The Political Astuteness of Nurse Practitioners

Following a Successful Legislative Journey

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Abstract

Nebraska became the 20th state to modernize regulations to allow for full practice authority for nurse practitioners. Legislative victories such as those evident in Nebraska are often lead by professional associations and are dependent on the level of political astuteness found both in the leadership and members. Several studies have noted increased political astuteness in students through the use of health policy courses and activities and nurse legislative days, however the impact professional associations have on member nurse practitioners has not been reported. The aim of this study was to measure the level of political astuteness of member nurse practitioners (N=96) following participation in health policy advocacy activities, done on behalf of the state and national professional nurse practitioner associations, during the 2014 and 2015 legislative sessions in Nebraska. A cross-sectional survey, using a retrospective pretest-posttest design of the Political Astuteness Inventory, demonstrated an increase in overall astuteness and political participation of association members.

Keywords: nurse practitioner, political advocacy, political astuteness, political participation
The Political Astuteness of Nurse Practitioners Following a Successful Legislative Journey

The nursing profession has a fundamental duty, ethical and social responsibility to engage in political advocacy for the betterment of the health and wellness of individuals, families and communities as defined by the Nursing Code of Ethics and Social Policy Statement (American Nurses Association [ANA], 2001). Political advocacy is a role underrepresented by nursing and with 3.1 million nurses and 257,000 nurse practitioners (NPs) in the United States (US) the political impact of the profession, falls short of it’s potential (Phillips, 2012). Research shows nurses generally feel uncomfortable and unprepared to engage in advocacy at the political or legislative level (Abood, 2007). Abood (2007) outlines the power bases, political skills and knowledge needed to be effective in the political arena and to actualize the power of this workforce. Nursing scholars such as Meleis (2012) write that the profession of nursing has been empowered through stakeholder groups such as the Institute of Medicine (IOM) to engage in political action and to be leaders of health care reform (Institute of Medicine, 2011).

Nebraska Nurse Practitioners (NNP), empowered by health care stakeholders and members of the association, took up the legislative challenge to advocate for the direct access to the high quality care provided by NP’s for those who reside in Nebraska. The Nebraska Nurse Practitioners (NNP) is the state professional NP association. NNP brought forth legislative bill 107 (LB107) and successfully eliminated the career-long collaborative agreement between a physician and an NP, allowing for full practice authority (Nebraska State Legislature, 2015). Nursing associations such as NNP play a critical part of increasing the political skills, knowledge and awareness of health care issues in members and policymakers. The political advocacy of nursing provides an opportunity to impact the broad scope of factors influencing the care of individuals and communities (Rains & Barton-Kriese, 2001).
Significance

Health System

One of the most compelling reasons for the political advocacy of nursing lies within the World Health Organization’s (WHO) declaration to act on the social determinants of health and declares the ultimate goal of primary care as “better health for all” (World Health Organization [WHO], 2013, p.2). In order to reduce social disparities, five key elements of action were outlined and include reforms in the areas of universal health coverage, service delivery, leadership and public policy and increasing stakeholder participation (WHO, 2013).

The movement for reform in the US parities the goals of the WHO and calls for changes as set forth in the Patient Protection and Affordable Care Act [PPACA] (PPACA, 2010). Characteristics of a reformed health system should reflect greater access to care, which includes increased primary care services and reflects the dimensions of safety, effectiveness, patient-centeredness, timeliness, efficiency and equity (Institute of Medicine [IOM], 2001). It is broadly accepted that the triple aim of quality, cost and value are central to these reforms (Goldman & McGlynn, 2005).

Access to care remains a significant issue in the current and proposed health care delivery models and it should be noted that although insurance coverage is significant, it does not guarantee access to care (Russell, 2014). Hofer, Abraham and Moscovice (2011) report by 2019, primary care visits and utilization rates will increase to between 15 and 24 million, reflecting a nearly eight percent increase in current utilization rates under the health care coverage expansion provisions of the PPACA. There is a current shortage of nearly 46,000 primary care physicians in the US. In order to meet the needs of the PPACA, an additional 4,000 to 7,000 primary care physicians will be needed over the next 15 years.
In 2011, the number of primary care designated health provider shortage areas (HPSAs) was 5,870 (National Governors Association, 2012), the number has grown to represent 6,087 (Health Resources and Services Administration [HRSA], 2014). Attempts to increase the recruitment of medical students through higher payment reimbursements for primary care has unsuccessfully competed with the high salary of specialized practice (Hofer et al., 2011).

**Economic Impact**

The economic impact of this scholarly project is reflected in decades of research representing the quality and value of the care provided by NP’s. The American Association of Nurse Practitioners (AANP) notes 80% of NP’s are being trained and educationally prepared in primary care programs, whereas physicians entering primary care residency programs was less than 17% (American Association of Nurse Practitioners[AANP], 2013a). In 2011, the American Colleges of Nursing (AACN) noted that the tuition cost and preparation for NP’s was approximately 25% of the cost required for physicians. According to the US Department of Labor statistics (2014), NP salaries represent approximately 50% of the salary command of primary care physicians with a mean salary in 2012 of $96,460 and $220,942 respectively.

In 2009, the average cost of a visit with the NP remained 20% lower than the cost to visit a primary care physician. NPs and Physician Assistants (PAs) are generally reimbursed at a rate of 75-85% of what is usual and customarily paid to physicians under Centers for Medicare and Medicaid Services (CMS). This equates to a national savings of just under nine billion in health care savings making use of this workforce to full potential (Missouri Foundation for Health Publication [MFH], n.d.).

The Missouri Foundation for Health (MFH) estimates the effects of enacting enabling legislation would increase the number of NP and PAs by nearly 500 and produce an overall eight
percent reduction in the unmet primary health care needs in the Missouri. The result is a savings of nearly $684.00 for every Medicare recipient and a net savings of 1.6 billion dollars from 2012 to 2022.

Health Policy

Advanced practice registered nurses (APRNs) represent a viable and relevant workforce, capable of filling primary care shortage gap and contributing to a full primary care workforce (Fairman, Rowe, Hassmiller, & Shalala, 2011). The IOM (2011) report, *The Future of Nursing: Leading Change, Advancing Health* recognizes the contributions of APRN practice in health care and notes that regulatory practice barriers prevent the full-actualization of this qualified workforce. To address the regulatory barriers to APRN practice, the National Council of State Boards of Nursing (2008) proposed a framework for standardized statutory and regulatory authority across states. Currently, only nine of the 50 states have met the requirements of the APRN consensus model (NCSBN, 2013).

Local Issues

Nebraska is a largely rural state with 42% of the population living in a rural areas (K. Mueller et al., 2009). Nebraska is not exempt from the impact the shortage of health care providers has had on the national scene. Over the next 10-15 years, Nebraska will see nearly 33% of physician’s retire and the ability to recruit physicians to rural areas has proven difficult (Centers for Work Force Studies, 2012). Nearly 65% of Nebraska counties are in HPSAs for primary care and 95% of counties HPSAs for psychiatric and mental health providers (HRSA, 2014).

Diversity and NP Workforce
Nebraska has 823 licensed NP’s in the state in 2012, demonstrating a 20% increase since 2010 (Nebraska Center for Nursing, 2013). Male’s account for less than four percent of practicing NP’s. Primary care NP’s represent family, internal medicine/adult, women’s health and pediatric specialties with 44% practicing in rural counties (Bhuyan, Deras, Cramer, Cuddigan, & Stimpson, 2013). The majority of NP’s are employed full-time (63%) with the majority practicing in physician offices (39%), followed by outpatient clinics (31%), inpatient settings (13%) and public/community health centers (11%). In 2011, the average age of NPs in rural and urban areas was 42.1 and 45.4 years respectively.

Problem Statement

If nursing is to advocate against health disparities, lead health care reform, impact the outcomes of health policy and make possible ‘health for all’ they will need to be an active force in the political process. Primomo and Björling (2013) note increased literature on political participation. However, there is little evidenced-based research on how to do health policy (Phillips, 2012) and what propels nurses into action (Cramer, 2002). Professional associations play an active role in the political process and little is known about the impact health policy activities has on the political astuteness of association members following an active legislative session.

Purpose Statement

The purpose of this scholarly project was to determine if policy advocacy activities done on behalf of professional NP associations during the 2014-15 legislative seasons increased political astuteness and political participation of member NPs in Nebraska.

Facilitators and Barriers
Interventions done to promote grassroots engagement of NP’s during the legislative sessions were done through the use the NNP and AANP list-services and NNP membership meetings. NNP’s participation was paramount to facilitating this project. Participation and survey completion of organizational members was necessary to reach appropriate sample size for statistical validity and reliability.

Potential barriers existed in the recruitment of participants. An active email list was available for members of NNP for survey recruitment. Addresses of licensed NPs were obtained from the Department of Health and Humans Services, the two lists compared to formulate a distribution list. There was some discordance and some NPs may not have received an email or the initial invitation. An AANP member list to include email or addresses was not available for survey recruitment; therefore AANP members were not specifically solicited for participation.

**Review of Evidence**

**PICOT**

Does the level of political astuteness and political participation of member NP’s increase as a result of participation in health policy advocacy activities done on behalf of professional nurse practitioner associations during the 2014 and 2105 legislative sessions, when compared to retrospective pre-test level?

**Literature Search Strategies**

A review of literature search was performed using electronic databases Medline, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane Database of Systemic Reviews, American College of Physicians (ACP) Journal Club, Medline and Google Scholar. The search was limited to the English Language and to include classic references and seminal works related to the scholarly topic and dates to limiting the inquiry were not used as to
not exclude seminal and classic works contributing to advocacy in nursing. Key words include political advocacy, political participation, or political activism and nursing revealed 420 articles. A second search included political knowledge, political astuteness, political involvement or political awareness and nursing to reveal an additional 428 articles for review and a final search to include health policy advocacy and nursing produced 68 additional articles. The 916 works include editorials, professional opinions, expert opinions and both qualitative and quantitative research studies and were reviewed for inclusion in this scholarly project.

Of the 916 works, seven were selected for inclusion in this scholar project. Four of the studies had the commonality of using the Political Astuteness Inventory (PAI) as an evaluation tool (Byrd et al., 2012; D. Mueller, 2013; Primomo, 2007; Primomo & Bjorling, 2013). One study used the Civic Volunteerism Model (CVM) (Cramer, 2002) and one combined both the PAI and the CVM to determine the political participation of registered nurse (Vandenhouten, Malakar, Kubsch, Block, & Gallagher-Lepak, 2011).

Evidence by Subtopics

Dimensions of Political Astuteness

Political astuteness includes the awareness of health policy issues, an understanding of the political process, political knowledge and skills and involvement in the political process (Byrd et al., 2012; Primomo, 2007). Political knowledge and skills represents knowing who policy-makers are and how to effectively communicate with such representatives (Byrd et al., & Primomo, 2007). Political interest represents an awareness, inquisitiveness or concern about health policy issues (Primomo & Björling, 2013; Vandenhouten et al., 2011).

Political participation, political involvement and political advocacy terminology was used throughout this project (see appendix A for a list of definitions). Schlozman, Burns and Verba
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(1994) identify political participation as any activity that influences governmental actions. Political advocacy is similarly defined as knowledge-based action intended to influence system level decisions or policies to improve health (Spenceley, Reutter, & Allen, 2006). Political participation includes different activities such as voting, providing testimony, contributions to political campaigns, and participation in professional organizations (Primomo & Björling, 2013).

**Facilitators to the Political Participation of Nurses’**

Antecedents to political participation include self-esteem and confidence (Mason et al., 1991), self and political efficacy (Cramer, 2002; Mason et al., 1991; Vandenhouten et al., 2011), political skills and knowledge (Cramer, 2002; Mason et al., 1991; Vandenhouten et al., 2011), and political astuteness (Byrd et al., 2012; Primomo, 2007; Primomo & Björling, 2013). Cramer (2002) discovered factors predicting organizational nurse participation included resources specifically the amount of free time followed by that of money available for such activities, with civic skills being the least important predictor of membership. Psychological engagement is key component of political participation, and includes the concepts of political interest, political efficacy and political knowledge. Networks of recruitment did not accurately predict organizational membership. The studies by Cramer (2002), and Vandenhouten et al (2011) support the importance of the factors of psychological engagement to include political knowledge, political interest and political efficacy on nurse’s political participation.

Vandenhouten et al. (2011) in an online study of Midwest RN’s (N=468) using a 79-item questionnaire based on the CVM identified psychological engagement as most predictive factor of political participation followed by resources such as time, money and civic skills. Psychological engagement included factors of political interest, political efficacy, and political knowledge (Vandenhouten et al., 2011). In this study, 40% of participants felt they could make a
difference or change local policy decisions, and only 32% percent of participant’s felt they could make a difference in the state or national arenas. Eighty percent did not feel their education prepared them for political participation (Vandenhouten et al., 2011).

**Effects of an Educational Intervention on Political Astuteness**

Three studies evaluated the effectiveness of an educational intervention on participant’s level of political astuteness using the PAI. Primomo (2007) in a sample of Master’s students (N=57) with 40 students completing both pre-posttest PAI, found at baseline 20% were totally unaware politically, 65% were slightly unaware, and 15% were in the beginning to be astute category. A significant increase was noted in the level of political astuteness after graduate-nursing students completed a health systems course with 22.5 % were beginning politically aware, and 60% were beginning to be politically astute and 17.5% were politically astute and an asset to the profession.

In a study by Byrd et al. (2012), 300 students completed study requirements and data collection taking place from 2008-2011 with a pre-posttest design to measure political astuteness. A significant increase in political astuteness was noted after senior-nursing students took part in an active learning experience in health policy. In the same study, post-test political involvement was significantly predicted by participation in a professional organization and knowledge of legislative processes.

In a combined study of registered nurses and nursing students data was collected in a two studies: pretest- posttest design (N=84) and (N=34) respectively. A significant increase in political astuteness was noted in both study participants after attending nurse legislative day activities (Primomo & Björling, 2013). Combined results from the two groups identify 25% of the participants were totally unaware politically, and following the event only six percent
remained at this level of political astuteness. In both groups, the political astuteness scores were higher for participants (see Appendix B for synthesis of evidence table).

**Theory**

The Framework for Action (Mason, Leavitt, & Chaffee, 2012) provided the conceptual foundation of this scholarly project. The Framework for Action model was introduced by Mason and Talbott (1985) and revised since to reflect the tenant that advocacy and advancement of the nursing profession should promote the public’s health and have an impact social determinates (Mason et al., 2012).

The framework outlines four dynamic and interactive “spheres of influence” in which nurses use political action to shape health: 1) the workplace and workforce; 2) the government; 3) associations and interest groups; 4) and the community (Mason et al., 2012). The framework provides a list of strategies for individual nurse’s as to the who, where, what and why of nursing health policy influence (Mason et al., 2012).

The community sphere represents opportunities for nurses to engage in health policy activities through a community. Nurses may advocate for change through community activist projects, serve in an elected office or volunteer position in a civic organization of board (Mason et al., 2012).

The workforce and workplace sphere recognizes the many settings in which nurse’s work and the political aspect of those practice settings. This sphere recognizes the limited amount of resources and the need to have the nurse’s voice in the allocation of those resources when formulating health policies. This sphere includes policy that impacts the size of the nursing workforce through funding of nursing education and the regulation and licensing of nursing (Mason et al., 2012).
The government sphere of influence represents the relationship between the government and its people. The federal and state governments determine eligibility requirements for persons to receive care, provide care and be reimbursed for health care services. State governments determine the scope of practice for nurses and the framework provides strategies to influence health policy at this level. Strategies include obtaining appointment or running for office or to an influential committee, becoming a lobbyist and providing testimony and participation in grassroots advocacy efforts (Mason et al., 2012).

The final sphere of influence addresses the role of associations and interest groups have on health policy. Professional nursing associations promote health policy changes that impact members and the patients they serve. Professional organizations offer members an opportunity to serve on legislative committees, leadership and policy mentoring activities, opportunities to participate in health policy activities, to informed through organizational communication (Mason et al., 2012).

NNP policy advocacy activities are represented in the Framework for Action. NNP informed the membership of the tenets of proposed policy change through emails, calls for action, educational opportunities, legislative conference and outbreak sessions, focus groups, social media, as well as the building of coalitions among groups with this common interest. Measuring the impact and the astuteness of members and non-members can attest to the effectiveness of the association to promote political astuteness and political participation (see Appendix C theory to application diagram).

**Methods**

**Institutional Review Board, Ethical Considerations and Funding**
The primary Institutional Review Board is the University of Missouri Kansas City (UMKC). IRB approval was granted September 10, 2015 (see Appendix D IRB approval letter). Subjects for this project did not represent a vulnerable population. NNP student members did not receive an invitation and were filtered through a pre-qualifying survey. Health Insurance Portability and Accountability Act (HIPPA) consent was not required. The student researcher was president of the NNP association and members may have felt more obligated to complete the survey. An alternate member of the board sent requests for participation. Privacy was insured as survey results and those responding were anonymous. The finale cost of this scholarly project was $2,127.00. Opportunities for funding were unsolicited and paid by the student researcher (see Appendix E for project budget table).

**Setting and Participants**

Study participants inclusion criteria include non-student NP members of the NNP association during the 2014 legislative sessions, with the goal of greater than 10% of the sampling frame (N=392). An active list of NNP members was obtained from the association and from the Department of Health and Human Services for emails and mailing addresses. A convenience sample of association members was used in the study (2011). Potential participants were sent an invitation and a link to the web-based Redcap survey program provided through UMKC. A mixed-mode recruitment and invitation to participate was used according to the research proposed by Millar & Dillman (2011) to include an advanced token incentive in the initial invitation with multiple follow up email contacts.

Upon accessing the survey link, a series of demographic questions were asked to include age, years’ experience as an NP, highest degree completed (MSN, DNP, PhD). The participants were asked to identify which NNP health policy interventions they had participated in during the
2014 and 2015 legislative sessions to include: 1) I received and read organizational emails; 2) I attended legislative update sessions at educational conferences; 3) I attended health policy education continuing education sessions; 4) I attended policy focus group activities; or 5) I did not participate in the above activities.

A script describing the timeline of the NNP legislative journey preceded the beginning of survey. The project used retrospective pretest-posttest design to gather self-reported change on the PAI. The first section asked participants to report their current level of perceived astuteness or political awareness. The second section represented the same questions in past tense and participants were asked to reflect and report what their perceived level of skill or political awareness was prior to the 2014 and 2015 legislative sessions. Survey data was collected and reviewed by the student researcher in collaboration with the UMKC statistician.

**Evidence-Based Intervention**

Permission was obtained from the executive board of the NNP association. The student researcher was able to access all communications to the NNP membership. Health policy interventions implemented by NNP were evaluated by the student retrospectively and span the time frame from January 2014 to the close of legislative session June 5th, 2015. It was identified that during this time frame, NNP updated the official website to include information on the legislative processes, educational materials on NP practice and the tenets of the LB107. Emails were sent on the NNP list-service in an effort to keep the membership informed regarding progress regarding LB107 and to make “calls to action”. Calls to action by both NNP and AANP included requests for the membership to email, write or call Senators or to provide testimony at legislative hearings in support of LB 107.
Three membership meetings took place during this time period: February 2014, July 2014 and February 2015. The annual education conference featured invited speakers on health policy and political awareness topics. These opportunities were used to inform members on the legislative process, the status of proposed legislation and on current practice environments both nationally and at the state level. Included in these discussions were references to major stakeholder group supporters such as the Nebraska Action Coalition, the IOM, and American Association of Retired Persons (AARP). NNP also designed and distributed legislative talking points, policy briefs and power points on contacting policy-makers and providing testimony to membership. AANP provided policy briefs and calls for action at the both National and State levels to AANP members living in the state (see Appendix F for intervention plan flow diagram).

Change Process

The aim of the PAI was to describe individual political astuteness and political participation. Ultimately, increasing individual political astuteness contributes to advancing the stages of political development of the profession of nursing (Cohen et al., 1996). The change theory used for this project is Kotter and Cohen’s Model of Change as cited in Melnyk & Fineout-Overholt (2011). The model has eight steps for successful change and is based on organizational change. The steps for successful change include increased sense of urgency, building a guiding team, the right vision, communicate the buy in, empower and remove barriers, short-term wins, persistence and sustainability (Melnyk & Fineout-Overholt, 2011). These steps are consistent with the Framework for Action (Mason et al., 2012), and the measurement of political astuteness (Clark, 2008). This project contributes to best practices for increasing the political astuteness of NP’s and increasing political participation. (see Appendix G for change theory diagram).
Study design

This scholarly project represents a cross-sectional survey using a retrospective pre-test and a post-test to measure self-reported changes in the level of political astuteness and political participation.

Validity

Several issues with this study may have had impact on the validity and generalizability of the outcomes. Interventions took place over 18 months and were evaluated retrospectively. Membership attendance to the membership meetings, educational conferences and focus groups were unlikely attended by every survey participant. Emailed legislative and health policy updates may not have been received and reviewed by all members. Members may have been added or discontinued from the organization membership list at any time during the process.

Threats to validity also may be present with self-report and recalling information. The retrospective pre-test has been used in educational studies to prevent response-shift bias. Response shift bias is a result of participants over or underestimating the initial degree of knowledge or skills prior to the full understanding of skills following interventions. This retrospective survey method avoids the likelihood of response-shift bias (Fernandez, Noble, Jensen, & Steffen, 2014; Pohl, 1992). Generalizability of the outcome data is limited by the convenience sampling and the limitations associated with retrospective interventions.

Outcomes

NP members demonstrate an increased level of political astuteness and political participation when compared to retrospective pre-test levels. The Political Astuteness Inventory (PAI) (Clark, 2008) provided a tool to evaluate participant outcomes in content areas such as civic voting practices, participation in professional organizations or activities, knowledge and
awareness of the political process and health policy issues, the ability to both identify and contact elected legislators and political participation (Primomo, 2007) (See Appendix H for the Logic Model).

**Measurement Tool**

The PAI was first developed in 1981 by P. E. Clark and was first published for use by individual community health nurses in 1984 (Clark, 1984; 2008). The PAI is a 40-item questionnaire with each affirmative response valued at one point. For the purpose of this project, the PAI was modified to create a version in the past tense to accommodate the “current” and “prior to” inquires for the retrospective pretest and posttest design and it took 15-20 minutes to complete. As Nebraska has a unicameral question #23 was modified to add legislative aide in place of state house representative (see Appendix I for the Redcap survey questionnaires). Permission was obtained from the author to use the PAI (see Appendix J for permissions).

The summation and levels of the PAI include: 1) totally politically unaware (0-9 points); 2) slightly aware of the implications of political activity for nursing (10-19 points; 3) shows a beginning political awareness (20-29 points); and 4) politically astute and an asset to the profession (30-40 points). Examples of questions asked on the PAI include “I am registered to vote”, “I belong to a professional or student nurses’ organization” and “I have provided testimony at a public hearing on an issue related to health”. Internal consistency reliability on the PAI, using Cronbach’s alpha was reported in several studies: .81 (Primomo, 2007); .84 (Byrd et al., 2012); and Primomo and Björling (2013), Study 1 pre-post intervention .945 and .877 and Study 2 range was .989 to .939 respectively.

**Quality of data**
The quality of data will be positively influenced by several factors in this study. The study did have a response rate greater than 10% of the sampling frame to add to the strength of the study. Benchmark data and comparison baseline data on political astuteness is available through studies having previously used nurses, nursing students and graduate nursing students, member group scores should preform similarly.

Analysis plan

Cronbach’s alpha was used to evaluate the internal consistency reliability of the PAI measurement on factors measuring the political participation of participants. Demographic data was collected and descriptive statistics was used to describe the sample characteristics. Inferential statistic t-tests and non-parametric testing was used to compare the member’s retrospective pre and post-test scores. A summation of affirmative responses for each question was performed and percent of total calculated for each of the four categories of astuteness (see Appendix K statistical plan). Survey data was collected and reviewed by the student researcher in collaboration with the UMKC statistician.

Results

Setting and Participants

Participant recruitment was prepared and sent to prospective participants (N=392) beginning December 15th, 2016. The initial recruitment letter included a $2.00 bill token incentive and was mailed three days before the initial email containing the survey link (see Appendix L for invitation to participate). Subsequently, four emails were sent at strategic intervals to encourage participation (see Appendix M for recruitment notifications). The last survey included in the study was submitted on February 3rd, 2016. There were 147 surveys
queried with 96 surveys meeting the study inclusion criteria to include being a non-student and active member of NNP during the 2014-2015 legislative sessions.

**Intervention Course**

NNP emails, programs and agenda’s were reviewed for health policy interventions retrospectively. A timeline of the NNP legislative journey was outlined for study participants. In 2013, NNP association competed the Credentialing Review Program as the initial step for removing the Integrated Practice Agreement. In 2014, Eliminate Integrated Practice Agreements and Provider for Transition to Practice for Nurse Practitioners (LB916) was introduced and subsequently vetoed by Governor Dave Heineman. In 2015, the bill was reintroduced by Senator Sue Crawford and became known as LB107. LB107 was signed by Governor Pete Ricketts on March 5th, 2015, with full enactment on August 30th, 2015. During the 2014 and 2015 legislative sessions, NNP made use of membership emails, legislative updates, continuing education sessions and focus groups to promote grassroots involvement in the process of policy change. The study participants were asked to reflect on their current level of political astuteness and in the second set of questions to reflect on the time period prior to the 2014 and 2015 legislative sessions.

**Outcome Data**

**Level of Political Astuteness**

The first research question addresses whether the level of political astuteness of member NP’s increased as a result of health policy advocacy activities done over the course of the legislative sessions when compared to pre-session levels. The frequency and percentage distributions indicate, 20% of member NP’s were totally unaware politically compared to 3.1% following the intervention. The level demonstrating the largest transformation was the
“beginning astuteness” level reaching 50% and demonstrating a trend up from the lower levels. The highest level, “politically astute”, actually decreased by from 19.8% to 18.8% respectively. The frequency data sets do not account for missing data. The missing data report indicates that between 0-3% on each variable has a possibility of having a missed data set. As the scores are a summation, missing data likely has an overall effect. Paired t-tests were performed using only those surveys that were fully completed (n=66) to further assess the overall astuteness scores and to see if the change was significant. The overall increase in political astuteness participant scores was significant when compared between the prior to interventions and current astuteness measurements (t=3.3619, df=65, p-value=0.001) (see Appendix N statistical table 1).

McNemar’s Chi-squared with continuity correction tests were run on each of the 40-items on the PAI. Ten of the survey items were significant for changes in political astuteness scores when the comparing the prior to and current political astuteness surveys using p=<.001 cut-off (see Appendix O statistical table 2).

**Level of Political Participation**

To address the political participation scores of NP’s, a set of questions that require action were taken from the PAI and analyzed. The questions included in the analysis were “I belong to the state nurse practitioner or nurses’ organization”; “I participate in that organization”; “I supported my state professional organizations political arm”; “I actively supported a candidate for U.S. Senate or House of Representatives or state Unicameral during the last election”; “I have written regarding a health issue to one of my state or national representatives in the last two years”; “I am personally acquainted with a senator or representative or a member of his or her staff”; “I serve as a resource person for one of my representatives”; “I have written regarding a health issue to one of my state or national representatives in the last two years”; “I attend public
hearings related to health issues”; and I have provided testimony at a public hearing on an issue related to health”. The increase in the political participation scores between the prior and current survey scores is significant ($v = 148$, $p = < .001$). In addition, NPs were consistent in their responses across the multiple measures of political participation as evidenced by Cronbach’s alpha (0.79) with 95% confidence level.

**Effect of Health Policy Activities**

The type and number of health policy activities on astuteness scores were additionally reviewed. Both the prior to (f-value 13.975 and $p < .001$) and current political astuteness scores (f-value 23.69 and $p < .001$) were positively correlated with activities.

**Effect of Age, Years as NP, and Degree**

The study gathered data on three demographical data sets: age, highest degree and number of years as a NP. The mean age range of the participants was 46-50 years. The highest degree completed was reported as MSN (66%). Thirdly, number of years as an NP had a mean range of 11-15 years (see Appendix P table 3). To evaluate the effect of degree on the overall astuteness scores non-parametric testing was performed and identified significant changes in post intervention scores with the DNP degree (f-value 3.0016; $p = 0.037$). DNPs have higher scores than MSNs after the program. No other differences exist between degree groups after correcting for comparisons (Appendix Q Table 4).

To predict the impact of age and number of years as an NP on overall astuteness ANOVA analysis is used. When controlling for the effect of a person’s age and the number of years as an NP, age demonstrates a trend however not significant ($f = 2.15$ $p = .059$), after the participation in the activities, the trend is not longer evident ($f = 2.19$; $p = 0.082$).
Discussion

Successes

The 2014-2015 legislative sessions in Nebraska lead to the passage of LB 107 and became the 20th State to have full practice authority for NPs. Embedded in this journey was a steep learning curve to develop the political skills and political astuteness needed to navigate and be successful in an arena.

Strengths

Collaboration with the NNP organization allowing for a retrospective review of their grassroots health policy activities was pertinent for the study. The willingness and feedback from members wanting to participate in the study was a very positive.

Comparison with Review of Literature

Study findings indicate a significant increase in astuteness scores when NPs in Nebraska were asked to reflect on the activities employed by the NNP and AANP associations during the legislative sessions. There was a positive correlation in both prior to and current level of astuteness surveys regarding the number of activities NPs participated in during the legislative sessions. Likely implies that individuals who participate in activities are generally more politically astute to begin with, more so than the activities actually make NPs more astute. Previous research has supported the tenet that members of professional organizations are generally more likely to be politically active and more political aware (Byrd et al., 2012; Gebbie, Wakefield, & Kerfoot, 2000). Before interventions, the study also revealed astuteness was predicted more so by the number of years as an NP and that experienced participants were more astute prior to the interventions than after the interventions. Age was not highly correlated in this
study as had been in the accounts of other research studies on political astuteness (Primomo & Björling, 2013).

**Limitations**

There are several limitations to this study, the treat of history as the interventions took place over 18 months. Interventions by the organization were reviewed retrospectively with the possibility of members adding and leaving the organization and not all members participating in the same number or types of activities. The generalizability of the study is limited as it uses a convenience sample of association members.

The sustainability of the study however is high. NNP continues to be active in the political area with the continued need to impact health policy for patients and the profession. The results of this study will be used to encourage the leadership to explore interventions that may have the greatest impact on the political astuteness and participation of members.

**Interpretation**

The results of this study taken in context of the passage of major legislation in Nebraska have value. It is noteworthy that the results demonstrate increased political participation and the 18 months timeline of this study allowed the measurement of actual increases in political participation. Previous studies were more limited due to the nature of the study design and timeline for the adequate evaluation of political participation (Byrd et al., 2012; Primomo, 2007; Primomo & Björling, 2013).

The overall increase in political astuteness and political participation was expected. Unexpected was the lack of association with the types activities on political astuteness and that the numbers of activities participated in, was correlated both before and after the interventions. Making the impact of the interventions much less clear.
Recommendations for future study should evaluate the baseline political astuteness of members and formulate interventions around those strengths and weaknesses. Secondly, are we asking members of associations the right questions when evaluating astuteness? A control group of non members likely would have provided a degree of better insight into member astuteness.

Conclusion

In 2013, Nebraska NP’s took up the call for political action and modernized outdated regulatory and statutory provisions preventing the direct access to the high quality care NP’s provide (AANP, 2013b)

The opportunities and rewards these legislative victories have for patients, communities and the nursing profession provide for quality, patient-centered and cost-effective care. Researching interventions that can be employed by professional organizations to increase political astuteness and the political participation of nursing are keys to impacting social determinates and health care reform. The results of this study are relevant for nurses in all points of education and practice. An invitation to share Nebraska’s Journey and disseminate these research findings through podium presentation at the National AANP Specialty Conference in September, 2016 at Chicago, Illinois have been accepted, and project will submitted for publication spring 2016.
References


Missouri Foundation for Health Publication. (n.d.). *Bending the health care cost curve in Missouri: Options for saving money and improving care.*


Appendix A

List of Definitions

**Political advocacy** - as knowledge-based action intended to influence system level decisions or policies to improve health (Spenceley et al., 2006).

**Political astuteness** - includes the awareness of health policy issues, an understanding of the political process, political knowledge and skills and involvement in the political process (Byrd et al., 2012; Primomo, 2007).

**Political participation** - as “any activity…that seeks to influence…what the government does” (Schlozman et al., 1994) as used by Cramer (2002) and Vandenhouten et al. (2011) (p.967).
Appendix B

Review of Evidence Table

<table>
<thead>
<tr>
<th>First Author, Year, Title, Journal</th>
<th>Purpose</th>
<th>Research Design</th>
<th>Sample, Sampling and Setting</th>
<th>Measures &amp; Reliability</th>
<th>Data Analysis and Findings</th>
<th>Limitations and Usefulness to Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primomo and Bjorling (2013). Changes in political astuteness following nurse legislative day</td>
<td>Identify the effects of learning activities on PA, decreasing barriers to political participation</td>
<td>Study 1: N=80 single retrospective before and after design Study: N=34 Real time pre-post test design</td>
<td>N=80 N=34 Indiv. Attend nurse legis. day</td>
<td>PAI 40 item (updated to use internet communication)</td>
<td>Descriptive stats used. Internal consist. Cronbach’s Responses: Study 1 .945 (n=65; .877 after attending; Study 2: .989, n=60 to .939 post activities; Paired t-test and ANOVA; Instrument valid and reliable</td>
<td>PA may be learned through learning activities. Limitations: the link between increase PA political participation needs more exploration; Instrument development in needed to clarify the dimensions of PA especially those requiring action (due to time limitations)</td>
</tr>
<tr>
<td>Byrd et al., (2012). Political Astuteness of baccalaureate nursing students</td>
<td>To describe changes in political astuteness (PA) in BSN students following</td>
<td>One group pre-post test design</td>
<td>300 BSN students in public /community health course</td>
<td>PAI used to compare levels of PA and identify conceptual factors to</td>
<td>Mean PAI scores significant increase (p =.000); professional organization</td>
<td>Further research should focus on validating the four levels of PA, through a likert scale.</td>
</tr>
<tr>
<td>Primomo (2007). Changes in Political astuteness after a health systems course</td>
<td>Describe levels of PA in graduate students to determine if PA changed after completion 10 week graduate health systems and policy course.</td>
<td>Pre-post test design. Master of nursing students (N=57)</td>
<td>40 students completed the study</td>
<td>PAI internal consistency reliability using Cronbach= .81.</td>
<td>Paired t-tests compared the levels of astuteness, at baseline and at follow up. Statistically significant increase at the end of course (mean [SD] =23.1 [5.8] as compared to baseline (mean [SD] 13.6 [5.2])); moved from</td>
<td>Small convenience sample; Future studies should address whether political awareness translated into actual political participation/engagement</td>
</tr>
<tr>
<td>Mueller, (2014). Political astuteness: Advocacy, efficacy and Education</td>
<td>To determine student entry-level knowledge and civic skills in a health policy course for RN-BSN students and changes on post-course. 2) Pending efficacy of specific health policy course</td>
<td>Pre-post test survey design, These are results of pre-post test has not be completed at time of publication.</td>
<td>n=101, RN-BSN students were enrolled in large minority serving public university in California.</td>
<td>No information on tool validity-refers to Primomo.</td>
<td>Ages 30-39 in practice &lt; 5 years. 85% registered to vote, 71% voted last election; Professional organization &lt; 10% answered affirmatively to participation, 79% lacked current education on current issues, Political process and elected officials 75% did not have good knowledge base.</td>
<td>Recommendations to have health policy activities threaded throughout program as opposed to an isolated courses. PAI indicated where skills and knowledge are needed to guide policy courses.</td>
</tr>
<tr>
<td>Pace &amp; Flowers (2012). Students perception of professional advocacy following a political advocacy course</td>
<td>To analyzed characteristics on pharmacy students who had take policy advocacy course with those who did not</td>
<td>Online survey, distributed to student body n=462</td>
<td>100 students or 21.6 % finished the survey</td>
<td>Descriptive statistics, mean and median t-test was performed using SAS. Statistical significance we set at 0.05 with 95% CI</td>
<td>Class participants rated knowledge (M=2.50±.7, n=16; to those who did not 1.67 ± 0.9, n=77, p =0.001. Participants had higher activities, 88.2% to 69.1%.</td>
<td>This study uses successes in Nursing draw conclusion about educ. pharmacy students advocacy. The course was important to change students perceptions;</td>
</tr>
<tr>
<td>Cramer (2002). Factors influencing organized political participation of nursing.</td>
<td>Addresses issues with organized political participation of nurses. Using the Civic Volunteerism model</td>
<td>Cross-sectional survey stratified two groups based on ANA membership and non-membership</td>
<td>Multi-staged sampling, random sampling 84 in each of three stages 252; total N=118 usable surveys</td>
<td>27 questions extracted from the CVM, one single political act was left-organized participation. Measures taken on resources, engagement, networks of recruitment</td>
<td>Multi-discriminate analysis; overall level of statistical significance was p&lt; .05. CVM was a predictor of nurses organized political participation</td>
<td>The CVM more accurately predicts membership than non-membership; ANA attracts Nurse with common group identity and desire political involvement. Most influencing factors include resources and engagement. Membership strongly associated with free time,</td>
</tr>
</tbody>
</table>
### Political Astuteness of Nurse Practitioners

<table>
<thead>
<tr>
<th>Study</th>
<th>Objective</th>
<th>Methodology</th>
<th>Measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Vandenhouten et al., 2011)</td>
<td>To determine level of political participation and factors contributing to participation in Midwest RNs</td>
<td>Descriptive predictive design.</td>
<td>Convenience sample of RNs in four health care institutions in Wisconsin, possible pool 1500 with 468 completions.</td>
<td>Registered to vote=95%, 83% in the last election; 30% belonged to a professional organization, Resources 88% perceived they had no time for political activities, 92% perceived inability to contribute monetarily to candidates... they were the most uncomfortable with testifying. No significant relationship between nursing political participation and course content; although there was a relationship between courses preparing them for political participation. Consistent is psychological engagement, was the factor most predictive of political engagement: political interest, political efficacy, political knowledge.</td>
</tr>
</tbody>
</table>

Measures:
- **PAI**: Political Participation Inventory
- **CVM**: Candidate Value Measure
- **ISI**: ISI civic literacy test

Reliability:
- **PAI**: r=.933
- **CVM**: r=.973
- **Political participation**: r=.755
| across disciplines | contribute to development of competencies to effectively influence policy and politics. | and N=8 Political science students | and service, “community” Political Sc. Grounded in theory. Inter-disciplinary dialogue, modeling competence | confounding variables. Interviewer bias |
### Appendix C

**Theory to Application Diagram**

<table>
<thead>
<tr>
<th>Who Acts to Influence Health Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP’s</td>
</tr>
<tr>
<td>NP Professional Organizations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In what spheres of influence do NP’s act to influence health policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>workplace/workforce, government</td>
</tr>
<tr>
<td>associations/interest groups/community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What strategies do NP’s use to influence health policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify problem, become knowledgeable, build support, write letters, provide testimony</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When do NP’s act to influence health policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health problem needs remedy, focusing event</td>
</tr>
<tr>
<td>ripe environment, national and local support, opportunity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Why do NP’s act to influence health policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>to improve the quality, cost and safety of care</td>
</tr>
<tr>
<td>Remove disparities, and improve human health</td>
</tr>
</tbody>
</table>

Figure adapted from (Mason et al., 2012).
Appendix D
UMKC IRB Approval Letter
Appendix E
Project Budget Table

Direct and Indirect Costs of DNP Research Project

<table>
<thead>
<tr>
<th>NP Leader</th>
<th>Direct Costs</th>
<th>Indirect Costs</th>
<th>Total Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentive 392 members $2.00 \times 492 = $784.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter to participate $1.50 \times 392 = $588.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poster</td>
<td>$100.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statistician</td>
<td>$700.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total costs</td>
<td>$2,172.00</td>
<td></td>
<td>$2,172.00</td>
</tr>
</tbody>
</table>
Appendix F

Intervention Flow Diagram

Political Astuteness and Participation

Educational conferences
Legislative Updates

Website
Facebook
Emails

Personal Calls for action
Testimony
Letters to Policy Makers
Appendix G

Kotter and Cohen’s Model of Change

- Increased Sense of Urgency
- Building a Guiding Team
- Right Vision
- Communicate Buy In
- Empower
- Remove Barriers
- Short-term Wins
- Persistence and Sustainability

Adapted from Melnyk & Fineout-Overholt (2011)
### Appendix H
#### Logic Model

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Interventions</th>
<th>Outputs</th>
<th>Outcomes-Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence, sub-topics</td>
<td>The EBP intervention which is supported by the evidence in the Input column</td>
<td>The members of NNP</td>
<td>Outcomes to be measured (Completed as a student).</td>
</tr>
<tr>
<td>-Health policy</td>
<td>Health policy activities on behalf of NNP: -Legislative updates at Annual education confer. -Membership emails with legislative updates, and -Calls for action/relationships with State Senators Health policy briefs</td>
<td>Time Frame -IRB 7/2016 -Close of session 6/29/15 Exempt 2 -LB 107 implementation 8/29/2015</td>
<td>Outcomes to be measured (Completed as a student).</td>
</tr>
<tr>
<td>-Legislative day activities</td>
<td>Single point data collection</td>
<td></td>
<td>Effectiveness of activities on increasing political astuteness of NP’s, drawing support for best practices</td>
</tr>
<tr>
<td>-Health policy directed activities</td>
<td>Completion of survey agreement to participants</td>
<td></td>
<td>Influence and develop interventions for state and national organizations to increase NP political participation among members</td>
</tr>
<tr>
<td>-Baseline PA is low for RNS</td>
<td>Person(s) collecting data</td>
<td>Political Astuteness Inventory (PAI) Identify areas needing additional research</td>
<td></td>
</tr>
<tr>
<td>Political Participation</td>
<td>Student</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Facilitators or Contributors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Nebraska Nurse Practitioners (NNP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Barriers or Challenges</td>
<td>Major steps of the intervention Timeline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Addresses non-members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Participation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Timeline**

- IRB 7/2016
- Close of session 6/29/15
- Exempt 2
- LB 107 implementation 8/29/2015

**Person(s) collecting data**

- Student Researcher
- Others directly involved - none

**Statistical analysis to be used.**

- t-test

---

Rev. 7/09, 1/2015

http://www.uwex.edu/ces/lmcourse/inteface/coop_M1_Overview.htm

Logic-Model Worksheet content revisions by Lyla Lindholm. Applied to DNP EBP Project. Not to be placed on web for public use. For UMKC DNP coursework only.
Appendix I
The Political Astuteness Inventory Tool and Data Collection Tool, Modified

Confidential

Preliminary Qualifying Data: The Political Astuteness of Nurse Practitioners in Nebraska Following a Successful Legislative Journey

Please complete the preliminary data set in the survey below. If you qualify for participation a second survey will appear. Please proceed.

Thank you!

1) Are you currently a student member of the Nebraska Nurse Practitioners? ☐ Yes ☐ No

2) Were you a member of the Nebraska Nurse Practitioners association during the 2014 and/or 2015 legislative sessions? ☐ Yes ☐ No
The Political Astuteness of Nurse Practitioners in Nebraska Following a Successful Legislative Journey

Please complete the following demographic data.

3) What is your current age range?
   - 24 or less
   - 25-30
   - 31-35
   - 36-40
   - 41-45
   - 46-50
   - 51-60
   - 60+

4) What is your highest degree completed?
   - MSN
   - DNP
   - PhD
   - Other

5) Number of years as an nurse practitioner?
   - < 1
   - 1-4
   - 5-10
   - 11-15
   - > 16

6) During the 2014 and 2015 legislative sessions, did you participate in one or more of the following health policy advocacy activities by NNP or American Association of Nurse Practitioners (AANP)?
   - [ ] I received and read organizational emails
   - [ ] I attended legislative update sessions at educational conferences
   - [ ] I attended health policy education CE sessions
   - [ ] I attended policy focus group activities
   - [ ] I did not participate in the above activities

Timeline of the Nebraska Nurse Practitioner Legislative Journey

In 2013, the Nebraska Nurse Practitioner (NNP) association completed the Credentialing Review (407) Program as the initial step for removing the Integrated Practice Agreement. In 2014, Eliminate Integrated Practice Agreements and Provide for Transition to Practice for Nurse Practitioners (NPs) (LB916) was introduced and subsequently vetoed by Governor Dave Heineman. In 2015, the bill was reintroduced by Senator Sue Crawford and became known as LB107. LB107 was signed by Governor Pete Ricketts on March 5th, 2015. The bill became law on August 30th, 2015.

During the 2014 and 2015 legislative sessions, NNP made use of membership emails, legislative updates, CE sessions and focus groups to promote grassroots involvement in the process of policy change.

Please complete the Political Astuteness Inventory below and reflect on your CURRENT level of political astuteness. The second section of the survey will have you reflect on the time period.
PRIOR TO the 2014 and 2015 legislative sessions and complete the same set of questions.

7) I am currently registered to vote. ○ yes ○ no

8) I know where my voting precinct is located. ○ Yes ○ No

9) I voted in the last general election. ○ True ○ False

10) I voted in the last two elections. ○ Yes ○ No

11) I recognized the names of the majority of candidates on the ballot in the last election. ○ Yes ○ No

12) I was acquainted with the majority of issues on the ballot at the last election. ○ Yes ○ No

13) I stay abreast of current health issues. ○ Yes ○ No

14) I belong to the state professional nurse practitioner or nurses' organization. ○ Yes ○ No

15) I participate (committee member, officer, etc.) in that organization. ○ Yes ○ No

16) I attended the most recent meeting of my district nurses' association. ○ Yes ○ No

17) I attended my last state or national convention held by my organization. ○ Yes ○ No

18) I am aware of at least two issues discussed and the stands taken at that convention. ○ Yes ○ No

19) I read literature published by my state nurses' or nurse practitioner association, professional magazines, or other literature on a regular basis to stay abreast of current health issues. ○ Yes ○ No

20) I know the names of my state senators in Washington, D.C. ○ Yes ○ No

21) I know the names of my representatives in Washington, D.C. ○ Yes ○ No

22) I know the name of the state senator from my district. ○ Yes ○ No

23) I know the name of the legislative aide of my state senator. ○ Yes ○ No

24) I am acquainted with the voting record of at least one of the above in relation to a specific health issue. ○ Yes ○ No

25) I am aware of the stand taken by at least one of the above on one current health issue. ○ Yes ○ No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>26) I know whom to contact for the information about health-related</td>
<td></td>
<td></td>
</tr>
<tr>
<td>policy issues at the state or federal level.</td>
<td></td>
<td></td>
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<tr>
<td>27) I know whether my professional organization employs a lobbyist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>at the state and federal level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28) I know how to contact that lobbyist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29) I support my state professional organizations political arm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30) I actively supported a candidate for U.S. Senate House of</td>
<td></td>
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</tr>
<tr>
<td>Representatives, or state unicameral (campaign contribution,</td>
<td></td>
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</tr>
<tr>
<td>campaigning service, wore a button, or other) during the last election.</td>
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<tr>
<td>31) I have written regarding a health issue to one of my state or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>national representatives in the last two years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32) I am personally acquainted with a senator or representative or a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>member of his or her staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33) I serve as a resource person for one of my representatives or his</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or her staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34) I know the process by which a bill is introduced in my state</td>
<td></td>
<td></td>
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<tr>
<td>legislature.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35) I know which senators or representatives are supportive of nursing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36) I know which House and Senate committees usually deal with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>health-related issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37) I know the committees on which my representatives hold membership.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38) I know of at least two issues related to my profession that are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>currently under discussion at the state or national level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39) I know of at least two health related issues related that are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>currently under discussion at the state or national level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40) I am aware of the composition of the state board that regulates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the practice of my profession.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41) I know the process whereby one becomes a member of the state</td>
<td></td>
<td></td>
</tr>
<tr>
<td>board that regulates my profession.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42) I attend public hearings related to health issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43) I find myself more interested in public issues now than in the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>past.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44) I have provided testimony at a public hearing on an issue related</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to health.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
45) I know where the local headquarters of my political party is located.  ○ Yes  ○ No

46) I have written a letter to the editor (or other piece or activity) for the lay press speaking out on a health related issue.  ○ Yes  ○ No

---

**Part two: Please complete the same 40-item Political Astuteness Inventory reflecting on the time period Prior to the 2014 and 2015 legislative sessions.**

47) I was registered to vote?  ○ Yes  ○ No

48) I was aware of the location of my voting precinct?  ○ Yes  ○ No

49) I voted in the last general election.  ○ Yes  ○ No

50) I voted in the two last elections.  ○ Yes  ○ No

51) I recognized the names of the majority of candidates on the ballot at the last elections.  ○ Yes  ○ No

52) I was acquainted with the majority of issues on the ballot at the last election.  ○ Yes  ○ No

53) I stay a breast of current health issues.  ○ Yes  ○ No

54) I belonged to the state professional nurse practitioner or nurses’ organization.  ○ Yes  ○ No

55) I participated (committee member, officer, etc.) in that organization.  ○ Yes  ○ No

56) I attended the most recent meeting of my district nurses’ association.  ○ Yes  ○ No

57) I attended my last state or national convention held by my organization.  ○ Yes  ○ No

58) I was aware of at least two issues discussed and the stands taken at that convention.  ○ Yes  ○ No

59) I read literature published by my state nurses’ or nurse practitioner association, professional magazines, or other literature on a regular basis to stay abreast of current health issues.  ○ Yes  ○ No

60) I knew the names of my state senators in Washington D.C.  ○ Yes  ○ No

61) I knew the names of my representatives in Washington D.C.  ○ Yes  ○ No

62) I knew the name of my state senator from my district.  ○ Yes  ○ No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>63) I knew the name of the legislative aide of my state senator.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64) I was acquainted with the voting record of at least one of the above in relation to a specific health issue.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65) I was aware of the stand taken by at least one of the above on one current health issue.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>66) I knew whom to contact for the information about health-related policy issues at the state or federal level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>67) I knew whether my professional organization employed a lobbyist at the state and federal level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>68) I knew how to contact that lobbyist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>69) I supported my state professional organizations political arm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70) I actively supported a candidate for U.S. Senate or House of Representatives (Assembly) or state Unicameral (campaign contribution, campaigning service, wore a button, or other) during the last election.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>71) I had written regarding a health issue to one of my state or national representatives in the last two years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>72) I was personally acquainted with a senator or representative or a member of his or her staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>73) I served as a resource person for one of my representatives or his or her staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>74) I know the process by which a bill is introduced in my state legislature.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75) I knew which senators or representatives are supportive of nursing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>76) I knew which House and Senate committees usually deal with health-related issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77) I knew the committees on which my representatives held membership.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78) I knew of at least two issues related to my profession that were under discussion at the state or national level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>79) I knew of two health-related issues that were under discussion at the state or national level.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80) I was aware of the composition of the state board that regulates the practice of my profession.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>81) I knew the process whereby one becomes a member of the state board that regulates my profession.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
82) I attended public hearings related to health issues.  
   ☐ Yes  ☐ No

83) I found myself more interested in public issues than in the past.  
   ☐ Yes  ☐ No

84) I had provided testimony at a public hearing on an issue related to health.  
   ☐ Yes  ☐ No

85) I knew where the local headquarters of my political party was located.  
   ☐ Yes  ☐ No

86) I had written a letter to the editor (or other piece or activity) for the lay press speaking out on a health related issue.  
   ☐ Yes  ☐ No

87) Optional: Add up your "yes" responses on part one and then separately, part two. Use the key below to see your political astuteness stage, then please submit survey.
   
   0-9  Totally politically unaware
   10-19 Slightly aware of the implications of political activity for nursing
   20-29 Shows a beginning political astuteness
   30-40 Politically astute and an asset to the profession

(Clark, 1984)
Appendix J
Permission to Use Tool

On Jun 21, 2015, at 3:37 PM, Mary Jo Clark wrote:

Dear LaDonna,

It is actually my husband's tool (created when he was in a master's program in nursing many years ago). He doesn't like to bother responding to permission requests, but always tell me to tell people to go ahead and use it. You definitely have our permission to use the tool…

Sincerely,
Mary Jo Clark, PhD, RN

---- LaDonna Hart wrote:
Dear Dr. Clark,

My name is LaDonna Hart and I am a DNP student at the University of Missouri Kansas City. I am working on my scholarly project and I am requesting permission to use the Political Astuteness Inventory located in the Community Assessment Reference Guide and to adapt it for online use, at this time I would not foresee any changes to the questions. I am the president of the Nebraska Nurse Practitioner professional organization and we just became the 20th state to have full practice authority for nurse practitioners. My PICOT, investigates whether political advocacy activities done on behalf of the organization during this legislative journey, increased the political astuteness of NNP members when compared to non-members a combined sampling frame of about 900 NP’s.

Thank you so much, I look forward to hearing from you. I certainly could work through your staff or others if needed

LaDonna Hart APRN-NP
Student researcher UMKC
Appendix K
Outcome Data Statistical Analysis Table

**Statistical Analysis template:** SPSS, “R”
Policy advocacy activities performed by nursing organizations increases political astuteness and political participation of member nurse practitioners.

Dependent variables: Political astuteness and political participation of nurse practitioners
Independent variables: Policy advocacy activities

Nominal data
Licensed to practice y or n
PAI 41 items y or n

Ordinal data
PAI stages (1-4) number of correct responses
Descriptive stats for demographics
T-tests for comparisons among the different groups.
Appendix L

Invitation to Participate

The Political Astuteness of Nurse Practitioners in Nebraska Following a Successful Legislative Journey

Dear Nurse Practitioner,

You are invited to participate in a study conducted by LaDonna Hart, MSN, APRN-NP, on the Political Astuteness of Nurse Practitioners in Nebraska Following a Successful Legislative Journey. The research being conducted is open to nurse practitioner members of the Nebraska Nurse Practitioners association. The student researcher attends the University of Missouri-Kansas City and is enrolled in the Doctor of Nursing Practice program.

Participation in the study requires completion of a 41-item online-survey taken twice to reflect now and then perceptions of behavior, titled the Political Astuteness Inventory and takes approximately 15-20 minutes to complete.

Confidentiality of individual responses are not linked to an email or IP address and no identifiable information will be collected. The anonymous survey responses will be maintained through the Research Electronic Data Capture (Redcap) program. Once data has been analyzed, the data will be deleted per UMKC institutional protocol.

Participation in this study is voluntary. If you have any questions of concerns you may contact the student investigator at (email) faculty advisor Renee Endicott at endicotr@umkc.edu. If you have any questions regarding your rights you may visit http://ors.umkc.edu/research-compliance-(iacuc-ibc-irb-rsc)/institutional-review-board-(irb)/research-subject-participant-information-and-resources.

Your participation is important. While there is no direct benefit for participation, your responses and experiences are valuable and will contribute to the body of evidence supporting best practices for building political astuteness and political participation in Nurse Practitioners for the purpose of impacting health policy and positive patient outcomes.

Please click on the link below to complete the survey

Thank you for your participation.

Lindsay Iverson
NNP Membership Chair
Appendix M

Recruitment Notifications

<table>
<thead>
<tr>
<th>Table 1. Recruitment Notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Contact</td>
</tr>
<tr>
<td>2\textsuperscript{nd} contact-3 days post mailing</td>
</tr>
<tr>
<td>3\textsuperscript{rd} contact -8 days after initial contact</td>
</tr>
<tr>
<td>4\textsuperscript{th} Contact-3 weeks after initial contact</td>
</tr>
<tr>
<td>5\textsuperscript{th} Contact- 5 weeks after initial</td>
</tr>
</tbody>
</table>
# Appendix N

Statistical Table 1

Table 1. Stages of Political Astuteness, frequencies and Percent

<table>
<thead>
<tr>
<th>Stages of Astuteness as defined by Clark</th>
<th>Prior to Astuteness</th>
<th>Total Percent</th>
<th>Current Astuteness</th>
<th>Total Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally unaware politically (points 0-9)</td>
<td>20</td>
<td>20.8</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>Slightly aware (points 10-19)</td>
<td>31</td>
<td>32.2</td>
<td>27</td>
<td>28.1</td>
</tr>
<tr>
<td>Beginning astuteness (points 20-29)</td>
<td>26</td>
<td>27.0</td>
<td>48</td>
<td>50.0</td>
</tr>
<tr>
<td>Politically astute and asset to the profession (points 30-40)</td>
<td>19</td>
<td>19.8</td>
<td>18</td>
<td>18.8</td>
</tr>
</tbody>
</table>

*Note: Percent values rounded, does not account for missing data*
Appendix O  
Statistical Table 2

<table>
<thead>
<tr>
<th>PAI Item</th>
<th>chi-squared</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am acquainted with the voting record of at least one of the above in relation to a specific health issue.</td>
<td>17.3913</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
<tr>
<td>I am aware of the stand taken by at least one of the above on the current health issue.</td>
<td>12.96</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
<tr>
<td>I know whom to contact for the information about health-related policy issues at the state or federal level.</td>
<td>18.05</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
<tr>
<td>I know whether my professional organization employs a lobbyist at the state and federal level.</td>
<td>13.0667</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
<tr>
<td>I support my state professional organizations political arm.</td>
<td>12.5</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
<tr>
<td>I have written regarding a health issue to one of my state or national representatives in the last two years.</td>
<td>16.9615</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
<tr>
<td>I know the process by which a bill is introduced in my state legislature.</td>
<td>14.0625</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
<tr>
<td>I know which senators or representatives are supportive of nursing.</td>
<td>12.8929</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
<tr>
<td>I know which House and Senate committees usually deal with health-related issues.</td>
<td>10.3158</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
<tr>
<td>I find myself more interested in public issues now than in the past.</td>
<td>22.0417</td>
<td>1</td>
<td>p = &lt; .001</td>
</tr>
</tbody>
</table>

*Note:* McNemars with continuity testing
### Table 1. Demographics

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
<th>M/SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-30</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>31-35</td>
<td>12</td>
<td>12.5</td>
<td>12.5</td>
<td>13.5</td>
<td></td>
</tr>
<tr>
<td>36-40</td>
<td>8</td>
<td>8.3</td>
<td>8.3</td>
<td>21.9</td>
<td></td>
</tr>
<tr>
<td>41-45</td>
<td>8</td>
<td>8.3</td>
<td>8.3</td>
<td>30.2</td>
<td></td>
</tr>
<tr>
<td>46-50</td>
<td>11</td>
<td>11.5</td>
<td>11.5</td>
<td>41.7</td>
<td></td>
</tr>
<tr>
<td>51-60</td>
<td>36</td>
<td>37.5</td>
<td>37.5</td>
<td>79.2</td>
<td></td>
</tr>
<tr>
<td>60+</td>
<td>19</td>
<td>19.8</td>
<td>19.8</td>
<td>99.0</td>
<td></td>
</tr>
<tr>
<td>24 or less</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>100.0</td>
<td>5.14/1.727</td>
</tr>
<tr>
<td>Total</td>
<td>96</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highest Degree</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSN</td>
<td>66</td>
<td>68.8</td>
<td>68.8</td>
<td>68.8</td>
</tr>
<tr>
<td>DNP</td>
<td>14</td>
<td>14.6</td>
<td>14.6</td>
<td>83.3</td>
</tr>
<tr>
<td>PhD</td>
<td>7</td>
<td>7.3</td>
<td>7.3</td>
<td>90.6</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>9.4</td>
<td>9.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>96</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years as NP</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
<th>M/SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>6</td>
<td>6.3</td>
<td>6.3</td>
<td>6.3</td>
<td></td>
</tr>
<tr>
<td>1-4</td>
<td>12</td>
<td>12.6</td>
<td>12.6</td>
<td>18.9</td>
<td></td>
</tr>
<tr>
<td>5-10</td>
<td>26</td>
<td>27.1</td>
<td>27.4</td>
<td>46.3</td>
<td></td>
</tr>
<tr>
<td>11-15</td>
<td>21</td>
<td>21.9</td>
<td>22.1</td>
<td>68.4</td>
<td></td>
</tr>
<tr>
<td>&gt;16</td>
<td>30</td>
<td>31.3</td>
<td>31.6</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
<td>99.0</td>
<td>100.0</td>
<td></td>
<td>3.6/1.233</td>
</tr>
<tr>
<td>Missing System</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>96</td>
<td>100.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. MSN = Master’s in Science of Nursing. DNP = Doctor of Nursing Practice. PhD = Doctoral Degree in Nursing. Other = Certificate of Nurse Practitioner.*
Table 5. Effect of Degree on the Current Political Astuteness scores

Note. MSN = Master’s in Science of Nursing. DNP = Doctor of Nursing Practice. PhD = Doctoral Degree in Nursing. Other = Certificate of Nurse Practitioner.