patient care and the amount of time nurses can spend with patients.⁹ Looking forward, nurses see the shortage in the future as a catalyst for increasing stress on nurses (98 percent), lowering patient care quality (93 percent) and causing nurses to leave the profession (93 percent).⁹

A report released by the PricewaterhouseCoopers' Health Research Institute found that though the average nurse turnover rate in hospitals was 8.4 percent, the average voluntary turnover for first-year nurses was 27.1 percent.¹⁰ More recent data suggest that approximately 13 percent of newly licensed RNs had changed their principle RN positions after one year, and 37 percent felt they were ready to change jobs.¹¹

In addition to nurses' high turnover rate, many nurses will be retiring from the profession within the next decade. According to the *National Sample Survey of Registered Nurses*, the average age of the RN population in March 2004 was 46.8 years of age, up from 45.2 in 2000.⁵ The RN population under the age of 30 dropped from 9.0 percent of the nursing population in 2000 to 8.0 percent in 2004.⁵ If significant efforts are not made to retain experienced and new nurses, the nursing shortage will grow exponentially.

Recruitment

According to the *National Sample Survey of Registered Nurses*, the total RN population has increased at every four-year interval in which the survey has been taken since 1980.⁵ Although the total RN population increased from 2,696,540 in 2000 to 2,909,357 in 2004, this increase (7.9 percent) was comparatively low considering growth between earlier report

⁸ Institute of Medicine (2004). *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC: The National Academies Press.

⁹ Buerhaus, P.I., Donelan, K., Ulrich, B.T., Norman, L., and Dittus, R. (2005) Is the Shortage of Hospital Registered Nurses Getting Better or Worse? Findings from Two Recent National Surveys of RNs. *Nursing Economics*, 23(2), 61-71.

¹⁰ PricewaterhouseCoopers' Health Research Institute (2007) *What Works: Healing the Health care Staffing Shortage*.

¹¹ Kovner, C.T., Brewer, S.C., Fairchild, S., Poornima, S., Kim, H., Djukic, M. (2007). Newly Licensed RN's Characteristics, Work Attitudes, and Intentions to Work. *American Journal of Nursing*. 107(9).

intervals (i.e. the RN population grew 14.2 percent between 1992 and 1996). In 2004, an estimated 83.2 percent of RNs were employed in nursing.⁵

The nursing population also struggles to recruit nurses that parallel the diverse cultural and ethnic needs of health care consumers. According to the U.S. Census Bureau, the nation's minority population totaled 100.7 million of the total population in 2007.¹² HRSA reports that only 10.7 percent of the nursing workforce identifies themselves as an ethnic or racial minority.⁵ According to the National Advisory Council on Nurse Education and Practice, policy advisors to Congress and the Secretary of Health and Human Services, diversifying the nursing profession is essential to meeting the health care needs of the nation and reducing health disparities that exist among many underserved populations.¹³ Additionally, nursing's academic leaders recognize a strong connection between a culturally diverse nursing workforce and the ability to provide quality, culturally competent patient care.¹⁴

In response to the need to enhance diversity, schools of nursing have substantially increased their minority enrollment. In fact, minority students currently account for 25 percent of enrollees in entry-level baccalaureate nursing programs.⁶ While nursing has made great strides in recruiting and graduating nurses that mirror the patient population, more must be done to keep pace with the changing demographics of our country to ensure that culturally sensitive care is provided.

Besides diversity being an important recruitment issue to address, certain areas of nursing experience substantial difficulties in hiring nurses. The top two areas of hospital nursing practice that have had the highest amount of open positions are the general medical/surgical units and the critical care units. The emergency department (ED) is the third most common source of nursing position openings in hospitals.¹⁵ EDs are particularly vulnerable to the nursing shortage. Because of the intensity of emergency care, EDs often have more vacant nursing positions than the hospital's average. Nationwide, it is estimated that 12 percent of RN positions for which hospitals are actively recruiting are in EDs.

The public health infrastructure also is experiencing a great demand for nurses. The public health nurse workforce decreased from 39 percent in 1980 to 17.6 percent in 2000.^{16,17} Thirty states reported public health nursing as the profession to be most affected by future

¹² United States Census Bureau. (2007). *Minority Population Tops 100 Million*. Accessed February 20, 2008 from <http://www.census.gov/Press-Release/www/releases/archives/population/010048.html>

¹³ National Advisory Council on Nurse Education and Practice (2003). *Third Report to the Secretary of Health and Human Services and the Congress*. Accessed February 20, 2008 from <ftp://ftp.hrsa.gov/bhpr/nursing/nacreport.pdf>

¹⁴ American Association of Colleges of Nursing. (2001). *Effective Strategies for Increasing Diversity in Nursing Programs*. Washington, DC.

¹⁵ Institute of Medicine. (2007) *Future of Emergency Care in the United States Health System – Hospital-Based Emergency Care: At the Breaking Point*. Washington, DC: The National Academies Press.

¹⁶ Council on State Governments, Association of State and Territorial Health Officials, National Association of State Personnel Executives.

State Public Health Employee Shortage Report: A Civil Service Recruitment and Retention Crisis. 2004.

¹⁷ Association of State and Territorial Health Officials. (April, 2005) Issue Brief: Public Health Workforce Shortage- Public Health Nurses.

workforce shortages in their state.¹⁸ Some of the issues influencing the shortage of public health nurses are non-competitive salaries in comparison to other nursing workforce areas and in light of the current worldwide nursing shortage, lack of qualified candidates, and structural changes in many health departments. Public health nurses often face lengthy hiring processes, insufficient opportunities to advance, and lack of flexible schedules.

Reversing the Nursing Shortage: A Federal Solution

Throughout previous nursing shortages, particularly in the 1970s and 1980s, the federal government has offered relief to nursing schools and students to reverse the negative trend. In particular, the Nursing Workforce Development programs offered viable solutions to nursing shortages, expanded nursing school programs, increased the number of nurse faculty, and helped ensure nurses were practicing in areas with a critical shortage. As Congress searches for programs to address the nursing shortage and in turn reform the health care system, Title VIII programs have been and continue to be a proven solution.

Nursing Workforce Development Programs

The Nursing Workforce Development programs support the supply and distribution of qualified nurses to meet our nation's health care needs and provide care to individuals in all health care settings. Over the last 44 years, Title VIII programs have addressed each aspect of nursing shortages – education, practice, retention, and recruitment. The programs provide the largest source of federal funding for nursing education, offering financial support for nursing education programs, individual students, and nurses. These programs bolster nursing education from entry-level preparation through graduate study. Title VIII programs favor institutions that educate nurses for practice in rural and medically underserved communities. According to HRSA, these programs provided loans, scholarships, and programmatic support to 71,729 nursing students and nurses in FY 2007.¹⁹

The Nursing Community has found that these programs are effective. In a 2008 survey by the American Association of Colleges of Nursing (AACN), 720 Title VIII student recipients reported that the programs have played a critical role in funding their nursing education. The major themes identified in this qualitative study indicated that the programs allowed students to attend school full-time, work fewer hours, and alleviate the high financial burden of nursing education.²⁰ While the students greatly appreciated the funding they received from Title VIII, many indicated that the levels did not completely erase their educational debt.²⁰

Statement from the Nursing Community

The Nursing Community strongly believes that the programs under Title VIII are viable, effective, and do achieve their authorized mission. While minor revisions to the authorities

¹⁸ Council on State Governments, Association of State and Territorial Health Officials, National Association of State Personnel Executives. (2004). State Public Health Employee Shortage Report: A Civil Service Recruitment and Retention Crisis.

¹⁹ Electronic Mail Communications from the Health Resources and Service Administration, Division of Nursing, 2008.

²⁰ American Association of Colleges of Nursing. (2008). The Effectiveness of Nursing Workforce Development Programs. Washington, DC.

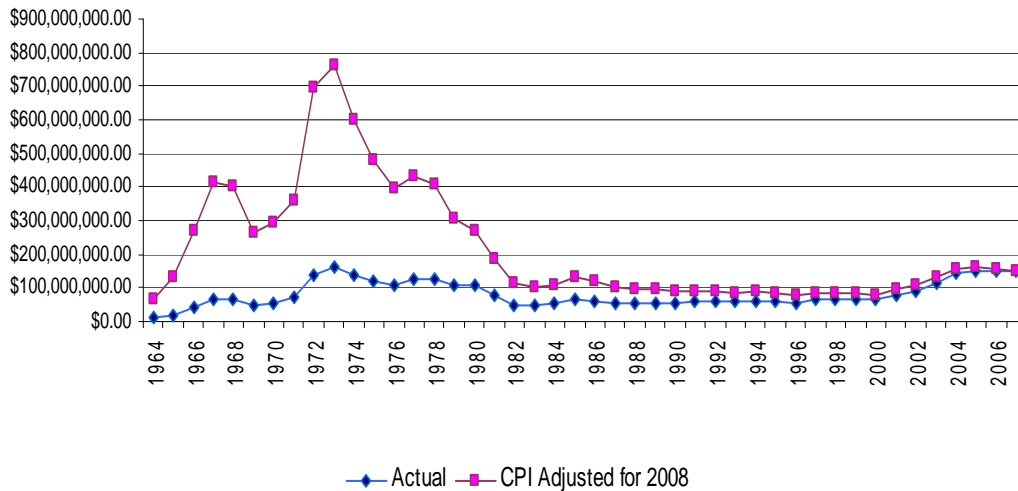
should be made during the Title VIII reauthorization, this document details the overarching principles the Senate Health, Education, Labor, and Pensions (HELP) committee and the House Energy and Commerce committee should consider during this process.

Overarching Principle: Increase Funding for Title VIII

In FY 1964, the Title VIII programs received \$9.92 million. Over the next 44 years, funding levels for the Title VIII programs ebbed and flowed in accordance with national nursing shortages and interest in the profession (See Appendix A). During the nursing shortage of the 1970s, Congress addressed the problem by providing higher levels of funding for Title VIII programs. Specifically in 1973, Congress appropriated \$160.61 million to Title VIII programs. This is the highest level of funding Title VIII has ever been appropriated. This amount is close to the current funding level of \$156.05 million. However, adjusting for inflation to address the 35 year difference, this level would be \$763.52 million (See Figure 1). At a time when our nation is experiencing a nursing shortage of epic proportions, the current funding levels for Title VIII programs do not address the demand for professional nurses.

Figure 1

Historical Funding for Title VIII Nursing Workforce Development Programs (in millions)



Source: Health Resources and Services Administration (HRSA), Division of Nursing, 2008 & U. S. Bureau of Labor Statistics, Inflation Calculator, 2008

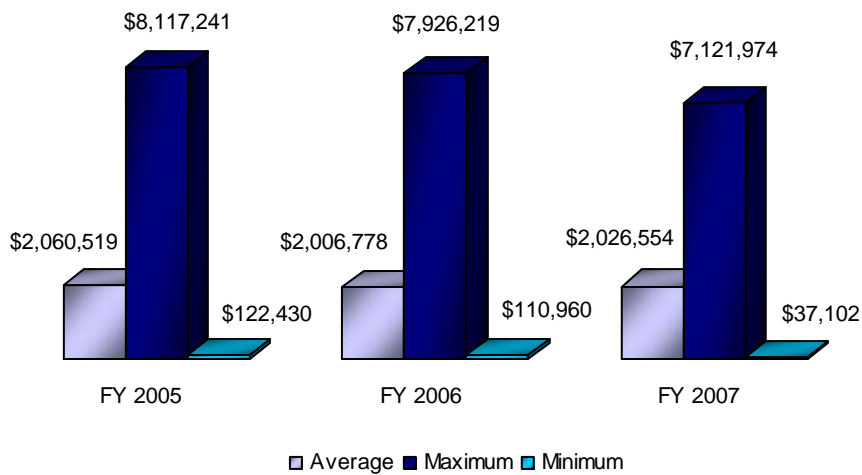
Due to level funding for Title VIII over the past three years, state funding levels continue to decline (See Figure 2). Between FY 2005-FY 2006, 54 percent of the states experienced a decrease in Title VIII funding, and 46 percent saw a decline in funding between FY 2006-

2007. During FY 2006, these states lost, on average, \$537,282 and \$425,591 in FY 2007.²¹

Each year, the Nursing Community advocates to increase funding for Title VIII. Unfortunately, varying political factors have halted the purchasing power of the Title VIII programs. In FY 2006, the Title VIII programs supported 75,946 nursing students and nurses.²² Yet, in FY 2007, the programs only supported 71,729 nursing students and nurses. In FY 2006 and 2007, \$149.68 million was appropriated to Title VIII.

Figure 2

State Title VIII Funding



Source: HRSA, Division of Nursing, 2008

The Nursing Community certainly understands the difficult fiscal choices Congress must make regarding funding for health and education programs, and is appreciative for the funding that is appropriated to Title VIII. However, the national nursing shortage is placing a constant strain on the health care delivery system. As the largest source of federal funding that is specifically designed to address all aspects of the nursing shortage, it is imperative that Congress invest more in Title VIII programs. These programs are a long-term solution. Yet without additional funding attempts to address the shortage through Title VIII becomes short-sighted and restricts further progress.

All of the recommendations made within this consensus document are contingent upon increased funding. A reauthorization of the Nursing Workforce Development programs will not be complete if significant attention is not paid to the overall funding level of the authorities.

²¹ Electronic Mail Communications from the Health Resources and Service Administration, Division of Nursing, 2008.

²² Electronic Mail Communications from the Health Resources and Service Administration, Division of Nursing, 2008.

Guiding Principle: Increase Support for Nurse Faculty Education

The nursing shortage can no longer be explained by the need to simply increase the number of nurses in the workforce since a parallel shortage of nurse educators further complicates the problem. According to an AACN survey conducted in 2007, schools of nursing turned away 40,285 qualified applications to baccalaureate and graduate programs primarily due to insufficient numbers of faculty.⁶ This element of the shortage has created a negative chain reaction — without more nurse faculty additional nurses cannot be educated, and without more nurses, the shortage will continue. Increased support for nurse faculty education under Title VIII can help to break this chain by providing the essential resources needed to expand the nursing workforce and nurse faculty pipeline.

Current Authority: Advanced Education Nursing Grants (Sec. 811)

Under section 296j(f)(2), “*The Secretary may not obligate more than 10 percent of the traineeships under subsection (a) of this section for individuals in doctorate degree programs.*”

Recommendation:

During the reauthorization of Title VIII programs under the PHSA, the Nursing Community urges Congress to lift the 10 percent cap imposed on traineeship grants awarded to doctoral degree programs under Sec. 811.

Rationale:

Schools of nursing are utilizing all available resources to educate additional nurses and in doing so have increased graduations by 8.6 percent from 2006 to 2007 in entry-level baccalaureate nursing programs.⁶ During the same period, schools have increased enrollment by 5.4 percent.⁶ However, this increase is not enough to provide the needed supply of nurses. According to HRSA’s projection, nursing schools must increase the number of graduates by 90 percent in order to adequately address the nursing shortage.⁴

It has been well documented that the current and projected nurse faculty shortage has inhibited the growth of students needed to meet the future demand for RNs. According to a study released by the Southern Regional Education Board (SREB), a serious shortage of nurse faculty was documented in all 16 SREB states and the District of Columbia.²³ Survey findings show that the combination of faculty vacancies and newly budgeted positions points to a 12 percent shortfall in the number of nurse educators needed. According to a *Special Survey on Vacant Faculty Positions* released by AACN in 2008, a total of 814 faculty vacancies (7.6 percent) were identified at 449 nursing schools with baccalaureate and/or graduate programs

²³ Williams BG, Hodges LC, (2002). SREB Study Indicates Serious Shortage of Nursing Faculty (Southern Regional Education Board)

across the country.²⁴ Most of the vacancies were faculty positions requiring or preferring a doctoral degree.²⁴ Additionally, survey data show that 94 percent of academic health centers' Chief Executive Officers (CEOs) believe that faculty shortages are a problem in at least one health professions school.²⁵ The majority of CEOs identified the shortage of nurse faculty as the most severe.²⁵

A number of contributing factors inhibit schools of nursing from attracting and retaining nurse faculty, ultimately stifling student and nursing workforce growth capacity. Unfilled faculty positions, resignations, projected retirements, and the shortage of students being prepared for the faculty role pose a threat to the nursing education workforce over the next five years.²³

Faculty retirement is a significant factor contributing to the nurse faculty shortage. The average age of nurse faculty at retirement is 62.5 years.²⁶ With the average age of doctorally-prepared faculty currently 55 years, a wave of retirements is expected within the next ten years. It has been projected that between 200 and 300 doctorally-prepared faculty will be eligible for retirement each year through 2012.²⁶

Additionally, an April 2007 Robert Wood Johnson Foundation issue and policy briefing paper suggests that as educators retire, nursing programs will yield a dual loss from the "decrease in the total number of faculty available to teach entry-level students and a reduction in the number of seasoned educators who can orient and mentor new faculty and advise graduate students."²⁷ An untapped resource of talent, where schools of nursing could nurture replacements for experienced faculty or additional faculty to handle enrollment expansion, is among the minority populations currently composing the nurse faculty workforce: males and underrepresented racial-ethnic groups (e.g., American Indians, Asians, African Americans, Hispanics).²⁷

Doctoral programs in nursing are not producing a large enough pool of potential nurse educators to meet the demand. AACN reveals that in 2007 enrollments in doctoral nursing programs were up by only 0.9 percent from the previous academic year.⁶ Further, an AACN study on employment plans found that almost a quarter of all graduates from doctoral nursing programs do not plan to work in academic settings.²⁸

By increasing the amount of advanced education traineeship funding given to doctoral students, the potential for additional nurse faculty increases. Moreover, this

²⁴ American Association of Colleges of Nursing. (2008). *Special Survey on Vacant Faculty Positions*. Washington, DC.

²⁵ Moskowitz MC (2007) Academic Health Center CEOs Say Faculty Shortages Major Problem, Association of Academic Health Centers. Accessed February 19, 2008 from http://www.aahcdc.org/policy/reports/AAHC_Faculty_Shortages.pdf

²⁶ Berlin LE, Sechrist KR. (2002). The shortage of doctorally prepared nursing faculty: A dire situation. *Nursing Outlook*. 50(2).

²⁷ Robert Wood Johnson Foundation. Charting Nursing's Future, April 2007 - The Nursing Faculty Shortage: Public and Private Partnerships Address a Growing Need. Accessed January 10, 2008 from <http://www.rwjf.org/pr/product.jsp?id=18661>.

²⁸ American Association of Colleges of Nursing. (2007). Nursing Faculty Shortage. Accessed February 20, 2008 from <http://www.aacn.nche.edu/Media/FactSheets/FacultyShortage.htm>.

revision will directly impact the practice and faculty shortage by assisting students who wish to obtain their degree to pursue a teaching, research, or advanced clinical practice career. This change to the existing authority will become more relevant as advanced practice nurses move toward doctoral preparation in the near future.

Guiding Principle: Strengthen Specific Resources for the Education of Advanced Practice Nurses and Advanced Education Nursing

Current authorization and appropriations for Title VIII programs provide specific funding for Advanced Education Nursing (AEN) Grants and Traineeships. This program supports grant and traineeship awards to educational programs for the four advanced practice nursing specialties of Nurse Practitioner (NP), Certified Nurse-Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), and Clinical Nurse Specialist (CNS). The program also supports awards to the advanced education specialties of nurse educator, nurse administrator, public health nurse, or other nurse specialties as determined by the Secretary to require advanced education. Additionally, for the purpose of determining eligibility for grants for nurse anesthesia education, the statute recognizes the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) so that only appropriately accredited nurse anesthesia programs retain eligibility for federal funding.

For the past two years, the Bush Administration has recommended that the AEN program be eliminated in FY 2008 and 2009 with the justification that this program is ineffective. The Nursing Community strongly disagrees with the Administration's findings and believes that the AEN program should be strengthened during the Title VIII reauthorization.

Recommendation:

During the reauthorization of Title VIII programs under the PHSA, the Nursing Community urges Congress to continue and improve the language authorizing grants and programs for advanced practice nurses and advanced education nursing under Section 811.

Rationale for Continued Support and Improved Language of Advanced Practice Nurses:

Nurse Practitioners (NP) form the foundation of primary care, providing essential primary care services in both rural and urban underserved areas of the country. These underserved populations are frequently those at highest risk for health disparities. Recent reports cite a decline in interest in family practice among medical school graduates, with only 1,000 medical school graduates choosing family medicine annually, in comparison with the more than 3,000 nurse practitioner (NP) graduates who choose family practice annually. Nurse practitioner educational programs and traineeships referenced in the current statute need to be included in the new reauthorization. The need for continued and increased provision of funding for educational programs and traineeships that prepare nurse practitioners is greater than ever. Nurse practitioners provide critical services in ambulatory, acute and long-term care facilities. While funding for these programs has led to increases in the primary care workforce, the need for additional funding has been well documented in the primary care arena.

Certified Nurse-Midwives (CNM) provide essential primary care services to women in the U.S. In 2005, the most recent year which data is available from the National Center for Health Statistics, there were 306,377 CNM-attended births in the nation (11.2 percent of all vaginal births that year). Of patient visits to CNMs, 90 percent are for primary, preventive care, which includes gynecologic care. Currently, 70 percent of the women seen by CNMs are considered vulnerable by virtue of their age, socioeconomic status, education, ethnicity, or location of residence. With the aid of Title VIII resources, the number of CNMs in the United States has more than doubled in the last 10-15 years. Continuing shortages of obstetrical providers make it essential to continue support for CNM programs and their students.

Certified Registered Nurse Anesthetists (CRNA) provide 27 million anesthetics in the U.S. annually, predominate in rural and medically underserved America, and have contributed to the Institute of Medicine reporting anesthesia is 50 times safer today than in the early 1980s. A 12 percent vacancy rate of nurse anesthetists persists because of the growing numbers of CRNA retirements and of locations where surgical and invasive diagnostic procedures are performed. Since 2000, grants authorized by Title VIII have helped increase the number of nurse anesthesia educational programs by 30 percent, and the annual number of graduates by more than 100 percent, during this time of great and growing national need. A GAO report released July 2007 (GAO-07-463) found that regions of the United States with relatively greater percentages of Medicare patients, and where the gap between private and public payments was least, were more likely to have anesthesia care delivered by CRNAs rather than anesthesiologists.

Clinical Nurse Specialists (CNS) are licensed registered nurses who have graduate preparation (master's or doctorate) in nursing as a Clinical Nurse Specialist. The CNS role was first developed in the 1950's. The CNS influences health care outcomes by providing expert consultation for nursing staff and other colleagues as well as by implementing improvements in health care delivery systems. Clinical nurse specialists are expert clinicians that specialize in a specific area of nursing practice that is often defined by a specific population, setting or disease type. The practice of the CNS greatly contributes to improved patient outcomes within the health care system. CNSs can demonstrate that their practice reduces hospital costs and length of stay, frequency of emergency room visits, decreased medical complications in hospitalized patients and increased patient satisfaction. An estimated 72,000 nurses have education and credentials to practice as a CNS. Including a definition for a clinical nurse specialist for the Advanced Nurse Education section will allow more clarity for the agency when considering programs that relate to clinical nurse specialist education and practice.

Rationale for Continued Support of Advanced Education Nursing:

Public Health Nurses: Public health nurses improve public health through population focused interventions with individuals, groups, families, and communities. They are a first line of defense for protecting communities by providing health education and preventative care such as immunization, recognizing and dealing with infectious diseases, responding to disasters, and making home visits to vulnerable

populations. Public health nurses comprise the largest group of professionals in public health, 10 percent of the total workforce.²⁹

Nurse Educators: Nurse educators combine clinical expertise and a passion for teaching into rich and rewarding careers. These professionals, who work in the classroom and the practice setting, are responsible for preparing and mentoring current and future generations of nurses. Nurse educators play a pivotal role in strengthening the nursing workforce, serving as role models, and providing the leadership needed to implement evidence-based practice. Nurse educators are prepared at the master's or doctoral level and practice as faculty in colleges and universities. A nurse educator is a registered nurse who has advanced education, including advanced clinical training in a health care specialty. Nurse educators serve in a variety of roles that range from adjunct (part-time) clinical faculty to dean of a college of nursing.

Nurse Administrators: The professional nurse administrator is a member of the health care management team and is considered to be a leader and nursing expert in the management and administration of patient care services. The work of the nurse administrator encompasses such responsibilities as organizing, supervising, and coordinating the work of nursing care, patient care and health care services in a variety of settings and also maintains professional, educational, legal and ethical standards of performance, and the development of policies and procedures.

Guiding Principle: Increase Efforts to Develop and Retain a Diverse and Professional Nursing Workforce for the Transforming Health Care Delivery System

Retention

As evidenced by the increase in nursing school enrollment and thousands of students applying to the nursing programs, substantial efforts have been made to recruit new nurses, including individuals who are changing careers to pursue nursing. As a result of the nursing shortage, schools of nursing across the country have created new and innovative approaches to educate qualified nurses, such as accelerated, second-baccalaureate degree programs. The demand for these programs has grown rapidly. They have successfully graduated 5,236 new nurses in 2006 and in 2007, 5,881 individuals began a nursing career after graduating from these fast-track nursing programs.⁶

While recruitment is essential to building a thriving nursing workforce, retention of new and experienced nurses is equally important. However, this aspect of addressing the nursing shortage has not received as much attention.

²⁹ Gebbie, K., Merrill, J., Tilson, H.H. (2002). The Public Health Workforce. *Health Affairs*. 21(6).

Recommendation: Increase Retention within the Current RN Population

During the reauthorization of Title VIII programs under the PHSA, the Nursing Community urges Congress to designate the Retention priority area under the current Nurse Education, Practice, and Retention Grants (Section 831(c) of Title VIII) as a separate program under Title VIII.

Rationale:

Due to the current retention problems within the nursing profession, which spans both ends of the experience spectrum, a separate Title VIII section should be created to retain our experienced and new nurses. This section should be titled Nurse Retention Grants and be aligned with Section 831 as Section 831a. Section 831 should be changed to Nurse Education and Practice Grants. By delineating the retention aspect of this program, a specific funding stream would be created to ensure proper consideration is given to retaining nurses and would address the unique barriers associated with retention.

Current funding for the Nurse Education Practice and Retention Grants is \$36.64 million. No specific funding recommendation is being made for the separate retention program. However, this recommendation would be contingent upon additional funding for Title VIII.

The Transforming Health Care Delivery System

One of the most prevailing trends in health care is the need to provide primary care. Advanced practice nurses, in particular nurse practitioners and nurse-midwives, are being relied on to help fill the gaps in primary care – due in part to the physician shortage. According to an editorial in the September 2007 *Academic Medicine*, Dr. Richard Cooper expressed the need for nurse practitioners to play a larger role in providing primary care. The need for primary care providers is critical. Yet, our nation is also in need of community facilities that offer primary care services. Nurse Managed Health Clinics (NMHCs) are one type of facility that can house the primary care providers and offer essential services.

NMHCs help strengthen the nation's health care safety net for the medically underserved. By providing a full range of primary care services, the NMHCs offer quality nursing care to over 2.5 million annual clients and provide primary care to approximately a quarter of a million patients.

Recommendation: Recognize Nurse Managed Health Clinics as a Mechanism to Expand Clinical Educational Experiences for Nurses and Primary Care Services

During the reauthorization of Title VIII programs under the PHSA, the Nursing Community urges Congress to include nurse-managed health clinics as a definition in Section 801. This definition would read:

A nurse-managed health clinic (NMHCs) is an accessible service site that delivers family and community-oriented primary health care. The majority of care is

provided by nurse practitioners and nurse-midwives in collaboration with other nursing and health care providers. At a NMHC, the patient is at the center of care delivery, able to work collaboratively with a staff of advanced practice nurses to address a wide spectrum of primary health concerns with an emphasis on continuity of care.

Rationale:

The nurse-managed care model is recognized as a key to efficient, sensible, cost-effective primary health care. NMHCs are especially effective in providing individualized primary care that includes health promotion, disease prevention and early detection, health teaching, management of chronic conditions, treatment of acute illnesses, and counseling. Research has documented that patient satisfaction with care is very high, the management of patients with chronic illnesses is especially comprehensive and effective, and NMHCs are successful in increasing access to care for at-risk populations and managing their care. NMHCs traditionally focus on populations underserved by the larger health care system. In partnership with schools of nursing, NMHCs are exciting learning environments for nurses of all levels that provide: (1) opportunities for innovative practice development; (2) sites for faculty practice and research, student education and research, and community service; and (3) a source for diverse learning experiences. NMHCs, on average, currently provide clinical education experiences to 42 students per site per academic year.

Guiding Principle: Increase the Efforts of HRSA and the Division of Nursing to Release Timely and More Comprehensive Data on the Nursing Workforce

Accurate and timely data is an essential component to understanding the nursing workforce. It informs policy and helps quantify the workforce needs. Without this data, attempts to reform health care will not be effective. Understanding all sub-sets of the nursing population, and in particular where the nursing shortage is most severe, helps determine where to best place limited resources.

Recommendation: Support HRSA Data Collection Initiatives

During the reauthorization of Title VIII programs under the PHSA, the Nursing Community urges Congress to increase the quality and frequency of the *National Sample Survey of Registered Nurses*. Additionally, the Nursing Community requests data to be released by HRSA that creates nursing workforce data sub-sets.

Rationale:

This would provide Congress, the Nursing Community, and interested stakeholders a more accurate description of the nursing population and help to better understand the supply and demand needs of the profession.

While the Nursing Community wishes to address this recommendation, its inclusion is contingent upon increased funding for Title VIII. More specifically stated, the community believes that appropriations should not be redirected from existing authorities to fund this initiative.

Patient Safety and Quality of Care Demonstration Projects

Protecting patient safety by ensuring quality patient care results or “outcomes” is fundamental to nurses and the vital care they provide. The IOM reported in 2004, “how we are cared for by nurses affects our health, and sometimes can be a matter of life and death... in caring for us all, nurses are indispensable to our safety.”⁸ Mechanisms must be in place to investigate the changing practice of patient care and how that impacts nursing education.

Recommendation: Support the Role of Nursing in Patient Safety and Quality of Care

During the reauthorization of Title VIII programs under the PHSA, the Nursing Community urges Congress to amend the authorities by adding a new section that addresses the role of nurses in improving health care quality and safety. The following language is currently proposed:

Part J – Nursing and Improving Health Care

The Secretary in collaboration with the Administrator of the Health Resources and Services Administration and the Director of the Agency for Healthcare Research and Quality shall award grants to entities to carry out demonstration projects that advance the education, delivery or measurement of quality and patient safety in nursing practice. Grants will be given priority to those initiatives in professional nursing education that enhance patient safety efforts through evidenced-based practice and quality improvement strategies to include partnerships among eligible entities that will enhance clinical leadership, mentoring, interdisciplinary team management, systems administration, outcomes and risk management, and nursing intensity.

Furthermore efforts will be directed to integrate quality competencies into the curriculums of schools of nursing that are consistent with technical standards that are developed or adopted by the voluntary consensus standards of the National Technology Transfer and Advancement Act of 1995.

Rationale:

Nurses’ role in achieving quality within health care systems and the relationship of nursing workforce characteristics to patient outcomes needs further investigation. As health care technology changes, nursing practice and education must be equipped with the appropriate skill set and knowledge to provide care to patients.

While the Nursing Community wishes to address this recommendation, its inclusion is contingent upon increased funding for Title VIII. More specifically stated, the community believes that appropriations should not be redirected from existing authorities to fund this program.

Nursing Organizations who Have Supported the Consensus Document

The Nursing Community extends our appreciation to Senator Mikulski and her staff for providing the opportunity to present our guiding principles for a Title VIII reauthorization. Senator Mikulski has been a proven leader and champion for nursing issues. The Community looks forward to a strong working relationship with the Senator and the HELP Committee Members as the reauthorization process continues.

American Academy of Nursing
American Academy of Nurse Practitioners
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses, Inc.
American College of Nurse-Midwives
American College of Nurse Practitioners
American Nephrology Nurses' Association
American Nurses Association
American Organization of Nurse Executives
American Public Health Association
American Society of PeriAnesthesia Nurses
Association of Community Health Nursing Educators
Association of Perioperative Registered Nurses
Association of Rehabilitation Nurses
Association of State and Territorial Directors of Nursing
Association of Women's Health, Obstetric and Neonatal Nurses
Dermatology Nurses' Association
Emergency Nurses Association
Infusion Nurses Society
National Association of Clinical Nurse Specialists
National Association of Nurse Practitioners in Women's Health
National Association of Orthopaedic Nurses
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National League for Nursing
National Organization of Nurse Practitioner Faculties
National Student Nurses' Association
Oncology Nursing Society
Society of Urologic Nurses and Associates
Tri-Council for Nursing
UnitedHealth Care
Visiting Nurse Associations of America
Wound, Ostomy and Continence Nurses Society

Historical Funding for Title VIII Nursing Workforce Development Programs

Year	Actual	CPI Adjusted for 2008
1964	\$9,921,000.00	\$67,552,410.00
1965	\$19,779,000.00	\$132,538,140.00
1966	\$41,462,000.00	\$270,117,250.00
1967	\$65,672,000.00	\$415,031,310.00
1968	\$66,755,000.00	\$404,903,600.00
1969	\$45,523,000.00	\$261,825,470.00
1970	\$54,383,000.00	\$295,854,730.00
1971	\$69,385,000.00	\$361,624,340.00
1972	\$137,975,000.00	\$696,740,740.00
1973	\$160,605,000.00	\$763,524,850.00
1974	\$139,457,000.00	\$597,090,940.00
1975	\$122,709,000.00	\$481,438,950.00
1976	\$107,500,000.00	\$398,789,100.00
1977	\$124,000,000.00	\$431,912,870.00
1978	\$125,500,000.00	\$406,296,630.00
1979	\$106,250,000.00	\$308,915,290.00
1980	\$106,250,000.00	\$272,175,360.00
1981	\$80,113,000.00	\$186,031,380.00
1982	\$50,835,000.00	\$111,194,320.00
1983	\$48,523,000.00	\$102,833,680.00
1984	\$52,466,000.00	\$106,588,290.00
1985	\$66,700,000.00	\$130,846,060.00
1986	\$61,152,000.00	\$117,773,400.00
1987	\$53,300,000.00	\$99,036,650.00
1988	\$54,046,000.00	\$96,433,050.00
1989	\$55,547,000.00	\$94,555,330.00
1990	\$56,636,000.00	\$91,466,920.00
1991	\$58,524,000.00	\$90,699,310.00
1992	\$59,572,000.00	\$89,625,500.00
1993	\$58,487,000.00	\$85,435,540.00
1994	\$61,487,000.00	\$87,575,410.00
1995	\$58,640,000.00	\$81,218,710.00
1996	\$56,187,000.00	\$75,589,240.00
1997	\$63,188,000.00	\$83,101,080.00
1998	\$63,102,000.00	\$81,715,150.00
1999	\$65,555,000.00	\$83,057,320.00
2000	\$65,562,000.00	\$80,364,850.00
2001	\$78,740,000.00	\$93,847,770.00
2002	\$92,740,000.00	\$108,813,560.00
2003	\$112,760,000.00	\$129,355,330.00
2004	\$141,920,000.00	\$158,583,770.00
2005	\$150,670,000.00	\$162,843,950.00
2006	\$149,680,000.00	\$156,718,520.00
2007	\$149,680,000.00	\$152,378,460.00
2008	\$156,050,000.00	\$156,050,000.00

Source: HRSA, Division of Nursing, 2008 & U. S. Bureau of Labor Statistics, Inflation Calculator, 2008.

Appendix B

Federal Funding for Title VIII Programs by State and FY

	FY 2006-FY 2007			State	FY2005-FY 2006			FY 2006- FY 2007
	FY 2006	FY 2007	2007		FY 2006	2006	FY 2007	
Alabama	6,170,161	7,043,777	873,616	Montana	687,963	84,212	1,309,439	621,476
Alaska	848,247	920,168	71,921	Nebraska	545,333	-177,653	484,596	-60,737
Arizona	3,029,009	2,271,634	-757,375	Nevada	110,960	-20,029	538,852	427,892
Arkansas	650,833	421,546	-229,287	New Hampshire	394,248	207,347	196,008	-198,240
California	6,155,085	5,625,360	-529,725	New Jersey	3,365,289	703,154	2,845,610	-519,679
Colorado	754,085	1,392,093	638,008	New Mexico	1,307,700	317,547	499,043	-808,657
Connecticut	609,256	632,719	23,463	New York	7,926,219	-191,022	7,121,974	-804,245
Delaware	156,002	128,825	-27,177	North Carolina	4,066,407	-150,720	4,303,885	237,478
District of Columbia	2,227,714	1,671,344	-556,370	North Dakota	578,558	-186,891	1,135,682	557,124
Florida	3,167,875	3,376,530	208,655	Ohio	2,981,422	-1,058,516	2,339,535	-641,887
Georgia	3,031,007	3,563,585	532,578	Oklahoma	775,697	-894,168	934,925	159,228
Hawaii	1,472,208	1,745,625	273,417	Oregon	1,017,631	-1,393,850	1,541,084	523,453
Idaho	270,751	37,102	-233,649	Pennsylvania	3,579,973	562,761	4,049,292	469,319
Illinois	4,573,177	4,632,555	59,378	Puerto Rico	1,372,451	668,846	1,346,934	-25,517
Indiana	1,738,795	1,513,457	-225,338	Rhode Island	310,974	7,847	305,517	-5,457
Iowa	334,230	337,078	2,848	South Carolina	1,807,631	-161,499	2,375,864	568,233
Kansas	612,850	748,901	136,051	South Dakota	1,103,368	410,060	1,039,612	-63,756
Kentucky	1,149,999	1,284,673	134,674	Tennessee	6,112,434	2,646,322	4,810,024	-1,302,410
Louisiana	1,055,180	893,973	-161,207	Texas	5,882,682	-2,074,360	5,482,205	-400,477
Maine	115,186	95,766	-19,420	Utah	1,308,148	318,236	1,122,802	-185,346
Maryland	1,406,320	2,532,055	1,125,735	Vermont	213,622	-300,056	212,974	-648
Massachusetts	2,673,130	3,642,186	969,056	Virginia	3,101,467	-1,458,185	1,831,125	-1,270,342
Michigan	2,825,265	3,791,804	966,539	Washington	4,182,002	-283,129	4,286,494	104,492
Minnesota	1,254,473	1,059,336	-195,137	West Virginia	536,197	16,511	266,163	-270,034
Mississippi	1,392,204	1,917,105	524,901	Wisconsin	1,697,590	-419,724	2,244,526	546,936
Missouri	1,257,186	960,700	-296,486	Wyoming	456,248	-69,824	516,771	60,523

From American Association of Colleges of Nursing (2008f). Nursing Workforce Development Programs: Supporting the next generation of nurses and the faculty who educate them. Washington, DC.

Appendix C



Health Sciences Institutional Review Board • 540 East Liberty Street, Suite 202, Ann Arbor, MI 48104-2210 • phone (734) 936-0933 • fax (734) 998-9171
•irbhsbs@umich.edu

To: Suzanne Begeny
From: Charles Kowalski
Richard Redman

Cc: Beatrice Kalisch
Suzanne Begeny

Subject: Notice of Exemption for [HUM00030728]

SUBMISSION INFORMATION:

Title: Federal Nursing Education Funding

Full Study Title (if applicable): Making the Case for Nursing Education: Determining Optimal Lobbying Strategies for Federal Funding

Study eResearch ID: HUM00030728

Date of this Notification from IRB: 5/22/2009

Date of IRB Exempt Determination: 5/22/2009

UM Federalwide Assurance: FWA00004969 expiring on 4/18/2011

OHRP IRB Registration Number(s): IRB00000245

IRB EXEMPTION STATUS:

The IRB Health Sciences has reviewed the study referenced above and determined that, as currently described, it is exempt from ongoing IRB review, per the following federal exemption category:

EXEMPTION #2 of the 45 CFR 46.101.(b):

Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Note that the study is considered exempt as long as any changes to the use of human subjects (including their data) remain within the scope of the exemption category above. Any proposed changes that may exceed the scope of this category, or the approval conditions of any other non-IRB reviewing committees, must be submitted as an amendment through eResearch.

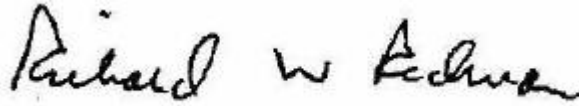
Although an exemption determination eliminates the need for ongoing IRB review and approval, you still have an obligation to understand and abide by generally accepted principles of responsible and ethical conduct of research. Examples of these principles can be found in the Belmont Report as well as in guidance from professional societies and scientific organizations.

SUBMITTING AMENDMENTS VIA eRESEARCH:

You can access the online forms for amendments in the eResearch workspace for this exempt study, referenced above.

ACCESSING EXEMPT STUDIES IN eRESEARCH:

Click the "Exempt and Not Regulated" tab in your eResearch home workspace to access this exempt study.

A handwritten signature in black ink that reads "Richard W. Redman". The signature is written in a cursive style with a small dot above the 'i' in Richard.

Richard Redman
Co-chair, IRB Health Sciences

A handwritten signature in black ink that reads "Charles J. Kowalski". The signature is written in a cursive style with a small dot above the 'i' in Charles.

Charles Kowalski
Co-chair, IRB Health Sciences

Appendix D

Introductory Script

Hello, my name is Suzanne Begeny and I am a doctoral student at the University of Michigan, School of Nursing. I am also a registered lobbyist for nursing education and research. I am conducting a study on effective lobbying and other advocacy strategies used to secure high levels of funding for federal programs. Your participation in this study is completely voluntary. The intent of this study is to expand nursing's knowledge on how appropriations decisions are made and what interventions can be undertaken to support federal funding for nursing programs. **(For nursing lobbyists)** You have been selected for this study because your organization advocates for Title VIII, which is the largest source of federal funding for nursing. Your expertise will be critical in learning best practices in appropriations advocacy. **(For medical lobbyist)** You have been selected for this study because your organization advocates for CHGME, which is a well funded federal program. Your expertise will be critical in learning best practices in appropriations advocacy. If you agree to participate, the interview length can range from 20 minutes to an hour depending on your responses.

The participant will be asked if now is an appropriate time for the interview or when they would like to schedule it. He or she will be asked if the interview can be recorded. If the participant decline he or she will be told that they can still participate but their answer will not be recorded.

Interview Guide: CHGME or Title VIII Lobbyist

- 1) How long have you been covering CHGME or Title VIII appropriations for your association?

- 2) How do you decide what will be your "ask" or appropriations level for each fiscal year for CHGME or Title VIII?

- 3) What strategies, or activities, do you use to secure your appropriations "ask" or a higher level of funding for CHGME or Title VIII?
For example, do you create "one-pagers," make appropriations visits with members of the House and Senate LHHS Appropriations subcommittee?
 - a. Do you use different strategies for the House and Senate?

 - b. Do you use different strategies based on the political party?

 - c. Which of these strategies do you find work the best?

- d. Do you find that any of the strategies are ineffective?
- 4) Year to year, do you use a process to review strategies?
For example, how can successful strategies be maximized for similar success or what strategies should no longer be used?
 - 5) What advice would you give a lobbyist about how to achieve their appropriations ask?
 - 6) How much money does your organization put forth to advocate on behalf of CHGME or Title VIII?
 - 7) What have you found to be barriers that have inhibited you from obtaining increased levels of funding for CHGME or Title VIII?

Appendix E

Introductory Script

Hello, my name is Suzanne Begeny and I am a doctoral student at the University of Michigan, School of Nursing. I am also a registered lobbyist for nursing education and research and understand the appropriations process. I am conducting a study on effective lobbying and other advocacy strategies used to secure high levels of funding for federal programs. Your participation in this study is completely voluntary. The intent of this study is to expand nursing's knowledge on how healthcare appropriations decisions are made and what interventions can be undertaken to support federal funding for nursing programs. Your expertise will be critical in learning best practices in appropriations advocacy. I understand that as legislative staff your time is valuable as I briefly worked on Capitol Hill. If you agree to participate, the interview length can range from 20 minutes to an hour depending on your responses and I will be cognizant of your time.

The participant will be asked if now is an appropriate time for the interview or when they would like to schedule it. He or she will be asked if the interview can be recorded. If the participant declines he or she will be told that they can still participate but their answer will not be recorded.

Interview Guide: Appropriations Staffers

- 1) What kind of organizations come to visit you for appropriations requests?
For example, professional organizations, non-profit organizations, academic institutions.
- 2) Which of these organizations visit you the most?
- 3) When these organizations come to visit, who do you most often meet with?
For example, a lobbyist or a constituent?
- 4) Tell me about your experience when lobbyists come to visit?
 - a. How long are the visits?
 - b. In general, do they bring materials for you?
 - c. Are these materials helpful?

I am interested in how lobbyists influence appropriations decisions.

- 5) How do you think lobbyists influence the appropriations process?
 - a. Which organizations did you hear from most during the last appropriations cycle (either through visits, calls, or emails)?
 - b. Which of these organizations were most helpful?
 - c. Did you rely on them for expertise?
 - d. Did they help you figure out the political support for the funding?

- 6) How do you think lobbyists influence funding levels for federal programs during the appropriations process? What are examples of effective and ineffective influence strategies?
 - a. Tell me about time(s) when you sought lobbyists' assistance when making appropriations decisions?
- 7) In your experience, what have been some of the more successful approaches lobbyists have used to achieve their appropriations "ask" for a particular program? Can you site any examples where the lobbyist method or message did not work?
- 8) In your experience, what have been some of the ineffective approaches lobbyists have used that have inhibited their chances of achieving their appropriations "ask" for a particular program? Can you site any examples where the lobbyist method or message did not work?

I am interested in learning about appropriations decisions for healthcare professions. In particular, I would like to ask you about two programs funded under the Health Resources and Services Administration, Children's Hospital Graduate Medical Education Program and Title VIII Nursing Workforce Development Programs.

- 9) When you are "lobbied" of behalf of these two programs can you name any specific groups that consistently come to visit your office?
 - a. CHGME?
 - b. Title VIII?
- 10) Tell me about strategies used by either group that have been particularly effective in achieving their appropriations ask?
- 11) Tell me about strategies used by either group that have been particularly ineffective in achieving their appropriations ask?
- 12) What advice would you give a lobbyist about how to achieve their appropriations ask?
- 13) Currently, CHGME is funded at \$301.6 million and Title VIII is funded at \$156.05 million. Both programs have been level funded for the last five fiscal years. Why do you think CHGME is funded at a higher level than Title VIII?

Appendix F

Debriefing Script

Thank you for your participation in this study. Your responses will be kept confidential and when the data is analyzed no identifying factors will be apparent. As mentioned earlier, the intent of this study is to expand nursing's knowledge on how appropriations decisions are made and what interventions can be undertaken to support federal funding for nursing programs. Your expertise is critical in learning best practices in appropriations advocacy. Do you have any questions for us at this time?

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