An Evidence-Informed Health Policy Model: Adapting Evidence-Based Practice for Nursing Education and Regulation

Jacqueline M. Loversidge, PhD, RNC-AWHC, CNS

Evidence-based practice (EBP) models help address clinical problems; translate relevant research to practice; and improve care, outcomes, and systems quality. These models designed to solve clinical problems can be adapted to solve health policy problems in nursing education and nursing regulation. This article describes a model for evidence-informed health policy (EIHP) in nursing based on Melnyk and Fineout-Overholt's EBP model. The EIHP model combines the use of the best available evidence and issue expertise with stakeholder values and ethics to inform and leverage dialogue toward the best possible health policy agenda and improvements. Unique to this model are dual uses for the PICOT question: to clarify the policy question driving the evidence search and to deconstruct and analyze existing or pending policy retrospectively. Implications for the model's use in nursing education and nursing regulation are described, and implementation challenges are addressed.

Keywords: Evidence-based practice, evidence-informed health policy, health policy, nursing regulation

Health policies have substantial effects on consumers, government, health care systems, and health professionals. Because the effectiveness of health policy is associated with access to and provision of safe, quality health care, nursing educators are charged with integrating health policy content into curricula (American Association of Colleges of Nursing [AACN], 2008, 2011). Additionally, nursing regulators find that complexity in practice settings is driving a need for evidence-based regulation (Spector, 2010). Use of an evidence-based practice (EBP) model adapted to the health policy environment can facilitate the goals of educators and regulators.

This article describes the usefulness of EBP models for addressing clinical problems. It also compares models of EBP and evidence-based health policy and discusses their relevance to nursing regulation. The article then proposes an evidence-informed health policy (EIHP) model adapted from Melnyk and Fineout-Overholt's (2015) EBP model and identifies implications of and challenges for EIHP model use in nursing education and nursing regulation.

Evidence-Based Practice and Evidence-Informed Health Policy and Regulation

EBP began in medicine and legitimized the process of balancing research evidence with clinician expertise and patient values. An updated, well-accepted definition states that evidence-based medicine (EBM) "requires the integration of the best research evidence with . . . clinical expertise and . . . patient's unique values and circumstances" (Straus, Richardson, Glasziou, & Haynes, 2005, p. 1).

Among nonphysicians, the term *practice* is now widely used rather than the term *medicine*. Approximately 50 EBP models for nursing practice, education, and science as well as one transdisciplinary model have emerged in the literature (Satterfield et al., 2009; Stevens, 2013). EBP models differ, but commonalities in purpose and emphasis are apparent. The models provide a systematic approach to knowledge synthesis and research translation and aim to facilitate clinical decision making to improve patient care quality and outcomes (Mitchell, Fisher, Hastings, Silverman, & Wallen, 2010). An accepted definition of EBP is "a paradigm and lifelong problem-solving approach to clinical decision making that involves the conscientious use of the best available evidence . . . with one's own clinical expertise and patient values and preferences to improve outcomes for individuals, groups, communities, and systems" (Melnyk & Fineout-Overholt, 2015, p. 604).

Evidence-Informed Policy and Regulation

As the call for health policy development practices grounded in credible evidence has increased, a number of evidence-based policy frameworks and models have emerged. These models remind policy makers of the critical role of evidence and help them advance policy agendas and understand why policy-making efforts halt unexpectedly or disappear entirely (Shamian & Shamian-Ellen, 2011). However, differences between clini-

cal and policy applications exist, so appreciating the breadth of health policy is essential.

Health policy is defined as a course of action taken by government or other societal actors to improve the health of populations and attain specific societal health care goals (Niessen, Grijseels, & Rutten, 2000). Health policies include laws, regulations, judicial decrees, agency guidelines, position statements, resolutions, and budget priorities (Brownson, Chriqui, & Stamatakis, 2009; Milstead, 2016). Health policy is also understood as both an entity and a process. As an entity, it is the result of a government initiative, for example, laws or regulations. As a process, it is the nonsequential, nonlinear translation of a public health issue into policy. A policy's course is shaped by innumerable social and political forces and factors, including political ideology, public opinion, stakeholder engagement, and media coverage (Milstead, 2016; Shamian & Shamian-Ellen, 2011).

Because of this complexity, a gap frequently exists between supportive scientific evidence and policy as enacted (Brownson et al., 2009). Thus, the term *evidence-informed*, rather than *evidence-based*, health policy making has been proposed. Oxman, Lavis, Lewin, & Fretheim (2009) established the following definition of evidence-informed policymaking: ". . . an approach to policy decisions that . . . aims to ensure that decision making is well informed by the best available research evidence. . . characterized by the systematic and transparent access to, and appraisal of, evidence as an input into the policy-making process" (p. 1). The influence of evidence is more indirect than direct. That is, evidence is best used to inform dialogue and guide stakeholder debate (Campbell et al., 2009; Morgan, 2010).

A systematic review revealed six factors essential to the development of EIHP (Morgan, 2010):

- Multidisciplinary team involvement
- Broad evidence base
- Acknowledgment of the circular research–policy relationship
- Locally sensitive policy implementation
- Stakeholder participation
- Government support.

The use of evidence to make quality regulatory decisions has also been advanced (Ridenour, 2009; Spector, 2010). Ridenour (2009) suggests a framework of inquiry aimed towards delivery of results for which regulators are accountable. Additionally, Spector (2010) recommends three regulation-friendly EBP models with strong organizational integration components.

An EIHP Model for Nursing

Models of evidence-informed health policy making and the use of EBP in nursing regulation (Ridenour, 2009; Spector, 2010) advance EBP beyond traditional clinical uses into the policy arena. However, the language and components of EBP are clinically focused. Additionally, EBP, and EIHP as it has been used thus far, are primarily prospective, linear processes. EBP begins with clinical problem identification and moves toward a practice improvement goal. Health policy problems can be more complex and less predictable than clinical problems because of multistepped policy processes and stakeholder interests. As a result, processes for analyzing policy and identifying useful solutions require different handling. The EIHP model serves as an instrument for prospective policy improvement as well as a tool for retrospective analysis. Thus, using the model can improve the understanding of proposed policies needing amendment and current policies needing revision.

Melnyk and Fineout-Overholt's (2015) EBP model adapts well to health policy contexts for two reasons: The major components can accommodate the shift from a clinical to health policy focus, and the stepwise process is adaptable as long as users acknowledge the nonlinear nature of the policy environment. Melnyk & Fineout-Overholt describe three clinically focused core EBP components (p. 4):

- External evidence, including evidence-based theories and expert opinion
- Clinical expertise, including internal evidence from organizational quality improvement or outcome management projects, patient assessment, and other available resources
- Patient preferences and values.

In the EIHP model, the external evidence component is expanded to include data from the government, the private sector, and other sources essential for informing policy change. The next component, called issue expertise, considers information from professional associations, health care organizations, government agencies, and relevant professional groups as forms of internal evidence. The last component is adapted to consider the values and ethics of stakeholders, including health care providers, policy shapers (legislators and regulators), health care consumers, consumer interest groups, health care organizations, and government agencies. Government agencies include departments and regulatory bodies potentially responsible for policy implementation. (See Table 1.)

Steps of EIHP

The steps of EBP described by Melnyk and Fineout-Overholt (2015) have been modified for the EIHP model. (See Table 2.)

Step 0: Cultivate a Spirit of Inquiry in the Policy Culture or Environment

Health care system leaders may influence organizational cultural change; however, individuals or single-interest groups are less likely to effect significant cultural change of political systems. Therefore, health professionals need to plant the seeds of change. Policy makers respond to issues with a sense of inquiry when presented with compelling evidence regarding citizens' best interests.