with 500 or more employees; (d) repealing the 2.3% sales tax on medical devices; and (e) modifying sections of the ACA to help states innovate and enter into compacts to allow the sale of coverage across state lines (Jackson, 2017). Similarly, bipartisan efforts are being made by senators (Groppe, 2017) and governors (Cohn, 2017b) to modify the ACA. But President Trump has opposed such measures and has moved to slash advertising grants designed to help U.S. individuals sign up for coverage (Goldstein, 2017). The president has also opposed state waiver efforts to control the price of premiums and, once again, discussed the possibility of ending the cost-sharing payments to insurers (Eilperin, 2017). The resolution of these conflicting approaches (possibly through the 2018 election cycle) will determine the fate of the ACA in the coming years.

Social Issues Impacting the Nursing Workforce

Violence in the Health Care Workplace

Health executives recently coined the phrase "the Quadruple Aim," which is defined as the Triple Aim (improved outcomes, patient experience, and cost efficiency) plus health care professional satisfaction (O'Connor, 2017). To address the fourth aim, both health systems and professional organizations are taking a closer look at a long-standing issue that is finally coming to the foreground—violence in the health care workplace.

Violence against nurses in the workplace, especially in the hospital setting, has been referred to as an epidemic and is considered a serious health hazard and public health crisis. According to the U.S. Department of Labor (2017), workplace violence is defined as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site." Nursing is one of the most dangerous jobs in the United States. In fact, nurses are assaulted more often than police officers and prison guards (Dvorak, 2017).

Anecdotally, hospital staff identified the increasing number of patients with behavioral health issues as a contributing factor, and facilities have linked the opioid epidemic and associated spike in overdose admissions as other factors (Burmahl, Morgan, & Hoppszallern, 2017). Among nurses, a dangerous perception exists that assault and threats from patients are "just part of the job" (Integrity Legal Nurse Consulting, 2017) and occur because of patients' conditions. Violence from patients and visitors is often associated with long wait times (especially in the ED), lack of information, crowding, receipt of bad news, stress, and poor coping skills (Hackethall, 2016; Casey, 2017). Nurses and other health care workers often do not report incidents of patient and/or visitor aggression and violence due to fear of retaliation from their employers.

Over the past year, the media has reported several incidents of workplace aggression against nurses. An Illinois prisoner influenced a corrections officer to remove his shackles to allow him to go to the bathroom, took the officer's gun, and sexually assaulted a nurse before being fatally shot by police (Ault, 2017). Another instance of workplace violence involved a Massachusetts ED nurse who was stabbed with a knife by a patient she was assisting (Massachusetts Nurses Association, 2017).

Several states have introduced legislation in response to this growing issue. In Massachusetts, state legislators are working to pass "Elise's Law" [S. 1374], which would require health care employers to "develop and implement individualized workplace violence prevention plans" and allow for a period of paid leave for health care provider victims of assault (Massachusetts Nurses Association, 2017; Mass. Legis., 2017). In Virginia, legislation was passed in 2017 that directs the Department of Health to convene stakeholders and develop model guidelines aimed at violence prevention and publication of penalties associated with perpetrators of violence in the ED and all other health care settings (Virginia Nurses Today, 2017).

Effects of Violence on Health Care Employees and Employers

Beyond the physical pain associated with being a victim of violence, psychological effects are experienced as well, including posttraumatic stress disorder. Upon return to work, it is important for employees to have employer support and a culture of safety to feel secure. From a financial perspective, employers incur the costs of workplace violence associated with the lost work days, increased turnover, the costs related to treatment of physical and psychological results, and the stress on other employees (Yarovitsky & Tabak, 2009).

Approaches to Dealing With Health Care Workplace Violence

The International Council of Nurses recently revised their workplace violence position statement to support development of "zero-tolerance" policies of violence in any form, including those associated with such issues as workplace bullying and lateral violence of nurses to each other (2017). Often underreported, bullying has been associated with a negative work environment that impacts job satisfaction, morale, and health and well-being of employees. These negative impacts affect patient safety and can lead to absenteeism and intention to leave one's job and the profession.

It is difficult to obtain accurate statistics on the prevalence, scope, and severity of workplace violence because it is underreported. Underreporting workplace violence, whether it be between health care workers or from patients and family members, hinders the de-

velopment and implementation of violence prevention programs and strategies. Hospitals are beginning to address the mindset that incidents of violent behavior are part of the job by taking a systems-based approach, rather than a reactive incident-specific approach, to its elimination (Stempniak, 2017). However, data are needed to understand the scope of workplace violence and to identify where to target resources to address and prevent it. For example, implementing an employee call center to report verbal and physical incidents is one approach to collect data and respond accordingly to reduce violence. By taking a data-based approach, hospitals and other workplace settings can move toward the prevention of violence.

Another health care system formed a multidisciplinary assault-reduction team that used assault data and created a Behavioral Emergency Response Team (Code BERT). Similar to Rapid Response Teams that react to patient emergencies to prevent cardiac arrest and other life-threatening situations, these multidisciplinary teams respond at any time to actual or potential violent situations (Stempniak, 2017).

Other strategies include staff training to recognize signs of escalating behavior and learning de-escalating techniques and other methods of violence prevention. Such training has seen more widespread adoption in the past 2 years as hospitals take a preventative response. Recognizing that uniformed security presence at the scene of an incident may aggravate matters, clinical staff are taught methods to potentially de-escalate on their own (Burmahl, Morgan, & Hoppszallern, 2017). Other promising practices include using scenario-based simulation training exercises (Allison, Macphee, & Noulett, 2017).

In addition, some hospitals are putting resources into technological prevention methods. Such strategies include metal detectors, surveillance systems, electronic lockdown systems, radio frequency tracking for equipment, and even biometric authentication for certain sensitive areas. These technological prevention methods aim to provide a safe environment for health care employees and patients (Burmahl, Morgan, & Hoppszallern, 2017).

Constant security staffing issues are part of the challenge in facility response to violence. Many health systems have reported an increase in incidents while their security budget has remained the same or decreased, possibly because little data exist that show increased security staff improves outcomes (Burmahl, Morgan, & Hoppszallern, 2017).

Professional organizations advocate that hospitals and other health care settings have "zero-tolerance" policies for workplace violence and assist in developing and implementing such policies. The American Nurses Association's (ANA's) position statement emphasizes the ethical, moral, and legal responsibility of health care employers to create a healthy and safe work environment for RNs and other health care team members,patients, families, and communities (ANA, 2015). AACN published its six Healthy Work Environment standards relating to skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership (Blake, 2016). The American Organization of Nurse Executives and the Emergency Nurses Association developed a list of eight guiding principles on mitigating workplace violence and recommended implementing health workplace safety assessments and de-escalation training techniques.

State and federal organizations and hospital accreditors also are addressing the epidemic of violence against nurses and other health care workers. The Office of Occupational Safety and Health Administration (OSHA) has guidelines for preventing workplace violence for health care and social service workers (2016) and recently announced plans to issue a regulation on violence to protect health care workers. The Joint Commission released an advisory for preventing violence and criminal events and recommended actions to identify risks for violence and to develop plans to reduce the risks. The guidelines also focused on improved staffing and establishing a "zero-tolerance" policy (The Joint Commission, 2014).

Several states have introduced new bills proposing to raise the punishment for harming a nurse; in 2018, Florida and Hawaii have such legislation pending (Fla. Legis., 2018; Hawaii Legis., 2018).. OSHA has gathered public comment and is considering updating guidance to health care worker safety. The Centers for Disease Control and Prevention (CDC)/OSHA course, "Workplace Violence Prevention for Nurses," is an applicable tool for educators and administrators (CDC, 2017a).

Cannabis as a Therapeutic Treatment

An increasing cultural acceptance of cannabis prompted 31 states (including the District of Columbia), Guam, Puerto Rico, and all Canadian provinces/territories to legalize medical cannabis. An increasing proportion of these states have also decriminalized and legalized recreational cannabis use (National Conference of State Legislatures, 2017b). The surge of legislation has outpaced research, leaving nurses with a lack of evidence-based resources when caring for patients who use medical or recreational cannabis. Without experimental evidence that is scientifically rigorous, statistically reportable and based on patient populations, nurses will face increasing challenges about medical cannabis.

Schedule I substances are considered to have no accepted medical value and to present a high potential for abuse. Cannabis and its derivatives have been classified as Schedule I substances since the enactment of the Controlled Substance Act (1970). This Drug Enforcement Agency (DEA) classification not only prohibits practitioners from prescribing cannabis, it also prohibits most research using cannabis, except under rigorous oversight from the government.