

TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practices for Guideline Development,
Implementation Science, and Evaluation



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NEXT STEPS:
FROM PRACTICE TO POLICY

| | | |
|----|--|-----|
| 18 | SCALING DEEP TO IMPROVE PEOPLE'S HEALTH: FROM EVIDENCE-BASED PRACTICE TO EVIDENCE-BASED POLICY | 465 |
|----|--|-----|

SCALING DEEP TO IMPROVE PEOPLE'S HEALTH: FROM EVIDENCE-BASED PRACTICE TO EVIDENCE-BASED POLICY

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LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Understand how nursing can become a body politic and why this is important to advance healthy public policy
- Grasp the central role of professional and labor associations in taking political leadership to ensure the public has the highest-quality health system
- Describe how nurses make a contribution at the micro, meso, and macro levels and why nursing involvement at all levels is vital to a healthy society
- Outline the pillars and stages of the Framework for Advancing Healthy Public Policy and describe how each is necessary to shape the health policy agenda and achieve change
- Discuss how RNAO's BPGs and evidence-based clinical recommendations can be used to influence policy improvements at the macro systems level
- Discuss the concept of social movements and how it applies to successful advocacy
- Identify the components of a successful advocacy campaign and the role of nurses and of the professional association in such a campaign

INTRODUCTION

“We must create a public opinion which must drive the government, instead of the government having to drive us—an enlightened public opinion, wise in principles, wise in details.”

—Florence Nightingale, 1892

This book, of which this is the last chapter, is primarily about using evidence, in particular clinical evidence and evidence relating to healthy work environments, with the aim to improve people’s health. The book’s focus so far has been mainly on strengthening nurses’ clinical practice through the systematic application of evidence drawing from the leadership and experience of the Registered Nurses’ Association of Ontario (RNAO). Health policy has not been salient, except for a peripheral focus in some of the chapters, particularly Chapters 10, 12, and 17.

Realizing nursing as a body politic is central to advancing healthy public policy and ensuring that the public—in any and all countries and communities around the world—fully benefit from nursing and nurses’ contribution as evidence-based experts. As this book shows, nurses must and do impact the micro systems of patient care, the meso systems of health organizations, and the macro health systems (Grinspun, 2006a, 2006b, 2013, 2015). This chapter argues it is the impact to health systems that nurses must continue to conquer.

In reality, it is seldom the case that policy changes can be achieved only with the persuasion of clinical evidence—a point we emphasize below. Furthermore, many changes required to improve health outcomes fall outside the realm of clinical evidence. This is especially true for social and environmental determinants of health, health system design, and nursing human resources. Thus, given RNAO’s broad scope of policy interventions, our need to continue to shape clinical practice through evidence goes hand-in-hand with our need to shape healthy public policy through evidence. This is why, 20 years ago, we endeavoured to learn systematically how to impact the political and policy sphere. What we uncovered follows.

This chapter focuses specifically on the link between evidence-based practice and evidence-based policy and how to move from one to the other and leverage both to achieve healthy public policy. How do you shift from making a difference for a patient or a health organization, in the case of bedside or street-side nursing, or for a community, in the case of public health, to influencing systemic change in the provision of health services across an entire jurisdiction?

NURSING AS BODY POLITIC

This chapter also tells a larger story about how a nursing organization can become a transformative social force and an effective policy advocacy machine that is respected and influential in a key jurisdiction—the province of Ontario, Canada’s largest—as well as in Canada and internationally. It is the story of how a group of nurses, who 2 decades ago sat many times on the sidelines as spectators and watched policy processes unfold, is now a leading contributor and formulator of policy. This is a success story that is worth telling because it has lessons for nursing organizations that want to become policy and politically relevant, anywhere. It shows how one can link the clinical work that nurses do

with the policy frameworks and social contexts that enable or hinder their day-to-day work. It shows, with concrete examples, how nurses' evidence-based work impacts patient health outcomes and how nurses can leverage evidence and advocacy to affect health system policy changes that ultimately feed back into practice.

If one were to measure RNAO's current stage of political development using Cohen's four stages of political development framework (Cohen et al., 1996), it would be categorized as stage 4, where nursing "leads the way." This is a stage in which the profession is envisioned as providing proactive political leadership on broader policy issues that speak to the public's interests. Here the profession is leading agenda-setting for a broad range of health and social policy issues, introducing terms that reorder the debate, and initiating coalitions with nursing and non-nursing stakeholders for broad policy concerns. At this stage, many nurses are sought to fill nursing and health policy positions because of the value of nursing expertise and knowledge. The authors argue that the further the profession is able to move into this stage, the more the public will benefit from nursing's expertise and the advocacy on behalf of the public (Cohen et al., 1996). Indeed, the sophistication of RNAO and its members—both in evidence-based practice through our Best Practice Guidelines (BPG) Program and in evidence-based policy activation as described in this chapter—is well recognized in Canada and abroad (Amela, 2012; Factor Hispano, 2006; Gardner, 2010; Jordan, 2005; Marti, 2014; Pantaleoni, 2014).

Ellenbecker and colleagues (2017) propose a staged approach to nursing education in health policy at each level of nursing education, very much in following with Cohen's four stages of political development in nursing. The focus of health policy content these scholars propose is to progress from the organizational level to local, state, and finally national level health policies. While we fully concur with such an approach to nursing education, we urge a parallel fast-tracked approach by all nursing associations, nursing labour organizations, and others to embrace policy and politics as much as we have embraced evidence-based clinical practice if we are to reach our full potential for influence and impact at the organizational and governmental levels—locally, nationally, and internationally (Grinspun, 2016c). We hope the experience of RNAO inspires others to mobilize their expertise to shape policy and galvanize their power to conquer politics.

THE NECESSITY BUT INSUFFICIENCY OF AN EVIDENCE-BASED APPROACH

For nurses embedded in an evidence-based practice approach, the shift to health policy raises a striking realization: Evidence—even the best and most robust evidence—is a necessary but for the most part insufficient tool to shape healthy public policy. Policy advocates over the years have learned to accept that evidence alone does not influence whether a policy change will occur, nor how it occurs or when; it is but one factor in a seemingly disorderly array of influences, vested interests, and scarce resources. Years ago, a highly esteemed Canadian researcher approached some of us for comments on a polished, evidence-based paper on a policy change that had just taken hold in Ontario. As we read it, we smiled, as the paper was as exquisite as everything else this scholar had written. The paper, however, was naive and inaccurate in its thinking that evidence alone had moved forward the government's policy decision. Indeed, how nice it would be if that were the case, and how sad to recognize that it seldom is that way.

This reality—of policy driven by small politics and entrenched interests rather than evidence on how to advance the right values and services—was the fuel that propelled RNAO to fast track our own

journey into the arena of political and policy engagement. Indeed, the key purpose of RNAO is to advance healthy public policy to affect people's health, healthcare, and nursing services. Undaunted, like most nurses, we decided to tackle the challenge as problem solvers. And, like most nurses, we never gave up (Grinspun, 2017). Instead, we set ourselves to observe and articulate what truly moves policy forward and came up with a basic operational framework that has guided RNAO's advocacy work and has delivered profound changes.

This evolution started with the vision of a professional association that would influence policies pertaining to the practice of the nursing profession, as well as the healthcare system and the broader set of public policies that affect health and well-being—namely, social and environmental determinants of health. This vision embodied a different kind of professional association, a high-profile one that is an agenda setter in public policy. No other nursing association in Canada, and only a handful in the world, has dared to adopt—in depth—such a broad and ambitious mandate.

What follows is a glimpse into this transformation that we hope will whet the appetite of others to learn more. First, we introduce the conceptual framework that has guided this work (Grinspun, 2006b; 2007a). Next, with two lived-experience case studies we provide a flavour of the actual work and accomplishments that have followed. The first case study focuses on supervised injection services as part of a comprehensive harm-reducing strategy. The second case study relates to improving access to health services, in particular universal access to offloading devices for persons with diabetes and foot ulcers. Following the case studies, we draw a conclusion and explore what will come next.



REFLECTION

Think about a healthcare policy that has been implemented in your jurisdiction; does it surprise you that evidence may not have been the primary motivator in the adoption of it? Why or why not?



REFLECTION

Do you think the description provided here about the political advocacy ability of nurses in Ontario, Canada mirrors nursing in your jurisdiction? Around the world? If so, in what ways?

FOUNDATIONAL IDEAS AND CONCEPTUAL FRAMEWORK FOR ADVOCACY

In considering how advancing public policy becomes a reality, does robust evidence suffice? In this section we address the unsettling recognition that the answer to this question is “no.” In fact, there is hardly any historical experience where this has been the case. Policy change requires, in addition to solid evidence, the mustering of political will through concerted and informed advocacy. The following discussion presents foundational ideas related to advancing public policy and how they have been conceptualized as a framework built on two key pillars of evidence and advocacy to realize evidence-based policy and practice.

THE TWO PILLARS FOR ADVANCING HEALTHY PUBLIC POLICY


The fundamental recognition that evidence is necessary but not sufficient is at the root of our framework for advancing healthy public policy. Thus, the two pillars to RNAO's framework for advancing

healthy public policy are robust evidence and robust advocacy. The first is the design of robust evidence-based policies—we refer to this as the “evidence” pillar. The second is engaging advocacy action with nurses, the media, and the public to create the political will to make them a reality—we refer to this as the “political action” or “advocacy action” pillar. Both of these pillars provide support to the five stages of policy advancement.

Table 18.1 provides a template of RNAO’s Framework for Advancing Healthy Public Policy (adapted from Grinspun 2007b), useful for drafting a plan to advance healthy public policy on a specific agenda. The table presents the two pillars of the framework in the left column, and the stages required to successfully advance the policy goal in the upper row. The resulting matrix when completed with data relevant to the policy issue creates an evidence-based plan of action.

TABLE 18.1 RNAO’S FRAMEWORK FOR ADVANCING HEALTHY PUBLIC POLICY PLANNING TEMPLATE

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|  | | | | | | |
|--|--|---------------------------------------|------------------------------------|-----------------------------------|----------------------------------|---------------------------------------|
| PILLARS | STAGES/ DOMAINS OF ACTION | FRAMING (POSITIONING THE ISSUE) | PROMOTING AWARENESS (BUY-IN) | ENSURING UPTAKE (INFLUENCE) | SUSTAINING CHANGE (IMPACT) | EVALUATION (MEASURING OUTCOMES) |
| Evidence | Statistics | | | | | |
| | Policy papers | | | | | |
| | BPGs | | | | | |
| Advocacy | Knowledge mobilization | | | | | |
| | Communi- cation and grassroots mobilization | | | | | |
| | Coalition building | | | | | |
| | Mass media and social media | | | | | |
| | Direct advocacy with politicians and civil servants | | | | | |

Adapted from Grinspun, 2007b.
Used with permission.

THE FIRST PILLAR: AN EVIDENCE-BASED APPROACH

A foundational aspect of RNAO’s approach to policy is that it should be evidence based. This is the reason for the first pillar, which starts from the belief that policy should rest on careful analysis and research—this is what we refer to as “evidence-based policy.” The nature of the evidence varies depending on the subject matter or the desired policy outcome. On matters of social determinants of health, statistics and a plethora of interdisciplinary social policy evidence become relevant. Similarly, on environmental determinants, the evidence arises from the natural social and epidemiological sciences. On nursing and health policy issues, the relevant literature applies. We use a variety of “knowledge tools” that are deployed to the specific policy imperative, including the use of statistics and available data that are essential no matter what policy topic we are pursuing. On clinical issues that are the focus of this book, we rely on the best clinical evidence, and for RNAO the BPGs are central to related policymaking.

RNAO’s evidence-based approach to policy also requires disregarding positions based on narrow concepts of self-interest and insists that core values—such as human dignity, people’s well-being, health for all, and the public interest—should guide policy. The intent is that policy design harnesses the best available evidence on how to advance those values. That’s why RNAO has produced some of the best and most detailed policy documents from health professionals in North America and arguably in the world. Many of these policy documents and policy proposals, especially in areas of nursing and health policy, are directly linked to our work on BPGs; and that is also the case in both case studies in this chapter.

Using evidence encompasses a number of forms: a mindset for statistics, accessing the most robust literature on the topic, and approaching the best experts in the field for their knowledge and insights. The end goal is to present rock-solid policy proposals that are fully backed by evidence.

THE SECOND PILLAR: PURSUING A STRATEGIC ADVOCACY CAMPAIGN

The second pillar involves a political and advocacy campaign to create the political will for change. This is a multipronged, adaptive, and nimble approach that entails the use of a variety of tools and tactics that are individually important and collectively powerful. It includes knowledge mobilization; communication and grassroots mobilization of members; coalition building; intensive use of mass social and alternative media; as well as direct engagement with politicians, bureaucrats, and opinion leaders. Each one of these tactics is based on long traditions of work and theoretical insights about their effectiveness in advancing policy change (Stachowiak, 2013).

REFLECTION

How could you see yourself using this Framework for Advancing Healthy Public Policy? Would it also be a helpful tool to use in analyzing a policy initiative from the perspective of evidence and advocacy as well as the five stages of policy advancement? In what ways? See the list of RNAO policy initiatives in this chapter for consideration.

REFLECTION

If there are so many factors influencing the creation of public policy, why do you think it is so important to have the best evidence to back political advocacy work?

The analysis of policy change processes helps us understand the myriad of factors that influence successful policy mobilization and the need to intervene at multiple levels to secure policy uptake (Edwards, Rowan, Marck, & Grinspun, 2011). In designing an advocacy campaign, one must determine the potential for moving evidence into policy adoption; this requires understanding the factors that influence the uptake of new policies and the mechanisms that come into play that either accelerate or hinder adoption (Edwards et al., 2011; Grinspun, 2012, 2015).

The necessity of this second pillar arose early on with the realization that little is achieved if outstanding policy proposals end up lying dormant on someone's desk. That's why we set out to transform and galvanize RNAO's membership into becoming a highly informed, courageous, mobilized, and politically involved group of health professionals. RNs, NPs, and nursing students in Ontario have given massive support for such an activist approach. Moreover, this also has resulted in substantive increases in membership numbers that in turn strengthen our collective voice. RNAO's successes have made us keenly aware of the power of nursing as a body politic to advance collective good.

The second pillar entails the strategic use of five key advocacy domains (Grinspun, 2006b, 2007a). Each domain, in turn, applies a number of tactics and tools according to the circumstances and needs. These five domains of advocacy reflect the collective experience of others and have been adapted and perfected through repeated use in multiple RNAO policy campaigns:

- **Knowledge mobilization**—Knowledge mobilization encompasses activities relating to the production and use of research results, including knowledge synthesis, dissemination, transfer, and exchange. In particular, it informs public debate, policies, and practices in a particular area (Social Sciences and Humanities Research Council [SSHRC], 2017). For RNAO, advocacy action on a particular issue starts with making evidence-based knowledge available to RNAO members, other health professionals as appropriate, researchers, policymakers, stakeholders, and civil servants. It happens through various means including conferences, seminars, webinars, background papers, summary sheets, slide presentations, newsletter items, poster campaigns, as well as the President and CEO columns in RNAO's *Registered Nurse Journal (RNJ)* (Grinspun, 2014).
- **Communication with members and grassroots mobilization**—RNAO's work builds on a long tradition of grassroots movements, which believes groups can gain power by engaging in collective action for change (Alinsky, 1989). As discussed below, grassroots mobilization of its members is central to RNAO's policy successes, including those in the two case studies that follow. This has entailed keeping members well informed through a monthly "In the Loop" e-newsletter; building a grassroots organization for all members supported by RNAO's staff, board of directors, assembly, local chapters, and interest groups; a culture of political action; nurturing of a collective identity; and the refining of tools such as action alerts, nursing week campaigns, and the various topics we tackle in the *RN7*.
- **Coalition building**—An advocacy coalition is an effective tool to advance changes in public policy; it involves seeking out allies with similar core beliefs and coordinating actions with them. Thus, advocacy coalitions include participants that both share similar policy core beliefs and engage in nontrivial degree of coordination (Weible & Sabatier, 2006, p. 128). RNAO has not only been effective in seeking powerful coalition allies, but also often plays a leading role, as exemplified in the case studies in this chapter.

- **Mass social and alternative media**—RNAO is keenly aware of the agenda-setting role of mass media and its power to shape public opinion and influence how we picture public affairs (McCombs, 2014). From the outset, RNAO’s advocacy role required connections with journalists and a concerted effort to have its voice amplified through mass media: op-eds, letters to the editor, interviews, etc. RNAO also sought a variety of other venues to bring forward its message. As stated above, RNAO’s *RN7* has played an important role as each issue highlights key policy interventions RNAO and its members are making, and RNAO’s CEO and President’s columns are carefully dedicated to difficult policy areas we are collectively tackling (Burkoski, 2015; McNeil, 2012). Other venues can include, for example, nursing week posters in public transportation (RNAO, 2010). We have made concerted investments in talent development and, with much success, on expanding the use of social media (Twitter, Facebook, Instagram) and RNAO’s influence within the alternative media such as blogs, websites, online media, etc. (Grinspun 2015). Media presence in all its forms is captured and evaluated.
- **Direct engagement with politicians, bureaucrats, and other opinion leaders**—RNAO recognizes the reality of concentrated power and influence and the power of key people to effect change. RNAO’s planning of a policy campaign includes a detailed understanding of the distribution of power and decision-making on the subject matter. Thus, advocacy efforts focus on influencing key individuals, organizations, and political levers. In the case of RNAO, this has entailed a close working relationship with, and advocacy campaign toward, the Government of Ontario. The quality of the engagement matters substantively; for example, RNAO’s strictly nonpartisan and issue-focused approach to policy engagement has earned it the respect of all political parties in Ontario and the ability to work with governments of any stripe. The engagement itself is done through the wise use of formal and informal meetings, calls, letters, participation in public consultations, Twitter, email, and phone call campaigns targeting particular individuals (such as with RNAO’s Action Alerts).


REFLECTION

What are the characteristics of a professional association that make it most suitable as an advocacy body? Are there any characteristics that may have a negative impact on advocacy activities?

ADVANCING HEALTHY PUBLIC POLICY INITIATIVES

RNAO success stories in the province of Ontario, Canada (Grinspun, 2012, 2015, 2016a, 2017):

- **Nurse practitioner legislation and funding (1998)**—The Ontario government issues legislation and funding for NPs after ongoing advocacy by RNAO to promote their integral contributions and to widen their scope of practice.
- **Baccalaureate entry to practice (2000)**—Provincial government passes legislation making a baccalaureate degree mandatory for RN practice in Ontario.
- **New graduate employment guarantee (2007)**—Provincial government establishes a full-time employment guarantee for Ontario’s new nursing graduates.
- **Ontario’s Nurse Practitioner-Led Clinics (2007)**—Canada’s first NP-Led Clinic opens in Sudbury, Ontario. The following year, the provincial government promises to open 25 clinics in communities across Ontario.
- **Ontario’s Poverty Reduction Strategy (2008)**—The Ontario government announces this strategy, signalling a new vision for a fairer society.

- **Provincial prohibition of pesticides for cosmetic use (2008)**—Bill 64, provincial legislation to ban the use and sale of pesticides for cosmetic purposes, is passed.
- **Expanded scope of practice of NPs (2010)**—Important changes to the NP role are made, granting NPs the authority to work autonomously, prescribe without “a list,” and to admit, treat, transfer, and discharge patients in hospital. Ontario becomes the first jurisdiction in North America, and Canada one of only three countries in the world, to enjoy the expanded scope of practice for NPs.
- **Empowering leadership positions in nursing (2011)**—The Ontario government operationalizes the 2011 *Excellent Care for All Act* (Bill 46) and amends regulations to mandate that chief nursing executives (CNE) are appointed as permanent members of hospital boards and quality committees, and the same for chief nursing officers (CNO) in public health units. Bill 46 also demands a focus on evidence-based practice for health organizations.
- **Closing of coal plants (2011)**—Ontario’s Minister of Energy announces the permanent closure of two additional coal-fired generators, in partial response to an RNAO, Canadian Association of Physicians for the Environment, and Ontario Clean Air Alliance campaign to close coal plants immediately.
- **70% full-time employment in nursing (2012)**—RNAO’s “70% solution” is implemented province wide, whereby at least 70% of the RNs in each work setting are permanent full-time (RNAO, 2003, 2005). As a result, in Ontario, 68.6% of RNs had full-time employment in 2012, while in Canada the corresponding rate was 54% (RNAO, 2014).
- **Banning medical tourism (2014)**—Ontario Health Minister issues a directive to all Ontario hospitals to not market to, solicit, or treat international patients, except in cases related to existing contracts. He also asks hospitals not to enter into new international contracts that include treating foreign nationals in Ontario (Glaser, 2014).
- **Protecting refugee health (2015)**—Provincial government listens to the outcry from RNAO and other healthcare providers against cuts to the Interim Federal Health Program (IFHP), a national health insurance program covering refugees and refugee claimants until they are eligible for provincial and territorial health plans. They also vow to make IFHP more comprehensive than it was before the cuts.
- **Adoption of RNAO’s ECCO model for community care (2016): Bill 210**—Patients First Act is introduced, with the release of a discussion paper by the Ontario Health Minister, which proposes that Local Health Integration Networks (LHINs) assume responsibility for whole system planning and performance accountability. In addition, it proposes that major sectors of the health system be aligned under one umbrella: LHINs. The report credits RNAO’s work and cites its groundbreaking report *Enhancing Community Care for Ontarians* (ECCO) (RNAO, 2012, 2014) by name.
- **Adoption of \$15 minimum wage (2017)**—The Ontario government raises minimum wage to \$15 per hour, the largest increase in the province’s history.
- **Public inquiry into the safety and security of residents in long-term care (2017)**—Ontario appoints a judge to lead an independent public inquiry into the policies, procedures, and oversight of long-term care homes, which may have contributed to the assault and death of eight residents who were under the care of convicted serial killer and former registered nurse, Elizabeth Wettlaufer.

Building a Grassroots Movement

A crucial element in the second pillar has been RNAO's ability to mobilize its members—currently counting over 41,000—around public policy issues. In effect, this has been a strategy to build a grassroots movement, ready to mobilize in a concerted fashion and apply maximum pressure at all levels, from the “bottom” and from “above.”

It all starts with genuine, purposeful, and continuous capacity-building of members, utilizing policy backgrounders, webinars, political action workshops, and more. It also entails supporting members through ongoing mentorship and equipping them with the tools they need to uptake political action and deploy their individual and collective power (RNAO, 2015c). Members receive training, and often these meetings (in person or virtually through webinars) happen with much personal connectedness, commitment, and passion. Members also link through RNAO's network of regional chapters and interest groups, thus creating local and specialty contingents of committed members ready to mobilize on particular policy matters of interest (e.g., fetal alcohol syndrome disorder) or bring voice to collective concerns and solutions (e.g., RN replacement) to the local level. Getting to know local politicians and other local stakeholders has earned members respect in their local setting and expanded the scope of influence of RNAO collectively. Members are also encouraged and supported to participate in public forums, attend chapter and interest group meetings, and express views through the media, “action alerts,” and letters to the editor.

The RNAO board of directors and the RNAO staff have inculcated a sense of empowerment in members by demonstrating that being a member of RNAO means being in the loop, being part of the bigger picture, and being able to gain influence and have a positive impact. Not surprisingly, RNAO's presence, influence, and impact have escalated over the past decade, in Ontario, across Canada, and abroad. The growth in membership has meant a scaling up of mobilization. The outcome has been a remarkable policy and advocacy effort that has engaged Ontario governments of different political stripes to effect positive change in the nursing profession and the healthcare system.

An important example is RNAO's assembly of representatives—the association's formal leadership—composed of about 140 RNs, nurse practitioners, and nursing students, including the leaders of all 35 local RNAO chapters and 31 interest groups across the province of Ontario. Recognizing the paramount importance of political activism, RNAO has invested time and resources to advance capacity-building amongst these leaders.

For the past 20 years, the assembly has been formally trained and continuously supported by RNAO staff in each of the five advocacy domains. This includes providing them with materials and guidance on how to use the evidence that is relevant to the policy imperative the association is advocating for; coordinating and providing them with backgrounders to actively engage with members of the provincial parliament and/or of the federal parliament; and leveraging media and communications through the stages of our policy advocacy. As you will read in the first case study, RNAO also issues evidence-based action alerts focused on topic-specific areas that are sent to all parties' political leaders.

Direct Advocacy with Politicians and Civil Servants

As part of a rich array of advocacy tactics that have been built over 2 decades, RNAO conducts three formal yearly policy activation events, with one leading to the next.

Take Your MPP to Work: Created in 2001, this initiative takes place every year during nursing week and targets the three main political parties. RNs, NPs, and nursing students invite an MPP (member of the provincial parliament) to see firsthand the expertise needed to provide high-quality healthcare to Ontarians every day. The site visits also allow the politicians to better understand the breadth and depth of nursing practice across Ontario (Canada's largest jurisdiction), and the opportunities and challenges associated with providing care in different settings. Since its inception, *Take Your MPP to Work* has grown into a popular signature event for nurses and MPPs alike. Our members have taken premiers, cabinet ministers, opposition leaders, and backbench MPPs to work in primary care settings, NP-led clinics, street nursing programs, public health units, schools, hospitals, rehabilitation centers, long-term care homes, and more. Every year about 60 to 70 MPPs enjoy the unique experience of seeing RNs, NPs, and nursing students deliver health services in every type of practice setting across Ontario (RNAO, n.d.-c).

Queen's Park on the Road (QPOR): This initiative takes place from September to December. QPOR was originally proposed in 2013 as an event to replace RNAO's Queen's Park Day (discussed next) because the legislature in that year had been prorogued and elections had been called. The event was so successful that members told us they wanted to meet with MPPs in their riding offices every year. Since then, every year, RNs, NPs, and nursing students—members of RNAO—meet with MPPs from all political parties in the MPPs' offices and urge them to adopt specific recommendations. In these meetings, members focus on increasing access to nursing services, improving healthcare, and enhancing social and environmental determinants of health. Nurses come to the meeting well prepared with a comprehensive evidence-based policy package (titled "backgrounders"), prepared by RNAO's expert policy department and communications' staff. Queen's Park on the Road (QPOR) is an effective political engagement activity for members. The opportunity to meet with MPPs to discuss priority nursing and health issues empowers nurses and demonstrates that they can make an impact on public policy and influence healthy change for all (RNAO, n.d.-b).

Queen's Park Day is a dynamic and very meaningful event for both RNAO and the political leaders. It occurs in February when the legislature is in session, which allows RNAO's board of directors and the assembly leaders (composed of 140 representatives) to visit and meet with members of the provincial parliament (MPPs) for a full day at the legislature. It begins with a breakfast with MPPs, followed by seating at Question Period where many of the nurses and nursing student leaders are individually recognized by their local MPPs, and then a full hour to have dialogue and ask questions with Ontario's Premier and the Minister of Health, as well as an hour with each of the opposition party leaders and their health critics (RNAO, 2017d).

Ontario has 107 MPPs. In total, 98 to 104 MPPs participate in at least one of the events throughout the year, every year. Over 60 participate in two, and up to 45 in all three events.

RNAO evaluates each of these events to ensure our continued effectiveness in impacting healthy public policy. What is most important is that these political activation initiatives are anchored in deep-seated values at RNAO aimed at achieving health for all. Fuelled by sound, evidence-based intellectual work, and a good dose of courage, this extensive membership advocacy



REFLECTION

How do these three advocacy tactics influence the political process? Can you give an example of how an initiative incubated at such an event could develop to become part of a broader policy agenda?



REFLECTION

Can you identify similar advocacy tactics used by your professional association and reflect on their outcomes?

work empowers RNAO and its members to persuade politicians to muster the will to do what's right for the public (Grinspun, 2017). The case studies below exemplify this critical point.

STAGES OF POLICY ADVOCACY

As indicated in the upper row of Table 18.1, the framework for advancing healthy public policy delineates five stages in the advocacy campaign to advance a particular policy issue. Successfully advancing from one stage to the next requires the strategic engagement of both pillars of action—harnessing evidence and pursuing an effective advocacy campaign involving a number of action domains. The strategic challenge of a campaign is to select the “which,” “how,” and “when” of the domains and specific actions within each domain to be engaged at each turn singularly or collectively. The five stages are:

1. **Framing (positioning of the issue)**—According to linguist George Lakoff (2004), *frames* are mental structures that shape the way we see the world. Frames shape the goals we seek, the way we act, and what counts as good or bad. In politics, our frames shape social policies, what we support, and what we reject. To change our frames is to change all this; thus, reframing represents social change (Lakoff, 2004, p. xv). RNAO's advocacy work starts by framing the issue at hand for our members, the public, and the opinion leaders. We want to frame the issue in a way that makes people care, that speaks to their values and interests, and that makes it clear why change must happen. In the first case study, why should we care if people die in the streets as a result of drug overdoses? In the second case, why should we care if two thousand amputations happen every year?
2. **Promoting awareness (buy-in)**—This is the stage when decision-makers decide they must act. This could be the result of effective framing of the issue amongst important sectors of the public through a successful awareness campaign. Or it could be the result of an efficacious advocacy campaign with substantial political impacts for decision-makers and the recognition that the only way to stop the campaign is by acting on the demands. No matter how the buy-in of policymakers happens, this is the stage where a policy direction is adopted or promised. It represents an important milestone in the advocacy campaign, but by no means the end. This is a progression stage that as you will see in the case studies is vulnerable, as promises do not always get us to the finish line.
3. **Ensuring uptake (influence)**—As stated above, in an ideal world, once decision-makers have decided to act and have announced their plans, all is settled. In reality, the struggle around the adoption of new policies continues throughout its implementation. At this stage, advocacy focuses on making sure the right changes and effective policies are enacted. With entrenched interests surely affected by the proposed policies, the fight will be on the terms, timing, and depth of the new policies. So this is all about making sure that what was promised actually happens. It is a process, with setbacks and successes that can be prolonged and uneven. When it comes to successful fruition, the policy changes have been implemented and institutionalized. Again, we will see evidence of this stage in both case studies.
4. **Sustaining change (ensuring impact)**—This is the stage where policy changes are implemented. Advocacy focuses on sustaining the change—making sure that political, financial, or other resources, such as education, policy uptake by stakeholders, and monitoring progress, are there to sustain change. At this stage, it is critical to continue being vigilant about particular

interests that may continue to try to derail or dilute change or distort its implementation. This is a stage of accompaniment of the expected changes, which may entail active support for implementation or “low-key” advocacy action.

5. **Evaluation (measuring impact)**—This is a longer-term stage where the actual impacts of the policy change are evaluated and measured. Were the results of the policy those that were expected when the policy was envisioned? Or were the results different and unexpected? This is a stage of extracting lessons and analyzing results. In most cases, this evaluation is complex given the challenge of isolating the impacts of one particular policy change from many other changes in the policy environment.



REFLECTION

As you read the case studies presented next, consider using the Framework for Advancing Healthy Public Policy to help guide your assessment of how this framework directed the process.

We turn now to the presentation of the two case studies. The next section presents a case study on supervised injection services, and the following one, a case study of access to services for persons with diabetes.

C A S E S T U D Y

LINKING EVIDENCE AND ADVOCACY FOR SUPERVISED INJECTION SERVICES IN ONTARIO

Comprehensive harm-reduction programs are critical to save lives and help people with substance use, minimize stigma, and build healthier communities. RNAO has developed two well-recognized Best Practice Guidelines (BPG) on the topic. The first is *Supporting Clients on Methadone Maintenance Treatment (MMT)* released in 2009. The second is *Engaging Clients Who Use Substances* (RNAO, 2015a).

Supervised injection services (SIS) are an important component of a comprehensive harm-reduction program. SIS have generated much debate, scrutiny, and calls to shape policy with evidence. The issue came to the forefront in 2011, when Insite, North America's first legal SIS facility (Vancouver, British Columbia [BC]), was threatened with closure by a federal government that refused to heed the evidence and took the matter to the Supreme Court of Canada.

RNAO is a staunch supporter of Insite as an evidence-based public health service that demonstrates harm-reduction benefits to individuals and communities (Grinspun, 2016b). In 2007, RNAO's resolution in support

of nursing advocacy to ensure Insite's long-term sustainability was passed at the Annual General Meeting of the Canadian Nurses Association. RNAO formed a coalition of nursing organizations to seek intervener status and present arguments before the Supreme Court of Canada. We secured intervener status and spread the word through the media (RNAO, 2011c), and communications to members (RNAO, 2011b). Ultimately, the evidence and public interventions contributed to the ruling that allowed Insite to keep its doors open. Insite's victory laid the groundwork for bringing SIS to Canadians in other provinces, including Ontario.

This case study examines the integral role of evidence in advocating for and informing change and how RNAO mobilized the profession, media, and public to move evidence into policy. We highlight the multipronged approach RNAO played in the association's pivotal role to land the approval of three proposed SIS sites throughout Toronto. We end the case study with a return to evidence-based practice as RNAO launches the development of a BPG centered on the nursing care of persons at SIS.

MOBILIZING CHANGE WITH EVIDENCE

According to 2012 Statistics Canada data, about six million people (about 21.6% of Canadians) met the criteria for a substance use disorder during their lifetime (Pearson, Janz, & Ali 2013). While tobacco and alcohol are responsible for more deaths and hospitalizations than illicit drugs (Single, Rehm, Robson, & Truong, 2000), dramatic increases in sudden deaths due to opioid overdoses prompted British Columbia's Minister of Health to call for recognition of a "national public health emergency" (Woo, 2017). Jane Philpott, Canada's then Minister of Health, acknowledged that the escalating number of overdoses deaths may be "the greatest public health crisis we face in Canada" (Woo, 2017, para. 2).

Preliminary federal estimates for 2016 are that there were 2,458 opioid-related deaths in Canada, which is an average of almost seven people per day (Public Health Agency of Canada, 2017). These numbers are sure to increase as the data do not include Quebec and use Ontario data from 2015. The annual rate of opioid-related deaths in Ontario has increased 285% from 1991 (144 deaths) to 2015 (734 deaths) (Gomes et al., 2017). In 2015, on average two people died in Ontario every day of opioid-related causes (Gomes et al., 2017). The crisis continues to escalate. Ontario announced there were 412 opioid-related deaths during the first 6 months of 2016, which is an 11% increase compared with the same time period in 2015 (MOHLTC 2017). In addition to deaths from prescribed opioids, the introduction of fentanyl and carfentanil into substances purchased illicitly greatly increases the chances of fatal overdoses (Howlett, 2016; Howlett, Giovannetti, Vanderklippe, & Perreux, 2017).

MOBILIZING CHANGE WITH POWER: SPEAKING OUT FOR INSITE

Insite opened in 2003 as the first legal supervised injection site in North America. It is an integrated part of Vancouver Coastal Health's continuum of care, where people with problematic substance use can inject pre-obtained drugs and connect with healthcare and addiction services (RNAO, 2011a). It operates on the premise of harm reduction, which aims to decrease the adverse

health, social, and economic effects of drug use without requiring abstinence from using drugs (RNAO, 2011a). Having opened under the leadership of the federal Liberal government, Insite faced a number of attempts to shut its doors since the Conservatives came to power in 2006. Despite two court decisions in BC in favour of its continued operation, the Supreme Court of Canada agreed in June 2010 to hear the federal government's appeal of those rulings. Recognizing the threat to Insite as well as its clients, nurses, other employees, and overall impact of harm reduction, RNAO invited the Canadian Nurses Association (CNA) and the Association of Registered Nurses of British Columbia (ARNBC) to form a "nursing coalition" to counter politics with evidence (RNAO, n.d.-a, 2011a).

The nursing coalition spoke out about the effectiveness of Insite, based on ample evidence and research. For instance, Insite received an average of 702 daily visits in 2009 and saw an average of 491 supervised injections (RNAO, 2011b). Nearly 500 overdose interventions were performed with no fatalities, and more than 6,200 people were referred to detox and addiction treatment at other service agencies (RNAO, 2011b). More than 30 peer-reviewed studies yielded findings of Insite's benefits to clients and the greater community, ranging from reduced public injecting, to lower levels of HIV risk behaviours and an increase in the pursuit of addiction treatment (RNAO, 2011b). Anecdotal accounts, such as RNAO's (2011b) *RN/J* feature on two RNs working in harm reduction, further supplement the data to demonstrate that Insite is run by knowledgeable professionals and powered by evidence to make a difference in people's lives. The nursing coalition drew on the strong evidence and the collective force of nursing to earn intervener status before the Supreme Court of Canada at the hearing in May 2011 (RNAO, 2011d). Later that year, the coalition celebrated the high court's unanimous ruling to keep Insite open (RNAO, 2011c).

The victory for Insite represented progress in more than one direction. It affirmed the life-saving and life-changing effect of supervised injection services as integral to harm reduction for clients who need help and support. It highlighted the contribution of nurses, both to their clients' well-being and to the decisions that affect nurses and the public we serve. The victory that was attained through collective action reflected the power of combining

evidence, policy expertise, media, and communications. It is the same elements of this framework that would guide RNAO's efforts in the next phase of bringing supervised injection services to Ontario.

AMPLIFYING THE CALL FOR SIS IN ONTARIO

Although the 2011 ruling in favour of Insite was an encouraging sign for the harm-reduction movement, another barrier arose in 2013 when the federal government introduced Bill C-65 (RNAO, 2013c). The new bill posed onerous requirements designed to prevent SIS implementation. This regressive move contrasted with the research evidence that recommended the integration of SIS into existing health services in Toronto and Ottawa (Bayoumi et al., 2012). In order to respond to the documented need for SIS sites, the Toronto Drug Strategy Implementation Panel struck a working group (of which RNAO was a member) to look at SIS implementation and challenges. With the release of the working group's *Supervised Injection Services Toolkit* (2013) and staff recommendations from Toronto Public Health, the Board of Health was urged to advocate for provincial funding to integrate SIS into existing clinical health services and to oppose Bill C-65.

RNAO showed support for SIS implementation in Toronto by providing a quote in a media release by Toronto Public Health (2013). CEO Dr. Doris Grinspun represented RNAO as the first speaker to the Toronto Board of Health with a clear message: "Implementing SIS is a pragmatic, evidence-based policy that will improve health outcomes,

prevent needless deaths, and contribute to safer communities" (RNAO, 2013a, para. 2). CEO Grinspun pointed out that strong leadership from Toronto was "critical not only for the people of Toronto but also for vulnerable people across Ontario and Canada" (RNAO, 2013a, para. 7).

At the same time, RNAO submitted an open letter to then-Minister of Health and Long-Term Care (MOHLTC) Deb Matthews, copied to the Premier and provincial opposition party leaders, which urged the Ontario government to speak out against Bill C-65 and fund the integration of SIS into existing clinical health services (RNAO, 2013b). In the spirit of combined action, RNAO cited its support for the latter alongside the Canadian Nurses Association, Canadian Medical Association, Canadian Public Health Association, Community and Hospital Infection Control Association-Canada, Public Health Physicians of Canada, and Urban Public Health Network (RNAO, 2013b).

RNAO also solicited further support with an action alert. RNAO *action alerts* mobilize nurses, other health professionals, and members of the community to be part of a movement by joining, and thus amplifying, the voice for change. Members are equipped with the necessary background on the issue as well as modes of action. In this case, they could sign the action alert to reinforce the asks in RNAO's open letter, which would also reach the Health Minister, Premier, and provincial party leaders (RNAO, 2013c). As a result, 1,038 people sent a strong message to the Minister and Premier. This action alert is featured in Figure 18.1, while the sidebar shows a later action alert (RNAO, 2017a), asking the provincial government to provide immediate funding for SIS.

ASK QUEEN'S PARK TO PROVIDE IMMEDIATE FUNDING FOR SUPERVISED INJECTION SERVICES (SIS)

Thank you to the more than 750 people who have signed RNAO's action alert urging Premier Wynne to announce funding for SIS in Toronto and Ottawa. We are getting traction and that is why we ask those of you who haven't yet signed to please take a minute to add your voice to urge immediate funding for renovations at four prospective sites so that Health Canada's SIS approval process can move forward.

Every 13 hours, an opioid-related death occurs in Ontario. As in British Columbia, many of these deaths are from accidental overdoses linked to fentanyl. Supervised injection services (SIS) can prevent overdose deaths, but these services are not currently available in Ontario.

The evidence is conclusive: Access to SIS will save lives.

The Ontario government must immediately announce funding for SIS in Ottawa and Toronto to complement existing health services and save lives.

Copies will be sent to:

- Premier Kathleen Wynne
- Patrick Brown, PC Leader
- Andrea Horwath, NDP Leader
- John Fraser, Parliamentary Assistant to Minister of Health and Long-Term Care
- Jeff Yurek, PC Health Critic
- France Gélinas, NDP Health Critic

RNAO (2017a) Action Alert: Ask Queen's Park to Provide Immediate Funding for Supervised Injection Services (SIS). Used with permission.

Your Name: *
Please enter your full name.

Your Email: *
Please enter your email address.

Email Subject: *
Email Subject
Save Lives by immediately Funding Supervised Injection Services

Your Profession: *
Please select your profession
- Select -

Email Body: *
Editable email body to be sent in email.
Dear Premier Wynne,

In 2014, there were 674 opioid-related deaths in Ontario -- one death every 13 hours! Early figures from the Coroner's office for 2015 show that number has grown to 707. Two-hundred and three of those deaths involved fentanyl, a highly potent narcotic. Accessing care for addiction or substance use shouldn't be any different than accessing care for cancer or diabetes or any other health issue.

This growing crisis needs your immediate action to save lives. I urge you to make a public announcement that provincial funding is available for supervised injection services (SIS), so that these health services can be available in Toronto and Ottawa.

Premier Wynne, every day that funding is delayed prevents progress on this important public health crisis. Operational funding and resources to undergo the necessary renovations, is critical, so the health facilities that have applied to offer SIS can move speedily to do so. As you know, these renovations are expected to take several months, and approval from Health Canada is pending on-site inspection of the renovated facilities.

Ontarians are dying daily from preventable deaths. Please act now.

FIGURE 18.1 RNAO action alert: Save lives by immediately funding supervised injection services (RNAO, 2017c).

Used with permission.

URGING EVIDENCE-BASED DECISION-MAKING

Although support for SIS was endorsed by the Toronto health board, more work and pressure were needed for it to materialize. Such pressure came in September 2015, when the Toronto Public Health Unit's Medical Officer of Health Dr. David McKeown presented a report to the board on trends, prevention, and response for overdose in Toronto. The report underlined concerns about the rise in drug-induced deaths in Toronto over the last decade. MOHLTC called a meeting that RNAO attended, and the focus was on the use and misuse of narcotics in Ontario (RNAO, 2015b). Following that, RNAO issued a letter to the Premier with recommendations on ways that the province could prevent premature deaths and improve health outcomes related to drugs (2015b). Of these, SIS was a key recommendation for government to prevent deaths from overdose (RNAO, 2015b).

The next window of opportunity came in March 2016, when the Toronto Board of Health considered the proposal for three health services in Toronto to add small-scale SIS to their existing clinical services. RNAO (2016c) again secured a deputation, and in addition to using robust evidence, it echoed the voices of lived experience that gave weight to the decision at hand. Just ahead of RNAO's deputation, a mother who had lost her daughter to a drug overdose, Donna May, made a heart-wrenching deputation. For RNAO's CEO, it was clear. The remarks she had brought, so well prepared and filled with evidence, were no longer sufficient. Grinspun's deputation was spontaneous, unapologetically sharp, and harsh.

The proposal was unanimously approved and moved to Toronto City Council.

MOBILIZING CHANGE WITH EVIDENCE, COMMUNICATIONS, AND MEDIA

To increase momentum, RNAO called on members and the media to give legs to the SIS movement. In a matter of days, RNAO issued two letters to the editor (*National Post*, 2016; *Toronto Star*, 2016), and CEO Dr. Doris Grinspun was quoted and counted in "Toronto VIPs [who] give support to safe injection sites" (Davidson, 2016). By injecting evidence into each media response, RNAO positioned itself and the issue firmly for serious consideration.

RNAO also harnessed the power of narrative, such as in the sad instance of Brad Chapman, who collapsed on a downtown Toronto street from a drug overdose (Chapman & Grinspun, 2016). Brad is the brother of Leigh Chapman, a registered nurse and member of RNAO. Leigh became an advocate, speaking with insight from her brother's experience, for evidence-based public policies including supervised injection services to prevent further tragedies.

"What else do you need to make a unanimous decision in favour of SIS," Grinspun asked the councillors.

"How many more mothers who have lost their children do you need to hear? How many more fathers, husbands, or sisters do you need to see suffering to say—unanimously—that the time for SIS is now? Nurses urge you to act swiftly," she added.

CHAPMAN: LEARNING FROM THE TRAGIC DEATH OF A BROTHER

Brad Chapman was found collapsed on a downtown Toronto street from a drug overdose in August 2015 and died eight days later in hospital. When not in jail, Brad lived on the streets for the last 20 years. He died at 43, but his mental health and addiction challenges took him away long before then.

Over the past few months, Brad's sister, Leigh, and mother, Cori, have had the privilege of meeting several people who shared memories of Brad. They learned that Brad could still play the guitar, liked to rollerblade, and brightened the lives of others with a kind word and a smile. It consoled them to know that Brad is missed—not just as a son, brother, father, grandfather, and uncle, but also as a friend and a member of the community.

But even with this consolation, Leigh Chapman, a registered nurse, knows there are evidence-based public policies that could have helped save Brad.

A supervised injection service is a health service that provides a safe and hygienic space where people can inject preobtained drugs under the supervision of nurses. There are more than 90 SIS sites worldwide, including those in Australia, Germany, Luxembourg, Netherlands, Norway, Spain, Switzerland, and two in Vancouver. Two decades of research on SIS show they reduce deaths from overdoses, reduce transmission of infectious diseases, increase use of detox and other addiction treatment services, and improve community safety.

Brad felt safe at a nearby harm reduction program where he could exchange used needles for clean ones, access safer crack kits, and engage with nonjudgmental public health staff. He would regularly call home from this facility, which offered Brad a sense of belonging and way of checking in with those who loved him.

But a needle exchange is different from SIS. Brad got his needles but then shot up alone, unsupervised, in an alley, which is where he was found by police after overdosing.

What if, instead, Brad had been able to access SIS within a harm reduction program where he felt welcome? Would he still be with us today?

There is also naloxone, a short-acting drug used to reverse a suspected narcotic overdose. Health Canada has determined naloxone's ability to quickly respond to an overdose far outweighs its minimal risks. Ottawa Public Health has successfully trained at least 150 people to provide naloxone, and about 50 local overdoses have been reversed. Because of the increasing number of deaths associated with prescription and nonprescription narcotics, some jurisdictions in the United States are training those most likely to arrive first at a scene (fire and police personnel) to recognize overdoses and administer naloxone. What if the first responders who arrived on the scene had been able to immediately give Brad naloxone and start CPR?

This is why the Registered Nurses' Association of Ontario has spoken out for SIS and called for easier access to naloxone. Nurses were at the forefront of creating Insite, the safe injection site in Vancouver, and RNAO fought then-prime minister Stephen Harper to keep it open.

The City of Toronto is moving forward with plans for SIS. Isn't it time other municipalities such as Ottawa—where overdoses took the lives of 40 people in 2014—took similar steps to avert tragedies? We have the evidence; we just need the political will. And with federal Health Minister Jane Philpott expressing her support for Insite, nurses are hopeful we can prevent others like Brad from dying.

Leigh Chapman is a registered nurse and the sister of Brad Chapman. Doris Grinspun is a registered nurse and the chief executive officer of the Registered Nurses' Association of Ontario (RNAO).

From <http://ottawacitizen.com/opinion/columnists/chapman-learning-from-the-tragic-death-of-a-brother>.

RNAO (2016g) wove evidence, narrative, and media into another powerful action alert for its members and the public to voice their support for SIS. It provided an update on developments since the deputation, including a vote by the Ottawa Board of Health in favour of proposals to set up SIS at community health centers, and studies underway in London and Thunder Bay on the need and feasibility of SIS in their communities (RNAO, 2016g). It also provided a letter template for members to write to their city councillor, in advance of the SIS motion proceeding to the Toronto City Council.

GAINS, LESSONS, AND NEXT STEPS FOR SIS IN ONTARIO

Advocates for SIS saw the fruits of their labour in July 2016, when Toronto City Council approved 36-3 the

proposal to support integration of three supervised injection services into existing health facilities throughout the city (RNAO, 2016b). To celebrate the milestone, RNAO (2016f) added its own announcement of a new Best Practice Guideline (BPG) on SIS. Using a systematic review and guided by a panel of experts in the field, RNAO's BPG will provide recommendations to guide this critical harm-reduction initiative.

The cochairs supporting the guideline include Toronto's former Medical Officer of Health, Dr. David McKeown, who helped make SIS a reality in Toronto under his leadership; and Marjory Ditmars, a registered nurse with 5 years of practical and leadership experience at Insite.

IMPLEMENTING SUPERVISED INJECTION SERVICES: A HEALTH EQUITY BPG

In November of 2016, RNAO convened the SIS guideline development panel consisting of individuals with expertise in harm reduction and substance use. The panel includes individuals holding clinical, administrative, and academic positions, as well as those with lived experience. These experts work either directly with people who inject drugs (PWID) in a variety of health settings (e.g., supervised injection services, community health centers, harm-reduction programs, and primary healthcare), or indirectly in other types of organizations, such as associations and academic institutions.

To determine the purpose and scope of the guideline, the RNAO BPG Development Team conducted a gap analysis of existing guidelines, 12 key informant interviews, and two focus groups with experts in the field. These experts included direct-care staff, administrators, researchers, and individuals with lived experience, representing various Canadian organizations in Toronto, Vancouver, Edmonton, and Ottawa. It became apparent that a guideline was required for nurses and other health workers in SIS to provide recommendations on the most effective way to deliver service to PWID that would: 1) improve client engagement and inclusion; 2) support positive health outcomes; and 3) reduce harms associated with injection drug use. The main focus of the guideline was to ensure equity-oriented services for PWID through harm-reduction, trauma-informed, and culturally safe approaches.

Specifically, the practice recommendations provide guidance on how to engage PWID in SIS through establishing trusting relationships; practicing critical inquiry (i.e., reflective practice); and promoting and engaging in shared decision-making. The education recommendations provide direction on the structure and format of educational programs shown to be effective at increasing knowledge, skill, and confidence of individuals working with PWID. The policy recommendations provide guidance to organizations and the health system on how to build SIS that promote high-quality, equitable care for PWID. This includes: the integration of peers and comprehensive services into SIS operations, as well as the integration of SIS into existing health settings (e.g., hospitals); access considerations for rural environments and for vulnerable PWID; considerations related to facility size and hours of operation; and implementation of regulations and operational procedures that support people who require assisted injections and youth who inject drugs.

The latest achievement for SIS is the commitment by the Ontario government to fund renovations and operating costs at three SIS facilities in Toronto and one in Ottawa (RNAO, 2017c). This was announced as part of the 2017 provincial budget, which RNAO was pleased to see following its letter to political leaders urging provincial support and funding for SIS (RNAO, 2016d), and its earlier recommendation in a prebudget submission (RNAO, 2017b).

Through this strategic and planned advocacy initiative, RNAO and its coalition partners leveraged different avenues for shaping policy, all of which were rooted in evidence. Submissions and letters to the government form the starting point, first setting out the concerns and asks in relation to the issue at hand, as well as recommendations for action. Mobilizing a collective voice made up of nurses, healthcare professionals, and community members is the next step in amplifying the call to action. The media serves as another powerful platform for strengthening the call, and one supported by evidence gives substance and credibility to both the association and the media agency. The landmark achievements for

SIS in BC and Ontario set a precedent not only for harm reduction, but on a broader scale, for linking evidence with advocacy and policy, to effect real change.

In a time of a global opioid crisis, RNAO publicly promoted the research evidence demonstrating that SIS saves lives and, armed with evidence, advocated politically for SIS as a necessary harm-reduction strategy. This advocacy work and subsequent development of a SIS BPG is one example of how a nursing professional association can effectively link evidence-based practice and evidence-based policy to advance healthy public policy and the health and well-being of people. See Figure 18.2.

Linking BPGs & Policy

**R
N
A
O**

ic BPG
Clinical Best Practice Guidelines

Engaging Clients Who Use Substances

Board of Health
Supervised Injection Services: Over 2,100 have signed showing support, are you one of them?

Board of Health - March 21, 2016

Speaking Notes: Deputation to the Toronto Board of Health in Support of Supervised Injection Services
March 21, 2016
Dr. Doris Grinspun
RN, MSN, PhD, LL.D(hon), O.ONT.
Chief Executive Officer

Toronto City Council approved 3 supervised injection sites

RNAO celebrates approval of supervised injection services by launching best practice guideline
2016-07-14

RNAO.CA

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FIGURE 18.2 Linking BPGs and policy—supervised injection services.
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C A S E S T U D Y

LINKING EVIDENCE AND ADVOCACY FOR FUNDING OFFLOADING DEVICES IN ONTARIO

Diabetes is a serious metabolic condition that affects people of all age groups, worldwide (Canadian Diabetes Association Clinical Practice Guidelines Expert Committee, 2013). The International Diabetes Federation (IDF) estimates that the global prevalence of diabetes in 2012 was 8.3% (approximately 371 million people) (International Diabetes Federation, 2012). Moreover, 4 out of 5 people living with diabetes reside in low- and middle-income countries. Indigenous and South East Asian populations, both in Canada and abroad, are especially vulnerable to the disease (Davis, 2011).

People with diabetes are at high risk of developing long-term complications, including foot ulcers and amputations. Diabetes-related foot problems, ulcerations, and amputations significantly impact the person and the community in which patients live. Foot ulceration precedes 84% of nontraumatic lower extremity amputations in those with diabetes. The risk of death is 2.4-fold greater than for patients without ulcerations (Singh, Armstrong, & Lipsky, 2005). The treatment of diabetes-related foot ulcers is an expensive, lengthy, and time-consuming process when ulcers are not detected and managed early. In fact, it accounts for an estimated 15% of total healthcare resources dedicated to diabetes in high-income countries and as much as 40% in low- and middle-income countries (International Diabetes Federation, 2017). The International Diabetes Federation indicates that comprehensive diabetic foot assessments and foot care, based on prevention, education, and a multidisciplinary team approach, may reduce foot complications and amputations by up to 85% (International Diabetes Federation & International Working Group on the Diabetic Foot, 2005).

As alarming as this evidence is, evidence is not always enough to create change. Next in this chapter we discuss a successful case study leveraging three necessary factors—evidence, political pressure, and opportunity—to secure a policy change regarding universal funding for patients with diabetes living with foot complications to prevent amputation (Elliott, 2015). We will explore practical principles of government advocacy to empower

our readers to help achieve positive policy change that can improve patient outcomes.

COMING TOGETHER

In 2012, Canada's Council of the Federation endorsed the Registered Nurses' Association of Ontario (RNAO)'s *Best Practice Guideline Assessment and Management of Foot Ulcers for People with Diabetes* for national implementation (The Council of the Federation Health Care Innovation Working Group, 2012). Provincial governments across Canada have publicly declared that foot care for people with diabetes is a significant health challenge and one of their top priorities for care. RNAO was committed to supporting the dissemination, adoption, and uptake of their guidelines at a national level (see Figure 18.3).



FIGURE 18.3 Meeting between Wounds Canada and RNAO. Used with permission.

For 2 decades, Wounds Canada (formerly the Canadian Association of Wound Care) has been leading the charge in wound treatment and prevention across Canada. Wounds Canada worked with both Public Health Canada and Diabetes Canada (formerly the Canadian Diabetes Association) from 2009 to 2012 to raise awareness of diabetes-related foot complications and of prevention and management strategies. In 2012, Wounds Canada established a new division, Diabetic Foot Canada (DFC), to focus solely on foot disease in those living with diabetes, with a strong tie-in to the important etiological issues surrounding diabetes. Diabetic Foot Canada was designed to be the national go-to program for online

information and education for clinicians and patients in support of effective self-monitoring, early detection, prevention, and treatment.

In 2013, Wounds Canada and RNAO identified this area of healthcare as a priority that affects both quality of life and healthcare costs. Thus, they joined forces to produce the *Diabetic Foot Canada Journal* (DFCJ), an online publication targeted at multidisciplinary healthcare professionals, to provide education, disseminate best evidence and educational tools, and raise awareness of the importance of preventing diabetes-related foot complications and amputations.

Wounds Canada and RNAO also recognized that, historically, the Canadian diabetic foot care community has struggled to fully leverage the power of our collective voices. Thus, they formed a coalition with each other, along with Diabetes Canada and the Canadian Association for Enterostomal Therapy (CAET), to jointly engage the government. One of the key alliance goals of this coalition is to prevent diabetes-related foot complications, including preventable lower limb amputations, through evidence-based Clinical Practice Guidelines (CPGs) and timely management of abnormalities.

JOINT LETTER TO MINISTRY OF HEALTH AND LONG-TERM CARE (MOHLTC)

On December 9, 2014, Wounds Canada, RNAO, and nearly 50 other supporters delivered a letter on care for diabetes-related foot ulcers to the top levels of the Government of Ontario. This letter is one of the most powerful and unified messages that has ever been delivered to a Canadian government on the issue of diabetes-related foot care.

In the letter, the Coalition highlighted to the ministry the importance of a coordinated and integrated system of care to improve patient outcomes, while providing the healthcare system with substantial cost savings. Currently, most Ontarians with diabetes-related foot complications have to pay out of pocket for the care they need, which includes preventative shoes, socks,

offloading devices, and chiropody, podiatry, or nursing treatment. As a result, many of the people most in need of the devices and care are least able to afford it. The letter presented a number of key suggestions the ministry could implement to drastically improve the diabetes-related foot care situation in the province, including:

- Providing universal access to preventative foot care services, including supplying preventative shoes, socks, and offloading devices to those in need, free at the point-of-care, for all Ontarians living with diabetes
- Developing policies that enable every Ontarian with diabetes to have appropriate foot assessments as outlined by the International Diabetes Federation 2017 guideline document (an annual exam for all persons with diabetes, with higher-risk individuals having assessments more frequently)
- Adopting an Ontario-wide interprofessional approach to diabetics-related foot care, with at least one interprofessional diabetes foot-care team, with a well-defined referral pattern, in each Local Health Integration Network (LHIN)
- Publishing, on an annual basis, reliable data on diabetes-related foot care, using internationally recognized metrics, to assist ongoing quality-improvement efforts

Chief amongst these gaps is the fact that most Ontarians with diabetes-related foot complications have to pay out of pocket for the care they need, which includes preventative shoes, socks, offloading devices, and chiropody, podiatry, or nursing treatment.

The coalition believes that universal access to preventative foot care for people living with diabetes will decrease the number of ulcers and amputations in the same way that retinopathy screening and treatment has decreased diabetes-related blindness. In addition, it will also decrease overall provincial spending (see Figure 18.4).



FIGURE 18.4 A Canadian report card on funding for offloading devices for persons with diabetes.

Used with permission.

The letter and subsequent meetings have focused on increasing policymakers' awareness by outlining cost-effective methods for improving foot care for people with diabetes and, ultimately, reducing the number of preventable amputations in the province. A jurisdictional report on offloading funding was also created and submitted. However, these meetings were not followed up with specific commitments from the MOHLTC.

INCREASING AWARENESS

Following the delivery of the letter, meetings and other events were held to increase the awareness of policymakers about these issues. The organizations and individuals of the coalition continued to work together and separately to improve the provincial politicians' awareness about the issue in general and advocate for universal public funding of offloading devices in particular.

To reinforce the message, the coalition highlighted cost-effective methods for improving foot care for people with diabetes and, ultimately, reducing the number of preventable amputations in the province. For example, in early 2015, Diabetes Canada developed an economic analysis and accompanying report revealing that diabetic foot ulcers currently cost the government of Ontario between \$320 million and \$400 million a year, whereas the public funding of offloading devices could produce a net savings of between \$48 million and \$75 million (Somerville & Nagpal, 2015).

Later that year, Diabetes Canada and its volunteers held an information session with MPPs at Queen's Park to advocate for amputation-prevention supports and public funding for offloading devices. An embargoed copy of Diabetes Canada's economic analysis and report was provided to the Health Minister's Office, which was in turn shared with the Treasury Board and Finance Minister's Office.

In April 2016, RAO and Wounds Canada hosted a successful reception with 28 members of the Ontario legislature, partnering associations, clinicians, and patients to lobby the ministry to fund offloading devices. Materials had been developed as part of the legislators' information packages. These materials were designed to help them assess the problem and impact of not changing policies. The event itself included an overview of the problem through presentations from clinical and policy experts and the sharing of patient stories by patients and family members. Representatives from each political party delivered a response to the information they had received and their plans for addressing the issues. What is interesting is that many of the attendees, including many in key policy and decision-making positions, were surprised to learn that something as seemingly minor as a foot ulcer could lead to amputation and increased mortality (see Figure 18.5).

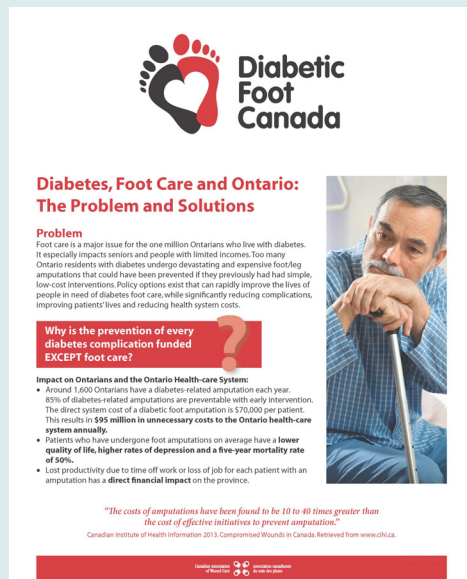


FIGURE 18.5 Diabetes, foot care and Ontario: The problem and solutions. Used with permission.

The problem is that “evidence is often not presented in a language that governments speak.” (Elliott, 2015, pg. 9)

MEDIA AND OPPOSITION

Following the April event, a media release outlining the problem and stating the recommendations of the coalition was used by several news outlets to develop stories about the issue, many of which included interviews with representatives of coalition organizations (Artuso, 2016; RNAO, 2016a).

Over the next many months, the coalition continued to work collectively to increase political pressure and engage all political parties, including the opposition.

LEVERAGING OPPOSITION

On World Diabetes Day, November 14, 2016, the Ontario Minister of Health was challenged during Question Period on the issue of offloading devices by Ontario Progressive Conservative Health Critic Jeff Yurek, prompted by Diabetes Canada.

FORMALIZING THE PROCESS

The coalition was invited to submit a formal Ontario Health Technology Advisory Committee (OHTAC) request

outlining the evidence supporting removable cast walkers (RCW) and RCWs rendered irremovable (ITCC) in May 2016. OHTAC is composed of a group of evidence-based experts from across the province who review health technology assessments and make recommendations on which healthcare services and devices should be publicly funded.

SUCCESS AT LAST: THE HEALTH MINISTER'S COMMITMENT

In February of 2017 at RNAO'S Queen's Park event, the Minister of Health committed to public funding for offloading devices and to accepting OHTAC's recommendations to publicly fund total contact casts (TCC), RCWs, and ITCC for diabetic neuropathic foot ulcers.

After this long process of providing information, recommendations, and follow-up, the coalition recognized that decision-makers were finally beginning to understand the impact of diabetes on the health of Canadians. However, comprehension is only the first step. It is important to acknowledge that the “what” is only part of the equation. The “how” is also necessary for successful implementation of the recommendations. Therefore, the coalition has continued to advise the ministry on successful options for safe and effective rollout of this initiative.

Part of the coalition strategy was the creation for the ministry of a document comparing three implementation methods for ensuring direct-care patient access to offloading devices for people with diabetes and foot ulcers. These are:

- Offloading devices added to formularies and accessed at point-of-care
- An Assistive Devices Program (ADP) funding model accessed by the organization where offloading devices are obtained by patients at the point-of-care
- A direct-to-patient ADP funding model

The implementation method recommended by the coalition is #1: offloading devices added to formularies and accessed at point-of-care.

Specific recommendations to support this option include:

- Immediate point-of-care dispensing at the time of the assessment based on qualifying criteria

- No patient copayment for standard stock devices (this will require Local Health Integration Network [LHIN] copayment or a creative funding model) but rather direct billing for reimbursement of the device from the hospital or community organization
- Fitting and application completed by qualified healthcare professionals only
- Ability of the LHIN or other organization to fund alternatives to the above devices (TCC/RWC) if patients have contraindications (e.g., unsteady balance, heel ulcers, ischemia, deep infection)
- A MOHLTC policy to provide direction to hospitals and community organizations (in order to gain their support and understanding of the process for patients to be able to access the offloading device at the point-of-care)

foot ulcers, as well as ensuring that we reduce the growing numbers of preventable diabetes-related amputations across Canada. The work has started across Canadian provinces.

This case study was a description of a strategic and planned policy advocacy initiative that did not take place overnight but required strong vision focused on improving patient outcomes, collaborations between organizations, persistence, and outstanding leadership.

We need to reiterate that clinical excellence and the use of best evidence in practice, related specifically to care for persons with diabetes and actual or potential foot ulcers, while absolutely necessary, is not enough. We need to work with governments to ensure organizational policy to support foot assessments of all patients with diabetes on a regular basis and preventative care and management. These interventions do cost money, but they are a far cry from the cost of an amputation in terms of quality of life, loss of productivity, and healthcare dollars. The Narayan public health principles have indicated that the identification of the high-risk diabetic foot is both cost-saving to healthcare systems and improves patient outcomes (Venkat Narayan et al., 2006). See Figure 18.6.

NEXT STEPS

The coalition remains committed to working with other provincial organizations and key stakeholders to address the gaps in care and policy in the area of diabetes-related

Linking BPGs & Policy

RNAO
Public and Registered Nurses' Association of Ontario (http://rnao.ca)

Low-cost interventions could save people's limbs, lives, and millions of Ontario's health-care dollars

2016-04-12
MAGG ZUCCHINI

TORONTO - Apr. 12, 2016 - Each year, almost 2,000 Ontarians are forced to endure a diabetes-related amputation, 85 per cent of whom could be spared from this terrible suffering. In addition to the human cost of the direct health system cost of a diabetic foot amputation, estimated at about \$70,000 per patient's limb, the overall annual cost to the health system is \$140 million dollars. That's why nurses, doctors, other health professionals and patients are heading to Queen's Park today.

The Canadian Association of Wound Care (CAWC) and the Registered Nurses' Association of Ontario (RNAO) are bringing recomme Ontario MPPs on how to improve the quality of life of people who suffer from complications related to diabetes, and save millions of dollars.

People with diabetes are at high risk for foot ulcers because many of them develop a condition that results in damage to the nerves. Th damage inhibits a person's ability to feel sensation in their feet. As a result, bruises, bumps and even cuts to their feet can go unnoticed may fail to seek help until the problem is severe, leaving them with a foot ulcer that is difficult to heal, may be very deep to the bone affected. Once this happens, RNAO and the CAWC say it's too late and they are at high risk for amputation.

Diabetes-related foot ulcers are a costly problem for the system that has devastating effects on patients and their families. "As a result, the number of resources for the public, and for health practitioners that help prevent and better treat diabetic foot ulcers, is estimated to be in the millions of health-care dollars annually."

RNAO and CAWC have developed a number of resources for the public, and for health practitioners that help prevent and better treat diabetic foot ulcers. RNAO has developed research-based guidelines and teaching tools directly related to diabetic foot ulcers. Together, they are urging all four areas:

1. Provide universal access and free preventative foot care services, including offloading devices, to relieve pressure on the feet of Ontarians living with diabetes.
2. Ensure all Ontarians with diabetes have at least one annual foot assessment by a qualified health professional who can refer to a podiatrist if needed.
3. Adopt an Ontario-wide interprofessional approach to diabetic foot care at the Local Health Integration Network (LHIN) that supports timely access to podiatry services.
4. Publish reliable data related to foot care for those with diabetes on an annual basis.

Canadian Association of Wound Care
Association canadiens de soins des plaies

D. Grinspun, RNAO, All Rights Reserved. 1

FIGURE 18.6 Linking BPGs and policy—funding for offloading devices.
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CONCLUSION

As you can see from these two case studies, RNAO has taken a leadership role in organizing the nursing community and collaboratively supporting others in advancing healthy public policy. Evidence—and especially clinical evidence—is a necessary component of the multipronged strategy to advance healthy public policy. However, as this chapter highlights and the two case studies prove, evidence alone does not suffice to make macro policy changes. As a nursing collective, we can throw up our hands in frustration, or we can choose to join together using our clinical expertise and our collective influence as a body politic, truly speaking truth to power (Grinspun, 2016c).

Activism on broader health and social issues does not preclude continued activism on professional issues related to nursing practice. Indeed, stage 4 in Cohen and colleagues' (1996) framework for nursing political development does not rule out pursuit of self-interests; it merely does so within a context that emphasizes the larger public good. According to the authors, pursuit of stage 4 can be enhanced by: 1) building coalitions and constituencies around health and social issues; 2) developing leaders and supporting visionaries and risk-takers; 3) mobilizing nursing for campaigns; 4) integrating health policy into curricula; 5) developing public media expertise; and 6) gaining increased sophistication in policy analysis and related research. RNAO's experience, described in this chapter, shows achieving stage 4 following this type of approach is both doable and thrilling to attain.

Improving the health outcomes of the world's people and the effectiveness of our health systems requires the ongoing and persistent engagement of nursing as a collective in the political process. This engagement must be multipartisan to enrich our democracy and grow the respect we have achieved from the public, the politicians, and the media (Grinspun, 2006a, 2012, 2015). By targeting specific policies aimed at closing the gap between what the public needs and what nursing can offer, we can improve our contributions to health for all.

As described in Chapter 1, governments and health service organizations worldwide are seeking to improve healthcare, lower or contain costs, and optimize health outcomes. A large focus is on ensuring appropriateness of clinical interventions, including reducing those interventions that have proven to be unnecessary or ineffective and demanding that clinical care be based on evidence. However, the evidence of clinical care is not always supported by the broad policies and funding that are needed to deliver appropriate interventions. This was the case with both supervised injection services and off-loading devices in the province of Ontario. This reality brings opportunities to nursing and nurses as a knowledge- and solution-oriented profession.

Augmenting the narrative of evidence-based clinical practice with one of demanding evidence-based policies is urgent and achievable. As this book attests, nursing and nurses already have remarkable clinical expertise with proven health and system outcomes. With a nursing collective that also leads the way in policy, we can set endless agendas that, if purposefully guided, can and will benefit the public at large. Moreover, nurses' natural orientation toward upstream approaches to health and healthcare, as well as the profession's strong focus on health promotion and disease prevention, position us as key players in solving the health and healthcare imperatives facing the public both as funders and users of health services.

REFLECTION

Based on your review of the cases above, do you think there is a role for direct-care nurses or nursing students in policy advocacy? If so, what is it? If not, why not?

KEY MESSAGES

- Nursing, as a profession, has a responsibility to assume its role as a body politic to advance healthy public policy. This will ensure the public fully benefits from nurses' contribution as evidence-based experts.
- Nurses and nursing organizations can and should provide political leadership on broader policy issues that speak to the public's interests.
- Evidence-based policy proposals are only one of two vital pillars required to drive healthy public policy at the macro health system level; in addition to the "evidence" pillar, a second pillar of effective "advocacy action" is required to achieve change.
- An advocacy campaign should be strategic, multipronged, adaptive, and nimble, entailing a number of domains of action: knowledge mobilization; communication and grassroots mobilization; coalition building; use of mass social and alternative media; as well as direct engagement with politicians, civil servants, and other opinion leaders. Nurses should educate themselves in all these domains of action.
- Successful advocacy requires building a grassroots movement, ready to mobilize in a concerted fashion and apply maximum pressure at all levels, from the "bottom," from the "sides," and from "above" at the local, state, and federal levels.

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