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HEALTH POLICY ENGAGEMENT AMONG NURSE EDUCATORS: A

DESCRIPTIVE, CROSS-SECTIONAL STUDY INTO POLITICAL ASTUTENESS

AND POLITICAL SELF-EFFICACY AND THE IMPACT OF PERSONAL AND

PROFESSIONAL FACTORS

A Dissertation

Submitted to the School of Graduate Studies and Research

in Partial Fulfillment of the

Requirements for the Degree

Doctor of Philosophy

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Indiana University of Pennsylvania

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Title: Health Policy Engagement Among Nurse Educators: A Descriptive,
        Cross-Sectional Study Into Political Astuteness and Political Self-Efficacy and the
        Impact of Personal and Professional Factors

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Nurse educators are expected to teach nursing students health policy advocacy; however, there continues to be an absence of strong nursing presence within health policy creation and engagement. A nurse educator's own political knowledge (political astuteness) and confidence (self-efficacy) in health policy may be a contributing factor to the absence of nurses' lack of health policy engagement in practice.

This descriptive, cross sectional study evaluates the political astuteness and political self-efficacy reported by nurse educators and the impact personal and professional factors have on their self-reported political astuteness and political self-efficacy. The study used the Political Astuteness Inventory developed by Philip Clark in 1984 and the Teacher's Political Self-Efficacy tool developed by Dr. Mary Catherine Hammon in 2010. The theoretical framework for this study was Bandura's Social Cognitive Theory (SCT).

This study used a random sample of 112 nurse educators from CCNE accredited BSN nursing programs in the Mid-Atlantic region of the United States. The results indicate that there is a strong correlation ($r = .809$, $p = .000$) between political astuteness and political self-efficacy. Additionally, results of the study supported Bandura's SCT, indicating that nurse educators with role models in their professional nursing organizations reported higher scores in both political astuteness and political self-

efficacy. Age was also a significant finding impacting nursing educators' political astuteness and political self-efficacy. Older nurse educators reported higher political astuteness and political self-efficacy.

Implications of this study suggest more external motivation should be placed on nurse educators by deans, nursing department chairs and professional nursing organizations to increase political astuteness and political self-efficacy. Nurse educators who are more politically astute and have political self-efficacy could be more effective health policy role models for nursing students, which could lead to an increase in a student nurse's political astuteness and political self-efficacy. A nurse who is more knowledgeable and confident about a health policy topic could be better equipped to participate in health policy creation and engagement, thereby improving overall health through policies derived from front-line health care workers.

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Finally, and most importantly, I could not have completed this journey without the loving support of my family. Thank you to my mom and dad, Nancy and Marty Hudacs. Thank you for being willing to babysit the kiddos when I had writing to complete and a special thanks to my dad for reading and editing my completed papers and chapters. Thank you to my mother-in-law, Judy Modene and my sister Bridget Hudacs for also picking up extra babysitting time as needed. Thank you to my children Sarah and Phillip whose constant support and motivation to keep going was inspiring. Finally, to my husband John, there are not enough words to express how grateful I am of

your unending support, encouragement and love through my entire PhD program and during my dissertation. You make me want to strive to be the best I can be, and I feel your love every step of the way.

For all of their support, I dedicate my dissertation to John, Sarah and Phillip.

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CHAPTER ONE

INTRODUCTION

Nurse educators are required to provide high quality, relevant knowledge to nursing students. Nursing curricula in the United States have evolved from the previous apprenticeship model, where physicians were the primary educators, nursing students learned through experience, and formal education only occurred after service to the hospital was complete. Nursing school priorities in the past were "service first, education second" (Michaels, n.d., para. 7). Present nursing education is being taught in college and university settings by nurse educators, rather than physicians.

Currently, nursing education is based on a science-driven curriculum relying on evidence-based practice to shape curriculum development (Keating, 2015). Nursing curricula drive the content students learn in formal nursing education. Fundamental nursing skills and assessment techniques are critical to develop throughout a nursing curriculum. Equally as important, current baccalaureate nursing curricula covers more abstract concepts such as nursing theory development, evidence-based practice research analysis, quality and safety concepts, as well as leadership and professional values concepts (American Association of Colleges of Nursing, 1986; American Association of Colleges of Nursing, 1998; American Association of Colleges of Nursing, 2008). All of these elements are essential to develop nursing curricula.

The evolution and development of guidelines for current nursing curricula require nurse educators to teach concepts that may not have been a priority in their formal nursing school curricula. One such topic is health policy engagement content, which now falls under professional values in nursing schools' curricula. Health policy engagement

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includes political astuteness and political efficacy. Political astuteness is defined as knowledge of the political and policy process (Primomo & Bjorling, 2013). Political efficacy is ones' confidence in the ability to participate in the policy process and confidence that the political system is one that is amenable to change (Bandura, 1986). Historically, nurses at all levels of education are disengaged from participating in health policy (Gardner, 2012). Health policy is part of the American Association of Colleges of Nursing (AACN), *Essentials* documents, which now serve as a guide for nurse educators to follow while developing curricula. However, nurse educators have not always had standard guidelines to follow regarding curricular content.

Move Toward Standardizing Nursing Curricula

The need for nursing curriculum standardization became apparent in the Institute of Medicines' (IOM) 1983 study on Nursing and Nursing Education. In 1979, Congress passed the Nurse Training Act Amendment of 1979. Within the Act, Congress mandated the Secretary of Health, Education and Welfare to ask the IOM through the National Academy of Sciences to conduct a study, justifying the need for continued federal funding toward nursing education (Civic Impulse, 2017). As a result, the IOM completed a two-year study of the nursing profession and education by collecting reports from national nursing and health care organizations, national registered nurse surveys from 1977 and 1980, ad hoc committees of representatives from nursing and related health care fields, and an extensive literature search (IOM, 1983). The two-year study revealed 21 recommendations for the nursing profession and nursing education. Recommendations from the study included ways to increase minority populations into the nursing field, ways to decrease nurses from leaving the profession, and ways to increase advanced

degrees in nursing. In terms of nursing education specifically, recommendation 19 highlighted that the three different educational pathways (Diploma, Associate, and Baccalaureate) to become a registered nurse created confusion on the "knowledge, skill, and range of competencies" of newly graduated registered nurses for employers (IOM, 1983, p. 20).

The confusion for employers was rooted in the three educational pathways that a nurse could become licensed, and the educational expectations for each graduate. Zarett (1980) compared perceptions of diploma, associate (ASN), and baccalaureate (BSN) registered nurse graduates readiness for practice, by surveying 154 directors of nursing (DON) in the acute care setting in Pennsylvania. The survey was an 11- item tool listing nursing functions, in which DONs used a five-point Likert scale to rate readiness for practice. A score of five indicated "strongly agree" and a score of one indicated "strongly disagree." The findings revealed that DONs perceived diploma graduates to have statistically higher scores in six of the 11 nursing functions. Additionally, the DONs agreed that diploma graduates required far less orientation time compared to ASN and baccalaureate BSN graduate nurses (Zarett, 1980).

Therefore, from an employer's perspective a diploma graduate was a far more desirable nurse to hire. However, several DONs did specifically note within the study that within six months, a BSN graduate surpassed the diploma graduate in two important areas "identifying the need for self-actualization and continuing education" and "applying selective knowledge concerning biopsycho-social influences on health status" (Zarett, 1980, p. 31). This study highlights the misunderstanding in educational focus between the diploma, ASN, and BSN degree, in the 1980s. As both diploma and ASN programs focus

on task-oriented nursing, whereas a BSN graduate has both nursing tasks, as well as leadership and management integrated into the curriculum.

As a direct result of the IOM report, including employer confusion of educational preparation competencies, the AACN developed a task force of nurses, health care administrators, professional organization leaders, and higher education faculty members to outline the specific content areas that every nurse should know as a graduate from a BSN program (AACN, 1986). The AACN is, "the national voice for baccalaureate and graduate nursing education" (2017, para. 1). The 1986 *Essentials of College and University Education for Professional Nursing* detailed 14 essential areas that a newly graduated nurse should be competent in upon graduation from a BSN program. For BSN nurse educators, The *Essentials* document provided a framework to develop nursing curricula.

Curriculum Development

Curriculum development requires integration of content material that meets the requirements from both the state board of nursing (BON) and the accrediting agency for the nursing school (Keating, 2015). State BON regulations for pre-licensure nursing schools include clinical hours and classroom hours, the programs length, faculty to student ratios, faculty education qualification and curriculum. For many states the BON and accrediting agencies share information regarding evaluation of nursing schools and encourage visits from the BON and the accrediting agency at the same time (National Council State Board of Nursing, 2012).

Accrediting agencies such as Commission on Collegiate Nursing Education (CCNE), Accreditation Commission for Education in Nursing (ACEN) and Commission

for Nursing Education Accreditation (CNEA) all provide accreditation to BSN degree programs. Accreditation standards help educators evaluate curricula. The accrediting branch of AACN is the CCNE. As AACN is the organization that developed the *Essentials* document, CCNE is the only accrediting agency that specifically requires nursing curricula to integrate the *Essentials* document into the accreditation process (AACN, 2017; CCNE, 2013).

When nurse educators develop curricula, it is imperative to create a progressive sequence of content from freshman year through senior year to meet the *Essentials* outcomes. Educators often rely on Bloom's taxonomy to develop objectives based on incremental steps in the learning process. In 1956, Dr. Benjamin Bloom and colleagues developed Bloom's taxonomy. Bloom's taxonomy of educational objectives provides a classification framework for educators to establish clear objective terms to measure outcomes (Bloom, 1956).

According to the 1956 version of Bloom's Taxonomy, he contended that learning occurs in a linear way. Bloom (1956) identified three distinct patterns of learning: the cognitive, affective and psychomotor domain. Objectives and outcomes in nursing curricula most often use the cognitive domain. Within the cognitive domain there are six major classes: knowledge, comprehension, application, analysis, synthesis and evaluation (Bloom, 1956). "The objectives in one class are likely to make use of and be built on the behaviors found in the preceding classes" (Bloom, 1956, p. 18). Nurse educators build course objectives and curricular outcomes using Bloom's cognitive, affective and psychomotor domains.

The affective educational taxonomy developed by Bloom (1956) focused on objectives that measure values and emotions attached to concepts. There are five classes within the affective domain: receiving, responding, valuing, organization and characterization by a value or value complex, and internalizing a value. Similar to the cognitive domain, each class increases in complexity within the affective learning process.

Anderson and Krathwohl (2001) revised the cognitive domain in Bloom's Taxonomy. The revisions created a clearer framework for educators to use the levels of knowledge based on the taxonomy class. The overall construct of Bloom's Taxonomy remains the same. Learning occurs from simple to complex concepts that build on one another. However, Anderson and Krathwohl (2001) changed key terminology within Bloom's taxonomy to align with current education research. Table 1 illustrates the cognitive domain in 1956 compared to 2001 Bloom's taxonomy and demonstrates the change in complexity for each level increase in the Bloom's Taxonomy Sequence.

Table 1

Bloom's Taxonomy of the Cognitive Domain in 1956 Compared to 2001

1956*		2001**	
Class	Description	Class	Description
Class 1: Knowledge	The ability to recall specific facts and concepts	Class 1: Remembering	The ability to identify or recall previous knowledge from memory
Class 2: Comprehension	The ability to understand facts within a specific context	Class 2: Understanding	The ability to construct meanings from different forms such as written or pictorial messages.
Class 3: Application	The ability to transfer learned content to a new environment	Class 3: Applying	The ability to execute or implement a concept in a new environment.
Class 4: Analysis	The ability to break down a concept into parts and make inferences from the concepts	Class 4: Analyzing	The ability to break concepts into parts and determining how those parts relate to one another.
Class 5: Synthesis	The ability to pull multiple parts together and create new concepts	Class 5: Evaluating	The ability to make judgments based on specific criteria through examining and critiquing a concept.
Class 6: Evaluation	The ability to make conclusions on values place on concepts	Class 6: Creating	The ability to put elements together in a new way to produce a whole new concept.

Note. *Bloom, B. S. (1956). *Taxonomy of educational objectives: The classification of educational goals.* New York, NY: David McKay Company; **Anderson, L. R. & Krathwohl, D. R. (Eds.). (2001). *A taxonomy for learning, teaching, and assessing: A revision of Bloom's taxonomy of educational objectives.* New York, NY: Longman.

Evolution of Health Policy in Nursing Education

Anderson and Krathwohl's 2001 revision of Bloom's 1956 taxonomy version is not the only evolution that has impacted nursing curricula. Nurse educators and leaders in nursing practice deemed health policy crucial to include in the 1986 *Essentials* for BSN curricula (AACN, 1986). Since 1986, to maintain accreditation with CCNE nursing curricula needed to integrate the *Essentials* into nursing courses (CCNE, 2013). Since the release of the first *Essentials* document the AACN has made two revisions to the document. With each revision, the complexity of health policy content continues to increase. In the 1986, there were 14 *Essentials*. Within the document, Essential 13 and 14 contained health policy content; however, both *Essentials* only require a *knowledge* level of health policy (AACN, 1986). Bloom's taxonomy identified a hierarchy to educational objectives development. Therefore, the *Essentials* in 1986, recommended that nursing curricula integrate health policy process facts and concepts.

In 1998, the AACN revised the *Essentials* document, and increased the expectation for graduating BSN nurses regarding health care systems and policy. Two statements within the document reference health policy: "identify the economic, legal and political factors that influence health care delivery; participate in efforts to influence health care policy on behalf of patients or the profession" (AACN, 1998, p. 15). *Identify* is at the first cognitive objective class, *knowledge*, but the verb *participate* is part of the affective domain.

The affective domain taxonomy was also integrated into the 1986 and 1998 *Essentials* with the use of the verb *participate,* which is part of the affective objective second class *responding*. The *responding* objective measures "learning by doing"

(Bloom, 1956, p. 118). The addition of an outcome that integrated a higher order affective category term demonstrates the increase in expectation for graduating BSN nursing students.

 The last revision to the *Essentials* document for BSN education occurred in 2008, once again an increase in the emphasis on health policy, for graduating nursing students. *Essential V: Healthcare Policy, Finance and Regulatory Environments* highlights 12 key areas that a BSN program should integrate into the curriculum to properly prepare a graduating nurse (AACN, 2008). Eight of these areas are specific to health policy and regulations. Because of the AACN (2008) revision to the *Essentials*, graduating BSN nurses should be prepared to:

- Demonstrate basic knowledge of healthcare policy at the state, national and global level

- Examine legislative and regulatory processes relevant to the provision of health care.

- Describe state and national statutes, rules and regulations that authorize and define professional nursing practice

- Explore the impact of…political factors influencing healthcare delivery and practice

- Discuss the implication of healthcare policy on issues of access, equality, affordability and social justice in healthcare delivery

- Articulate, through a nursing perspective, issues concerning healthcare delivery to decision makers within healthcare organizations and other policy arenas

- Participate as a nursing professional in political processes and grassroots legislative efforts to influence healthcare policy

- Advocate for consumer and the nursing profession (AACN, 2008, p. 20-21).

Based on Anderson and Krathwohl's (2001) revised taxonomy classification dimensions, the foci of *Essential V* represent higher levels of the cognitive domain and involve understanding, applying, and analyzing. In 2008, a clear shift in student outcome expectations occurred within health policy content for the BSN graduate, as the *Essentials* increased in cognitive complexity from class 1- remembering to class 4 - analyzing. The expectation for the graduating nurse requires health policy engagement, which includes political astuteness and political efficacy. Baccalaureate nurses are expected to have knowledge of the political process and the ability to engage in health policy at all levels from the individual healthcare organizations level through global initiatives. Table 2 illustrates the three versions of the *Essentials* documents compared to Bloom's Taxonomy.

Table 2

BSN Essentials *Documents Increase in Complexity Compared to Bloom's Taxonomy*

Essentials Version	Essential	Bloom's 1956 Taxonomy
Essentials of College and University Education for Professional Nursing (1986)	Essential 13 – Knowledge needed to serve as a health care advocate in monitoring and ensuring the quality of health care practice. • 13.1 Professional judgements and related skills need to act as a health care advocate • 13.3 Professional judgements and related skills needed to participate in monitoring nursing and health care services to ensure safe, legal and ethical health care practices Essential 14 – Knowledge needed to promote nursing as a profession • 14.1 Professional judgements and related skills needed to support activities of the profession that improve nursing and health care delivery and advance the discipline of nursing	Class 1-Knowledge Class 2 - Responding (Affective domain) Class 1 - Knowledge
The Essentials of Baccalaureate Education for Professional Nursing Practice (1998)	Health Care Systems and Policy • Identify the economic, legal, and political factors that influence health care delivery • Participate in efforts to influence health care policy on behalf of patients or the profession	Class 1-Knowledge Class 2 - Responding (Affective domain)
The Essentials of Baccalaureate Education for Professional Nursing Practice (2008)	Essential V – Healthcare policy, Finance, and Regulatory Environments • Demonstrate basic knowledge of healthcare policy at the state, national and global level	*Class 1-Remembering

	• Examine legislative and regulatory processes relevant to the provision of health care.	*Class 4 - Analyzing
	• Describe state and national statutes, rules and regulations that authorize and define professional nursing practice	*Class 1 – Remembering
	• Explore the impact of…political factors influencing healthcare delivery and practice	*Class 2 - Understanding
	• Discuss the implication of healthcare policy on issues of access, equality, affordability and social justice in healthcare delivery	*Class 2 - Understanding
	• Articulate, through a nursing perspective, issues concerning healthcare delivery to decision makers within healthcare organizations and other policy arenas	*Class 3 – Applying
	• Participate as a nursing professional in political processes and grassroots legislative efforts to influence healthcare policy	Class 2 – Responding (Affective domain)
	• Advocate for consumer and the nursing profession	Class 2 – Responding (Affective domain)

Note: American Association of Colleges of Nursing [AACN]. (1986). *Essentials of colleges and university education for professional nursing, 18.* Washington, D.C.: American Association of Colleges of Nursing; American Association of Colleges of Nursing [AACN]. (1998). *The essentials of baccalaureate education for professional nursing practice, 15-16.* Retrieved from http://www.aacn.nche.edu/ccne-accreditation/BSNEssentials1998.pdf;
American Association of Colleges of Nursing [AACN]. (2008). *The essentials of baccalaureate education for professional nursing practice, 20-21.* Retrieved from http://www.aacn.nche.edu/education-resources/BaccEssentials08.pdf; Bloom, B. S. (1956). *Taxonomy of educational objectives: The classification of educational goals.* New York, NY: David McKay Company

*Anderson, L. R. & Krathwohl, D. R. (Eds.). (2001). *A taxonomy for learning, teaching, and assessing: A revision of Bloom's taxonomy of educational objectives.* New York, NY: Longman.

The 2008 version of the BSN *Essentials* are what current nursing faculty who teach at CCNE-accredited universities and colleges must integrate into the nursing curricula. Most undergraduate didactic nurse educators in academia are required to have a minimum of a Master's degree. Therefore, it is also important to explore the development of graduation outcome expectations for the MSN and DNP *Essentials*. Understanding the evolution of knowledge expectations for nurses in health policy with advanced degrees assists in placing a timeline together of when nurse educators potentially receive health policy education.

The first *Essentials of Master's Education for Advanced Practice in Nursing* was released by the AACN in 1996. Health policy was the second *Essential,* and it required that Master's prepared students analyze policy research; differentiate legislative and regulatory processes; evaluate local, state and national health policy issues and trends; articulate concerns to elected officials; serve on boards or task forces that influence health policy; and articulate and interpret the significance of the advanced practice nurse's role to policymakers (AACN, 1996). The verbs in the second publication of the *Essentials* are higher-level cognitive domain verbs, which places these statements in the applying, analyzing and evaluating level of thinking for health policy. In 2011, the AACN revised the Master's *Essentials* by including:

- Analyzing how policies influence health care practice and outcomes,
- Participate in the development and implementation of institutional, local, state and federal policy,

- Interpret research from a nursing perspective for policy makers and stakeholders

- Advocating for polices that improve the health of the public and the profession of nursing (AACN, 2011, p. 21).

The Master's *Essentials* shift to the highest-level of thinking on Bloom's Taxonomy, *creating,* occurred in the 2011 *Essentials* revision, with the introduction of the requirement that nurses, "*participate in the development and implementation of policy*" (p. 21).

In 2006, AACN released *Essentials* that focused on doctorate level education, specifically the Doctor of Nursing Practice (DNP), since PhD programs do not require a formal accreditation process. The DNP *Essentials* focus on leadership, education, and advocacy for the DNP graduate to be an active participant in the health policy process. The DNP *Essentials* require the highest level of Bloom's Taxonomy of *creating* and, focus on higher levels of the cognitive domain of *analyzing* and *evaluating* healthcare policies. Table 3 illustrates the Graduate *Essentials* documents compared to Bloom's Taxonomy.

Table 3

MSN and DNP Essentials *Documents Compared to Bloom's Taxonomy*

Essential Version	Essential	Bloom Taxonomy
The Essentials of Master's Education for Advanced Practice Nursing (1996)	Essential II – Policy, Organization and Financing of Health Care A. Health Care Policy • Analyze the results of policy research relevant to health care delivery	Class 4 – Analysis
	• Differentiate and delineate legislative and regulatory processes	Class 2 – Comprehension
	• Evaluate local, state and national socioeconomic and health policy issues and trends	Class 4 – Analysis
	• Articulate health care issues/concerns to elected and appointed officials, both public and private and to health care consumers	Class 3 – Application
	• Serve on boards or tasks forces that influence health policy	Class 2 – Responding (Affective domain)
	• Interpret health care research for consumers and officials	Class 4 – Analysis
	• Serve as a consumer advocate on health issues	Class 2 – Responding (Affective Domain)
	• Articulate and interpret the significance of the advanced practice nursing roles to policy makers, health care providers, and consumers	Class 3 - Application
The Essentials of Master's Education in Nursing (2011)	Essential VI - Health Policy and Advocacy • Analyzing how policies influence health care practice and outcomes	*Class 4 – Analyzing
	• Participate in the development and implementation of institutional, local, state and federal policy	*Class 3 - Applying

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	• Interpret research from a nursing perspective for policy makers and stakeholders	*Class 5 – Evaluate
	• Advocating for polices that improve the health of the public and the profession of nursing	Class 2 – Responding (Affective domain)
The Essentials of Doctoral Education for Advanced Nursing Practice (2006)	Essential V – Health Care Policy for Advocacy in Health Care	
	• Critically analyze health policy proposals, health policies, and related issues from the perspective of consumers, nursing, other health professions, and other stakeholders in policy and public forums.	*Class 4 – Analyzing
	• Demonstrate leadership in the development and implementation of institutional, local, state, federal and/or international health policy.	*Class 6 – Creating
	• Influence policy makers through active participation on committees, boards, or task forces at the institutional, local, state, regional, national, and/or international levels to improve health care delivery and outcomes.	Class 2 – Responding (Affective domain)
	• Educate others, including policy makers at all levels, regarding nursing, health policy and patient care outcomes,	*Class 3 – Applying
	• Advocate for the nursing profession within the policy and healthcare communities.	Class 2 – Responding (Affective domain)
	• Develop, evaluate, and provide leadership for health care policy that shapes health care financing, regulations, and delivery	*Class 3 - Applying

Note. American Association of Colleges of Nursing [AACN]. (1996). *The essentials of master' education for advanced practice nursing*, *14-15*. Retrieved from http://www.aacn.nche.edu/education-resources/MasEssentials96.pdf;
American Association of Colleges of Nursing [AACN]. (2011). *The essentials of master's education in nursing*, *20-21*. Retrieved from http://www.aacn.nche.edu/education-resources/MastersEssentials11.pdf and American Association of Colleges of Nursing [AACN]. (2006). *The essentials of doctoral education for advanced nursing practice*, *13-14*. Retrieved from http://www.aacn.nche.edu/dnp/Essentials.pdf; Bloom, B. S. (1956). *Taxonomy of educational objectives: The classification of educational goals.* New York, NY: David McKay Company
*Anderson, L. R. & Krathwohl, D. R. (Eds.). (2001). *A taxonomy for learning, teaching, and assessing: A revision of Bloom's taxonomy of educational objectives.* New York, NY: Longman.

The shift in preparation requirements aligns with the Institute of Medicine's (IOM's) reports on nursing from *To Err is Human: Building a Safer Health System* (IOM, 2000) and *Keeping Patients Safe: Transforming the Work Environments of Nurses* (IOM, 2004). With the passage of the Patient Protection and Affordable Care Act (ACA) (2010), the American healthcare system underwent its largest reform since the addition of Medicare in the 1960s. Additionally, the IOM's (2011) *Future of Nursing: Leading Change, Advancing Health* report articulated the potential transformative effects that nurses could have in healthcare when put in leadership positions in boardrooms and in policy discussions at all levels of the healthcare system.

Although, nurses possess knowledge of healthcare in practice, policy development requires an understanding of a desired outcome and the steps needed to get to that goal. Nurses can provide the knowledge of how a goal can be reached through their application of healthcare in practice. The seminal reports from the IOM created a possible transitional path for nurses to serve the patient and the profession in a more influential way by making nursing a profession actively engaged in the policy making process. However, while the number of BSN, MSN, and DNP-prepared nurses continues

to rise, the number of nurses participating in policy making discussions on hospital boards remains around six percent, while physicians make up 20% of that policy making group (Hassmiller & Combes, 2012). In the 113th Congressional House of Representatives there were six total registered nurses in office, but there were 20 physicians who sat in House of Representative chairs (Patton, Zalon, & Ludwick, 2015). Sigma Theta Tau International has also charged nurses with the responsibility to influence health policy in the 2015-2017 biennium call to action (Burke, 2016). This call charges nurses to see themselves with a professional duty to influence all current and future health policy initiatives (Burke, 2016). Despite these calls to action, a challenge persists with getting nurses to engage in health policy from advocacy to policy development.

Current Educators' Experience With Health Policy Education

Nurse educators are required to educate current nursing students on health policy, even though they may have received minimal formal education on the topic throughout their educational experience. There are many areas in nursing that have changed since current educators attended nursing school, such as technology use, pharmacology knowledge, and approaches to pain management due to evolving evidenced based practice. One difference between health policy compared to other changes in nursing practice is that nurse educators see effective examples of the evolution of nursing practice in nursing textbooks and on clinical nursing units throughout the formal education process. Effective health policy examples can be demonstrated through role models. According to Bandura (1997a) an effective role model can increase a person's self-efficacy, which is the confidence one has in the belief that a specific task can be done.

However, based on the literature, historically there remains a lack of health policy role models who have both health policy political astuteness and political self-efficacy and are far less prevalent in nursing practice (Boswell, Cannon, & Miller, 2005; Buck-McFadyen & MacDonnell, 2017; Cohen et al., 1996; Gardner, 2012; Kelly, 2007; Khoury et al., 2011; Rains &Barton-Kriese, 2001). Furthermore, health policy creation occurs behind closed-door meetings and in the legislative halls at state capitals and congress. It does not occur openly on clinical floors, but it impacts professional nursing practice and patient safety profoundly.

A lack of health policy role models for nurse educators to follow may decrease self-efficacy toward health policy. Additionally, differences in the health policy content taught in nursing schools for nurse educators may decrease political astuteness. Nurse educators who completed a BSN degree prior to 1986 or attended a non-CCNE accredited nursing school, may not have had health policy content included in the curricula. Even if an educator did complete his/her BSN after 1986, there has been an increase in the content and critical thinking expectations from 1986 to 2008. If a nurse educator started nursing school in their late teens to early twenties, health policy education requirements in nursing schools were much different than current health policy education requirements. According to the National League for Nursing (NLN) (2009) data, 57% of part-time faculty were over the age of 45. In 2015, the NLN reported over 70% of full-time faculty were over the age of 45, more precisely 50% were ages 46-60 and 20% of full time faculty were over the age of 60. In 2015, the AACN (2015) reported the average age of doctoral-prepared nursing faculty at the professor, associate professor and assistant professor rank were 61.6, 57.6 and 51.4, respectively. At the master's-

prepared level the average age according to the identified ranks are 57.1, 56.8, 51.2 (AACN, 2015).

Therefore, based on the average age of current faculty, many completed their BSN degrees well before the current 2008 *Essentials* were integrated into nursing curricula. The NLN (2015) reported 64% of fulltime faculty are MSN prepared, and 69% of part-time nurse educators are MSN prepared. Faculty who graduated with an MSN after the 2011 MSN *Essentials* were published may be more prevalent. However, given the average age of faculty, the likelihood that a faculty member started and completed a MSN after 2011 may still be in the minority. Those nurse educators who are PhD prepared may or may not have received formal education on health policy at a higher level of engagement. Given that there is no formal accreditation process for PhD programs and no *Essentials* document for PhD education, it is difficult to assess the formal knowledge faculty members received during their PhD education.

Additionally, faculty members received education from nurse educators who may not have been formally or informally socialized about health policy. Health policy engagement in nursing was not established as a priority for nurses before 1980 for multiple reasons: it was not a part of the Nurses' Code of Ethics, curriculum guides or accreditation standards. Even if nurse educators received their education after key changes in the *Essentials* documents, there may have been a lack of role modeling and socialization in health policy. Therefore, education on health policy may have been no more than an academic exercise, rather than a key aspect of the nursing profession. Within the nursing profession, the paradigm shift from nurses as patient advocates exclusively to health policy advocates and policy influencers continues to unfold.

Behavior socialization through role modeling is an impactful way to learn new skills and behaviors. As a nursing student, a current faculty member may not have been exposed to nurse educators or staff nurses participating in health policy. Thereby limiting exemplar health policy role models and decreasing self-efficacy. Having decreased self-efficacy toward health policy engagement coupled with decreased political astuteness may hinder an educator's ability to be a positive role model for health policy engagement behaviors to current nursing students. Therefore, current nurse educators may continue to jeopardize the transfer of theoretical health policy engagement knowledge into practice for nursing students because of a decrease in their own political astuteness and political self-efficacy.

Given the average age of current faculty and a likelihood that the majority of current faculty received their formal education in alignment with earlier publication dates of the *Essentials* documents, faculty may have received very little formal education on health policy. Yet, faculty are expected to teach BSN students at a higher level of engagement and critical thinking than they were taught. Therefore, the responsibility of political astuteness falls on the individual faculty member who may have decreased political self-efficacy in the ever-changing landscape of health policy and the health care system.

Statement of the Problem

The nature and scope of health policy changes rapidly. Nursing curricula have increased the amount and the depth of information that nursing faculty need to teach current BSN students, based on the AACN's *Essentials* document for baccalaureate nursing graduates (AACN, 2008). Nursing faculty must stay abreast of changes within

health policy and teach relevant and critical material to students, as well as teach students how to participate in health policy engagement at the institutional, state, national and global level.

Given the current average age of nursing faculty in the United States, many faculty may not have been formally taught health policy at the current knowledge level that graduating BSN students are expected to know. Furthermore, current nurse educators may not have the self-efficacy about health policy engagement because of a lack of participation in the health policy process themselves or lack of a nurse role model active in health policy. Therefore, for faculty the combination of a lack of formal education or informal socialization on health policy engagement may lead to a lack of self-efficacy in health policy engagement. A decrease in self-efficacy regarding health policy, may be related to a decrease in political astuteness due to a lack of confidence in ones' own ability to create change within health policy. This cascade of events may lead to ineffective health policy education and underprepared future nurses who are disengaged in health policy, which could impact the health care for all patients and the nursing profession.

<div align="center">**Purpose**</div>

The purpose of this study is to determine if a relationship exists between a nurse educator's self-reported political self-efficacy score and self-reported political astuteness score. An additional purpose of this study is to describe the relationships between personal and professional factors including age, gender, educational degree, formal education graduation years, faculty rank (if applicable), professional organization membership, previous health policy education and having a health policy role model that

could affect nurse educator's political self-efficacy and political astuteness. There are no empirical studies describing professional factors that may influence faculty understanding and teaching of health policy, current self-efficacy perceptions about health care policy engagement or the overall political astuteness of nurse educators. Identifying significant professional factors that have a predictive impact on political astuteness and/or political self-efficacy can enhance awareness for current nurse educators to develop way to increase political astuteness and political self-efficacy for themselves and colleagues.

Research Questions

The research questions for this study are:

1. How do current nurse educators perceive their political self-efficacy?

2. How do current nurse educators perceive their political astuteness?

3. What is the relationship between nurse educators' political self-efficacy and nurse educators' political astuteness?

4. What personal and professional factors (age, gender, education degree, formal education graduation years, place of employment, faculty rank (as applicable), professional organization membership, previous health policy education and health policy role model presence for nurse faculty) impact nurse educators' political self-efficacy and/or nurse educator's political astuteness?

Conceptual Framework

The conceptual framework for this study is Albert Bandura's (1988) Social Cognitive Theory (SCT). SCT presents the idea that a person can learn new knowledge by directly observing, "behaviors, cognitive and other personal factors and environmental events… as interacting determinants" that all influence each other (Bandura, 1988, p.

275). Self-efficacy is a component of Bandura's SCT. The key to self-efficacy is a person believing that he/she has the knowledge and skill to perform a specific task. It is not enough for a person to learn new information to change his/her actions. To integrate a new behavior into ones actions the person must have the confidence that one can perform the task (Artino, 2012). Bandura (1997a) stated, "The major goal of formal education should be to equip students with the intellectual tools, efficacy beliefs, and the intrinsic interests needed to educate themselves in a variety of pursuits throughout their lifetime" (p. 216). Educators who have a high self-efficacy regarding a topic can influence the efficacy beliefs of others by demonstrating a clear path to achievement (Artino, 2012).

Definition of Terms

This section will include definitions of terms that are relevant to the proposed study. The following definitions include:

Health policy – "refers to decisions, plans and actions that are undertaken to achieve specific health care goals within a society" (World Health Organization, n.d., para. 1). For the purpose of this study, identification of any policy at all levels of health care society including individual organizations, state, federal or global will be considered a health policy.

Health policy engagement – comprises the definition of health policy from WHO, but also integrates the concepts of active involvement in a policy process including political astuteness and political self-efficacy. For the purpose of this study, it is the overarching concept derived from the current literature. Nurse educators must teach students to be knowledgeable about the process of health policy and demonstrating health policy

advocacy to build a sense that changes can be made by the student's involvement and that the overall system (local, state, national, and global) can be changed.

Health policy role model – Bandura defines a role model as a person who demonstrates an action. Based on that action an observer forms an idea of how new behaviors are performed, and later this information serves as a guide for the observer's actions (Bandura, 1997b). For the purpose of this study, a health policy role model is a designated person who demonstrated to a nurse educator how to engage in health policy.

Nurse educator – "Faculty in RN programs (full-time and part-time) shall have either a master's degree or a doctoral degree in nursing. Their education should include graduate preparation in teaching and learning including curriculum development and implementation" (Jackson et al., 2008, p. 2). For the purpose of this study, nurse educators participated in the study and identify as primarily teaching in a CCNE accredited BSN program with a MSN or doctoral degree in a related nursing or education field.

Political astuteness – Is composed of the awareness, knowledge and involvement in the political system (Primomo & Bjorling, 2013). For the purpose of this study, the Political Astuteness Inventory measured political astuteness of nurse educators.

Political self-efficacy - Is a person's belief in their capabilities to organize and execute the courses of action required to attain a specific result (Bandura, 1986). For the purpose of this study, the nurse faculty self-reported their political self-efficacy using the teacher political self-efficacy scale developed by Hammon (2010).

Professional factors – Are the aspects of a professional that impact the knowledge and competencies of the practice professional (Finke, 2015). For the purpose of this study

professional factors include formal graduation years from BSN, MSN, and doctoral (if applicable), years in nursing, tenure status and rank (if applicable), professional organization membership, previous health policy education and presence of a health policy role model.

Assumptions

This study has two major assumptions. The first assumption is that the year that a nurse educator started his/her nursing education may impact the knowledge and confidence the educator has on teaching health policy. Health policy was first recommended as a part of nursing curriculum in 1986, but nursing schools curricular changes occur at different times. It is during accreditation reviews that curricula are reviewed by outside institution reviewers. However, nurse educators should review program curricula at a minimum of a yearly basis to ensure curricula and courses meet current accreditation standards and make changes accordingly (Keating, 2015). Additionally, the *Essentials* are only guidelines for curriculum development, schools determine how in-depth content is covered within the curriculum leading to variances from program to program. Therefore, the year of graduation from a BSN, MSN, and doctoral level program may impact the expected level of health policy engagement knowledge upon graduation for that faculty member. The second assumption in this study is that nurse educators will truthfully respond to the self-assessment tools in this study. The tools utilized for this study are the Teacher Political Self-Efficacy Scale and the Political Astuteness Inventory, which use self-reported perceptions of the participant.

Significance

Nurses make up the largest portion of the healthcare workforce in America (Hahn, 2010). Nurses have the responsibility to be participants in health policy, but also need to inform those around them on how current health practices are improving or preventing the delivery of access to quality, cost-effective care (Gardner, 2012). Baccalaureate nursing students are poised to make a difference in the future of health policy when given the tools and examples by experienced nurse educators. Potentially nurse educators as role models are the missing link to get more nurses involved in the development of health policy based on evidenced-based practice and current knowledge of the state of the healthcare system. Nurse educators with high political self-efficacy and political astuteness could be a key element of health policy education to make the connection for nurses and health policy engagement.

Professional nursing organizations, healthcare organizations and nursing education accrediting bodies encourage all nurses to engage in health policy (AACN, 2017; ANA, 2017). Many nurses may assume this means becoming part of the political process by running for an elected office (Gardner, 2012). While this does give a formal voice to the nursing profession, there are many other ways that nurses can engage in health policy. Grassroots advocacy including participation in institution, state, national, and global health policy initiatives as well as engaging other nurses in advocacy are all ways that a nurse can participate in health policy. Nurses who remain silent allow the creation of health policy to occur without a nursing perspective. Nurses are best suited to speak for the nursing profession. Patients' safety is dependent on health policy created

by those who know health care, the health care system, and nurses' roles within the system (Patton et al., 2015).

Nurse educators need to teach and influence current nursing students about health policy. Nurses are the frontline healthcare workers who possess the knowledge about effective and ineffective health policies. Nurses see the potentially devastating impact, well intended but ineffective health policy, can have for patients and the health care system. They can also be the workforce promoting and witnessing the possibilities that effective health policy can have on an individual patient, an institution, and a state health care system, as well as nationally and globally. However, nurses need the knowledge and skills to engage in health policy in practice.

Nurse educators are expected to know a lot of information and to convey that information to nursing students. Many nurse educators may have received their BSN education prior to the 2008 BSN *Essentials* guidelines, based on the average age of current educators (AACN, 2017; NLN, 2015). These recommendations increased the required knowledge regarding health policy for graduating BSN nurses after 2008. Nursing faculty are required to educate nursing students on health policy (CCNE, 2013). However, many current educators were not educated under the same expectations of knowing and engagement that nursing students are now expected to understand and demonstrate. In addition to potentially not receiving formal education on the topic of health policy, there may be other professional factors that impact the self-efficacy and political astuteness level of nurse educators to adequately teach health policy to future nursing students. If there are additional personal or professional factors that impact knowledge or self-efficacy toward health policy, a plan to mitigate or increase those

factors for nurse educators could impact the overall perception of political knowledge and self-efficacy. When a nurse educator is knowledgeable about and has self-efficacy regarding any nursing topic, it is logical to assume that topic knowledge and confidence has a greater likelihood of being transferred to nursing students.

According to Bandura's (1988) SCT, one can learn new knowledge and behaviors through the actions of others. However, the question remains, did current nurse educators have registered nurses to use as role models for health policy engagement, given the relative new addition of health policy into nursing curricula. If nurse educators did not receive health policy education in a formal education setting and were not exposed to registered nurses engaged in health policy are they learning political astuteness and gaining political self-efficacy on their own? Nursing students may be missing these interactions because nursing faculty may not be serving as health policy role models. The job of health policy role model may be missing because nurse educators could have a low self-efficacy regarding health policy and decreased political astuteness.

Therefore, this study describes the current level of political self-efficacy and political astuteness that nursing faculty self-report. If nursing faculty have a higher political self-efficacy, then based on Social Cognitive Theory, faculty could be more effective role models of health policy knowledge and engagement to nursing students. When students see health policy as something nurses can and should be participating in as professionals, there is a higher likelihood that students will embody that professional nursing role. Nurses are a key component in creating safe and effective health policy at the institution, state, national and global levels and nurse educators are the key to instilling self-efficacy and political astuteness in nursing students.

Summary

This study will describe the political self-efficacy and the political astuteness of current BSN faculty. It will also explore the impact of professional factors that may influence a faculty member's political self-efficacy and political astuteness. Knowledge gained from this study could be used to reshape faculty's view on health policy by accounting for a lack of formal education on the topic and other professional factors. This chapter included the background, problem statement, purpose, research questions, definition of terms, assumptions, and significance of the study. The next chapter will include a review of the literature regarding the conceptual framework of Bandura's Social Cognitive Theory, the concepts of health policy in curriculum, current practice to teach health policy, and an overview of the research using both the teacher political self-efficacy scale and the political astuteness inventory.

CHAPTER TWO

LITERATURE REVIEW

The preceding chapter discussed the evolution of health policy content in nursing curricula. It also detailed the scope of the problem with educators required to teach nursing students at a much higher level of cognitive processing than current educators may have learned in their formative nursing education. This gap between what present educators were taught in school and what they are expected to teach current students may be a key issue why nurses remain largely uninvolved in health policy discussions. Nurse educators have much higher expectations for health policy engagement for current students than they expect of themselves (Staebler et al., 2017). Because of this disconnect between what nurse educators are teaching and what they are doing, students may not see health policy being role modeled for them and could be a factor in nurses not applying health policy content into practice. Current nurse educators may not possess health policy engagement skills, which are high political self-efficacy and political astuteness. Health policy engagement occurs when an individual has sufficient knowledge of the political and policy process, together with a high level of political self-efficacy. Political efficacy includes self-efficacy toward political efforts and being part of an open social system with built in structures capable of change (Bandura, 1997a).

A review of literature on the concept of health policy in nursing education includes multiple topics. Therefore, this chapter will review the current literature related to the conceptual framework of Social Cognitive Theory, health policy engagement in nursing practice, the gaps between health policy in education to practice, and health policy integration in nursing education and explore the research using the two tools

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within this study the *Political Astuteness Inventory* tool and the *Teachers Political Self-efficacy* tool. The purpose of this study was to examine and describe the relationship between nurse educators' political self-efficacy and political astuteness, then determine if any professional factors affect a nurse educator's perceptions of political self-efficacy and political astuteness. This purpose statement guided the literature review.

Search Criteria

A review of the literature on the concept of health policy engagement was conducted through CINAHL, Academic Search Complete, Medline, PubMed, ERIC and ProQuest databases from 1980 – 2017. The search terms included: "advocacy," "health policy," "health policy engagement," "nurs*," "educat*," "political astuteness," "political efficacy," and additional terms related to teaching, health policy, and research. The search revealed several research studies, many information-based articles and two dissertations. The search terms of "advocacy," "engagement," "health policy," "nurs* educat*," "role modeling in education," "social learning theory," "self-efficacy," "political astuteness inventory," "political self-efficacy scale" were used to examine research related to Social Cognitive Theory and the tools used in this research.

Theoretical Framework – Social Cognitive Theory

The following section will outline Albert Bandura's Social Cognitive Theory. This section will also discuss the key tenets of Bandura's theory: self-efficacy and modeling and specifically political efficacy. Additionally, this section provides a clear explanation of how Social Cognitive Theory is utilized in nursing education and political efficacy education. Finally, this section will highlight the gaps in the literature to show

how Social Cognitive Theory can be applied to nurse educators to appropriately model health policy engagement for nursing students.

Albert Bandura developed Social Cognitive Theory (SCT) in 1986. SCT expanded upon Bandura's Social Learning Theory. Social Learning Theory (SLT) developed in 1977, asserted that a person can learn through observation, which expanded upon commonly held views that learning only occurred through classical (biological response) and operant (reward/punishment) conditioning (McLeod, 2016).

The central idea in SCT is that learning is complex. Within the learning process there are three mutual interactions. The three mutual interactions occur between 1) the person, 2) the environment and 3) behaviors (Taylor, 2016). These interactions help to explain the influences that help a person develop and continue a specific behavior, while also understanding the social environments impact on a person's behavior (Taylor, 2016). Figure 1 illustrates the relationship that role modeling, political astuteness, and political efficacy impact the interactions between the person, the environment and behaviors. Political astuteness is overall knowledge of the political and policy process and participation in the process.
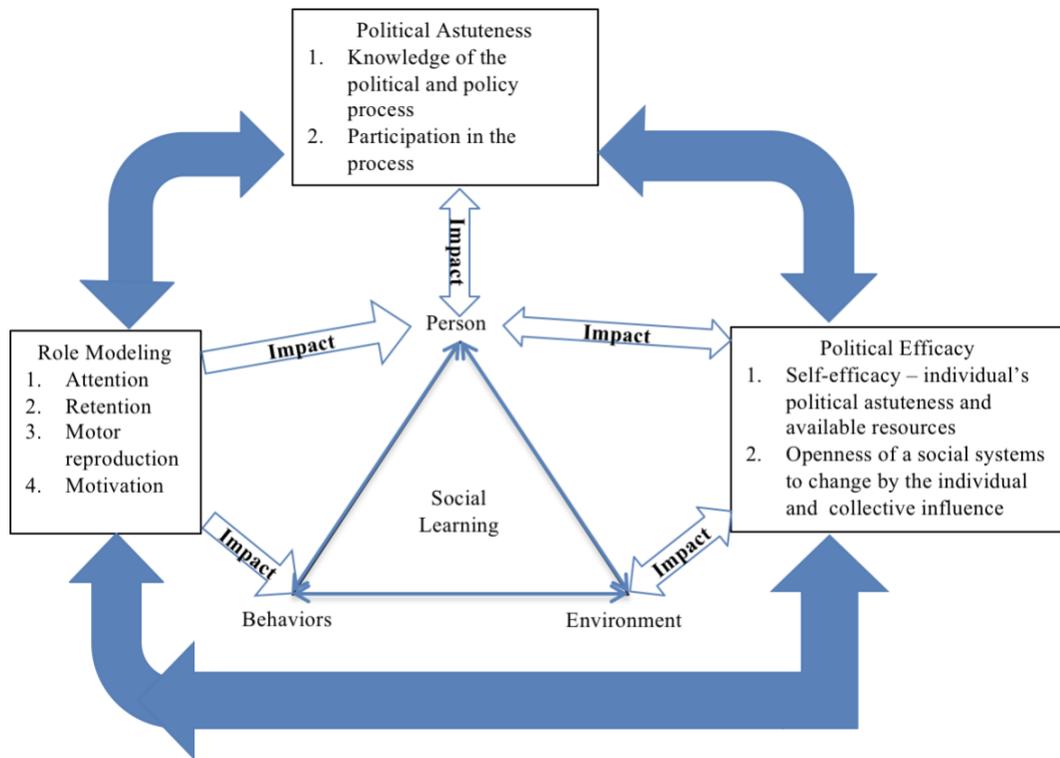
Figure 1. Diagram of Social Cognitive Theory with political astuteness, political efficacy and role modeling

Self-Efficacy

Self-efficacy is a key expansion of SLT to SCT and is a motivator for learning new ideas. "Self-efficacy refers to an individual's confidence about his or her abilities to mobilize the motivation, cognitive resources and courses of action needed to successfully execute a specific task within a given context" (Stajkovic & Luthans, 1998, p. 66). While perceived self-efficacy is a similar concept; Bandura (2006) explains that "perceived self-efficacy is a judgment of capability to execute given types of performances" (p. 307). A person who has high self-efficacy or perceived self-efficacy has a greater likelihood to

overcome barriers and achieve a set goal. Conversely, a person with low self-efficacy or perceived self-efficacy will see barriers as inflexible obstructions to the end goal.

In addition to self-efficacy, one of the central ideas in Social Cognitive Theory are that learning is multifactorial. Stajkovic and Luthans (1998) explained Bandura's theory further by noting that Social Cognitive Theory recognizes that learning involves a cognitive process which acknowledges the social aspect of learning. The social aspect of learning encompasses knowledge acquisition that occurs by an individual being part of a society. The cognitive aspect of SCT recognizes the influence of human motivation, attitudes and actions. Essentially, SCT marries the multiple influences an individual's experiences and how those experiences both on a societal and individual level influence the learning process. Therefore, to learn health policy engagement, an educator must address societal influences and individual influences for successful knowledge acquisition.

Modeling

Social Cognitive Theory contends that most human behavior is learned observationally through modeling. A role-model demonstrates an action and an observer forms an idea of how new behaviors are performed, and later this information serves as a guide for actions (Bandura, 1997b). Modeling serves as a powerful means of transmitting values, attitudes and even patterns of thoughts and behaviors. However, Bandura (1988) stresses that there are four components necessary to move modeling from imitation of behaviors to a cognitive process of behaviors. The four components necessary beyond reinforcement are: 1) attention; 2) retention; 3) motor reproduction; and 4) motivation (Bandura, 1997b).

Attention, retention, motor reproduction and motivation are four essential components for an observer to gain from a role model, and ultimately, with positive reinforcement, lead to higher self-efficacy toward the observed task (Bandura, 1997b). The observer of the model must move beyond watching and reproducing behaviors without asking any further details to achieve cognitive behavior changes. Therefore, the attention component for the observer relies on a model who not only demonstrates the desired behavior, but also has the observer ask questions and reflect on the observed behavior. This allows for the behavior to be properly coded within the observer's mind.

The second component in modeling is retention. Retention is dependent on the observer's ability to use visual imagery and verbal cues to code the information in his or her mind. Once the behavior is effectively coded within the mind, recall and performance success increases self-efficacy toward the task (Bandura, 1997b). The third component in modeling, motor reproduction, changes the first two components of attention and retention into action (Bahn, 2001). Production is closely linked to the individual's performance skill; therefore, guided practice with feedback is required to enable more complex skills to develop appropriately (Bandura, 1997b). Observers rely on feedback to enhance skills. A negative feedback experience can stifle self-efficacy for the observer's skill attainment. These components of modeling when demonstrated by a competent role model could be essential to increase health policy action by nurses. Health policy engagement skills include applying political process knowledge to the specific health issue that requires a health policy change or creation, as deemed by the nurse or group of nurses.

The final component in desired behavior change through modeling is motivation. There are three types of motivation: external, vicarious and internal. External motivation relies on external rewards to enhance behaviors (Bandura, 1997b). Vicarious motivation is motivation gained through watching others' successful achievement (Bandura, 1997b). Internal motivations are based on self-reward or self-punishment for attempting a behavior (Bandura, 1997b). When an observer witnesses a role model receiving a negative reward while performing a task, that observation impacts the internal motivation system developed by the observer (Bandura, 1997b). An observer who uses all four components of attention, retention, motor reproduction and motivation and receives positive reinforcement or witnesses a role model's success with positive reinforcement has a greater likelihood to change behaviors and internalize new behaviors modeled for them (Bandura, 1997b).

Political Efficacy

Bandura describes political efficacy within the context of SCT as a two- part process. The first piece is self-efficacy toward an individual's knowledge and available resources. The second piece of political efficacy relies on how open "social systems are to change by individual and collective influences" (Bandura, 1997a, p. 483). Social systems most commonly refer to government and their agencies but can also apply to social systems within individual organizations. A person who is knowledgeable about the political process and has resources available, such as strong motivation and time, coupled with a system that can be changed has a greater likelihood to evoke change. In contrast, a person with little knowledge about a political process or a lack of resources available or living within a social system that is not amenable to change will likely not evoke change.

At a collective level, a group of individuals who embark in change within an open system all need to possess high self-efficacy toward the goal to overcome obstacles for success (Bandura, 1997a).

Summary

Albert Bandura's (1986) SCT theorizes that learning is a multifactorial cognitive process. Knowledge acquisition depends on the interactions between a person, the individual's environment and one's behavioral capabilities. A person's self-efficacy toward the learned behavior impacts the ability to gain new knowledge and skills. Modeling a new concept with positive reinforcement to a learner increases self-efficacy toward the new behavior (Bandura, 1986). Political efficacy specifically addresses the components necessary for participation in policy change at all organizational levels including local, state, national and global change. An individual or group of individuals can effectively create social system changes when high political efficacy is present. Health policy engagement is achievable when nurse educators create an environment that fosters high self-efficacy through modeling and collective motivation. The next section discusses current uses of SCT in nursing and nursing education.

Modeling and Self- Efficacy in the Clinical and Education Nursing Practice

The following section outlines the current research highlighting Bandura's Social Cognitive Theory in clinical and educational practice. In clinical practice, role modeling by experienced nurses demonstrates an effective way to produce greater clinical astuteness and self-efficacy for nurses. However, multiple authors anecdotally point to a lack of nurse role models negatively impacting current behaviors in health policy engagement (Thomas & Shelton, 1994; Wold, Williams, Spencer, Jakeway & McCombs,

2004; Woodward, Smart, & Benavidides-Vaello, 2016). Additionally, many studies point to the positive impact that role models can have on building self-efficacy in nursing practice and health policy engagement (DiCenso et al., 2012; Lasater, Johnson, Ravert & Rink, 2014; Perry, 2011; Taylor, 2016).

Role modeling in clinical nursing allows the observer to learn new behaviors through observation. Clinical excellence is a difficult concept to quantify in words, which is why Perry (2011) utilized the phenomenology approach to interview eight nurses, who were identified by their peers as being "the nurse you would want taking care of you if you were ill in the hospital" (p. 38). Each participant completed two interview sessions lasting between 30 – 60 minutes in which the researcher asked open-ended questions regarding their nursing practice. The researcher also observed the nurses in clinical practice. Analysis of the interviews and observed behaviors revealed five themes: "attending to the little things," "making connections," "maintaining a light-hearted attitude," "modeling and affirming others are present" (Perry, 2011). These five themes speak to the actions and attitudes that role model nurses exemplify with each nursing interaction. The observed nurses in this study, role modeled actions such as maintaining dignity of the patient through little things such as insuring a patient remained covered while changing a dressing. The experienced nurses exemplified excellent communication techniques to the patient by making meaningful connections, to colleagues by keeping interactions light-hearted, which can be difficult in healthcare, and to novice nurses by asking them to join in on new procedures (Perry, 2011). The eight exemplar nurses in this study demonstrated positive attributes of a clinical nurse. They served as role models to nursing students, novice clinical nurses, and patients. Therefore, theoretically, the

concept of clinical excellence can be taught in the classroom, and nurse educators can point to expert clinical nurses for students to observe. Additionally, nurse educators can serve as the expert clinical nurse for students to learn from in practice.

Lasater et al., (2014) completed a mixed method study that also looked at role modeling in nursing. The study analyzed role modeling clinical judgement in a simulation environment for nursing students. A total of 275 nursing students from four United States (US) schools of nursing (n = 221) and one United Kingdom (UK) school of nursing (n = 54) participated in the study. Each school of nursing randomly divided the students in to a control group (28 UK, 107 US) and a treatment group (26 UK, 114 US). Prior to the simulation experience, the treatment group watched a video of an expert nurse performing care on a post-operative older adult, which mirrored the simulation that the students were going to participate in. After the simulation, the student completed a survey and participated in a focus group interview during the debriefing session. Four weeks after the simulation the students again completed the survey and participated in a focus group interview during a debriefing process, but after taking care of a real-life post-operative older adult.

The findings between the two student groups were remarkably similar in the four weeks post simulation and post care of a real-life patient. The treatment group post-simulation scores differed in two areas: self-ranking of confidence and knowing what to expect. Students were asked to rate themselves on a 1 to 10 scale, with 1 being no confidence and 10 being the highest level of confidence. The treatment group rated themselves at a higher level of confidence compared to the control group with a between-group analysis of variance revealing ($p = 0.01$) at a medium effect size (Lasater et al,

2014, p. 261). No additional quantitative data was provided in this mixed method study. However, qualitative statements from the students in the treatment group also revealed they felt more comfortable knowing what to expect after watching the role model nurse demonstrate care of an older adult. One student stated, "I felt a lot more comfortable about what to expect after seeing that video. If I had gone in just with reading the articles, I wouldn't have felt as confident" (Lasater et al., 2014, p. 261).

Lasater's et al. (2014) study exemplifies the positive effects that a role model can have for students in clinical practice. The students who viewed a model nurse prior to the simulation and care of the real patient reported higher self-efficacy. The students' attention and retention of the model's actions allowed for more self-confidence to perform the skills in the simulation and in clinical practice. This study highlights the key tenants in Bandura's Social Cognitive Theory by demonstrating the difference role models can have on the three aspects of SCT: person, environment and behaviors. In this research study: the student was the person, the simulation scenario and then the nursing unit were the environments, and care for an elderly adult was the behavior. This same application of the theory can be integrated into health policy education.

The preceding two studies offer insight into the impact role modeling has on behaviors for current and future nurses. In nursing education, students are exposed to expert clinical nurses who demonstrate proper clinical techniques. Additionally, nurse educators most likely feel comfortable with their knowledge and skills to role model expert clinical techniques for students. The next three examples demonstrate the positive impact role models in health policy can make for novices.

Taylor (2016) conducted a web-based survey of 27 executive leaders from two Midwestern professional nursing organizations. The web-based survey gathered demographic data including professional and academic background, and specific role in public policy advocacy. Twelve executive leaders completed the web-based survey. The demographic results from the survey indicated that the executive leaders were all registered nurses and four of the 12 respondents were advanced practice registered nurses (APRNs). Each executive leader was actively involved in developing public policy within the professional organization. In addition to policy development within the organization, among the executive leaders there was between one and 22 years of formal public policy participation at local, state, and federal levels (Taylor, 2016).

The participants in the web-based surveys agreed to participate in a teleconference focus group with semi-structured interview questions. The interviews were audio recorded and transcribed verbatim. An inductive content analysis revealed "nine themes categorized as either *facilitators* or *challenges* to the impact advocacy initiative on nurses' motivation for sustained momentum in public policy advocacy" (Taylor, 2016, p. 240). The themes reveal the positive and negative forces that influence the ability of nurse executive leaders to remain engaged in public policy advocacy. One of the themes identified as a facilitator of nurses sustained momentum in public policy advocacy was "experiential learning in the context of coaching and mentoring" (Taylor, 2016, p. 240). Executive leaders within the study spoke positively about the influence that role modeling by experienced nurse colleagues in health policy advocacy played in their role development as public policy nurse advocates. Similar to the nursing students in Lasater's et al. (2014) study who watched the video of an expert clinical nurse, the

executive leaders expressed greater confidence in their role as advocates when they watched their seasoned politically astute colleagues demonstrate political advocacy through a public policy testimonial or watched and worked with them as they networked in a room full of politicians. One participant "found that being put in the position to testify or receiving help from a colleague member with written testimony, then testifying, increased her confidence" (Taylor, 2016, p. 241). When role modeling is integrated into the nursing profession and education, it is clear that self-efficacy builds through positive observation experiences.

A Canadian qualitative study by DiCenso et al. (2012) connected 13 graduate nurses (six nurse practitioners, one clinical nurse specialist and five other graduate nurses) with policy makers. The nurses participated in a six-month practicum with each student following a nurse policy maker. After the completion of the experience, educators conducted a qualitative study through a web-based, open-ended questionnaire sent to all participants. The researchers asked the participants to describe the objectives that the students and policy makers established at the beginning of the experience, the overall impression of the practicum journey, student learning that occurred during the experience, and the benefits and challenges to the experience.

An independent qualitative researcher analyzed the results. The researcher had no affiliation to the chair of the nursing department. Students' and policymakers' responses about the experiences were categorize, based on the open-ended questions, into five major categories: "objectives of the health policy practicum," "policy practicum journey," "student learning," "benefits" and "challenges of the policy practicum" with multiple sub-themes within each main category (DiCenso et al., 2012, p. 229).

Specifically, role modeling was a sub theme of the "benefits of the policy practicum" category (DiCenso et al., 2012, p. 230). One participant responded, "the most significant learning was observing my preceptor as she became newly established in her role as the provincial chief nursing officer" (DiCenso et al., 2012, p. 230). Overall, participants stated that they did not realize the systems complexity, but expressed feelings of preparation to continue policy engagement in the future. The experience benefitted policy makers as well because the graduate nurses could inform policy makers what the current realities were for nurses in advanced practice. The students made lasting connections with their policy makers, which could improve access to engagement in the future.

While not a research study, an anecdotal article defining a teaching strategy at the baccalaureate level written by Wold, et al., (2004) described the transformative effects a role modeling experience can have on self-efficacy and knowledge in health policy engagement. The 1998 Baccalaureate *Essentials* guidelines stress that nursing graduates should, "participate in efforts to influence health care policy on behalf of patients or the profession" (AACN, 1998, p.15). In Wold et al. (2004) example educators developed an experiential learning activity between nursing students in a community health rotation and the local county health department. The local health department received a federal grant aimed at chronic disease prevention. Educators facilitated a partnership between students and multiple local health agencies to collaborate on health policies that would help the health department meet the objectives of the grant. Together students and the local public health nurses completed community assessments and analyzed community health data to develop health policies. At the end of the experience, students along with the public health nurses presented their findings and health policy suggestions back to the

local health department. In the evaluation after the 15-week experience, students reflected on their health policy development experience. Students stated they had a deeper understanding of how policy development occurs. Moreover, students gained knowledge of the steps to creating health policy through the observation of public health nurses. Also, students participated in the process by pairing the community needs assessments, health data, and medical knowledge to create health policies that were focused on the local community.

Teaching strategies such as these emphasize the impact that role model observation of health policy makers can create for students. However, in both examples it is not nurse educators that are the role models and resources for the students; it is policy makers in DiCenso et al.'s (2012) study with graduate students and community public health nurses in Wold et al.'s (2004) example of a BSN teaching strategy. While these experiences can be transformational, adding educators as health policy role models may have a more lasting impact on student knowledge and application in professional practice.

<div align="center">**Summary**</div>

These examples highlight the influence a positive model can have on behaviors. Modeling values such as excellence in nursing, leadership and political skill are intangible abilities that can be difficult to teach theoretically; however, observing these skills in practice can put the concepts learned in the classroom into a more tangible construct for students.

Health policy engagement is a concept that can be difficult for nurse educators to describe to students in the classroom. However, as these studies demonstrate, using

Social Cognitive Theory including role modeling what health policy engagement is can be an effective method to teach this concept. Allowing students to visualize policy development from role models using the four components of modeling according to Bandura. The four components including attention, retention, motor reproduction and motivation give students the opportunity to increase political astuteness and political efficacy.

Gaps in the Literature

Role modeling in Social Cognitive Theory impacts the behaviors of individuals. Current nursing literature states that there are few nurses engaged in health policy but offers little quantifiable evidence to define the issue. Nurse educators are some of the earliest influencers for nursing students. However, the literature does not explore nurse educators comfort level to step into the role as model in health policy engagement. Qualitative studies exploring the perceptions among nurse educators' comfort and perceived barriers to become health policy role models could expose key areas of success and failure in this area. Continued quantitative research exploring the outcomes for students when exposed to nurse educators as role models is also imperative.

Research is needed to understand students' experiences with watching nurse educators engaging in health policy compared to watching other policy makers to determine if nurse educators do make a greater impact on self-efficacy and understanding of the policy process. It is logical to assume that nursing students would feel that nurse educators are more approachable to more fully engage with to ask the questions and ultimately hone health policy engagement skills. Additional studies focused on nurse educator's view of their role model position within health policy would benefit nursing

literature. A historical look at the role models who shaped nurse educators' health policy skills, would prove beneficial to determine where the most influential role models can be found within nursing and how they became role models. Unfortunately, these gaps may be viewed by students as a lack of importance on the concept of health policy engagement. Research focused on the role that educators play as role models directly, can help bridge the disconnect that seems to be present in the nursing profession (Taylor, 2016; Thomas & Shelton, 1994; Wold et al., 2004).

Health Policy Engagement in Nursing Practice

Historically, nurses have not been influential in health policies, yet nurses are the frontline workforce implementing them (Buerhaus, Ulrich, Donelan & DesRoches, 2008; Hahn, 2010). "A significant challenge for the nursing profession has been recognizing the impact of healthcare policy on practice and patient care" (Mund, 2012, p. 423). Nurses continue to remain disengaged in health policy creation (Short, 2008; Thomas & Shelton, 1994). The Institute of Medicine (IOM) (2011) report: *The Future of Nursing: Leading Change, Advancing Health* stated that nurses are to become leaders in health care policies at all levels. Nurses are called to engage in health policy from an organizational, community, state, national and global level. Health policy engagement occurs when an individual is politically astute and has a high level of political efficacy. Political efficacy includes self-efficacy toward political efforts through both an individual and collective means and being part of an open social system with the structure to change (Bandura, 1997a). Health policy engagement includes the ability to advocate to influential persons at all levels to ensure evidenced based health policies become practice.

Professional health policy advocacy is a nursing value. The American Nurses Association (ANA) (2015) *Code of Ethics for Nurses* outlined the value of health policy advocacy as an ethical responsibility of nurses in Provision 7: "The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy" (p. 27); and Provision 9: "The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy" (p. 35). Despite multiple professional organizations articulating the importance of nurses' role in health policy advocacy, the disconnect in practice continues.

Nurses have impacted health policy throughout history by advocating in a multitude of endeavors. Nurse activists such as Florence Nightingale, Margaret Sanger and Lillian Wald worked relentlessly to change health policy and ultimately improve the lives of the populations they served (Rains & Barton-Kriese, 2001; Stuart, 2010). Today, at the local level nurses' involvement in health policy is less impactful. Nurses' influence is lacking most notably in key positions within health systems (Khoury et al., 2011). In a review of 201 health systems nationally, with a total of 2,046 voting board members, nurses held only 2.4% of the hospital board seats, compared to the 22% held by physicians (Khoury et al., 2011). On the national level, there are currently three nurses out of 535 congressional members (ANA, 2017). This number represents less than 1% of the total number of congressional membership. Compared to just under 40% of lawyers within the congressional membership (Weiss, 2016).

America is home to over 3.6 million registered nurses (ANA, 2017). Smith (2014) estimates that one out of every 45 registered voters is a nurse. Despite this large number, nurses fail to recognize their collective capability and potential political influences (Zauderer, Bellestas, Cardoza, Hood, & Neville, 2009). The Pennsylvania State Nurses Association (PSNA), which is a state branch of the ANA represents 220,000 Pennsylvania nurses; however, their active membership comprises only 1% of all the nurses in Pennsylvania (B. Snook, personal communication, March 26, 2018). This finding is consistent with national professional nursing organization participation with reports as low as 7% of nurses belonging to professional organizations (Beauregard et al., 2003). As of 2014, Haylock (2014) reported only 6% of nurses were paying members to any professional nursing organization in America. In the political environment today, the ANA raised $1 million dollars in political action coalition funds to support candidates and touts an 88% election success rate of endorsed candidates (Hahn, 2010). Statistically, when nurses unite they can make great strides to create health care policy change; however, nurses gravitate toward implementation of policy rather than influencing and creating policy (Rains & Barton-Kriese, 2001).

In 2009 the Robert Wood Johnson Foundation (RWJF) commissioned Gallup to conduct a survey of opinion leaders. Most of the participants were outside of the nursing profession, including university faculty, insurance, corporate, health service executives, and government policy makers. The study specifically looked at nursing leadership and the roles and potential barriers to leadership in healthcare today (Khoury et al., 2011). Over 1500 opinion leaders completed the survey. "Opinion leaders viewed government (75%) and health insurance executives (56%) as the groups most likely to exert a great

deal of influence on health reform compared to nurses (14%)" (Khoury et al., 2011, p. 301). In contrast, leaders ranked nurses (51%) as influencing the quality of the healthcare system such as decreasing medical errors and improving patient safety (Khoury et al., 2011). This study identifies the role that nurses are comfortable with, working within the constraints of a health policy after it is developed, instead of helping develop the policy itself.

One of the key aspects of this study is the opinion leaders were asked to identify barriers to nurses having a voice in healthcare reform. One leader said, "the principal barrier to nurses having more influence and exerting more leadership include perception of their role as key decision makers when compared to physicians (69%)" (Khoury et al., 2011, p. 303). Additional items identified as major barriers for nurses' ability to contribute to health policy development included nurses lacking a unified voice to focus on key issues in health policy (56%), and the leaders felt there were a lack of opportunities for nurses in healthcare leadership roles (51%) (Khoury et al., 2011). The study also asked opinion leaders for suggestions on how nurses could take on more leadership positions to be more influential in healthcare. Responses to this question included that nurses needed to make their voices heard (15%) and have higher expectations/accountability (12%). The overall findings of the study indicate that despite the perception of influencing the safety of patients within the healthcare system, nurses are not viewed as influential to healthcare policy or as even having opportunities to become leaders in healthcare policy or leadership (Khoury et al., 2011).

Researchers suggest multiple reasons why nurses are under involved in health policy at any level. An overall social and political withdrawal from nurses can be tied to a

shift from population and prevention focus to individual outcome focused nursing, which

aligns more closely with the medical model (Carnegie & Kiger, 2009; Rains & Barton-

Kriese, 2001). Taft and Nanna (2008) postulated that the overall complexities of health

policy and the newness of its appearance in professional publications have led to an

underdeveloped relationship between nursing and health policy.

Stages of Political Development

One way that nurse educators can gauge where their own relationship with health

policy is through political development stages identified by Cohen et al., (1996). The

political development stages for nurses are based on the literature. These stages can

create a framework for a nurse to analyze her/his relationship with health policy

engagement. It can also work as a framework for nurse educators to gauge where student

engagement lies throughout a nursing curriculum. Cohen et al.'s (1996) article offers a

four stages of political development model. The four stages of political development are:

Stage 1 – buy in, Stage 2 – self-interest, Stage 3 – political sophistication and Stage 4 –

leading the way (Cohen et al., 1996). Progression through each stage indicates more

potential influence on developing and shaping health policy.

The four stages of political development were based on the current literature at

the time. The stages can also apply to the profession as a whole and on an individual or

professional organization level. Stage 1 – *buy in* is based on articles and books written on

health policy for nurses in the late 1970s and 80s. This stage is generally considered the

awakening stage. Nurses may have had their first political experience and begin to

understand the importance of political engagement (Cohen et al., 1996). Stage 2 – *self-*

interest is where nurses see political involvement as a professional goal and internalize

the importance of involvement. A key difference between Stage 1 and Stage 2 is the acknowledgement that nurses are a more influential force when resources from different self-interest groups of nurses come together in unified actions. In this stage, a nurse has joined a professional organization that supports the nurse's interests (Cohen et al., 1996; Kelly, 2007).

The remaining stages of Cohen et al.'s model include Stage 3 – *Political Sophistication* which recognizes the growth a nurse or nursing group makes through increasing political impact through more developed methods compared to the other two stages. In Stage 3, nurses develop connection and are part of the health policy leadership policy makers. Nursing language and political language are blended, which leads to a greater partnership and understanding of the nursing profession within the political atmosphere. In this stage the individual nurse is involved in committee work or board membership within a professional organization. The nurse recognizes the need for movement beyond self-interests for the overall health of the profession and public (Cohen et al., 1996; Kelly, 2007). Finally, Stage 4 – *Leading the Way*, involves nurse leaders developing the nursing political agenda with strategies detailing the path to further political development. This political strategy helps key issues take shape among nurses and policy makers. Individual nurses may serve as politically elected or appointed positions with in local, state or federal government or within professional organizations (Cohen et al., 1996; Kelly, 2007).

Unfortunately, little has changed in nursing's political development to bridge the gap from the profession to health policy engagement. Despite the growing body of nursing literature from the IOM, ANA and experts in health policy regarding the impact

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health policy has in shaping the profession and public health, nurses continue to remain disengaged (Kelly, 2007). To that end, in 2007, Kelly added *Apathy* as the first stage in Cohen et al., (1996) political development model. Kelly (2007) noted that a nurse who is not involved in any policy or political activities is in the apathy stage. These nurses are not part of any professional organization, and too often are not even registered to vote.

Barriers to Health Policy Engagement

In addition to an underdeveloped relationship with health policy engagement, other barriers persist for nurses. These barriers help to explain the general lack of interest in health policy including even basic policy engagement activities such as voting. Gardner (2012) noted that nurses have developed voter cynicism, the underlying belief that one vote does not make a difference, which is a sentiment that many Americans including nurses tout for being the reason not to vote. Other reasons that nurses have given for not voting include 1) scheduling conflict 2) unsure of whom to vote for in the election and 3) do not care about the election (Gardner, 2012). The view held by nurses mirrors the publics' current view of politics and the political breakdown along political party lines (Buerhaus et al., 2008). The nursing literature supports the previously discussed RWJF (Khoury et al., 2011) study where non-nursing leaders perceived that nurses have no common voice uniting the largest workforce in healthcare toward a common goal, resulting in a lack of influence within the political arena (Buerhaus et al., 2008; Gardner, 2012; Khoury et al., 2011). Therefore educators, through formal education, may be the bridge for nurses placing a high level of importance on health policy engagement at all levels of political influence, starting with voting.

While voting is an example of health policy engagemen,t on a personal level other engagement activities are also avoided by nurses. Nurses seem to avoid activities such as participation in rallies, personal financial investment in political candidates and professional nursing organization membership to engagement in political conversations. The literature suggests multiple reasons for this disconnect, including other commitments that take priority; general lack of interest, knowledge, and time and a lack of examples of beneficial policy change within the general political system (Holtrop, Price & Boardley, 2000; Manning & Grosso, 2011; Rains & Barton-Kriese, 2001; Short, 2008; Vanderhouter, Malakan, Kubsch, Block & Gallagher-Lepak, 2011).

Nursing is not alone in the lack of health policy engagement. The following study examines another health focused profession that also struggles to engage in health policy at all levels of engagement, from local to federal levels. The second study discussed in this section demonstrates quantitative research regarding barriers and perceptions that registered nurses express regarding health policy involvement.

Holtrop et al., (2000) conducted a quantitative study of health educators and their involvement in public policy. According to the American Association for Health Education (n.d.), health educators are professionals who specialize in promoting health education in a multitude of roles from K-12 education, community and public agencies, businesses and institutions of higher education. The sample included health educators, but specifically eliminated subjects who held other professional degrees such as nursing to capture only health educator's involvement in public policy. The study aimed to answer four research questions:

What are the level and type of public policy activities in which health educators are involved? What are health educators' perceptions regarding public policy involvement including barriers and benefits of involvement, perceived knowledge of how to go about changing public policy and interest in public policy issues? Is self-efficacy theory related to public policy involvement of health educators? What factors are predictive of health educators' involvement in public policy activities? (Holtrop et al., 2000, p. 2)

Data were collected via a mailed survey to 700 randomly selected health educators from the 1995 membership lists of "prominent health education organizations and the directory of Certified Health Education Specialists" (Holtrop et al., 2000, p. 3). A total of N=356 surveys were usable in the final data analysis. Subjects who did not complete the survey in its entirety, identified themselves as students or retirees, or did not identify health education as their primary professional role were eliminated from final data analysis. The final sample of health educators were mostly Caucasian (n = 306), female (n =280), and Master's (n=169) or doctorate prepared (n = 103), and employed at a college/university setting (n = 111), and the mean age of the subjects was 41 years old (Holtrop et al., 2000, p. 3).

Results were analyzed via SPSS software calculating demographic data results and utilizing linear regressions to calculate correlations between variables. There were statistically significant results between self-rated level of involvement and age (r =.20; p = <.001), employment setting (X^2 = 13.43; df =4; p = .01) and gender (X^2 =21.99; df =4; p = < .01). Older male health educators, who worked in a government setting were more likely to rate themselves as more involved in public policy (Holtrop et al., 2000). There

was a statistically significant relationship between self-rated level of involvement and barriers ($r =.23; p = .03$). Health educators identified multiple barriers to involvement including lack of time (69.4%), other priorities (43.3%) and frustration with the process (39%). Self-efficacy toward public policy involvement was measured using a Likert scale with 1 – 5 scale, with a higher score indicating greater self-efficacy. Subjects reported greatest self-efficacy in being able to vote ($M = 4.80; SD = 0.61$) and contacting a public official ($M = 3.71; SD = 1.12$) and reported less self-efficacy in providing technical assistance ($M = 3.63; SD 1.22$), organizing ($M = 3.41; SD = 1.2$), working on a campaign ($M = 3.36; SD = 1.32$), lobbying ($M = 2.81; SD 1.26$) and holding public office ($M = 2.42; SD 1.27$) (Holtrop et al., 2000, p. 8). A positive statistically significant relationship was found between self-efficacy and self-rated level of involvement ($r = .49; p < .001$). Finally, this study investigated health educators perceived knowledge, interest and exposure to public policy and found a positive relationship between perceived knowledge and interest and self-rated level of involvement ($r = .63; p < .001$) and ($r = .61; p < .001$), respectively (Holtrop et al., 2000). Health educators indicated that they had received at least some form of training on public policy involvement, with over half indicating they received the training at a conference (58.4%). This study illustrates that lack of policy involvement is not an issue isolated to the nursing profession. Additionally, it demonstrates that greater reported levels of involvement can increase self-reported political astuteness and self-efficacy.

Similarly, to Holtrop et al. (2000), Salvador's (2010) dissertation research looked at registered nurses' perceptions and practices related to health policy. The same tool was used in both studies. The tool was modified for this study by changing the term *health*

educator to *registered nurse* and the term *public policy* to *health policy*. The tool was piloted prior to the study and demonstrated consistent reliability with a Cronbach's alpha of .96; face validity was established by having three expert nurses in health policy look at the survey.

Researchers analyzed a sample size of 315 quantitative surveys. Similar to the sample in the Holtrop et al. (2000) study, the sample demographics were a majority Caucasian (87.9%) and female (91.9%), which is reflective of the national statistics of the registered nurse population. Much of the sample worked in the hospital setting (54.8%) (Salvador, 2010). The nurses within the study were asked to rate their level of participation in health policy as both a professional and citizen with a $1 - 5$ Likert scale. The higher the number a nurse reported, the more involved the nurse's health policy participation was. As a professional, nurses in the study rated their level of participation at just under 2 (M = 1.9; SD = 1.1) and as a citizen their involvement was just over 2 (M = 2.2; SD = 1.2). In both cases level of involvement was low. However, nurses rated their interest in influencing health policy on a $1 - 5$ Likert scale at just over 3 (M = 3.1; SD = 1.3) (Salvador, 2010). There was a statistically significant relationship between interest in influencing health policy as both a professional ($r = .58$, $p < .01$) and citizen ($r = .61$, $p < .01$), respectively. Unlike the study conducted by Holtrop et al., (2000) there was not a statistical significant relationship between level of involvement and gender ($p > .05$), level of education ($p > .05$) or employment setting ($p > .05$) (Salvador, 2010).

Similarly, to health educators, registered nurses rated lack of time (68.7%), other priorities (46.8%) and frustration with the process (45.5%) as barriers to involvement in health policy activities (Salvador, 2010). The nurses were also required to indicate how

many health policy activities they have participated in. Over half of the sample indicated they participated in one or no health policy activities (53%). The most frequently chosen activity was voting (60.1%) (Salvador, 2010, p. 57). There was a statistical significance correlation between self-rated level of involvement and the number of health policy activities they participated in ($r = .62$, $p < .01$) (Salvador, 2010, p.58). "There was also a statistically significant relationship between the total number of barriers identified and the number of health policy activities in which nurses participated ($r = .91$, $p < .001$)" (Salvador, 2010, p. 61).

The final piece of the study looked at self-efficacy toward being able to perform a list of 16 health policy activities. Nurses had to rate each of the 16 health policy activities on a five-point Likert scale that ranged from five, which indicated great confidence to perform the activity, to a score of a one, indicating little confidence to perform the activity. The total score range was $16 - 80$, with a lower score indicating less confidence and a higher score indicating more confidence in their abilities. The mean score for the nurse sample was just over 40 (M = 40.9, SD = 13.9) (Salvador, 2010). This score indicated a moderate to lower level of overall confidence among registered nurses to participate in health policy activities. Salvador's (2010) study demonstrated that registered nurses are not involved in health policy, but also that there is a level of interest to become involved in policy (M = 3.1). It is encouraging that the study revealed registered nurses who have a moderate interest to become involved in health policy, as that could be an area of internal motivation for nurses. However, nurses are not currently participating in health policy activities, and they are only moderately confident to participate in health policy activities. The missing piece between interest and

involvement may be formal education. A student nurse who participates in health policy activities in nursing school may be more likely to engage in policy activities as a nurse after graduation. It may be that educators can provide opportunities for student nurses to learn about the policy process, watch the policy process in action and participate in the policy process in practice and make a student nurse become a politically involved nurse in the profession. The key to this learning process is a nurse educator who is politically astute and has political self-efficacy.

Recognizing Nursing Strengths for Health Policy Engagement

The current recommendations for teaching health policy to nurses requires a greater understanding of the political process overall. Educators must teach knowledge and application of the skills needed to participate in policy making. Nurses possess many key qualities needed to participate with policy makers; however, it seems that nurses do not recognize the transferability of these skills. Boswell et al., (2005) specifically pulled out key skills documented in the literature that nurses possess such as "excellent negotiators, communicators, problem solvers and team players" (p. 7). Nurses also routinely, "manage challenging personalities, neutralize potentially unstable circumstances, and manage conflicts" (Boswell et al., 2005, p. 7). They use these skills daily with interdisciplinary health care providers, patients, and patients' family members.

Woodward, Smart and Benavides-Vaello (2016) completed a review of the literature to determine the modifiable factors that support nurses' political participation. Woodward et al. (2016) reviewed and 32 articles, and three themes from the literature emerged. The themes included, "a) integration of political education in the nursing curriculum, b) value of active psychological engagement including personal interest in

political knowledge and information and c) value of membership in a professional nursing organization" (Woodward et al., 2016, p. 56). The literature supports increased opportunities for student nurses to interact with civic leaders such as state and federal legislators as well as local leaders increases the applicability of the theoretical concepts taught in nursing school. Nurse educators should foster these relationships and demonstrate civic leadership themselves. Another modifiable factor is fostering psychological engagement. Nurses should be encouraged to find areas that they are passionate about and work on health policy campaigns that address that interest. This theme connects with the internal motivation aspect of Bandura's SCT to promote behavior change and learning. The final modifiable theme from the literature encourages participation in professional nursing organizations. Increasing nurses' collective voice in health policy discussion has demonstrated positive results from both the professional and at an individual level (Woodward et al., 2016).

Primomo and Bjorling's (2013) mixed methods study exemplified the changes in political astuteness for nurses who participated in a professional state nurses' association sponsored legislative day. Two groups of registered nurses were sampled during the experience in consecutive years. The first group in the study included registered nurses and nursing students (n = 80) who completed the Political Astuteness Inventory (PAI) at the beginning of the 2008 Washington State Nurses Association's (WSNA) legislative day.

The PAI is a set of 40-items that requires a yes or no response. A yes response indicates that the prompt is something the participant is aware of or participates in. Examples of items on the PAI include *I am registered to vote*, *I know how to contact the*

lobbyist [of a professional nursing organization] and *I attend public hearing related to health issues*. A yes response is scored with a one and a no response is scored with a zero, and the total score for the tool ranges between 0 – 40. A higher score equates to greater political astuteness.

Respondents were asked to answer the PAI based on how they perceived their political astuteness prior to the legislative day experience. Participants submitted their email addresses and a follow up PAI survey was sent to the participants after the legislative day experience. In the second group, participants (n = 34) were contacted prior to the 2009 WSNA legislative day event, completed the survey based on their current political astuteness and then completed the PAI again at the end of the legislative day experience.

A paired t-test using data from part one and part two of the study revealed a statistically significant difference in political astuteness: group one's pre-legislative experience (M = 16.6; SD = 9.8); and group one's post-legislative experience (M = 26.7; SD = 6.7); (t = 12.8, df = 79, p = .000); group two's pre-legislative experience (M = 19.3; SD = 10.5); and group two's post-legislative experience (M = 26.7; SD = 8.1); (t = 6.5, df = 33, p = .000) (Primomo & Bjorling, 2013). The results support the positive effect that education has on health policy and can have on political astuteness. There was also a positive relationship associated with political astuteness in both groups before and after the experience for both age and educational rank. There were additional open-ended questions for participants to answer to gain a better understanding of the experience. The overwhelming response from the participants were an increased knowledge of current legislative initiatives that impact health care. One participant stated, "I was not aware of

current issues before legislative day. It helped shed light on what concerns nurses have in the workforce today" (Primomo & Bjorling, 2013, p. 103). This study reveals the transformative impact on health policy engagement a professional nurses association connection can have on registered nurses and students alike.

Nurse educators teach communication and negotiation skills, as well as advocacy, attentiveness, empathy and active listening throughout nursing school curriculum (Boswell et al., 2005; Woodward, et al., 2016). However, the focus is consistently on navigating the health care landscape from day to day. Nurse educators also feel confident as role models of these skills for their nursing students. These are key skills needed to participate in health policy discussions and should be modeled to students in both patient advocacy and health policy content.

Summary

Despite the numerous professional and academic organizations that state health policy involvement is essential to the nursing profession, nurse remain disengaged (AACN, 2017; ANA, 2015). Worse yet, health care executives completely overlook nursing as an impactful force within health care organizations policy creation as evidenced by the results of the Robert Wood Johnson study. Moreover, nurses do not perceive themselves an impactful force in health policy development. Adding to the problem, other health educators are also staying out of health policy activities. Both health educators and registered nurses listed similar barriers to health policy involvement including lack of time, other priorities and confusion in the process (Holtrop et al., 2000; Salvador, 2010). It appears nurses and other health care providers are complacent by

allowing health policy creation by others, rather than by the workforce that is working day after day within the healthcare system.

Cohen et al. (1996) developed four stages of political development for nurses. However, based on the results of the two quantitative studies (Holtrop et al., 2000; Salvador, 2010) discussed within this section, it appears nurses and other health educators remain in the added category by Kelly (2007) at a level of apathy toward health policy engagement, as many nurses and health educators are not participating in health policy activities, but Salvador's (2010), study indicated there is an interest in participating in health policy. The nursing profession has several strengths, as highlighted through Woodward, et al.'s (2016) review of the literature, that can be applied to health policy engagement. Primomo & Bjorling's (2013) study demonstrates how formal education through a professional nursing organizations legislative day event improves nurses' self-reported political astuteness.

Gaps in the Literature

An analysis of the current research regarding health policy engagement in clinical practice reveals a paucity of data. The two quantitative studies have not been replicated. Repeating these studies with a larger sample size could assess the current state of health policy engagement among health care providers and nurse educators. These studies were national studies, which speaks to the breath of the disengagement.

Therefore, studies looking at different regions of America could reveal areas where health policy engagement is stronger compared to the national average. These regions may be utilizing teaching techniques, or professional development strategies that assist nursing students and professional nurses to integrate health policy engagement

more effectively than other regions. The Robert Wood Johnson Foundation 2009 study indicated that health care leaders perceive a lack of opportunities for nurses to become involved in leadership and policy influencing positions (Khoury et al., 2011). Consequently, a national study investigating healthcare systems organizational design may be beneficial to look at additional root causes of the health policy engagement issue beyond education. Additionally, qualitative research to discover the "why" behind registered nurses' perceptions could provide further insight into why nurses are disengaged, or why a nurse is engaged in health policy.

Bridging the Gap between Education and Practice in Health Policy

Registered nurses identified barriers to health policy engagement as lack of time and commitments to other priorities. These can be difficult to address in a formal educational setting. However, educators can bridge the gap between education and practice by addressing lack of political interest, political astuteness, and giving examples of the system working in a positive way. To be effective models, nurse educators must possess political astuteness and political self-confidence in order to teach these concepts to students in a meaningful way that will produce action in a student's professional career. The following studies look at the disconnect that continues for registered nurses to engage in health policy. Much of the disconnect can be tied back to the formal educational environment and perception formed in nursing school.

Vanderhouter et al., (2011) studied nurses (N = 468) from four health care institutions and four educational institutions and investigated the most impactful variables on political participation. Variables studied were resources (time, money, civic skills), psychological engagement (political efficacy, political information/knowledge, nursing

education influences), and recruitment networks (Vanderhouter et al, 2011). Researchers

utilized a questionnaire based on the Civic Volunteerism Model (CVM). Items from the

Political Participation Survey, Political Astuteness Inventory and knowledge questions

based on the Intercollegiate Studies Institute (ISI) Civic Literacy test as well as

demographic items were used in the study. The sample nurses' education levels consisted

of 48% associate degree, 42%, baccalaureate degree, and 10% masters' degree.

Correlations drawn between political participation and resources, psychological

engagement and recruitment networks indicated that psychological engagement was the

strongest factor to political participation ($r =.67, p < .01$) (Vanderhouter et al., 2011).

Specifically, within psychological engagement variables were personal interest ($r = .62, p

< .01$), political efficacy ($r = .59, p < .01$), time/money ($r = .50, p < .01$), civic skills ($r

=.47, p < .01$) and family influences ($r = .32$). These findings support a literature

reviewed by Brown (1996) that postulated that early introduction of political participation

from family can influence the view a child has on the political system which can then be

refined throughout early adulthood. Nursing educational influences on political

participation had a weaker correlation but still statistically significant at ($r = .25, p < .01$)

(Vanderhouter et al., 2011).

Additionally, researchers found the subjects reported that their nursing courses

had minimal to no content on the political process (73%) and did not prepare them for

political participation (80%) (Vanderhouter et al., 2011). Finally, the study indicated that

there was no relationship between nurses' political participation and nursing courses

having content, discussion or activities related to the political process ($X^2 = 5.31, df = 4,

p = .257$). In contrast, there was a significant relationship that exists between nurses'

political participation and the feeling that nursing courses did prepare them for political participation ($X^2 = 11.33$, $df = 4$, $p = .023$) (Vanderhouter et al., 2011). This study serves as a call to action for nurse educators demonstrating a clear gap in curriculum content and application to policy participation in practice.

However, even when health policy content is taught in nursing school are nursing students recognizing the actions as health policy engagement? Rains and Barton-Kriese (2001) conducted a qualitative study of nine senior level nursing students and eight senior level political science students. The aim of the study was to assess the perceptions of public policy engagement between these two groups of students. Both groups of students were one to three months away from graduating and entering professional practice.

The contrast between the political science students and the nursing students' perceptions of public policy engagement highlight the disconnect of course content and application for nurse educators. Students in the study were asked, "what are your views on public policy?" (Rains & Barton-Kriese, 2001, p. 222). Nursing students viewed public policy as a restriction on practice. One nursing student described policy as, "guidelines that tell me what I can and cannot do" (Rains & Barton-Kriese, 2001, p. 222). Nursing students also saw policy development as something that others do, not something they need to participate in as a nurse. Interestingly, nursing students described examples of social actions that they participated in during community health rotations but did not recognize these actions as political or policy shaping actions (Rains & Barton-Kriese, 2001).

In contrast the political science students viewed public policy in a more favorable light. The students described, "public policy as the workings of democracy in action"

(Rains & Barton-Kriese, 2001, p. 222). When asked, "What are the sources upon which you base your opinions?", nursing students cited the perspective of the clients they work with, and meeting the needs of the population, in contrast political science students cited the media, community colleagues, and professional data sources as to where they based their opinions (Rains & Barton-Kriese, 2001, p. 222). One political science student summarized his answer by stating, "Knowledge is the most important aspect of policy." (Rains & Barton-Kriese, 2001, p. 222).

For nurse educators, the most telling responses from nursing students about the lack of connection students are making to policy into practice came with the responses to the question, "What ways do you exhibit democratic actions?" (Rains & Barton-Kriese, 2001, p. 222). Nursing students gave examples of advocating for clients in a multitude of ways during their nursing school experience, from testimonies in front of school boards advocating for children with disabilities to participating in committee work to start a nonfood pantry for HIV-affected families which resulted in an institutional policy. However, the nursing students did not correlate these actions to political change (Rains & Barton-Kriese, 2001). Whereas the political students could articulate ways to exhibit democratic actions but did not have examples in which they had actively participated in during their school experience. Given the response differences in this one school studied, nurse educators may not be using health policy language such as "health policy advocacy" and "political participation"; therefore, nursing students are categorizing actions as public health nursing or community health nursing skills and thereby not feeling empowered that the actions they took in front of school boards and committee work all influence health policy. The political science students indicated that the key to

policy is knowledge but a lack of political astuteness in these students, may have caused

them to distance themselves from their role as health policy advocates. Nurse educators

must continue to work to bridge that knowledge gap, by acknowledging the role that

nursing plays in health policy engagement.

Rains and Barton-Kriese's (2001) study highlights the disconnect that remains for

many nursing students that nurse educators can fix. Students are not making the

connections between the actions that nurses participate in and how these events can

directly impact policy. Vanderhouter et al.'s (2011) study demonstrated that nurses are

not connecting content learned in nursing school to policy engagement, as evidenced by

nurses stating they had little to no formal health policy education in school. However, the

Rains and Barton-Kriese (2001) study illustrates that students are participating in

activities to influence policy, but students do not recognize these actions as such. These

two studies highlight the need for nurse educators to understand and stress that nursing

actions can influence more than the individual client; therefore, helping students connect

those actions to impact a larger population through policy participation.

Nurse educators must have political astuteness and political efficacy to understand

that individual nurse advocacy can translate into policy engagement. Therefore, the

content within nursing curricula must teach health policy in an applicable manner. Also,

nurse educators need to serve as role models, so students can see the transference of

individual nursing actions into larger policy action.

A mixed method study by Staebler et al. (2017) of 596 nurse educators, found that

36% of nurse educators surveyed reported having any experience in policy work at any

level from local to international and only 21% reported active involvement in current

policy work. Although, 54% of the respondents reported integration of policy education across "their plans of study" (Staebler et al., 2017, p. 3). Educators active involvement in political advocacy remained low at 44.3%, but advocacy concepts were taught by 86.2% of the faculty sample (Staebler et al., 2017). In this study participants also responded to open- ended questions.

The open-ended responses highlighted many barriers that face nurse educators, which parallel the barriers that registered nurses describe in Salvador's (2010) study. Time constraints and other priorities were highlighted through statements such as, "[It's] hard to find a place for it within the curriculum" (Staebler et al., 2017, p. 4).   At the institutional level, there is often little incentive or importance placed on advocacy or political activism compared to research, scholarship, teaching and service. Additional barriers noted by faculty were lack of interest and knowledge as well as a lack of engagement from students. Notable quotes within the study includes "Much of the time the faculty have little 'real' policy experience…" and "Students do not always see relevance to nursing in large part because few faculty are politically active" (Staebler et al., 2017, p.4).

A barrier that is unique to current nurse educators compared to nursing students and recent nursing school graduates are the health policy expectations. The health policy content for current graduates is more complex compared to what the health policy expectations were for current nurse educators when they attended nursing school. As a result, "faculty expect more from students than they do themselves" (Staebler et al., 2017, p. 5). In 1986, when the first guidelines for professional nursing were released by the AACN, baccalaureate student nurses were expected to have knowledge of the political

process. The expectations for current students are much higher than the faculty's educational expectations. Therefore, nurse educators may struggle to participate in health policy as well, with few models to demonstrate how to engage in health policy.

In slight contrast to research by Staebler et al. (2017), Buck-McFadyen and MacDonnell (2017) completed a qualitative study in Canada including both nurse educators and nursing students. The aim of the research was to answer three questions: (1) "How do nursing educators and nursing students understand activism? (2) What are barriers and facilitators to teaching about political activism in nursing? and (3) How do nursing educators foster activism among their students?" (Buck-McFadyen & MacDonnell, 2017, p 2). Twenty-six participants including nurse educators (n = 13) and nursing students (n = 13) agreed to take part in the study. Nine educators and nine students took part in individual interviews. While four educators and five students took part in focus group interviews. Within the focus group interviews participants, three separate focus groups were established based on experience and education level. The educators were part of one focus group, three undergraduate students compiled another focus group, while the remaining two graduate students were in the third focus group (Buck-McFadyen & MacDonnell, 2017). Three themes emerged as a result of all the interviews: "1) Changing landscape for nursing practice, 2) drawing a line in the sand, and 3) inspiring nursing activism in education" (Buck-McFadyen & MacDonnell, 2017, p. 3).

The first theme was derived from the increase pressures that nurses face at the bedside. Nurses constantly feel the need to do more customer service type activities with tight budgetary constraints. One participant noted, "It's terrible on the floor…the way

people are understaffed" (Buck-McFadyen & MacDonnell, 2017, p. 4). Another educator noted that the "practice environment provided 'no shortage of issues' around which to speak up and organize" (Buck-McFadyen & MacDonnell, 2017, p.4). One educator even noted the shift to evidenced based practice by stating, "Have we shifted our focus away from being advocates to being professionals who practice best practices?" (Buck-McFadyen & MacDonnell, 2017, p. 5). Another educator noted that in nursing education, "It's getting more difficult to teach political action" (Buck-McFadyen & MacDonnell, 2017, p.5). The difficulty for the educator in this case was where to fit it into the curriculum because there was such a focus on acute care and care of the body, that finding time to teach how to build relationships that are essential to participate in health policy advocacy was much more difficult. These sentiments are strikingly similar to the results found by Staebler et al. (2017).

The second theme addressed was drawing a line in the sand. Both educators and students reflected on how they understood their role as an activist, as well as explaining the nature of their nursing activism in practice (Buck-McFadyen & MacDonnell, 2017). The students overwhelming describe activism as a positive opportunity to "make a difference in the world" (Buck-McFadyen & MacDonnell, 2017, p.6). The students could identify key faculty members who inspired their activism attitudes. These reflection contrast Rains and Barton-Kriese's (2001) findings comparing senior nursing students to senior political science students. Nursing students in the Rains and Barton-Kriese (2001) study described public policy as constraining and stated that policy development was something other people do. Staebler et al., (2017) students' responses also contrasted the Vanderhouter et al., (2011) study where registered nurses did not remember any health

policy content within their formal nursing education and thereby did not have a role model that they could identify, because they did not have a memory of even learning the content.

The final theme addressed inspiring activism in nursing education. Students and educators agreed that mentors within nursing, including educators "could foster political socialization and inspire political action in students" (Buck-McFadyen & MacDonnell, 2017, p. 7). There was also an agreed sentiment that political action concepts should be integrated throughout nursing curriculum. Additionally, it is important to relate political action to everyday work of nurses. One educator stated, "Political action has to be threaded in the same way that safety and leadership need to be threaded through a curriculum" (Buck-McFadyen & MacDonnell, 2017, p. 8). Interestingly these are recommendations that were made in 1994 by Thomas and Shelton, in their article reflecting on a teaching strategy integrating public policy in one community health course. Thomas and Shelton (1994), recognized that integrating policy content in one course limits the exposure and perspective that a student has on health policy. Therefore, after completing the community health public policy course exercise for one nursing Cohort the decision was made by the department of nursing within the university to integrate policy content across the curriculum. Thereby, increasing the amount of times and exposure to health policy through different teaching styles and goals, which could increase nursing students understanding. As a nursing student develops a deeper understanding of all the ways a nurse can participate in health policy, it may increase the likelihood that the student carries the content over into practice.

Overall the results of this study highlight the importance of practicing nurses to have health policy knowledge and self-efficacy to effectively recognize and engage in health policy. Both nursing students and educators recognized the changing landscape of nursing but expressed feelings of powerlessness to change the landscape of health care for the nursing profession. These feelings of powerlessness parallel the barriers identified in previous studies especially exemplifying "the frustration with the process" (Holtrop et al., 2000; Salvador, 2010). However, it also appears the undergraduate students had a positive view of the possibilities accompanying political action. Both educators and students agreed that proper mentorship, especially from educators, can create lasting impacts on political action in the nursing profession.

In America, the current guidelines for health policy education for BSN nursing students are contained in AACN's (2008) established *Essentials of Baccalaureate Education for Professional Nursing Practice*. The document outlines specific content areas that are recommended in all baccalaureate nursing programs. Article V concentrates on, "Healthcare policy, Finances, and Regulatory Environments" (AACN, 2008, p. 21). The AACN calls for nurse educators to prepare BSN graduate nurses to understand 1) the basics of healthcare policy including national, state and local healthcare policies and the impact on the nursing profession, 2) the implications of policy on access to care, equality as well as affordability, and 3) how to engage in the legislative process through grassroots political activism to influence healthcare policy (AACN, 2008, p. 21). The expectations for students are a clear understanding of and ability to participate in health policy as a professional nurse. Therefore, health policy engagement requires well-versed

educators to teach and demonstrate many aspects of health policy as outlined in *The Essentials.*

Summary

Nurse educators are expected to formally and informally teach health care policy content to nursing students. As an educator, students' perceptions of the role of the professional nurse can be molded through the student's education. Nurse educators not only need to teach the content, but they must also role model advocacy to assist students' internalization of the value of health policy engagement, within the profession. To role model health policy engagement nurse educators must possess and actively participate in health policy from advocacy to creation. Educators must also actively engage their students in health policy.

Current research and literature consistently highlights the shortcoming of nurses in health policy engagement in all capacities. Multiple professional nursing and health care focused organizations call for nurses to participate in health policy. The AACN began including health policy education in the Baccalaureate *Essentials* in 1986 and has increased the expectations of health policy education with each revision. However, throughout the years the literature demonstrates that health policy is outside of students' and educators' comfort zone. Educators are teaching nursing students the skills necessary for health policy engagement, but those skills are presented as patient advocacy skills. Nurse educators most be adept at recognizing how these skills also apply to health policy engagement. By teaching and demonstrating political astuteness and building political self-efficacy, nurse educators can teach baccalaureate nursing students how health policy engagement applies to professional nursing practice.

Gaps in the Literature

The research and literature addressing the call for health policy engagement focuses on student learning outcomes. Current nurses continue to avoid health policy engagement and Staebler et al.'s, (2017) research, although having a small sample size, demonstrates that many nurse educators are disengaged in health policy. Therefore, research into why this disengagement persists for nurse educators could allow for greater insight into another root cause of the issue. When nurse educators are disinterested in health policy engagement or lack a sufficient knowledge base on the topic it becomes clearer why the problem persists. More research focused on nurse educators specifically is needed in the nursing literature. Quantitative studies with larger sample sizes may help to get a true idea of the scope of nurse educators' involvement in health policy. The first contact many nursing students have with health policy content should be in nursing school. That places the nurse educator in the prime role of influencing behaviors, during a formal education experience, that could impact a student nurse's professional career and outlook regarding health care policy engagement.

Current Teaching Strategies for Health Policy Engagement

The preceding sections discussed health policy engagement in nursing practice and the gaps between nursing practice and education of health policy. Research and anecdotal experiences from educators have explored the teaching strategies used within nursing and other health care education setting. Educational studies regarding experiences in health policy education are minimal but are present throughout the nursing literature at both the undergraduate and graduate level. These studies demonstrate ways

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that educators integrate health policy content into the classroom. The evolution of teaching health policy content is evident in the literature.

Two of the earliest anecdotal articles discussing strategies for educators to teach health policy to undergraduate students suggested integrating health policy content across the curriculum (Brown, 1996; Thomas & Shelton, 1994). Brown (1996) highlighted the use of the Political Socialization Theory, which is the process of developing the "norms, attitudes, values and belief of politics in general and of one's own political system" (p. 120). Brown (1996) stressed the importance of integrating health policy content in all areas of the curriculum and not just teaching the content in one nursing course. This advice is not always followed, as many nursing programs continue to teach health policy in a leadership course rather than threading it throughout the curriculum. For student nurses to understand norms, attitudes, values and beliefs of health policy, students must be introduced to it more than once in their nursing education. Thomas and Shelton (1994) echo the sentiment that nurses across all clinical settings must be educated to analyze existing health policy and have the framework in place to challenge the status quo and empower nurses to engage in the policy arena at the institution, local, state, federal and global level. Health policy content across the curriculum was also supported by the previously discussed Buck-McFayden and MacDonnell's (2017) qualitative Canadian study with nurse educators and nursing students. One educator in the 2017 study noted specifically that health policy content must be spread throughout the curriculum in order to inspire activism.

The recommendation to teach health policy across the curriculum requires that all nurse educators have a basic understanding and level of comfort teaching content from a

health policy perspective. Staebler et al. (2017) reported that 46% of nurse educators surveyed identified a "lack of faculty experience" as a reason why students are not influential in health policy. Thirty one percent of the faculty surveyed indicated a "lack of faculty engagement" as another key reason (p. 4). A nurse educator uncomfortable with integrating health policy into course content is an obstacle for nursing programs. Curricula seems to continue to isolate health policy content into one or two courses rather than across the curriculum. However, spreading health policy content across the curriculum instead of focused in one or two courses allows more opportunity to develop knowledge in health policy. Due to the large amount of content to be covered in nursing leadership courses at the baccalaureate level, limited time is placed on teaching health policy content. "The nursing profession cannot rely on random experiences to develop nurse leaders who are adept in both policy and service areas" (Short, 2008, p. 266).

Nevertheless, even under the constraints of keeping health policy content in a few courses, some educators have reported changes in students' perceptions and knowledge toward health policy. Educators have touted successful education of students through a myriad of learning experiences. In the literature, different methods have been utilized to gather information from students engaged in an advocacy focused learning experience. These teaching strategies are single site examples and are often reported in the literature by the educators who taught the class where the health policy experience occurred. These experiences have been disseminated through both qualitative and anecdotal analysis as well as in more formal quantitative analysis.

Anecdotal Exemplar Teaching Strategies

In 2001, Faulk and Morris engaged RN-BSN students in reflective learning activity, which could be a potential catalyst to enable nurses to become personally invested in the political process. Educators informally surveyed students at one school of nursing after teaching health policy content and completion of assigned readings. Students' self-evaluated using the Political Astuteness Inventory to assess political knowledge and then reflected on where they felt they were in terms of political development, based on Cohen et al., (1996) Political Development Stages.

The reflective learning activity required students to assess their political knowledge and then their level of political development based on Cohen et al. (1996) model. Most students placed themselves at *Stage 1 – Buy In*. Students indicated that the self-assessment and reflection on their political development heightened their awareness of political involvement. One student admitted that prior to the self-assessment he was, "content with trudging along and letting others help to improve nursing in general" (Faulk & Morris, 2001, p. 220). The initial sentiments expressed by the student are mirrored in the Rains and Barton-Kriese (2001) interviews with nursing students and political science students whom were one to three months away from graduating. In Rains and Barton-Kriese's (2001) study, "Nursing students viewed politics as something other people do" (p. 222). While Faulk and Morris's (2001) students appeared to be aware of their flawed thinking after the reflective activity, it is reasonable to assume that the nursing students who participated in the Rains and Barton-Kriese (2001) study graduated and entered the profession with a persistent disconnected view of the role that nurses have in health policy engagement.

In 2009, Zauderer et al., took 64 senior nursing students to the *Lobby Day* event sponsored by the New York Nurses Association. The students were divided into groups before the legislative experience. Each student group analyzed a specific healthcare bill currently in the New York Legislative session. Part of the assignment for each group was to identify key points in the bill, research the stakeholders, and formulate key talking points to advocate for the bill to their legislators at the event. At the *Lobby Day* event, student groups met with their legislators to discuss the talking points in the bill. The experience became a transformative occurrence for the students. They expressed a deeper understanding of the political process and nurses' role within that process. One student stated, "I now understand why nurses should take part in political issues that affect the profession. It is a professional responsibility to be aware of issues that affect nursing" (Zauderer et al., 2009, p. 7). The students gained a greater understanding and sense of empowerment. The students actively participated in lobbying legislators. Through this action the students recognized why nurses' voices need to be part of the policy making environment, so legislators have a full picture of the impact legislation can make for patients and the community at large.

Similar experiences of transformational change occurred for students who participated in a community advocacy campaign to get fluoride in the public water system (Wold, Brown, Chastain, Griffis, & Wingate, 2008). Undergraduate RN-BSN students completed a needs assessment in a community health course and identified the community need. The students identified and contacted community and government stakeholders. As students received positive responses to their requests the students became more invested in the cause and began to realize, "the impossible could be

achieved, their own hope for successful change in this community flourished" (Wold et al., 2008, p. 174). Ultimately, the students presented their policy idea to the county board of commissioners, but the policy was not implemented. Despite the outcome, the students felt empowered to have made a difference by raising the issue, finding their voice and being heard (Wold et al., 2008).

In these examples, nurse educators guided the students on their health policy engagement journey through the active learning strategies. The students presented their own ideas after assessing legislative bills (Zauderer et al., 2009) and community stakeholder needs (Wold et al., 2008) for the respective issues. Educators supported the students through the process. In both examples, students were exposed to experiences outside of their comfort zone, but ultimately increased their self-efficacy and developed a sense of empowerment (Wold et al., 2008; Zauderer et al., 2009). Active participation in health policy allowed students to walk through the process of advocacy with the support of educators and peers. Ultimately, these activities removed the mystery that so often surrounds health policy advocacy. The questions remain; however, are these isolated examples of advocacy or will these nursing students take these experiences into the professional nursing world and continue to view issues through a health policy lens? Did the educators provide them with a solid foundation in health policy to transition their experiences into nursing practice? Will these students become nurse advocates in practice, or will this activity be a random experience that receives no further action or interest from the graduate student nurse?

Further attempts to engage students in health policy include nurse educators facilitating student development of policies based on current initiatives and community

assessments. The 1998 and 2008 *Essentials* documents guide faculty to have students "participate in health policy", "understand how to participate in the legislative process through grassroots political activism to influence healthcare policy", and "discuss the implications of policy on access to care, equality as well as affordability" (AACN, 1998, p. 15; AACN, 2008, p. 21). Policy focused learning activities engage students in grassroots efforts. In the literature, at the baccalaureate level, educators document examples of investigating current policies or issues, and going through the process of creating new policy in class (Logan, Pauling & Franzen, 2011; Nannini, 2009; O'Neill, 2016).

In the example described by Logan, Pauling and Franzen (2011) students used the four phase Grand View Critical Analysis Model. Within this model, students choose a specific policy either at a professional nursing organization level, public policy level, or institution/organizational policy level. The student then had to identify and collect opinions and data from colleagues and stakeholders who had a vested interest in the policy. Students had to analyze current evidenced-based research pertaining to the policy and concepts within the policy. Finally, students analyzed all the information from the vested stakeholders and the evidence from the literature to create a new policy and present the process to the class (Logan et al., 2011). Similarly, Nannin (2009) and O'Neill (2016) guided students through policy analysis by allowing students to choose a policy to analyze, collaborate with vested stakeholders, evaluate the current research and critique the policy. Students and faculty in all three examples in the literature expressed a greater understanding of policy evaluation and development after completion of the activities (Logan et al., 2011; Nannini, 2009; O'Neill, 2016).

Quantitative Analyzed Teaching Strategies

Anecdotal exemplars, such as in the aforementioned examples, deliver a glimpse into the impact that educators teaching strategies could make on student nurses. However, there are inherent limitations because the examples are not formal research studies and were all described by the nurse educators facilitating the teaching strategy. However, quantitative and qualitative studies provide greater insight into the changes in students' attitudes and understanding after a teaching strategy is implemented. One assessment tool that has been briefly described earlier in this chapter is the Political Astuteness Inventory (PAI). In 1981 Philip Clark developed the PAI to assess political knowledge, skills and attitudes (Primomo, 2007). The tool consists of 40 yes or no questions. An answer of a yes is worth one point and scores tallied for a final score range between 0 – 40. The lower the score the less political astute the test taker. The following two research studies provide examples of before and after, teaching strategy implementation, assessment with the PAI at the undergraduate and graduate level.

Byrd et al., (2012) sampled undergraduate nursing students (N = 300) in one school of nursing in a public/community health course from spring 2008 to spring of 2011. In a separate but similar study, Primomo (2007) sampled graduate nursing students (N = 40) before and after taking a 10-week graduate level health policy course in one school of nursing (Primomo, 2007). For both studies the PAI was administered as a pre-test on the first day of the course to collect baseline information on the students' current political astuteness and again on the last day of the course. In both studies, educators integrated a legislative letter writing assignment, analysis of current healthcare legislation, guest lectures, and a field trip to the state capital to witness legislators at work

(Byrd et al., 2012; Primomo, 2007). Despite the difference in educational level, the activities presented to the students at separate schools of nursing were remarkably similar, presumably the expectations for graduate nurses required a higher level of application compared to the undergraduate nursing students.

The activities produced comparable results between the two groups of students. Prior to participating in the course activities, the undergraduate nursing students (M = 10.5; SD = 5.5) compared to after participating in the course with a (M = 23.1; SD 5.7; p = .000), indicating the learning activities increased political astuteness for the undergraduate nursing students (Byrd et al., 2012). The graduate students pre-course results indicated eight of the 40 students scored less than nine initially on the PAI tool and 26 students scored between 10 – 19 indicating slight awareness of political implications. After participating in the 10-week graduate health policy course, no students scored under nine. Nine students scored between 10 – 19 and 24 students scored between 20 – 29 indicating the beginning of being politically astute. The first class (M = 13.6; SD = 5.2); last class (M = 23.1; SD = 5.8) and a paired t test revealed (t = -16.2, df = 39, p = .000), also indicating that the learning activities increased political astuteness (Primomo, 2007).

The results of these two studies indicate that nurse educators who integrate active learning strategies into a course can increase the students' level of political astuteness. A political astute student is more knowledgeable regarding political practice. The PAI is a self-assessment tool, which presents a limitation because the students may answer yes in an attempt to please the educator teaching the course. Additionally, having an increased political astuteness does not necessarily mean that the student will more actively

participate in health policy engagement in professional practice. However, it is promising that educators through active learning experiences can demonstrate an impact on the overall knowledge, skills and attitudes for the students.

Anecdotal Graduate Education Teaching Strategies – Health Policy Simulations and Fellowships

Baccalaureate nursing education should lay a strong foundation in health policy to prepare graduate nursing students for a more prominent health policy role. However, educators are using similar teaching strategies at the graduate level and within medical education. Since similar teaching techniques are illustrated in the literature, even though the expectations for the students are higher to meet the MSN and DNP *Essentials* expectations and medical school accreditation expectations. Educators highlight active learning strategies for masters and doctorate nursing students through simulation and fellowships (Crowder, 2016; Greysen, Wassermann, & Payne, 2009; Manning & Grosso, 2011).

Crowder (2016) created a simulation experience by having mock interview sessions between students. Masters, PhD, and DNP students in one course interviewed each other on aspects of the Affordable Care Act. Students were evaluated both on understanding of the Affordable Care Act and on their ability to present the material to the public. Another teaching strategy example found in the literature, for advanced practice registered nurses (APRN) in a DNP program and medical students, was participation in courses and fellowships dedicated to health policy. In separate teaching strategy examples, DNP nursing students and medical students partook in education sessions with policy experts and lobbied legislators on specific health care bills as

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culminating course and fellowship activities (Greysen, Wassermann, & Payne, 2009;

Manning & Grosso, 2011). The DNP APRNs completed a 15-week health policy focused

course health policy, throughout the course policy experts presented information and a

day was spent on Capitol Hill engaging with legislators regarding advanced practice

issues (Manning & Grosso, 2011). Medical students participated in 3-month health policy

fellowships. The students also were taught by policy experts and engaged with national

and global health care organizations to address policy issues. One important advantage

for the medical student's fellowship was the location at Georgetown University, which is

logistically close to many policy making entities including Capitol Hill (Greysen et al.,

2009).

     VanHoover (2015), in a distance-learning course assigned nurse midwife students

to follow a health care bill. Students had to choose a bill, research the origin of the bill,

engage with groups that supported or opposed the bill, develop advocacy strategies from

speaking with a legislator and write opinion editorials on the bills content. The course

culminated with students presenting findings and evaluating the advocacy process. In all

the aforementioned examples both graduate nursing and medical students initially voiced

uncertainty and feelings of being pushed outside of their comfort zone. However, after

the experiences students expressed more confidence in the legislative process and their

role as a health policy advocate (Crowder, 2016; Greysen et al., 2009; Manning &

Grosso, 2011; VanHoover, 2015).

Summary

     Within this section undergraduate teaching strategies were presented that actively

engage the student, increasing the student's political astuteness and self-efficacy.

Educators who push students outside of their comfort zone into policy engagement activities report positive results. Often educators themselves reported reservations to the exercises, but a greater self-efficacy toward the process post teaching strategy implementation emerged. Passive reflection and active learning strategies all produced positive experiences for students in the literature (Byrd et al., 2012; Logan et al., 2011; Nannini, 2009; O'Neill, 2016; Primomo, 2007; Wold et al., 2008; Zauderer et al., 2009). It is imperative that all health care educators continue to engage students in health care policy to create a strong network of engaged health policy advocates.

In graduate education, these are all anecdotal accounts written by the educators providing the teaching strategies. There is minimal data within the graduate health policy teaching strategies literature supporting these strategies as effective means to build political astuteness or political self-efficacy. Additionally, these examples rely on policy experts outside of nursing and medicine, so students are exposed to the information and participate in the activities, they are not exposed to other nurses in practice or medical doctors in practice teaching these concepts. While it is beneficial to have experts offer additional perspectives on a topic, leaving much of the education in undergraduate, graduate and medical education seems to perpetuate the thoughts of the nursing students in the Rains and Barton-Kreise (2001) study, that political activities are something other people do. Whereas having nurse educators in front of the classroom, speaking from a place of authority about their political astuteness and political self-efficacy, could make a greater impact for nursing students to see that health policy engagement is something all nurses do.

Gaps in the Literature

Given all the examples of educators working to increase health policy engagement through different teaching strategies nursing students are being introduced to the concepts of health policy. However, the content continues to be isolated in one or two courses, despite the recommendations to integrate health policy content throughout the curriculum. All of the examples and studies were single site convenience samples. The researchers conducting the studies were also the educators invested in the school of nursing and activities. Therefore, a potential for bias may exist. Multisite, non-entrenched researchers, exploring nursing schools' techniques to teach health policy may prove beneficial information to create a clear picture of what educators are teaching and how well students are learning the material. Research exploring nurse educators' self-efficacy toward health policy and current political astuteness coupled with teaching strategies currently utilized can assess the effectiveness of health policy education.

Measurement Tools for Health Policy Engagement

For the purpose of this study two tools were used to determine nurse educators' political astuteness and political efficacy. To measure political astuteness the *Political Astuteness Inventory* (PAI) created by Clark in 1981 will be used. To measure political efficacy the *Teacher Political Self-Efficacy* (TPSE) tool created by Hammon in 2010 will be used. The following section will describe each tool including the reliability and validity of each tool.

Political Astuteness Inventory

The Political Astuteness Inventory was created by Philip Clark in 1981. It was first published in the Community text book, *Community Nursing: Health Care Today and*

Tomorrow. The tool is a 40-item tool analyzing the, "voting behaviors, participation in professional organizations, involvement in the policy process, general awareness about health policy issues, knowledge of elected officials and the legislative process" (Primomo, 2007, p. 262). Each item is answered with a "yes" or "no" response. The tool total is scored with one point given to each "yes" response. Scores range from 0 – 40. Scoring for the tool is broken down into four categories. Zero to nine points is calculated as *totally politically unaware*; 10 – 19 points is *slightly aware of the implications of political activity for nursing*; 20 – 29 points is *shows a beginning political awareness* and 30 – 40 points is *politically astute and an asset to the profession*. Specific items from the tool that target voting behaviors and professional organization involvement include prompts such as *I am registered to vote*; *I voted in the last two elections*; *I belong to the state professional or student nurses' organization*; and *I participate in that organization* (Clark, 1984). Items such as, I read literature published by my state nurses' association, professional magazines, or other literature on a regular basis to stay abreast of current health issues and I know whom to contact for information about health-related policy issues at the state or federal level to address general awareness of health policy issues (Clark, 1984). Other items included on the tool are knowledge of elected officials and the legislative process asks questions such as *I know the name of my state senators in Washington DC.*, *I know the name of the state senator of my district*, and *I know the process by which a bill is introduced in my state legislature* (Clark, 1984).

Reliability. The *Political Astuteness Inventory* has been used in a few studies among nursing students, graduate students, and registered nurses. Clark did not complete a validation study on the tool; however, other researchers have since its development.

Byrd et al. (2012) used the tool among 300 undergraduate nursing students in a public/community health course. A pre and post-test design had students take the PAI on the first day of the course and again following a semester long experience with multiple health policy areas and activities addressed. A Cronbach alpha of internal consistency reliability for the tool was ($\alpha = .84$). Polit and Beck (2012) indicate a score above .70 indicates a high level of reliability for a tool. Primomo (2007) used the tool in a pre and post-design during a 10-week graduate course. A total of 40 graduate nursing students participated in both pre and post surveys. The internal consistency reliability for this study revealed a Cronbach alpha at .81. Primomo (2007) also notes that, "the content validity of the PAI was evident in that items on the instrument are similar to those reported in other political assessment tools" (p. 262).

Finally, the PAI was used in a study of both nursing students and registered nurses attending a state legislative day, presented by the state nursing organization (Primomo & Bjorling, 2013). The study measured two groups of students/registered nurses who attended the 2008 state nurses' association legislative day. Unfortunately, participants ($n = 65$) were not able to be contacted prior to the legislative day experience so the participants were asked to complete the PAI retrospectively on how they would have answered the items and then answer the tool again based on their legislative day experience. The internal consistency reliability for how the respondents would have answered before attending the legislative day was $\alpha = .945$. After the experience the PAI internal reliability was $\alpha = .877$ (Pimomo & Bjorling, 2013, p. 101). In the second group at the 2009 state nursing association legislative day event, a pre and post design was used for data collection. The pre-test for the student nurses and registered nurse participants

had an internal consistency reliability demonstrated a Cronbach $\alpha = .989$ and a post experience Cronbach $\alpha = .939$ (Primomo & Bjorling, 2013, p. 101). Each of these studies support the tool reliability with a Cronbach α inter-item reliability ranging between (.84 - .989).

Validity. Primomo (2007) also indicated that the individual PAI items demonstrate content validity based on other political assessment tools in the literature, including content covered through Cohen et al.'s (1996) Political Stages Model, the questions asked by Rains and Barton-Kreise's (2001) qualitative study comparing nursing students to political science students, and Faulk and Morris's (2001) reflective teaching strategies. These three examples in the literature highlighted key areas that knowledgeable nurses indicated were important to maintain awareness of health policy. Additionally, these examples in the literature recognized key areas that nurses who are not knowledgeable of health policy content did or did not know. These studies and other similar studies become the guide for researchers to ensure content validity, as the PAI includes items that are supported in the literature as areas that a politically knowledgeable nurse is aware, and where a politically ignorant nurse is unaware.

Teacher Political Self-Efficacy

The Teacher Political Self-Efficacy (TPSE) tool was developed by Hammon (2010) for her dissertation work. The original intent of the tool was to measure the political self-efficacy in K-12 educators and their political self-efficacy toward education public policy. Hammon (2010) tested and confirmed reliability in two separate studies. Construct validity was confirmed through comparing items on the TPSE to other established tools including the *Political Efficacy* tool as citizens, teacher *Instructional*

Efficacy tool and teach level of actual *Engagement* tool in political/civic/professional

activities (Hammon, 2010). Hammon created the items for the TPSE based on these

existing tools, by modifying the items from more general items to more specific items

that focused on K-12 education and education policy. The tool has not been used in any

research outside of Hammon's (2010) dissertation. It also has only been used on a sample

of K-12 education; therefore, a pilot study was conducted prior to use of the tool in this

research study. The results of the pilot study are discussed in detail in the methodology

section.

      Reliability. Hammon (2010) used two studies to establish reliability for the TPSE

tool. Prior to administering the 20 items tool, a pilot study was conducted with 38

classroom teachers who were also graduate students. The Cronbach $\propto$ for this pilot study

was .892. The tool was then tested in two different settings – study 1– a more rural school

district (n = 48) and – study 2 – a more urban school district (n = 103). In the study with

the rural district the correct item total correlations ranged from .476 to .745 with an

overall Cronbach $\propto$ = .939 (Hammon, 2010). Polit and Beck (2012) recommend retaining

items with a correct item total correlations of .40 or greater. The study in the urban school

revealed a Cronbach's $\propto$ = .899 and corrected item-total correction between .292 - .552.

The item that was at .292 brought the Cronbach's $\propto$ = .858 if deleted, so Hammon (2010)

decided to leave the item in the tool, based on the minimal difference in reliability

coefficient.

      Construct validation. According to Bandura (2006) when designing an efficacy

scale, it is imperative that the efficacy items accurately reflect specific constructs. The

three constructs within the TPSE are instructional efficacy, political efficacy and political

engagement (Hammon, 2010). While not specifically stated in Hammon (2010) dissertation it appears face validity of each item was used because each question within the TPSE was based on existing political self-efficacy tools.

The first tool used to develop the TPSE was the *Teachers' Sense of Self Efficacy Scale – Short Form (TES)*. Tschaneen-Moran and Woolfolk developed this tool in 2001 (Hammon, 2010). "The researchers report evidence of acceptable levels of both reliability (coefficient $\propto$ of .81 to .90) and validity based on studies that tested construct relationships with other teacher efficacy measures" (Hammon, 2010, p. 63). Adaptations were made to the items on Tschaneen-Moran and Woolfolks tool items to measure sense of self-efficacy specifically relating to education policy (Hammon, 2010). The second tool items used to develop the TPSE was the *Perceived Political Self-Efficacy Scale* developed by Caprara, Vecchione, and Mebane, (2009). The tool was developed to measure citizen's self-efficacy (Hammon, 2010). The reliability of the tool per Caprara et al. (2009) was between $\propto = .83$ to .96. Validity for the *Perceived Political Self-Efficacy Scale* is based on, "studies testing relationships with other measures of political efficacy" (Hammon, 2010, p. 64). Adaptations were made to two items on the *Perceived Political Self-Efficacy Scale* to make it applicable to an individual within an education setting in the United States. The third tool items used for the TPSE assessed internal political efficacy was the *American National Election Study (ANES) questionnaire*. This national survey is conducted on American voters post-election and assesses the confidence an individual has in one's competence to recognize and engage in politics (Hammon, 2010). Adaptations were made based on the four questions on the ANES regarding personal and internal confidence in politics. The modified items were designed to correspond to the K-

12 population regarding specifically education politics (Hammon, 2010). Niemi, Craig, & Mattei (1991) reported a Cronbach $\propto$ = .80, of the American National Election Study questionnaire. Finally, the teachers' actual engagement in political/civic/professional activities was selected through "similar measures used in political science research" (Hammon, 2010, p. 65).

The final version of the TPSE uses a Likert scale to measure each item. The five-point Likert scale ranges from *strongly disagree* to *strongly agree.* There are no items that are negatively worded, so there is no need for reverse coding. During the construct validation portion of the TPSE validation process, participants took the TPSE and also took each of the individual scales that were combined to create the final TPSE tool. The results on the TPSE were then compared to the results of the responses on each of the individual scale items. Hammon (2010) study 2 – the urban school study found "statistically significant relationships between Political Efficacy constructs measured by Caprara et al. (2009) and Niemi et al. (1991) scales ($r = .455$, $p = .001$) as well as each of these constructs with TPSE ($r = .449$, $p = .001$ and $r = .524$, $p = .001$ respectively)" (p. 84). Bandura (2006) states that demonstrating significant relationships between predicted effects helps to build support for a construct's validity. Therefore, Hammon (2010) TPSE tool is based on reliable tools and demonstrates construct validation which build support for overall tool validity.

Summary

The preceding chapter discussed the literature surrounding health policy engagement in nursing education. The theoretical basis for this study is outlined per Bandura's SCT, where self-efficacy and role modeling can impact behavioral changes in

nurses. Health policy engagement in nursing practice remains allusive to many bedside nurses. The impact of role modeling to affected change is evident in clinical nursing practice, but nurse educators have not adequately shown themselves to be role models in nursing education. To be an effective role model one must feel competent to demonstrate health policy engagement. A proficient level of political astuteness and political self-efficacy would be required to be a role model in health policy engagement, based on the current literature nurse educators may not be (Buck-McFadyen & MacDonnell; Gardner, 2012; Staebler et al., 2017). There continues to be a gap between educational theory and practical application in nursing. Registered nurses and other health care providers have noted many barriers to engaging in health policy. This disconnect between education and practice may be due to nurse educators lacking political astuteness and self-efficacy toward health policy. This lack of knowledge and confidence may hinder their ability to engage in health policy themselves, and ultimately affect the profession in translation of health policy concepts into practice. Therefore, the purpose of this study is to examine the concepts of political astuteness and political self-efficacy by surveying current BSN nurse educators using the *Political Astuteness Inventory* and the modified *Teacher Political Self-Efficacy* tools. The next chapter will discuss the methodology behind this study as well as discuss the process undertaken to modify the *Teacher Political Self-Efficacy* tool for the nurse educator population.

CHAPTER THREE

METHODOLOGY

This chapter describes the methods that were utilized to conduct the research study. This chapter begins with an explanation of the study design then proceeds to describe the setting and sample including consideration of human subject protection, instrument and procedures. This chapter concludes with a description of how the data was analyzed.

Study Design

This research relied on a quantitative, descriptive correlational design to investigate nurse educators' views of health policy engagement, to determine if the political self-efficacy and political astuteness influence the internalization of the professional advocacy role for the nurse educator. Polit and Beck (2012) stated, "the aim of descriptive correlational research is to describe relationships among variables…" (p. 226). Thus, the first goal of this research study is to describe the relationship between nurse educators self-reported political self-efficacy and nurse educators self-reported political astuteness. Brown (1996) determined that there are internal and external factors that impact the likelihood for student nurses to participate in political advocacy, but the same factors have not been explored to determine if they impact nurse educators. The second goal of this research study is to discover if there is a relationship between any personal or professional factors and nurse educators' political self-efficacy and/or political astuteness scores. Since the research goals are non-experimental and aim to describe the relationship, a quantitative, descriptive correlational design is the best fit for this study.

Ethical Considerations

Prior to starting, the study was approved by the Institutional Review Board (IRB) at the Indiana University of Pennsylvania (Appendix A). Potential participants received a solicitation email inviting them to complete the surveys within the study. This solicitation email contained a full disclosure of the aim and potential outcomes of the study (Appendix B). A link was included in the email for participants to anonymously gain access to the study. Prior to entering the surveys, the participants read and agreed to the informed consent (Appendix C) which contained the study aim, description of risks and benefits, and information regarding voluntary participation in the study. Participants were also informed that they could end the survey at any time. If there was incomplete data on any of the instrument sections of the survey the results were removed from the final sample. Participants who completed both the Political Astuteness Inventory (PAI) and Teacher's Political Self-Efficacy - Modified (TPSE - M) scales within the survey but did not answer one or more of the demographic questions were still included in the final data set. Additionally, because of anonymity of respondents, completed and submitted surveys could not be removed from the final data set. This was explained in the solicitation email and the informed consent document. No incentive was offered to nurse educators for participating in this survey.

Additionally, the study did not identify any conflicts of interests, did not focus on vulnerable populations or include any sensitive material that would cause the participant emotional or psychological harm. All electronic surveys were saved on a password-protected computer at the researcher's private residence. Any paper documents related to the research were kept in a secure filing cabinet locked with a key at the researcher's

private residence. Research data were aggregated and remained anonymous throughout the reporting process.

Setting

The goal of this research study was to develop a multi-site, multi-state sample. A list of undergraduate BSN nursing schools in the Mid-Atlantic region of the United States was compiled through the publicly available Commission on Collegiate Nursing Education (CCNE) list of accredited baccalaureate nursing degree programs. The setting was isolated to the Mid-Atlantic region of the United States because research indicates that there are distinct political trends in different regions of the United States (Rentfrow et al., 2013). In an effort to minimize a potential unintended variable within the study, the sample of nurse educators came from the Mid-Atlantic region of states including Pennsylvania, New Jersey, New York, Maryland, and Delaware.

Sample

This section describes the sampling technique for this study, as well as the study's target population and eligibility criteria, sample size, and power analysis.

Population and Sample

The study's target population included nurse educators teaching in CCNE accredited undergraduate pre-licensure BSN nursing schools within the mid-Atlantic region (PA, NY, NJ, DE, MD).

Eligibility Criteria

This section discusses the eligibility criteria for the study participants. Inclusion and exclusion criteria are reviewed.

Inclusion criteria. These are the study's inclusion criteria for nurse educators:

1. Current employment (full or part-time) as a nurse educator in a CCNE-accredited traditional BSN degree program, or accelerated BSN program within the mid-Atlantic region (PA, NY, NJ, DE, MD)

2. Teaching in the didactic classroom (virtual or face-to-face), including educators who teach in both the classroom and clinical settings.

3. Master's degree in Nursing

4. English speaking

Exclusion criteria. These are the study's exclusion criteria for nurse educators:

1. Associate and Diploma degree educators

2. Clinical educators teaching only in the clinical setting

3. Nurse educators working in non-CCNE accredited nursing schools

4. Nurse educators working outside of the Mid-Atlantic region (PA, NY, NJ, DE, MD)

Power Analysis

The specific minimum number of nurse educators needed to provide a statistically significant sample size was determined through a power analysis calculation. Polit and Beck (2012) recommend the establishment of the risk of a type 1 error (α) at .05 with a standard risk of a type II error (power) held at .95 and establishment of an effect size between .20 - .40, medium effect size. Furthermore, Polit and Beck (2012) noted that a medium effect size allows for a greater likelihood to capture the variability within the potentially heterogeneous sample and therefore capture any relationships between the variables in the study, given the variation among nurse educators from state to state. For

the purpose of this study, $\alpha = .05$, power = .95 and an effect size held at .30 resulted in a power analysis of a minimum of 111 nurse educators needed to complete the study, per G*Power version 3.1.9.2.

Instruments

This study used two instruments: the PAI and the TPSE - M. The PAI is a tool that measures the knowledge, skills, and attitudes regarding the legislative and policy process (Primomo, 2007). The TPSE is a tool that measures an educator's self-efficacy toward political engagement. The TPSE was created by Dr. Hammon (2010) in her dissertation work on K-12 educators and education policy self-efficacy.

Unlike the TPSE, the PAI has been validated for the nursing population, as discussed in Chapter Two. The PAI was developed by Philip Clark in 1981 and integrated into a Community Nursing Textbook, as a way for nursing students to survey community members. Dr. Clark, Philip Clark's wife and author of the community health book in which it was first published gave permission to use the PAI (Appendix D) in this study. The tool is a 40-item questionnaire with *yes* or *no* questions. A *yes* response is worth one point. The more *yes* responses, the more politically astute the individual is reporting. The tool separates the yes responses into four categories. A score of $0 - 9$ points indicates *totally politically unaware*, 10 -19 points indicates *slightly aware of the implications of political activity for nursing,* $20 - 29$ points indicates *shows a beginning political awareness* and a score of $30 - 40$ points indicates *political astute and an asset to the profession*. However, Clark never completed a validation study on the tool. Therefore, Primomo (2007) completed one of the first validation studies on the PAI. Primomo (2007) reported a Cronbach's alpha coefficient at .81 with n = 40 nursing students

participating in a pre-test and post-test study design. These results are similar to Byrd et al.'s (2012) pre-test and post-test study of baccalaureate nursing students with a reported Cronbach's alpha coefficient of .84.

The TPSE developed by Hammon (2010) is a 20-item survey integrating "classroom teachers' perceptions of the capabilities they bring to a political process characterized as education public policymaking" (Hammon, 2010, p. 58). Using Bandura's (2006) guide for making self-efficacy scales as a resource, Hammon's (2010) scale describes and measures "the different ways someone may operate with the domain of interest and at different levels of challenges and complexity" (p. 58).

Each item uses a five-point Likert scale response. The responses range from *strongly agree* to *strongly disagree*. The scale is designed to measure the concept of political self-efficacy as a whole. However, Hammon's (2010) TPSE scale reflect key areas of political self-efficacy including instructional efficacy, political efficacy and teachers' actual engagement in related activities. Hammon (2010) developed an item pool that reflected the three key constructs based on the literature and established self-efficacy tools. Hammon (2010) selected 20 items that equally assessed the three key areas of political self-efficacy.

After determining the 20 items to include on the TPSE, Hammon (2010) completed a pilot study of 38 graduate students who met the inclusion criteria of the overall study, namely students who were fully employed as a teacher in K-12 education, to assess reliability of each item to the overall concept. Hammon (2010) did not report on any specific data from the pilot study. However, after the graduate student pilot study, Hammon completed a full-scale reliability study of K-12 teachers (N=48). The result of

the scale reliability study was a Cronbach's alpha = .939 (Hammon, 2010). Polit and Beck (2012) recommend a reliability coefficient alpha (Cronbach's alpha) of .80 or higher to indicate scale reliability. Hammond (2010) analyzed each statement on the TPSE scale for internal consistency and found that each corrected item-total correlation was above the recommended .40 (Polit & Beck, 2012).

After the reliability study, Hammon (2010) completed a second study within her dissertation work to establish construct validity. Hammon (2010) used hypothesized relationships with known reliable and validated tools to build evidence to support the validity of the TPSE tool. Polit and Beck (2012) state that hypothesized relationships construct validity testing involves measuring the relationship between established theory, literature and instruments to the new instrument to establish support for the desired construct being measured. As previously stated in Hammon's (2010) study the three constructs within the TPSE scale were "instructional efficacy, political efficacy and teachers' actual engagement in political/civic/professional activities" (p. 65). A full description of the process Hammon (2010) used to established reliability and construct validity is described in Chapter Two.

A sample of 103 teachers in one Mid-Atlantic state school district participated in the study. The reliability for the second study was confirmed with a Cronbach's alpha at .858; however, the corrected item-total correlations indicated that Item 1 scored a .373 and if deleted would increase Cronbach's alpha to .898, and Item 6 was .313 and if deleted would increase the Cronbach's alpha score to .902 (Hammon, 2010). For this dissertation on health policy engagement, both items remain in the TPSE tool to stay consistent with Hammon's (2010) study results.

Pilot Study of TPSE-M in Nurse Educators

To date the TPSE has only been studied in the K-12 teacher population. Therefore, prior to initiating a full study using the TPSE-M, a pilot study was conducted to assess reliability within the target nurse educator population.

Prior to the pilot study, Hammon was contacted and gave permission (Appendix E) to use her tool with modifications to target the nurse educator population. Modification to the items on the tool included the following changes:

- Change the term *education* to *health.*

- Change the phrase *affiliates of the NEA or AFT that seek teacher inputs* to *professional nursing organizations that seek nurse educators' inputs.*

- Change the professional organization examples from *Maryland Council for Teachers of Mathematics, National Council for Teachers of English, Council for Exceptional Children* to *Pennsylvania State Nurses Association, American Nurses Association, Academy of Medical-Surgical Nurses, etc.*

- Change the phrase *affiliates of the NEA or AFT* to *affiliates of professional nursing organizations.*

- Change the term *K-12 education* to *community health outcomes*.

These modifications were approved by Hammon prior to continuing with the pilot study. Then approval for the pilot study was granted by the participating western Pennsylvania University Institutional Review Board (IRB).

An instrument reliability test–retest established the reliability of the TPSE-M with the approved modifications for the nurse educator target population. Twenty-two PhD

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nursing students from a university in western Pennsylvania participated in the pilot study. A solicitation email was sent to all PhD nursing students with a Qualtrics® link to the informed consent, TPSE-M survey and demographic questions. Access to the PhD students was gained through the PhD coordinator. The student emails were sent directly to the western Pennsylvania university's applied research lab (ARL). The ARL coordinated the data collection process throughout the study.

During the pilot study, coordination with the ARL allowed participant confidentiality to be maintained. With the assistance of the ARL the principal investigator could maintain an anonymous relationship to the participants because the test-retest methodology relies on participants taking the survey once and then taking the survey a second time two to four weeks after the first survey submission (Polit & Beck, 2012). Therefore, to link the two surveys together, first the ARL had access to the students returned surveys and paired the second submission via the students email addresses associated with the first submissions. In the informed consent, the participants were told that the survey was confidential to the ARL but would remain anonymous to the principal investigator. Next, the ARL compiled the paired surveys into a data set, de-identified the surveys by removing the emails and emailed the final data set to the principal investigator. This process allowed the participants to remain anonymous to the principal investigator.

When the first emails were sent out by the ARL, recipients were informed of the inclusion criteria for the pilot study which were the same as the final study. Therefore, participating PhD students were master's prepared registered nurses, employed as nurse educators in an undergraduate BSN nursing program, and currently teaching in the

didactic portion of the nursing program. Follow-up email reminders were sent through Qualtrics® two weeks after the first solicitation email was sent. Three weeks after the first solicitation email was sent the second survey was sent to only the students who participated in the first surveys.

The results of the first survey submission revealed a Cronbach's alpha at .919 and the Cronbach's alpha at .939 for the second group of returned surveys. These findings are consistent with the Cronbach's alphas of .939 (Study 1) and .898 (Study 2) in the TPSE study completed by Hammon (2010). Interestingly, examination of the corrected item-total correlation for Item 1 was .188 in the first survey results, but in the retest Item 1 went to .668. Table 4 contains the corrected item-total correlations for both test and retest. Since there was an increase in the corrected item-total correlation between the two test-retests the decision was made to maintain the TPSE-M tool as it was. Additionally, the Cronbach's alpha coefficient is well above the .8 recommendation by Polit and Beck (2012). The pilot study demonstrates that the TPSE-M tool adequately measures political self-efficacy for nurse educators and can be used in this dissertation study.

Table 4

Pilot Study of TPSE-M Tool Test-Retest Corrected Item-Total Correlations

Item	Corrected Item-Total Correlations Test	Corrected Item-Total Correlations Retest
I state my opinions about health policy issues openly even in public and challenging settings	.188	.668
I stay informed about national and state health policy initiatives.	.497	.584
I try to influence the health policy perspectives of my administrators.	.695	.838

I develop and maintain relationships with local and state government officials.	.659	.446
I respond to emails from or surveys sponsored by local, state or national professional nursing organizations that seek nurse educators' inputs.	.602	.771
I have made a formal presentation on an instructional best practice or a policy initiative at a profession specific meeting or conference.	.354	.547
I encourage and support other nurses and nurse educators who engage in health policy related activities.	.320	.553
I have participated in a deliberate information campaign in opposition to a particular health policy or position.	.691	.735
I solicit support for greater nurse involvement in health public policymaking from elected and appointed government officials.	.751	.819
I have distributed information for the purpose of informing and influencing the health policy perspectives of others.	.638	.752
I have served as a member of a work group or committee charged with researching and developing recommendations on a health policy issue.	.604	.655
I have served as a member of a committee or work group at the state or national level and sponsored by a specialized professional organization (e.g. Pennsylvania State Nurses Association, American Nurse Association, Academy of Medical-Surgical Nurses, etc.).	.374	.536
I use the means available to me to monitor the health policy positions and actions of elected government officials.	.662	.755
I try to influence the health policy perspectives of people or groups in my community	.567	.767
I keep informed about the health policy related positions and actions of local, state or national affiliates of professional nursing organizations.	.517	.740

I have expressed in writing to government officials my perspectives on health policy matters.	.586	.757
I have provided assistance with routine school responsibilities to a peer in order to facilitate his/her greater involvement in health policy related activities.	.762	.457
I am positively supported by family and friends when I participate in activities of a political or civic or professional nature outside the usual work day or work week.	.533	.400
I have served as a representative on a community group looking at constructive ways to improve community health outcomes.	.834	.687
I have played a role in the selection of members/leaders of school sponsored committees or work groups dealing with health policy matters.	.844	.381

Procedures

The following section outlines the specific study procedures. Nursing schools were selected through the CCNE publicly available website. The CCNE is the autonomous accrediting agency affiliated with the American Association of Colleges of Nursing. The role CCNE accreditation serves in nursing education is to ensure nursing school faculty are implementing specific standards to provide quality nursing education to future nursing students (CCNE, 2013).

The CCNE website is a publicly available website and provides a list of all CCNE accredited nursing schools in the United States. However, CCNE accredits both traditional and RN-BSN nursing schools and other degrees including masters and doctorate. For the purpose of this study, only faculty teaching at traditional BSN programs from PA, NY, NJ, MD, and DE were included.

The list of CCNE accredited traditional BSN nursing schools from the Mid-Atlantic region was divided by state and yielded 32 in Pennsylvania, 29 in New York, 12 in New Jersey, eight in Maryland, and one in Delaware. Each state's list of CCNE accredited traditional BSN schools was assigned a number starting with one and moving forward sequentially, for example the school sample pool from PA each received a number 1-32, and then NY school sample pool each received a number from 1-29 and so on.

After all five state's CCNE accredited traditional BSN programs school lists were numbered as described above, a web-based random number generator (https://www.random.org) was used to randomly select the sample of nursing schools that were included in the study. When a nursing school was selected, all of the nursing faculty emails available on the publicly accessible nursing faculty webpage for the chosen school were invited to participate. Because nursing faculty sizes differ from school to school, the number of schools selected from each state differed, based on the number of faculty at each randomly selected nursing school. The target number of faculty per state was approximately 100-150. However, Delaware was the exception because there was only one school that was CCNE accredited and offered a traditional BSN program; therefore, the nursing faculty from that school were automatically included to receive a solicitation email for the study. Table 5 describes the number of schools selected from each state and total number of faculty invited to participate.

Table 5

Total Number of Schools and Faculty Invited to Participate in the Study by State

State	Number of Schools	Number of Faculty
Pennsylvania	6	128
New York	5	150
New Jersey	6	127
Maryland	7	101
Delaware	1	35
Total	25	541

A list of publicly available nursing faculty emails was manually compiled by the

principal investigator. Using this nurse faculty email list, a solicitation email was sent to

each randomly selected nursing schools' nurse educator faculty inviting participation in

the study. To distribute emails to the selected school's nurse faculty, the nurse educators

school emails were populated into Qualtrics®. The use of Qualtrics® to send nursing

faculty emails allowed all emails to be sent via a blind recipients list and allowed

reminder emails to be sent automatically every week to those nurse faculty who did not

complete the survey to encourage participation. Data collection occurred over four

weeks.

Within the solicitation email to nursing faculty was the anonymous link to the full

survey. Participants who clicked on the anonymous link were presented the informed

consent. Prior to starting the survey, participants had to read the informed consent and

agree to participate in the survey. After agreeing to participate in the survey, the next

parts of the survey were the PAI tool (Appendix F), TPSE-M tool (Appendix G), and

demographic survey (Appendix H). The survey took approximately 20 minutes to complete.

Within the informed consent, participants were reminded that the study was completely voluntary. Therefore, nurse educators were able to exit the survey at any time by clicking on the "x" on the top left of their computer screen, and these surveys were not included in the final data set. However, after final submission of the survey, due to the anonymity of the survey responses, it could not be removed from the final data set. This information was clearly explained in both the solicitation email and the informed consent.

Data Analysis

Data was analyzed with the Statistical Package for the Social Sciences software, SPSS® Version 24. Data was visually analyzed for any errors in data entry or missing data. When missing data was present, specific data points were investigated to assess if the entire entry needed to be removed or if only demographic data points were missing. If any part of the two instruments was missing, the entire data set was removed from the survey. Assumption tests for sample size, normal distribution, outliers, linearity, multicollinearity and singularity, homogeneity of regression, and homogeneity of variances-covariance matrices were performed to assess the data to ensure there were no violations of assumptions (Pallant, 2013). The following section discusses the statistical approach used to analyze the demographic and research questions.

Demographic Data

Demographic data was organized through descriptive statistics. Data collected included: age; years of nursing experience; gender; highest earned degree in nursing; graduation year from BSN, MSN, doctoral program (if applicable); tenure track status;

current faculty rank; membership in a professional nursing organization; formal health policy education and health policy role model. Frequencies were used for gender; age; year of nursing experience; highest earned degree in nursing; graduation year from BSN, MSN, doctoral program (if applicable); tenure track status; current faculty rank; membership in a professional nursing organization and presence of a health policy role model within a professional nursing organization; formal health policy education and presence of a nurse educator as a health policy role model.

Means, standard deviations and ranges were computed for age, years of nursing experience, and graduation year. Additionally, for descriptive purposes nurse educators age was recoded and categorized into approximately 10-year age ranges (31-40), (41-50), (51-60), (61-75). Years of nursing experience was also recoded and categorized into approximately 10-year ranges starting at (8-15), (16-25), (26-35), (36-45), and (46-59). Nurse educators' graduation years from prelicensure, RN/BSN (if applicable), MSN and doctorate (if applicable) were also recoded and categorized into four ranges that correspond with the BSN *Essential* document revisions.

Research Question One

Research Question One asks: How do current nurse educators perceive their political self-efficacy? This is an analysis of the total score on the TPSE-M tool. The individual items of the TPSE-M were summed to get a total score. Then descriptive statistics including the mean, frequencies and standard deviations were used to analyze the scores of nurse educators. The descriptive statistics were analyzed through SPSS®.

Research Question Two

Research Question Two asks: How do current nurse educators perceive their political astuteness? This requires individual items on the PAI to be summed to get the total score. An analysis of the total score on the PAI includes descriptive statistics to analyze the total scores of the nurse educators including mean and standard deviation. An analysis of the yes response through frequencies and total percentage of nurse educators was also included in this descriptive evaluation. The descriptive statistics were analyzed through SPSS®.

Research Question Three

Research Question Three asks: What is the relationship between nurse educators' perceived political self-efficacy and nurse educators' political astuteness? Data were analyzed with the Pearson's Product Moment Correlation coefficient (Pearson's R) to determine the strength of the correlations that exists between these two variables the total scores on the two scales. This research question evaluated the relationship between the nurse educators self-reported PAI score and TPSE-M score. Prior to conducting the Pearson's R test, several assumptions were assessed to ensure appropriate use of the statistic. The assumptions are level of measurement, related pairs, independence of observations, normality, linearity and homoscedasticity (Pallant, 2013). Each of these assumptions were tested on both the PAI and the TPSE-M. The PAI and TPSE-M are continuous variables. Each participant provided a score for both variables. Data collection occurred over the same four-week period. Subjects independently self-reported their PAI and TPSE-M scores. The sample was evaluated for normal distribution. A scatterplot was used to evaluate linearity and homoscedasticity. The scatterplot displayed

no extreme outliers. After all assumptions were met, the Pearson's Product Moment Correlation coefficient was analyzed through SPSS®.

Research Question Four

Research Question Four asks: What professional factors impact nurse educators' perceived political self-efficacy and/ or nurse educators' political astuteness? To answer this question a multiple regression analysis was conducted. A multiple regression analysis is used "to explore the predictive ability of a set of independent variables on one continuous dependent measure" (Pallant, 2013, p. 108). The independent variables in this study are the personal and professional factors including: gender; age; years of nursing experience; highest earned degree in nursing; graduation year from BSN, MSN, doctoral program (if applicable); tenure track status; current faculty rank; membership in a professional nursing organization; presence of a health policy role model within a professional nursing organization; formal health policy education and presence of a nurse educator as a health policy role model. There were two continuous dependent variables (TPSE-M, PAI). Each dependent variable was analyzed with the independent variables to determine the predictive impact of each variable. The gender variable was not included in the analysis because only two subjects reported identified themselves as male; therefore there was not a large enough sample within the male variable to accurately detect any differences between mean scores compared to female educators. Also, the variables of age, years of nursing experience and graduation years were analyzed with a correlations technique, beginning with a visual inspection of the data points between each independent variable compared to each dependent variable to assess for any correlation trends.

With the exception of gender, age, years of nursing experience and graduation year all other variables were analyzed using an Independent sample T-test to determine the level of significance at $p < .05$. Only the variables that demonstrated a level of significance of $p < .05$ were used in the final multiple regression analysis. All statistical analysis required to perform the multiple regression were performed in SPSS®.

Summary

The purpose of this study was to determine the connection between the political self-efficacy and political astuteness scores of nurse educators based on scores in a multi-state research study. Additionally, the study aimed to discover the personal or professional factors that may impact a nurse educator's political self-efficacy score and the political astuteness inventory score. Chapter Three discussed the study design, setting and sample including both the intended study population and the estimated sample size needed to complete the study with adequate power. Additionally, descriptions of the tools that were used in the study and the procedure to conduct the study were described in this chapter. A detailed description of the pilot study completed on the TPSE-M tool was also discussed. Finally, each research study question was analyzed and a brief description of the data analysis technique that was used was discussed. Chapter Four discusses the results of this study.

CHAPTER FOUR

RESULTS

In this chapter, the data and analysis for the demographic variables and four research questions are presented along with a description of the sample, research questions and quantitative results.

Sample Description

The surveys were distributed via Qualtrics® with an email to nurse educators (N=541) who work in a Commission on Collegiate Nursing Education (CCNE) accredited nursing program. A total of N=541 email surveys were sent to account for an average response rate of 25% for online surveys (Saleh & Bista, 2017). One hundred and twenty eight surveys were returned. However, upon data inspection, 16 survey respondents did not complete either the Political Astuteness Inventory (PAI) or the Teacher Political Self-Efficacy-Modified scale (TPSE-M). After removal of incomplete tool survey results, the final number of completed surveys was 112. The sample was from the Mid-Atlantic region including Delaware (*n*=7), Maryland (*n*=20), New Jersey (*n*=17), New York (*n*=17), Pennsylvania (*n*=48) and missing (*n*=3). However, some variation occurs in the response rate to the demographic data, due to subjects not completing all demographic data questions. Variances in responses are noted throughout this chapter where applicable during the analysis.

Personal Characteristics

Demographic and descriptive statistics are presented in Table 6. Only 109 subjects responded to the questions of gender and the state where the subject works. Of the 109 subjects who answered, 93.8% (*n*=105) were female and 1.8% (*n*=2) were male,

1.8% (*n*=2) preferred not to answer, and 2.7% (*n*=3) did not answer. The representation of male educators in the study is below the national average of 6% (NLN, 2015). Most subjects worked in Pennsylvania 42.9% (*n*=48). The average age rounded to the nearest whole number was 54 (*M*=53.92; *SD* = 10.01; MIN/MAX=31/75). Over 67% of the sample was greater than 50 (*n*=75). The average age of nurse educators was within the national age range of nurse educators which is 46-60 years old (NLN, 2015). The average years of nursing experience was 30 (*M*=30.18; *SD* = 11.5; MIN/MAX=8-59).

Table 6

Demographic Personal Characteristics of the Sample (N=112)

Variable	Category	n	(%)
Gender	Male	2	(1.8)
	Female	105	(93.8)
	Prefer not to answer	2	(1.8)
	Not reported	3	(2.7)
Age	31-40	16	(14.3)
	41-50	19	(17.0)
	51-60	47	(42.0)
	61-75	28	(25.0)
	Not reported	2	(1.8)
Years of Nursing Experience	8-15	16	(14.3)
	16-25	23	(20.5)
	26-35	30	(26.8)
	36-45	34	(30.4)
	46-59	7	(6.3)
	Not reported	2	(1.8)
State	DE	7	(6.3)
	MD	20	(17.9)
	NJ	17	(15.2)
	NY	17	(15.2)
	PA	48	(42.9)
	Not reported	3	(2.7)

Educational Characteristics

The educational characteristics of the sample are displayed in Table 6 and Table 7. PhD-prepared faculty comprised almost half of the sample 47.3% (*n*=53), while MSN faculty represented 41.1% (*n*=46). Most subjects were full-time faculty 92.9% (*n*=104); however, over half were not on a tenure track at their academic institution 57.1% (*n*=64). Of the 112 subjects, 41.1% (*n*=46) identified that they held a faculty rank. Half of the nurse educators who identified a faculty rank held an Assistant Professor rank (*n*=23).

Table 7

Demographic Education Characteristics of the Sample (N=112)

Variable	Category	n	(%)
Highest Degree Earned	MSN	46	(41.1)
	DNP	9	(8.0)
	PhD	53	(47.3)
	Not reported	4	(3.6)
Employment	Full-Time	104	(92.9)
	Part-time	4	(3.6)
	Not reported	4	(3.6)
Tenure Track	Yes	45	(40.2)
	No	64	(57.1)
	Not reported	4	(3.6)
Faculty Rank[a]	Instructor	4	(3.6)
	Assistant Professor	23	(20.5)
	Associate Professor	12	(10.7)
	Professor	7	(6.3)

Note. [a] percent does not equal 100% because of missing data due to faculty rank question did not apply to all subjects in the study

Table 8 depicts the graduation year frequencies including the percentage of the total sample for each level of nursing education. A total of 105 nurse educators reported

graduating from a pre-licensure program (Diploma, Associates, or Pre-licensure BSN). The range of graduation years were 1958 to 2010. Only 25% ($n = 32$) of nurse educators reported graduating from a RN-BSN program with a range of graduation years from 1963 to 2011. While 103 nurse educators reported graduating from an MSN program with graduation years between 1967 to 2017, one of the inclusion criteria to participate in the study was an MSN as a minimum level of education. Finally, there were $n = 61$ doctoral-prepared nurse educators including PhD and DNP educators with a reported graduation and anticipated graduation range from 1970 to 2019. Seven respondents did not report any education focused demographic data.

Table 8

*Demographic Education Characteristics of the Sample (N=*112*)*

Graduation year	Pre-licensure Undergraduate		RN-BSN		MSN		Doctorate	
	n	(%)	n	(%)	n	(%)	n	(%)
Before 1986	53	(47.3)	11	(9.8)	19	(17.0)	1	(0.9)
1987-1998	33	(29.5)	8	(7.1)	21	(18.8)	8	(7.1)
1999-2007	14	(12.6)	10	(8.9)	23	(20.5)	8	(7.1)
2008-present	5	(4.5)	3	(2.7)	40	(35.7)	44	(39.3)
No degree			73	(65.2)			46	(41.1)
Not reported	7	(6.2)	7	(2.6)	9	(8.0)	5	(4.4)

Note. Pre-licensure Undergraduate includes Diploma, Associates, and BSN; Doctorate includes Ph.D., DNP; % may not equal 100 due to rounding.

Formal Education Experience

Table 9 reflects nurse educators responding *yes* to two questions. Within the formal education settings nurse educators were asked to identify *if they remembered receiving formal health policy education*. Educators could choose each nursing program level where they remembered receiving formal health policy education. The second question asked nurse educators *if they remember having a nurse educator as a formal or informal health policy role model,* and they could choose all nursing programs levels where they remember having a nurse educator in a health policy role model capacity. The percentages are the total number of educators who answered *yes* divided by the total number of nurse educators who indicated that they received that level of nursing education. There were 27 (24.1%) nurse educators who did not remember receiving any formal health policy education. A total of 59 (53.6%) nurse educators remember a nurse educator health policy role model in one or more nursing programs. In contrast, 51 (46.3%) nurse educators did not remember any health policy role model formal or informal at any level of nursing education.

Table 9

Nurse Educator's Affirmative Response to Remembering Formal Health Policy

Education and Having a Nurse Educator as a Formal Health Policy Role Model

	Pre-licensure N = 105[a]		RN-BSN N = 32[a]		MSN N = 103[a]		Doctorate N = 61[a]	
	n	(%)	n	(%)	n	(%)	n	(%)
Do you remember receiving formal health policy education in the following educational settings? (choose all that apply)[b]	21	(20)	8	(25)	58	(56.3)	42	(68.8)
Do you remember having a nurse educator as a (formal or informal) health policy role model within any of your formal nursing education?[b]	17	(16.1)	6	(18.8)	39	(37.9)	32	(52.4)

Note: [a] percentages based on total number of educators reporting graduating from each nursing education program; [b] Educators were able to answer *yes* in multiple education levels

The final demographic questions address nurse educators' membership in any professional nursing organizations. A total of 102 nurse educators indicated they belonged to a professional nursing organization. Of the faculty who are members of a professional organization, 51 indicated that they have a formal or informal health policy role model, with 49 of those role models being registered nurses.

Research Question One

Research Question One asks: How do current nurse educators perceive their political self-efficacy? This analysis used the total score on the Teacher Political Self-Efficacy - Modified (TPSE-M) tool. The individual items of the TPSE-M were summed to get a total score. Then descriptive statistics including the mean and standard deviations were used to analyze the scores of nurse educators.

Table 10 lists the mean scores and standard deviations for each of the statements on the TPSE-M scale. In the study, the TPSE-M was scored using a five- point Likert scale (1 = Strongly agree, 2 = Somewhat agree, 3 = Neither agree nor disagree, 4 = Somewhat disagree, 5 = Strongly disagree). However, for the purpose of analysis, a new variable was created, and the scores were re-coded in reverse order (5 = Strongly agree, 4 =Somewhat agree, 3 = Neither agree nor disagree, 2 = Somewhat disagree, 1 = Strongly disagree) so that a higher score indicated a greater self-efficacy and a lower score indicated less self-efficacy. The scale range, by using the Likert scale as a scoring system, is 20 to 100. The lowest score, indicating low self-efficacy, was 27 and the highest score, indicating high self-efficacy, was 100. The average total score was just under 63 (*M*=62.8; *SD* = 18.9). A score of four or higher on the Likert scale indicates a stronger sense of political self-efficacy. Only two individual scale items scored greater than 4.0 - *I stay informed about national and state health policy initiatives* (*M*=4.13) and *I encourage and support other nurses and nurse educators who engage in health policy related activities* (*M*=4.30).

Table 10

Teacher Political Self-Efficacy Tool - Modified

	M	*SD*
I state my opinion about health policy issues openly even in public and challenging settings	3.61	1.173
I stay informed about national and state health policy initiatives	4.13	.895
I try to influence the health policy perspective of my administrators	3.16	1.174
I develop and maintain relationships with local and state government officials	2.52	1.362

I respond to emails from or surveys sponsored by local, state, or national professional nursing organizations that seek nursing educators' inputs	3.80	1.038
I have presented on an instructional best practice or a policy initiative at a profession-specific meeting or conference	2.62	1.689
I encourage and support other nurses and nurse educators who engage in health policy related activities	4.30	.837
I have participated in a deliberate information campaign in opposition to a particular health policy or position	2.63	1.571
I solicit support for greater nurse involvement in health public policymaking from elected and appointed government officials	3.17	1.457
I have distributed information for the purpose of informing and influencing the health policy perspective of others	2.88	1.592
I have served as a member of a work group or committee charged with researching and developing recommendations on a health policy issue	2.40	1.498
I have served as a member of a committee or work group at the state or national level and sponsored by a specialized professional organization (e.g. Pennsylvania State Nurses Association, American Nurse Association, Academy of Medical-Surgical Nurses, etc.)	2.62	1.656
I use the means available to me to monitor the health policy positions and actions of elected government officials	3.38	1.370
I try to influence the health policy perspectives of people or groups in my community	3.21	1.345
I keep informed about the health policy related positions and actions of local, state or national affiliates of professional nursing organizations	3.67	1.165
I have expressed in writing to government officials my perspectives on health policy matters	3.12	1.541

I have provided assistance with routine school responsibilities to a peer in order to facilitate his/her greater involvement in health policy related activities	2.86	1.400
I am positively supported by family and friends when I participate in activities of a political or civic or professional nature outside the usual work day or work week	3.66	1.045
I have served as a representative on a community group looking at constructive ways to improve community health outcomes	2.62	1.578
I have played a role in the selection of members/leaders of school sponsored committees or work groups dealing with health policy matters	2.45	1.407

Research Question Two

Research Question Two asks: How do current nurse educators perceive their political astuteness? To answer this question, each individual item on the PAI was summed for a total score. An analysis of the total score on the PAI, including descriptive statistics to analyze the total scores of the nurse educators, were reflected through the mean and standard deviation. The total score on the PAI was calculated by adding each of the *yes* responses together to determine a total score for each educator. The total scale range is 0 to 40, and for this sample (N=112), the range was 6 to 39 with an average score just over 23 (*M*=23.43; SD = 8.39).

Table 11 reflects the frequency and percentage of *yes* responses for each of the statements on the PAI. The top three *yes* responses were related to voting: I am registered to vote (*n*=109; 97.3%); I know where my voting precinct is located (*n*=109; 97.3%); I voted in the last general election (*n*=104; 92.9%), The three lowest *yes* responses were items related to nurse educators sharing their health care knowledge in public ways: I serve as a resource person for one of my representative on his or her behalf (*n*=9; 8.0%); I

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have provided testimony at a public hearing on an issue related to health (*n*=16; 14.3%);

and I have attended public health hearing related to health issues (n=23; 20.5%).

Table 11

Political Astuteness Inventory 'Yes' Response Frequency and Percent

	Frequency	%
I am registered to vote	109	(97.3)
I know where my voting precinct is located	109	(97.3)
I voted in the last general election	104	(92.9)
I voted in the last two elections	102	(91.1)
I recognized the names of the majority of candidates on the ballet at the last election	102	(91.1)
I was acquainted with the majority of issues on the ballot at the last election	102	(91.1)
I stay abreast of current health issues	110	(98.2)
I belong to the state professional or student nurses' organization	76	(67.9)
I participate (committee member, officer, etc.) in that organization	32	(28.6)
I attended the last state or national convention held by my organization	27	(24.1)
I am aware of at least two issues discussed and the stands taken at that convention	58	(51.8)
I read literature published by my state nurses' association, professional magazine, or other literature on a regular basis to stay abreast of current health issues.	98	(87.5)
I know the names of my state senators in Washington DC.	93	(83.0)
I know the names of my representatives in Washington DC.	85	(75.9)

I know the name of the state senator from my district.	85	(75.9)
I know the name of the representative from my district.	84	(75.0)
I am acquainted with voting record of at least one of the above in relation to a specific health issue.	63	(56.3)
I am aware of the stand taken by at least one of the above on one current health issue.	77	(68.8)
I know whom to contact for information about health-related policy issues at the state or federal level.	77	(68.8)
I know whether my professional organizations employ lobbyists at the state or federal level.	62	(55.4)
I know how to contact the lobbyist.	37	(33.0)
I support my state professional organization's political arm.	58	(51.8)
I actively supported a candidate for the US, or state Senate or House of Representatives (Assembly, campaign contributions, campaigning service, wore a button or other) during the last election	39	(34.8)
I have written regarding a health issue to one of my state or national representatives in the last year	58	(51.8)
I am personally acquainted with a senator or representatives or a member of his or her staff	31	(27.7)
I serve as a resource person for one of my representative on his or her behalf	9	(8.0)
I know the process by which a bill is introduced in my state legislature	73	(65.2)
I know which senators or representatives are supportive of nursing	70	(62.5)
I know which House and Senate committees usually deal with health-related issues	57	(50.9)
I know the committees on which my representatives hold membership	32	(28.6)

I know of at least two issues related to my profession that are currently under discussion at the state or national level	79	(70.5)
I know of at least two health-related issues that are currently under discussion at the state or national level	87	(77.7)
I am aware of the composition of the state board that regulates the practice of my profession	74	(66.1)
I know the process whereby one becomes a member of the state board that regulates my profession	47	(42.0)
I attend public hearings related to health issues	23	(20.5)
I find myself more interested in public issues now than in the past	77	(68.8)
I have provided testimony at a public hearing on an issue related to health	16	(14.3)
I know where the local headquarters of my political party are located	59	(52.7)
I have written a letter to the editor or other piece for lay press speaking out on a health-related issues	26	(23.2)

Research Question Three

Research Question Three asks: What is the relationship between nurse educators' perceived political self-efficacy and nurse educators' political astuteness? Data were analyzed with the Pearson's Product Moment correlation coefficient (Pearson's R) to determine the strength of the correlations that existed between these two variables scores on the two scales. Nurses educators' PAI scores and TPSE-M scores were totaled based on the individual items on each tool.

Preliminary analyses for both the PAI and the TPSE-M tools were performed to ensure there were no violations of the assumptions of normality, linearity and homoscedasticity as discussed in Chapter three. Additionally, the Cronbach's alpha for

the PAI and TPSE-M were α = .923 and α = .945 respectively, supporting the reliability

of these two scales for this study.

Two new variables were created to represent the total score for each educator's

PAI and TPSE-M scale results. The PAI score is based on the number of *yes* responses;

therefore, a new variable was created that required computing the variable by adding each

item on the tool together to determine the total scale score for each educator. The scale

range is 0 – 40. The same process was utilized to calculate the total score for the TPSE-

M scale. However, the Likert scale used in the TPSE-M scale was 5 =Strongly agree, 4 =

Somewhat agree, 3= Neither agree nor disagree, 2=Somewhat disagree, and 1=Strongly

disagree. The total TPSE-M score range is 20 to 100. All nurse educators in the sample

completed both PAI and TPSE-M scales (N=112). The correlation between the two scales

indicates a strong positive correlation at .809. This finding shows that there is a

correlation between higher scores on the PAI and higher scores on the TPSE-M. Table

12 displays correlation between the Political Astuteness Inventory and the Teacher

Political Self-Efficacy-Modified tools from the Pearson's Product Moment Correlation

coefficient.

Table 12

Correlation Between the Political Astuteness Inventory and Teacher Political Self-

Efficacy-Modified

Variable	Total Political Astuteness Inventory (*r*)	*p*
Total Teacher Political Self-Efficacy - Modified	.809	.000

Note. Strengths of correlations: small (r=.10-.29), medium (r=.30-.49), and high (r=.50-1.0) (Cohen, 1988).

Research Question Four

Research Question Four asks: What professional factors impact nurse educators' perceived political self-efficacy and/ or nurse educators' political astuteness? To answer this question a multiple regression analysis was conducted. A multiple regression analysis was used "to explore the predictive ability of a set of independent variables on one continuous dependent measure" (Pallant, 2013, p. 108). The independent variables in this study were the personal and professional factors including gender; age; years of nursing experience; highest earned degree in nursing; graduation year from BSN, MSN, doctoral program (if applicable); tenure track status; current faculty rank; membership in a professional nursing organization; presence of a health policy role model within a professional nursing organization; formal health policy education; and presence of a nurse educator as a health policy role model.

Total Political Astuteness Inventory Scale

Prior to a completing a regression analysis, an analysis of each independent variables relationship to the dependent tool variables established which variables independently have a significant relationship ($p < .05$) to the dependent variables (Bannon, 2013). For analysis of independent variables, Cohen (1988) recommended a minimum of 30 subjects per variable to detect significance at a medium to large effect size. Unfortunately, only two subjects in the study identified their gender as male, so there was not enough of a difference in the sample to complete an analysis of the relationship of the gender variable. The demographic variable *Highest Earned Degree* was recoded to combine DNP and PhD options into one category because only nine nurse educators indicated a DNP as their highest degree earned. The variable of faculty rank

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was combined into a dichotomous variable of Instructor/Assistant and Associate/Full due to the sample size. Because two variables *Current Faculty Rank* and *Are you a member of a professional nursing organizations* had less than 30 subjects in one or more of the categories, the Mann-Whitney U Test was used to determine if the small subject number impacted the ability to detect a level of significance. The Mann-Whitney U test did not detect a level of significance with either variable.

The variable of graduation years from formal nursing education was analyzed for any significant relationship to the PAI score using a correlation analysis. A scatterplot graph was analyzed to assess for signs of any relationship. The scatterplot comparing the variable graduation years to total PAI scores displayed no evidence of any correlation. Therefore, years of graduation from formal nursing education was not included on the final regression model.

The variables age and years of nursing experience adhered to correlation assumptions that include linearity, normality and no outliers (Bannon, 2013). However, for the regression analysis, additional assumptions must be met, including multicollinearity. Pallant (2013) described multicollinearity as two independent variables that are highly correlated to each other specifically citing (r=.9 and above). A Pearson's R revealed that the nurse educator's age and years of nursing experience has a strong correlation (r=.893; p=.000). Therefore, both variables (age and years of nursing experience) could not be included in the final multiple regression analysis. An additional correlation between the two independent continuous variables, age and years of nursing experiences, compared to the two dependent continuous variables, PAI and TPSE-M scores. The analysis revealed a stronger correlation between age and the PAI (r=.343,

p=.000) and TPSE-M (r=.284, *p*=.003) scores compared to years of nursing experience (r=.332, *p*=.000 and r=.247, *p*=.009) respectfully. Therefore, age was the variable placed into the final regression analysis.

Using independent-sample t-tests, three additional variables did indicate a level of significance at (p<.05) in relation to the total PAI score: *Highest Earned Degree*, *Do you have a health policy role model (formal or informal) in your professional organization?* and *Do you remember having a nurse educator as a (formal or informal) health policy role model within any of your formal nursing education?* These three variables and the continuous variable of age were the only variables used in the regression analysis to determine the predictive ability of each individual item compared to the total PAI score. Table 13 demonstrates the results of the independent-sample t-test results between the dichotomous independent variables and the total PAI scores.

Table 13

Independent-Sample T-Tests Between Independent Variables and PAI Total Score

Variable	*n*	*M(SD)*	t(*df*)	*p*
Highest Earned Degree			-2.145 (106)	.034*
MSN	46	21.76 (8.075)		
DNP/PhD	62	25.18 (8.263)		
Tenure Track			1.103 (107)	.273
Yes	45	24.64 (8.375)		
No	64	22.84 (8.405)		
Current Faculty Rank			-1.294 (44)	.202
Instructor/Assistant	27	23.07 (8.128)		
Associate/Full	19	26.32 (8.699)		
Are you a member of a professional nursing organization?			1.092 (108)	.277
Yes	102	23.75 (8.634)		
No	8	20.38 (3.777)		

Do you have a health policy role model (formal or informal) in your professional nursing organization?			3.894 (100)	.000*
Yes	51	26.86 (7.736)		
No	51	20.63 (8.421)		
Do you remember receiving formal health policy education in the following educational settings?			1.165 (110)	.246
I remember receiving formal health policy education.	79	24.03 (8.061)		
I do not remember receiving health policy education/ did not report.	33	22.00 (9.128)		
Do you remember having a nurse educator as a (formal or informal) health policy role model within any of your formal nursing education?			2.233 (108)	.028*
Yes	59	25.14 (8.310)		
No	51	21.61 (8.208)		

Note. *significance indicated at p < .05

A regression analysis on the four variables that were statistically significant at a level of $p<.05$ during the independent-sample t-tests and correlation, were analyzed to determine the predictive ability of the independent variables on the Total Political Astuteness Inventory (TPAI) score. The overall model revealed that 31% ($R^2=.313$, Adjusted $R^2=.285$) of the TPAI scores variance could be predicted by two variables: *Do you have a health policy role model (formal or informal) in your professional organization?* and *age*. Therefore, the variables: *Do you remember having a nurse educator as a (formal or informal) health policy role model within any of your formal nursing education?* and *Highest Earned Degree* were greater than the $p<.05$ level of significance ($p=.092$ and $p=.696$), when put in the final regression analysis with the other two variables.

However, the variables *Do you have a health policy role model (formal or informal) in your nursing professional organization* revealed that there is a negative

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relationship with the dependent variable because both unstandardized β scores were negative values (β=-6.761). Specifically, for this variable a response of *no* decreases the total PAI score. However, there is a positive relationship to *age* and the PAI scores (β= .347), which supports that an increase in age has a positive relationship with a higher PAI score. Further analysis through an Analysis of Covariances (ANCOVA) to calculate the partial Eta squared effect size (PES) of the two significant variables revealed that *having a health policy role model within a professional organization* and *age* both had a large effect size on total PAI scores. Table 14 displays the regression analysis and the partial Eta squared effect size for the total PAI scores.

Table 14

Regression Analysis for Variables Predicting PAI Total Score (*N*=112)

Variable	Unstandardized Coefficients		Standardized Coefficients			
	B	*SE B*	β	*t*	*p*	*PES*
Highest Earned Degree	-.317	.810	-.035	-.392	.696	-
Do you have a health policy role model (formal or informal) in your professional nursing organization?	-6.761	1.507	-.393	-4.486	.000*	.184
Do you remember having a nursing educator as a (formal or informal) health policy role model within any of your formal nursing education?	-2.484	1.461	-.144	-1.700	.092	-
Age	.347	.076	.401	4.551	.000*	.183

Note. Overall test F (4,97) = 11.066, p<.000, R^2= .313; significance indicated at *p*<.05; PES = Partial Eta Size – small = 0.01, medium = 0.06, large = 0.14 (Bannon, 2013)

Total Teacher Political Self-Efficacy-Modified Scale

The same primary analysis techniques as described above for the PAI scores were used for the TPSE-M scores. In addition to the dichotomous categorical variables assessment for a level of significance at $p<.05$, a similar examination of the variable *graduation years from formal nursing education* was analyzed for significant relationships to the TPSE-M score using a correlation analysis. A scatterplot graph was used to assess for signs of any relationship between graduation years and the TPSE-M scores. The scatterplot comparing the variable *graduation years from formal education* displayed no evidence of any correlation. Therefore, graduation years were not included on the final regression model. However, as described in the analysis of the PAI variable, *age* was a positively and significantly correlated to the TPSE-M scale at ($r=.284$, $p=.003$), so the variable *age* was included in the final multiple regression analysis.

The same process described in the analysis of the PAI variable was used for the TPSE-M variable. In the analysis each independent categorical variable was compared to the TPSE-M scores using independent-sample t-tests. Two variables did indicate a level of significance (p<.05) in relation to the total TPSE-M score: *Highest Earned Degree* and *Do you have a health policy role model (formal or informal) in your professional organization?* The three variables (Highest Earned Degree, Health Policy Role Model in a Professional Organization and age) were the only variables used in the final regression analysis to determine the predictive ability of each individual item compared to the total TPSE-M score. Table 15 demonstrates the results of the independent-sample t-tests between the dichotomous independent variables and the Total TPSE-M scores.

Table 15

Independent T-Tests Between Independent Variables and TPSE-M Total Score

Variable	n	$M(SD)$	t(df)	p
Highest Earned Degree			-2.1349 (106)	.021*
MSN	46	58.50 (19.035)		
DNP/PhD	62	66.98 (18.207)		
Tenure Track			1.408 (107)	.162
Yes	45	66.33 (19.904)		
No	64	61.19 (17.966)		
Current Faculty Rank			-1.599 (44)	.117
Instructor/Assistant	27	61.78 (19.150)		
Associate/Full	19	71.26 (20.731)		
Are you a member of a professional nursing organization?			1.591 (108)	.114
Yes	102	63.87 (19.055)		
No	8	52.88 (15.047)		
Do you have a health policy role model (formal or informal) in your professional nursing organization?			3.306 (100)	.001*
Yes	51	69.82 (18.161)		
No	51	57.92 (18.203)		
Do you remember receiving formal health policy education in the following educational settings?			.366 (110)	.715
I remember receiving formal health policy education.	79	63.23 (17.509)		
I do not remember receiving health policy education/ did not report.	33	61.79 (22.120)		

			1.906 (108)	.059
Do you remember having a nurse educator as a (formal or informal) health policy role model within any of your formal nursing education?				
Yes	59	66.24		
		(18.397)		
No	51	59.41		
		(19.104)		

Note. *significance indicated at p < .05

A regression analysis on the three variables that were statistically significant at a level of *p*<.05 during the independent-sample t-tests and correlation testing, were analyzed to determine the predictive ability of the independent variables on the total TPSE-M score. The overall model revealed that 20% (R^2 =.200, Adjusted R^2=.175) of variance in the total TPSE-M scores could be predicted by the variables: *Do you have a health policy role model (formal or informal) in your professional organization?* and age. However, the variable *Highest Earned Degree* was greater than the *p*<.05 level of significance (*p*=.683). Additionally, the variable, *Do you have a health policy role model (formal or informal) in your professional organization?* revealed that there was a negative relationship with the Total TPSE-M score based on the unstandardized β score which was a negative value (β = -12.657). Therefore, within this variable a response of *no* decreases the total TPSE-M score. However, there is a positive relationship to age and the TPSE-M scores (β = .307), which supports that an increase in age has a positive relationship with a higher TPSE-M score.

Further analysis through an ANCOVA to calculate the PES of the two significant variables revealed that having a health policy role model within a professional organization and age both had a medium effect size on total TPSE-M scores. Table 16 displays the regression analysis for the total TPSE-M scores.

Table 16

Regression Analysis for Variables Predicting Total Teacher Political Self-Efficacy –
Modified (*N*=112)

Variable	Unstandardized Coefficients		Standardized Coefficients			
	B	*SE B*	β	*t*	*p*	*PES*
Highest Earned Degree	.787	1.920	.039	.410	.683	-
Do you have a health policy role model (formal or informal) in your professional nursing organization?	-12.657	3.553	-.334	-3.563	.001	.127
Age	.585	.180	.307	3.252	.002	.111

Note. Overall test F (3, 98) = 8.160, p<.000, R^2= .200; significance indicated at *p*<.05; PES = Partial Eta Size – small = 0.01, medium = 0.06, large = 0.14 (Bannon, 2013)

Summary

Chapter Four presented the data and analysis for the demographic variables and the four research questions within this study. The chapter also contained a description of the sample and the quantitative data for each of the four research questions. Descriptive statistics were reported for the overall sample, as were the nurse educators' total scores on the PAI and TPSE-M scales used within the study. Furthermore, a correlation was completed between these two scales and indicated a strong relationship between the two scales. Additionally, each independent variable was analyzed against the total PAI scores and the total TPSE-M scores using the independent-sample t-test statistic. Finally, all independent variables that were significant to the dependent variables individually were then analyzed collectively with a multiple regression analysis to determine the predictive

impact on each scale. The final chapter in this study presents a summary and discussion

of these results, implications for practice and recommendations for future research.

CHAPTER FIVE

DISCUSSION AND IMPLICATIONS

The following chapter discusses the overall results and implications for nursing education. The aim of this research was to investigate if a relationship exists between a nurse educator's self-reported political astuteness and self-efficacy. An additional aim of this study was to determine if any personal or professional factors impact a nurse educator's self-reported political astuteness and self-efficacy. This chapter includes a summary and discussion of the study's findings and comparisons of the findings to the current literature. This chapter also discusses implications for nursing faculty and administration and recommendations for future research.

Summary and Discussion of Results

The following section summarizes and discusses the demographic findings, Teacher Political Self-Efficacy - Modified (TPSE-M) and the Political Astuteness Inventory (PAI) results, and the personal and professional factors that impacted the PAI and TPSE-M faculty scores within this study.

Demographics

A total of 128 nurse educators participated in the study. The final data set included the 112 nurse educators who completed both the PAI and TPSE-M scales. However, not all 112 nurse educators completed the full series of demographic questions including gender, age, years of nursing experience, Mid-Atlantic state of employment (PA, NY, NJ, MD, or DE), highest earned degree, years of graduation from each nursing degree, tenure track, membership in a professional organization and formal health policy education at any level of their education, and health policy role models.

The National League for Nursing (2015) Nursing education Survey indicates a female to male ratio of full-time nurse educators is 94% female and 6% male, and for part-time educators, the ratio is 92% female and 8% male (NLN, 2015). Based on the NLN (2015) data, the sample used in this study underrepresented the male nurse educator population. Only 2 (1.8%) of the 109 participants who answered the demographic questions identified themselves as male. Both male respondents reported full-time employment, and one was in a tenure track position. As a result of the underrepresentation of males in the sample, this demographic variable was not included in any additional statistical analysis.

The average nursing faculty age in this study was 53.9 years old. The AACN (2017) Annual Faculty Survey indicates that the average faculty age for doctoral prepared faculty by tenure rank (professor, associate, and assistant) were 62.2, 57.6, and 51.1 respectively. The average age for MSN-prepared faculty by the same tenure rank were 57.8, 56.6, and 50.9 (AACN, 2017). While data regarding the overall average nursing faculty age regardless of education preparation or tenure status was not found in the literature, the average age of 53.9 based on the average age of faculty per the AACN data appears to be consistent with national trends. Additionally, national averages of the years of nursing experience for nurse educators was not located in the nursing literature. However, based on the graduation dates provided by the respondents and their reported years of experience, it appears that many of the nursing faculty were first degree nursing students who entered the nursing profession at an early age. The average years of experience within the sample at 30.18 years. Therefore, it is reasonable to assume that nursing faculty formal education was primarily in nursing and therefore minimizes the

impact of second degrees on health policy astuteness and self-efficacy in the findings. Vandenhouter et al. (2011) found that nurses who completed non-nursing courses with an emphasis on the political process had a higher political knowledge level and overall positive feelings associated with the political process compared to those who only took nursing courses. In the sample for the current study, it appears that most of the respondents only received formal nursing education.

In addition to gender, age, and years of nursing experience, nurse educators from each of the five states in the sample were represented in the study, with most educators being from Pennsylvania. It is also important to note that between because of the difference in size of nursing school faculties a range of seven to 10 nursing schools from each state were sampled in the study, with the exception of Delaware. In Delaware, only one school is a Commission on Collegiate Nursing Education (CCNE) accredited school. The demographic data on the state where the nurse educator works was not collected for consideration into the final regression analysis but was gathered to ensure that each state in the sample was represented in the study. Each state in the study was from the Mid-Atlantic region.

Educational factors within the demographic questions included highest earned nursing degree, employment status, tenure track and faculty rank. Specifically, in this sample there were a few more doctoral prepared nurse educators within this sample than master's prepared nursing educators. However, the national average in all ranks of full-time educators indicates a greater number of MSN prepared nursing educators at 64% (NLN, 2015). Another finding within the demographic data was an overwhelming majority of the sample were full-time nurse educators (92.9%). Both of these findings

may have been due to the sampling technique. Only nurse educators whose emails were listed on the randomly selected schools of nursing's websites were included in the initial solicitation email. Despite the predominately full-time nurse educators in the sample, only 40% were on a tenure track, which is consistent with the national average per the NLN's (2015) report where 22% of full-time educators were tenured and 16% were on tenure track, and the remaining 62% were not on a tenure track. Of the 45 nurse educators on the tenure track, over half were at an assistant professor level, which is generally the entry level rank on the tenure track.

Additional educational factors collected in the demographic portion of the survey included the graduation year from each formal nursing program the participant completed. This question evoked a wide range of answers. The earliest pre-licensure nursing degree was obtained in 1958 and the latest was in 2010. Due to the wide range of graduation years, the decision was made to organize and analyze the data compared to the first Baccalaureate *Essentials* document. Since the first publication of the CCNE Essentials was not until 1986, nurses who received their pre-licensure degrees prior to 1986 would not have the CCNE *Essentials* integrated into their nursing curriculum. With that in mind, almost half (47.3%) of the sample received their pre-licensure degree prior to the first published *Essentials* document. Only 32 respondents reported earning an RN-BSN degree: therefore, 73 nurse educators in the sample received their primary pre-licensure degree at the BSN, and not an associate or diploma degree. Five nurse educators reported receiving their pre-licensure degrees after 2008, which is when the current *Essentials* documents was published and could have been integrated into those five nurse

educators undergraduate nursing curricula particularly at CCNE accredited nursing schools. Seven participants did not disclose their highest earned degree.

The remaining demographic questions asked nurse educators their experience with formal health policy education and if they remembered a nurse educator as a health policy role model in their formal education. The respondent could choose more than one level of education as applicable for both questions. Finally, the educators were asked if they were a member of a professional nursing organization and if they had a health policy role model within their profession nursing organization. Interestingly, 24.1% of nurse educators did not remember receiving any formal health policy education, which is less than the number of nurse educators who received their education before 1986 indicating health policy education was being taught in nursing schools prior to the *Essentials* publication. The findings in this study differ from Vandenhouter et al.'s (2011) study. In Vandeerhouter et al.'s (2011) study a sample of registered nurses (N=468) from both educational and hospital settings were surveyed about political participation. Within the sample, 73% of the nurses had little to no recollection of political process or participation information discussed within their formal nursing school experience. While the question asked in Vandenhouter et al., (2011) study was more focused on a specific type of health policy information, it still demonstrates a lack of full health policy information discussed within nursing schools. However, the nurse educators in the current study reported remembering some type of health policy education at one or more level of nursing education. The largest percentage of nurse educators who remember receiving formal health policy education was at the doctorate level, which includes both PhD. and DNP, at 68.8%.

While a majority of nurse educators remembered receiving some form of health policy education, 46% of nurse educators did not remember a health policy role model in their nursing education. Again, the largest percentage, 52.4% (n=32), of nurse educators who remembered a health policy role model in their formal nursing school was at the doctorate level, but only 61 nurse educators indicated a doctorate degree. In a similar finding, when responding to the question addressing a nurse educator's membership in a professional nursing organization and the subsequent question regarding a health policy role model within a nursing organization, a majority of the sample responded that they were members of a professional nursing organization (n=102), and half of the educators who belong to a professional nursing organization (n=51) indicated they had a formal or informal health policy role model.

Nurse Educators' Political Self-Efficacy

Research Question One addressed nurse educators' political self-efficacy. The 20-item tool used a five-point Likert scale: 5=strongly agree, 4=somewhat agree, 3=neither agree nor disagree, 2=somewhat disagree, and 1=strongly disagree. The mean score for all nurse educators was 62.8. The scale ranged from 20 to 100. Therefore, the mean score places the average response at a level just about the response neither agree nor disagree. This response indicates a low self-efficacy or a level of apathy regarding political self-efficacy. Apathy as defined by Kelly (2007) is a nurse who does not participate or show any interest in participating in the political process. Kelly (2007) argued that apathy should be added to the Cohen et al.'s, (1996) four-stage framework to classify a nurse's political activism development with Stage 1 – buy in, Stage 2 – self-interest, Stage 3 – political sophistication and Stage 4 – leading the way. With an average response in the

neither agree nor disagree range, nurse educators in this study continue to demonstrate support for Kelly's (2007) assertion that a stage before Cohen et al's (1996) buy-in stage should be added for nurse educators. A stage of apathy with respondents indicating that they neither agree or disagree with statements on the tool would more accurately reflect the level of political self-efficacy for the sampled nurse educators in this study.

The findings in this study are similar to the findings of the K-12 teachers in Hammon's (2010) study. The average nurse educator response rate was a mean of 3.14, while the average a response rate in Hammon's (2010) study of K-12 classroom teachers was a mean of 2.89, which is slightly lower than the nurse educators' response rate. However, in both studies the average score indicates a low political self-efficacy with the average response close to the prompt neither agree nor disagree, indicating a level of indifference to political action items listed on the TPSE-M tool.

Within the TPSE-M, two items scored greater than four, indicating areas where nurse educators did perceive self-efficacy. Those items included: *I stay informed about national and state health policy initiatives* (*M*=4.13; SD=.895) and *I encourage and support other nurses and nurse educators who engage in health policy related activities* (*M*=4.30; SD=.837). The second statement was the highest rated of all 20 statements, indicating nurses support others participating in health policy activities. Multiple nursing studies and anecdotal literature similarly reported nurses feeling more comfortable having others engage in health policy activities (Buck-McFadyen & MacDonnell, 2017; Crowder, 2016; Rains & Kriese, 2001; Short, 2008; Staebler et al., 2017; Taft & Nanna, 2008; Van Hoover, 2015).

Interestingly, areas where nurse educators reported lower political self-efficacy were areas dependent on nurse educators acting as health resources and engaging in policy making activities. Low political self-efficacy items included: *I have served as a member of a work group or committee charged with researching and developing recommendations on a health policy issue* (*M*=2.40; SD=1.498); *I have played a role in the selection of members/leaders of school sponsored committees or work groups dealt with health policy matters* (*M*=245; SD=1.407); and *I develop and maintain relationships with local and state government officials* (*M*=2.52; SD=1.362). All three of these items are action-oriented. Nurses have historically removed themselves from participating in health policy actions and these low self-efficacy scores exhibit a continued trend for nurse educators. In Khoury et al.'s (2011) review of nursing leadership, nurses identified multiple barriers and reasons why nurses are not actively involved in health policy work, namely lack of time, lack of interest, lack of knowledge, and lack of opportunities to pursue policy and leadership positions. The current research supports that the nurse educators within this sample continue to lack self-confidence to share health care knowledge with key stakeholders to initiate possible change. This finding is similar to Staebler et al.'s (2017) study of nurse educators, a continued lack of desire and opportunity to participate in health policy activities was reported. The current study supports the literature's assertions, but offers an additional reason beyond lack of interest, time, or opportunity by adding a lack of self-efficacy to engage in these actions. Potentially, if an educator had an interest, time, and an opportunity to engage, they may still hesitate to actively participate due to an overall lack of political self-efficacy, ultimately perpetuating the cycle of nurses not engaging in health policy at any level.

Political Astuteness Inventory

A second aspect of this study focused on nurse educators' self-report of their political astuteness. Research Question Two addressed how nurse educators assess their own political astuteness. Political Astuteness is defined by Primomo and Bjorling (2013) as a combination of awareness, knowledge and involvement in the political system. The Political Astuteness Inventory (PAI) is designed to measure political astuteness on a 0 to 40 score. A higher score is associated with a greater awareness, knowledge and involvement in the political system. In this study the average score was just over 23. Based on the scoring criteria established by Clark (1984), an average PAI score of 23 places the aggregate sample within the 20 – 29 scoring category - *beginning political awareness*. It is reasonable to suggest, given the nature of their position, the average score for all nurse educators should be in the highest category 30-40: *politically astute and an asset to the profession*. The overall findings demonstrate that nurse educators with an average of 30 years of nursing experience working as full-time educators are still at the beginning level of political awareness, which supports the literature citing a continuing lack of political knowledge in nursing (Buck-McFadyen & MacDonnell, 2017; Hahn, 2010; Kelly, 2007; Primomo & Bjorling, 2013; Staebler et al., 2017; & Taylor, 2016).

However, the nurse educators' frequency of *yes* responses was most prevalent among the items focused on voting. The two items: *I am registered to vote* and *I know where my voting precinct is located* both had 109 of the 112 nurse educators respond yes. With nurses accounting for one out of every 45 registered voters, it is encouraging to see that nurse educators in this study participate in the political process through voting

(Desilver, 2017). Literature indicates that nurses generally vote at the same rate as the general public (55%) (Desilver, 2017). In addition to voting at the same rates as the general public, Gardner (2012) highlighted that nurses have developed voter cynicism. Voter cynicism stems from an overall feeling that one's vote does not matter and leads to citizens not participating in the election process. In today's environment this sentiment maybe growing. A recent Pew Research Center (2018) poll indicted only 3% of Americans have a "great deal" of confidence in their elected officials. In 2007, only 34% of Americans surveyed agreed that "most elected officials care what people like me think" (Pew Research Center, 2007, para. 23). Voter cynicism and a lack of confidence that elected officials represent their constituents can decrease overall voter participation. However, over 90% of the nurse educators in this study reported participation in the election process by voting in the last two elections, including the last general election. Nurse educators in this study also indicated they were informed voters, as over 90% indicated they recognized the names of candidates on the election ballot in the last election and were familiar with major issues on the ballot. This finding indicates that these nurse educators are more involved in the election process, compared to the general population.

While the majority of nurse educators self-reported active and informed voting records, there were some items that a majority of the sample responded *no* to, including providing health policy counsel to elected representatives, providing testimony at public hearings concerning health issues, and attending public health hearings related to health issues. These three activities have common traits such as requiring a greater time commitment, knowledge level and comfort level to engage in. Nurse educators'

responses may reflect the barriers that registered nurses and nurse educators have identified within the literature. Staebler et al.'s (2017) study cited a lack of faculty engagement and expertise as barriers to effective health policy education. Additionally, Vandenhouter et al. (2011) found that registered nurses reported a lack of resources, time and knowledge as reasons for not engaging in the political process or health policy engagement. Holtrop et al. (2000) also cited health educators in general noted that time was a major barrier to participating in policy activities. With their expertise in the field and knowledge of health issues, nurse educators should be contributing beyond the general public in political participation. Yet the results of the political astuteness inventory reflect that nurse educators remain disengaged in any health policy or political process. While nurse educators are more engaged in voting compared to the general public, other political advocacy activities remain consistent with all other American citizens, despite the *Code of Ethics for Nurses* inviting nurses to embrace health policy advocacy as a core professional value (ANA, 2015). Thereby, nurses and nurse educators should be more involved than the general populations level of policy involvement.

Relationships Between Dependent and Independent Variables

Dependent variables. Research Question Three addressed what relationship exists between the TPSE-M tool and the PAI. Dr. Hammon (2010) developed the TPSE and tested it in her dissertation, but it has not been used in a nurse educator population. The PAI is a well-established tool to measure political astuteness. Knowledge is one aspect of learning, Bandura (1986) explains in his Social Cognitive Theory (SCT) that social learning needs multiple facets to be present to promote a learning environment. Another key element in Bandura's (1986) SCT is self-efficacy. Bandura (1997a)

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described that when self-efficacy is positively fostered, it promotes overall learning. Overall knowledge on a selected topic can enhance positive perceptions of self-efficacy (Bandura, 1997a). In this study, the nurse educators' scores of political self-efficacy and political astuteness were strongly correlated to each other (r=.809, p=.000). This finding illuminates two discussion points: there is a correlation between nurse educators' self-reported knowledge and political self-efficacy and additional support can be given to strengthen the construct validity of Dr. Hammon's (2010) Teacher Political Self-Efficacy tool.

The findings support a positive relationship between political astuteness and political self-efficacy. Previous studies examined ways to increase political astuteness through pre and post-test study designs after exposing nursing students to some specific health policy education (Primomo, 2007; Primomo & Bjorling, 2013; Zauderer et al., 2009). All of these studies revealed improvements in nursing students' knowledge scores after health policy interventions. With the addition of this study to the literature, support toward a stronger correlation between self-reported political knowledge and political self-efficacy can be established. This concept is also supported by Bandura's SCT (1986), promoting knowledge can increase self-efficacy.

Application to theory. While Bandura's SCT requires knowledge to be present, the concept of self-efficacy can be difficult to empirically measure. Bandura (2006) introduced key concepts to aid in creating appropriate self-efficacy scales; one of which is that the validity of self-efficacy scales relies on the continued testing of the scale's construct against other valid tools. Therefore, Hammon (2010) completed construct validity testing on three constructs within her tool. The tool is designed to measure self-

efficacy, as the three constructs in the tool are teacher instructional self-efficacy, perceived and internal political self-efficacy, and actual engagement in professional/political/civic activities. Hammon's (2010) dissertation supported the construct validity of the TPSE through the correlations drawn when comparing the TPSE results to established tools to measure each of the three constructs within the tool. However, Bandura (2006) suggested self-efficacy scale development is ongoing through continued testing against predicted effects.

In this nurse educators' political self-efficacy and political astuteness study, Bandura's (1986) SCT framework was used to support an increase in the knowledge level of a subject raises overall self-efficacy. With this study's positive correlation results between the nurse educators' self-reported political astuteness and the higher level of political self-efficacy, Hammon's (2010) TPSE tool now has added support of its overall validity as a tool to measure Teacher's Political Self-Efficacy in two populations K-12 educators and nurse educators.

After the tools were determined to have a strong positive relationship with each other, the independent personal and professional variables were individually compared to each of the tools. After the final multiple regression analyses were complete, two variables emerged as predictor variables on the TPSE-M scale and the PAI scale. The variables were age and having a health policy role model (formal or informal) in their professional nursing organization.

Independent variables. The personal variable of age was calculated with a large effect size on the PAI score and a medium effect size on the TPSE-M score. However, it is important to note that the overall predictive impact of age and having a health policy

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role model in their professional nursing organization on the PAI and TPSE-M scores were 31% and 20%, respectively. Nevertheless, there is a predictive value associated with age in the general population. According to the Current Population Survey Voting and Registration database assessing data from 1964-2012, the following voting patterns emerged: 65 and older (69.7%), adults 45 to 64 (63.4%), 25 to 44 (49.5%) and 18 to 24 (38%) (File, 2014). Voting is one aspect of the political astuteness and political self-efficacy scales, and it is possible that older nurses have more life experiences that play a role in increasing self-reported political astuteness and political self-efficacy. Additionally, nurse educators who are older may have less barriers to overcome to engage in health policy. Nurse educators early in their career may have more family and social strains on time commitments, compared to a later career nurse educator who may have less family and social demands allowing more time to pursue health policy engagement interests.

Within this nurse educator sample, most participants were full-time educators who were already members of a professional organization. A few reasons may explain the samples participation in professional nursing organizations. Potentially, older nurse educators have more financial freedom to join a professional organization. Also, the promotion process within a specific college or university may require evidence of service to the profession; therefore, joining and actively participating in a profession nursing organization may provide opportunities to meet this requirement.

A large number of nurse educators in the study (n=102) indicated a membership to a professional nursing organization. The findings did not support a statistically significant relationship between being a member of a professional organization alone as a

contributing factor in higher PAI or TPSE-M scores. However, having a health policy role model within one's professional nursing organization was a significant variable on the total PAI and TPSE-M scores.

Interestingly, the variable of having a nurse educator as a health policy role model was not statistically significant; however, having a role model from a professional nursing organization was a significant indicator of higher PAI and/or TPSE-M scores. This finding leads the discussion to analyze what are the inherent differences between a nurse educator role model and a professional nursing organization role model. One explanation may be that many professional nursing organizations have advocacy as a core mission and thereby are more politically active compared to a nurse educator. Staebler et al.'s (2017) study found that 86.2% of nurse educators teach health policy content, but only 44% are actively involved in health policy advocacy. The nurse educators' political astuteness scores and political self-efficacy scores differences between those educators who are members of a professional nursing organization compared to being an active participant in professional nursing organization may be a key link to increasing overall political self-efficacy among nurse educators and nursing professionals in general.

This finding supports previous research indicating professional nursing organization membership is an important aspect of enhancing political engagement (Brown, 1996; Kelly, 2007; Logan et al., 2011; Nannini, 2009, Staebler et al., 2017; Vandenhouter, 2011; Woodward, 2016). Taylor (2016) identified that the act of joining a professional nursing organization may indicate that the nurse has a higher intrinsic motivation toward policy advocacy. Only nurses who responded *yes* to membership in a professional nursing organization were prompted to answer the follow up question

regarding a health policy role model. Therefore, the scores of nurses who had health policy role models within their professional nursing organization were statistically higher than those who are members of professional organizations but did not indicate a health policy role model. Hence, this study seems to indicate that having a role model within a professional nursing organization increases political astuteness and political self-efficacy.

Application to theory. Bandura's (1986) SCT also supports the finding that a health policy role model within a professional nursing organization leads to statistically higher political astuteness scores and political self-efficacy. As Bandura (1986) postulated self-efficacy increases with increased knowledge on a topic, an intrinsic or extrinsic motivation exists, and an environment where the learner can see a role model who is successful in demonstrating the skill or concept in action. Therefore, a nurse educator who is a member of a professional nursing organization may hold a higher intrinsic motivation regarding health policy engagement and when exposed to a health policy role model within the organization. Overall learning occurs regarding health policy engagement, increasing both political astuteness and political self-efficacy.

<center>**Study Limitations**</center>

There were multiple limitations within this study. The limitations include the sample technique, a specific region studied, male representation, the use of self-reported data, and missing demographic question responses. The study used a random cluster sample technique, where every faculty member listed on the nursing school's faculty website was included in the sample. However, this may have biased the sample to full-time nurse educators because part-time and adjunct nurse educators' emails may not be publicly available on the nursing school's website. This sampling technique was also

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reliant on the emails from the website, which may not have been up to date with current faculty. Also, when randomly selecting nursing schools to send the solicitation email, the researcher's own doctoral school was selected. However, after discussion with the researcher's dissertation chair and doctoral coordinator, the decision was made to include the school's faculty; however, the researcher's dissertation chair and committee members on the solicitation email list were not included due to their knowledge of the research. An additional limitation within the sample was an overall underrepresentation of male nurse educators, which required the personal variable of gender to be removed as a measurable variable. Finally, although the power analysis number was reached in the study, having a larger sample size would improve generalizability of result to all nurse educators. By increasing the size of the initial solicitation email group to mirror Polit and Beck's (2012) anticipated 10% return rate, compared to the Saleh and Bista's (2017) anticipated 25% return rate, a larger sample could be collected. Therefore, by anticipating a lower response rate and increasing the initial number of solicitation emails, it may have increased overall participation, specifically increasing the total number of invited participants from 541 to 1000.

Another limitation in this study included the reliance on self-reported information. Both surveys were based on nurse educators reflecting on their own actions. However, there may be political and policy actions that a nurse educator participates in such as, signing an online petition, that were not addressed in the two surveys. Therefore, because of the vast array of political and policy action one could participate in, if it was not captured on the two survey tools, it may have underrepresented a nurse educator's political astuteness or political self-efficacy actions.

A final limitation in this study was missing responses to demographic questions. There were as many as seven educators who did not answer all of the demographic questions. The demographic questions came after the two dependent variable surveys which contained 40 and 20 questions, respectively. There were an additional 10-15 demographic questions, which may have still been too many to include in the survey given the length of the two tools used within the study. Overall, maximizing the number of nurse educators solicited to be a part of the study while also decreasing the demographic variables and moving the demographic questions to the beginning of the survey may have improved the overall final data sample.

Implications

The findings in this study can provide nurse educators, including nursing department chairs and deans, with information on factors that impact political astuteness and political self-efficacy. This study also has implications for professional nursing organizations. The following section discusses implications for faculty, nursing department chairs and deans, and professional nursing organizations.

The first implication is that nursing faculty should continue to strive to increase their political astuteness. Based on Bandura's (1986) SCT and supported by the results of this study, increasing overall political astuteness of nurse educators will likely increase political self-efficacy. For nurse educators, this cannot be a passive process. It appears, based on the literature that nurses have relied on intrinsic motivation to guide health policy engagement (Brown, 1996; Kelly, 2007; Logan et al., 2011; Nannini, 2009, Staebler et al., 2017; Vandenhouter, 2011; Woodward, 2016). Perhaps it is time that active engagement opportunities are presented to nurse educators to encourage

participation in health policy activities. One example to encourage participation would be community advisory councils found on many colleges and university nursing departments. Nursing department chairs could invite local legislators to be a part of the advisory council to encourage interactions between legislators and educators. It gives an opportunity for legislators to learn what local nursing schools are teaching and promoting in nursing and it gives nurse educators an opportunity to speak to a legislator about health policy issues. Additionally, it opens the door for networking and nurse educators to become a resource for that legislator or reaching out to their own legislator. Also, through participation and publicizing the interactions with legislators, through social media pages or department websites, department chairs could create an atmosphere encouraging active health policy engagement.

Second, nurse educators should be strongly advised to join and actively engage in a professional nursing organization. Department chairs or deans could play a critical role in this by including participation in a professional organization as part of a nurse educator's performance review. Staebler et al. (2017) suggested that nurse educators who participate within a professional nursing organization should be recognized as either evidence of scholarship or service to the profession within the evaluation process and that those professional organization actions carry an appropriate weight within the overall performance evaluation. This change could increase participation in professional nursing organizations because it would place external motivation on professional nursing organization participation. By including health policy engagement activities as part of a nurse educator's performance evaluation as a duty to the profession, it creates an external motivation for the educator to engage in health policy through their professional nursing

organization. Incentivizing and encouraging participation in health policy fulfills the professional responsibility of a registered nurse per the ANA's Code of Ethics (ANA, 2015). Many studies in the literature demonstrated that once a registered nurse or student participated in a health policy activity, they felt more empowered to engage in subsequent activities (O'Neill, 2016; Van Hoover, 2015; Zauderer et al., 2009). Therefore, by initially creating an external motivator for nurse educators to be active in professional nursing organization, it will begin the process of nurse educators internalizing the engagement process and beginning to rely on intrinsic motivation.

Nursing department chairs and deans should actively seek out faculty who are interested in health policy. Ideally, identifying those nurse educators who display an interest in health policy and fostering that health policy interest for nurse educators may allow nurse educators to feel more supported to participate in activities that involve health policy advocacy. Deans and department chairs can demonstrate their commitment to health policy advocacy by budgeting specific funding to support faculty taking students to legislative day events held by many professional nursing organizations, which could increase health policy awareness. The literature supports an increase in political astuteness after attending specific health policy events (Primomo 2007; Primomo & Bjorling, 2013; Zauderer et al., 2009). Thereby, deans and nursing chairs promoting attendance at such event by faculty and student health policy knowledge could increase and could lead to higher political self-efficacy scores.

Additionally, deans and department chairs should encourage role modeling within the department. Ultimately, deans and nursing department chairs should be role models on health policy by discussing and inviting others to join health policy activities. Nurse

educators can gain more knowledge about health policy through continue education modules and conferences, with deans and nursing department chairs supporting the faculty's learning. A grassroots effort to encourage nurse educators within each nursing department could make health policy engagement more relatable. It is important the deans and nursing department chairs recognize the individual clinical areas of interest of each faculty member and encourage analysis of current health policies that relate to that faculty member's area of interest. Nursing department chairs can encourage conversation with nurse educators to help the nurse educator integrate his or her clinical background area and subject knowledge into action by investigating health initiatives at all levels from university through federal initiatives to improve health. Additionally, during curriculum meetings nursing department chairs could require all nurse educators to identify key health policy initiatives that are specialized to the course content. By requiring nurse educators to collectively identify content area focused on health policy initiatives, faculty promote engagement in current initiatives and will extend health policy content across the curriculum, which is a recommendation that has long been suggested in the literature (Brown, 1996; Staebler et al., 2017).

Also, faculty must actively encourage other faculty and students to participate in health policy engagement. Faculty can initiate visits to local, state and national legislators and then encourage other faculty and students to join in the meeting. Faculty can also demonstrate the importance of health policy engagement by participating in student nursing organizations programs to promote health policy knowledge and engagement. All faculty can assume health policy engagement responsibility with student nursing

organization through attendance at local meetings, instead of all the advising responsibilities of the organization falling on one faculty member.

Faculty should take an active role to engage student interest in health policy engagement. Nursing faculty should demonstrate competence in health policy information by explaining health policy terminology, role modeling effective health policy engagement, and actively drawing students into health policy engagement situations. Nursing faculty can also expand their health policy understanding through continuing education health policy seminars. Additionally, nursing faculty can utilize interdisciplinary resources through the use of faculty from different disciplines such as Political Science and Government to guest lecture on policy engagement. Actively engaging students will help students understand how to apply course content on health policy in their future professional nursing career.

This study has implications for professional nursing organizations as well. Current members within the professional nursing organization can connect with new members providing opportunities for engagement. Nurse educators can have health policy experts from nursing organizations come to their university to speak to all faculty and students about engagement in health policy and come with specific opportunities that need attention. By integrating resources such as a professional nursing organization faculty can keep the focus of health policy engagement on the overall health system. The important piece in this education should be focused on research supporting or not supporting current health policy initiatives, so educators and students can see the reason why engagement is important.

Professional nursing organizations should also establish formal mentoring programs for membership. Within professional nursing organizations there are members who are more intrinsically motivated to be health policy advocates. However, this study revealed the power of health policy role models; therefore, those role models need to be more prevalent within organizations. Professional nursing organizations can introduce policy process and health policy engagement seminars through online or face to face conferences. After these education seminars, faculty should be given the opportunity to develop mentorships with identified role models within the professional nursing organization. The role of these mentorships could be as a resource for faculty to learn and develop health policy engagement skills.

While many professional nursing organizations have legislative days where members go to a state capital or Washington D.C. to actively advocate for specific legislative initiatives too often these are only a one-day event. Therefore, activities throughout the year with opportunities to engage in health policy, using health policy role models could help build a larger network of engaged nurse educators. Additionally, having nurse educators examine what elements of health policy they are most passionate about and creating engagement opportunities for specific health interests could help bridge the gap in participation for nurse educators. For example, a nurse educator whose clinical background is maternity health, may not be interested in a legislative discussion on nursing staffing issues, but may be very passionate about access to perinatal care in rural areas. Therefore, professional nursing organizations could broaden the scope of health policy initiatives they are advocating for by aggregating health policy role models who may have similar interests. Thereby, focusing efforts on different health policy

initiatives could help more nurse educators find their intrinsic motivation to health policy engagement.

The literature revealed that barriers are present for nurses to enter into health policy activities, but the aforementioned implications may help nurse educators enter into health policy advocacy (Byrd et al., 2012; Taylor, 2016; Vandenhouter, 2011). It appears that after that first health policy engagement connection is made, nurses and nurse educators feel more comfortable with engaging in future activities. This study revealed that older nurse educators and those who have a health policy role model within a professional nursing organization indicated a significantly higher political self-efficacy score and political astuteness score. Those nurse educators may then be better equipped with both political knowledge and political self-efficacy, to act as health policy role models for both faculty and students. However, there must be a focus on creating opportunities for nurse faculty to begin the health policy engagement process and that may need to begin with more extrinsic motivators rather than relying on intrinsic motivators as has been the case thus far.

Recommendations for Future Research

The findings of this study revealed that political astuteness and political self-efficacy are strongly correlated. These findings support Social Cognitive Theory. Bandura's (1986) theory postulates that increased self-efficacy relies on knowledge of the subject matter and a positive role model to produce behavior changes. Nurse educators who responded that they had a health policy role model in their professional nursing organization had statistically higher political astuteness scores and political self-efficacy

scores. The study also supported that age also impacted political astuteness and political self-efficacy scores.

The first recommendation for future research includes replicating this study and expanding the sample nationally. A repeated study with a national sample could help validate these findings. It would also be interesting to also identify the type of professional organization that nurse educators are members of to determine if there are any differences between membership in state or national organization (i.e. American Nurses Association and state professional nursing organization) compared to specialty specific organizations (i.e. Critical Care Nurses Association or Academy of Medical-Surgical Nurses).

A second recommendation for future research is to explore what a professional nursing organization's health policy role model impact is on nurse educators. A qualitative study focused on the dynamic between health policy role models in professional nursing organization and nurse educators, could reveal key element of this relationship. A study examining the core values shared within the relationship, qualities of a professional nursing organization health policy role model and the specific modalities used to promote that interaction would be beneficial to explore. This study could provide insight for professional nursing organizations to use to purposefully establish effective role modeling relationships.

A final research opportunity is to examine nurse educators' health policy engagement over time. The current research reviewed for this study was composed of studies on nursing students change in political astuteness after a specific intervention but did not evaluate health policy engagement overtime (Primomo 2007; Primomo &

Bjorling, 2013; Zauderer et al., 2009). A longitudinal study with repeated measures testing could assess changes in political astuteness and political self-efficacy over time. Specifically, the personal variable of age was a statistically significant factor in this study, but the study did not explore if there are specific elements that come with age that are impacting political astuteness and political self-efficacy. A study measuring political astuteness and political self-efficacy variables along with having educators indicate what health policy activities they are participating in could prove beneficial to identify key areas that increase health policy engagement. Moreover, multiple literature reviews, quantitative studies, and anecdotal sources state the barriers to health policy engagement (Buck-McFadyen & MacDonnell, 2017; Holtrop et al., 2000; Primomo, 2007; Primomo & Bjorling, 2013; Staebler et al., 2017; Zauderer et al., 2009). However, no study specifically investigated what activities have occurred over time to increase or decrease health policy engagement. Continued research is needed to examine the part a health policy role model plays in promoting health policy engagement. The ability to move more nurse educators into the role model position could promote continued health policy engagement among educators and in the classroom student nurses as well.

Conclusion

This final chapter discussed the findings of this study and compared and contrasted with previous research and literature. The research aimed to fill a gap in the literature regarding nurse educators' self-reported political astuteness and political self-efficacy and to determine if any personal or professional factors that impact political astuteness and political self-efficacy. Current literature discusses registered nurses' general political astuteness, but no current studies address nurse educators' political

astuteness and political self-efficacy (Primomo 2007; Primomo & Bjorling, 2013; Zauderer et al., 2009). The results of this study found that nurse educators' political astuteness scores are positively correlated to their political self-efficacy scores, meaning that a higher political astuteness score corelated to a higher political self-efficacy score. However, overall nurse educators in this study did not have high political astuteness or political astuteness scores. Age and having a health policy role model in a professional nursing organization had a statistically significant relationship to both the political astuteness scores and the political self-efficacy scores, which adds validity to Hammon's (2010) original TPSE scale and support for Bandura's (1986) SCT. Specific implications for nurse educators, nursing department chairs and deans and professional nursing organizations were discussed in this chapter. Finally, future research recommendations were made to continue to explore how to most effectively encourage nurse educators to participate in health policy engagement.

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Appendix A

IRB Approval Letter

IUP Indiana University of Pennsylvania
www.iup.edu

Institutional Review Board for the
Protection of Human Subjects
School of Graduate Studies and Research
Stright Hall, Room 113
210 South Tenth Street
Indiana, Pennsylvania 15705-1048

P 724-357-7730
F 724-357-2715
irb-research@iup.edu
www.iup.edu/irb

January 30, 2018

Dear Rebecca Modene:

Your proposed research project, "Health Policy Engagement Among Nurse Educators – A Descriptive, Cross-Sectional Study into Political Astuteness and Political Self-Efficacy and the Impact of Personal and Professional Factors," (Log No 18-021) has been reviewed by the IRB and is approved as an expedited review for the period of January 30, 2018 to January 29, 2019. This approval does not supersede or obviate compliance with any other University requirements, including, but not limited to, enrollment, degree completion deadlines, topic approval, and conduct of university-affiliated activities.

You should read all of this letter, as it contains important information about conducting your study.

Now that your project has been approved by the IRB, there are elements of the Federal Regulations to which you must attend. IUP adheres to these regulations strictly:

1. You must conduct your study exactly as it was approved by the IRB.
2. Any additions or changes in procedures must be approved by the IRB before they are implemented.
3. You must notify the IRB promptly of any events that affect the safety or well-being of subjects.
4. You must notify the IRB promptly of any modifications of your study or other responses that are necessitated by any events reported in items 2 or 3.

Should you need to continue your research beyond January 29, 2019 you will need to file additional information for continuing review. Please contact the IRB office at irb-research@iup.edu or 724-357-7730 for further information.

The IRB may review or audit your project at random *or* for cause. In accordance with IUP Policy and Federal Regulation (45CFR46.113), the Board may suspend or terminate your project if your project has not been conducted as approved or if other difficulties are detected.

Although your human subjects review process is complete, the School of Graduate Studies and Research requires submission and approval of a Research Topic Approval Form (RTAF) before you can begin your research. If you have not

yet submitted your RTAF, the form can be found at
http://www.iup.edu/page.aspx?id=91683 .

While not under the purview of the IRB, researchers are responsible for adhering to US copyright law when using existing scales, survey items, or other works in the conduct of research. Information regarding copyright law and compliance at IUP, including links to sample permission request letters, can be found at http://www.iup.edu/page.aspx?id=165526.

I wish you success as you pursue this important endeavor.

Sincerely,

Timothy Runge, Ph.D.
Interim Chairperson, Institutional Review Board for the Protection of Human Subjects
Professor of Educational and School Psychology

TJR:bkj

Cc: Dr. Riah Hoffman, Faculty Advisor

Appendix B

Solicitation Email

Dear Nurse Educator,

My name is Rebecca Modene and I am a doctoral student at Indiana University of Pennsylvania. As a faculty member of a CCNE accredited undergraduate nursing school, I am inviting you to participate in my dissertation research. The aim of this research is to determine if a relationship exists between a nurse educator's self-reported political self-efficacy score and self-reported political astuteness score. As well as describe the relationship between professional factors to see if any correlations can be made between these factors.

The potential outcomes of this study, could shed more light on what factors impact nurse educator's health policy engagement, which could in future studies be mitigated. Ultimately findings could aid in determining more effective ways nurse educators can translate health policy teaching to nursing action.

Participation is completely voluntary and involves completing a Qualtrics® survey comprised of the Political Astuteness Inventory, the Teacher's Political Self-Efficacy survey and demographic questions including professional variables. It should take no longer than 20 minutes to complete the survey in its entirety. This is an anonymous survey. You may choose to stop the survey at any time by simply exiting the survey. However, do to the anonymity of the survey once you have completed the survey and submitted it your results cannot be removed from the final results.

If you are interested in being a part of my dissertation research please click on the link below, read and accept the terms of the informed consent and begin the survey.

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724-358-7730).

I appreciate you taking the time to consider this offer. If you have any additional questions please feel free to contact me:

      Rebecca C. Modene MSN, RN
      Doctoral Student, Department of Nursing and Allied Health Professions
      109 Spring Meadow Lane
      Washington Boro, PA 17582
      (717) 584-6630
      QHVT@iup.edu

      Faculty Advisor: Dr. Riah Hoffman
      214 Johnson Hall
      Indiana University of Pennsylvania
      Indiana, PA 15705
      (724)357-3265
      r.l.skavang@iup.edu

Sincerely,

Rebecca C. Modene MSN, RN PhD(c)
               [SPACE FOR LINK TO QUALTRICS SURVEY]

Appendix C

Informed Consent

Informed Consent Form

You are invited to participate in the research study titled *Health Policy Engagement Among Nurse Educators: A Descriptive, Cross-Sectional Study into Political Astuteness and Political Self-Efficacy and the Impact of Personal and Professional Factors*. The aim of this research is to determine if a relationship exists between a nurse educator's self-reported political self-efficacy score and self-reported political astuteness score. As well as describe the relationship between professional factors to determine if any correlations can be made between these elements.

 The purpose of this form is to give you a written description of the research study for your approval prior to participating in the study. Participation in this study will require completion of the Political Astuteness Inventory, The Teachers Political Self-Efficacy (modified) tool, and a demographic survey. The total survey including both tools and demographic questions should take no more than 20 minutes to complete.

Participation in the survey is completely voluntary. You may end the survey at any time and your results will not be aggregated in the final study results. However, due to the anonymity of the survey once submitted it cannot be removed from the final data set.

All data collected during this study will be kept in a password-protected file and/or in a locked file. All data will be reported as an aggregate. No personally identifying information from participants will appear in any presentations or publication of the data. Data will be kept for three years after the start of the data collection and then destroyed in compliance with federal regulations.

There are no anticipated physical, social, emotional or psychological risks for the participant in this study. The potential outcomes of this study, could shed more light on what factors impact nurse educator's health policy engagement, which could in future studies be mitigated. Ultimately findings could aid in determining more effective ways nurse educators can translate health policy teaching to nursing action.

You are free to decide not to participate in this study. There is no compensation for your participation in this study.

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724-358-7730).

If you have any questions or concerns please feel free to contact the principal investigator:

Rebecca C. Modene MSN, RN
Doctoral Student, Department of Nursing and Allied Health Professions
109 Spring Meadow Lane
Washington Boro, PA 17582
(717) 584-6630
QHVT@iup.edu

Faculty Sponsor: Dr. Riah Hoffman
214 Johnson Hall
Indiana University of Pennsylvania
Indiana, PA 15705

(724)357-3265
r.l.skavang@iup.edu

I have read and understand the information on the informed consent. I consent to participate in the study described on this form.

Appendix D

Permission Letter From Dr. Clark

IUP Indiana University of Pennsylvania
www.iup.edu

Department of Nursing
and Allied Health Professions
Doctorate of Philosophy in Nursing
Johnson Hall, Room 248
1010 Oakland Avenue
Indiana, Pennsylvania 15705-1063

P 724-357-3269
F 724-357-3267

March 31, 2017

Dear Dr. Clark:

I am a doctoral student at Indiana University of Pennsylvania and am writing for permission to use and include in my dissertation the entire version of the Political Astuteness Inventory created by your husband Philip Clark.

The focus of my dissertation is to assess nurse educator's political knowledge using the Political Astuteness Inventory and to assess political self-efficacy to determine if any relationships exist between these two concepts. I will also be assessing professional variables such as, but not limited to the, year of nursing school graduation, highest education level, and professional organization membership to determine if any professional factors impact political astuteness and/or political self-efficacy.

I am also asking for permission to reproduce the Political Astuteness Inventory in the appendix of my dissertation. After completion of my dissertation, the dissertation will be made available to the public through Indiana University of Pennsylvania's library. In addition, the dissertation will be microfilmed by ProQuest Information and Learning (formerly UMI), and copies of the dissertation will be sold on demand.

If you agree to the above, please sign this letter with an original signature, granting me permission to use your husband's tool and reproduce the tool in an appendix in my dissertation and email the letter to Rebecca Modene at QHVT@iup.edu.

Thank you for your help.

Sincerely,

Rebecca Modene PhD (c), RN

Rebecca C Modene
Rebecca Modene
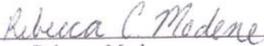
Mary Jo Clark
Dr. Mary Jo Clark

Appendix E

Permission Letter From Dr. Hammon

IUP Indiana University of Pennsylvania
www.iup.edu

Department of Nursing   P 724-357-3269
and Allied Health Professions   F 724-357-3267
Doctorate of Philosophy in Nursing
Johnson Hall, Room 248
1010 Oakland Avenue
Indiana, Pennsylvania 15705-1063

February 23, 2017

Dr. Mary Catherine Hammon
527 Bailey Education
1126 Volunteer Blvd.
Knoxville, TN 37996-3452

Dear Dr. Hammon:

I am a doctoral student at Indiana University of Pennsylvania and am writing for permission to include in my dissertation the entire version of the Teacher Political Self-Efficacy Tool created by Dr. Hammon with approved modifications.

Prior to my dissertation work, I will need to modify the tool and conduct a pilot study. Modifications to the tool will require changing terms such as education policy to terms such as health policy, and related items. All modifications to the Teacher Political Self-Efficacy Tool will be sent to Dr. Hammon for approval. The modifications to the tool are required to assess the political self-efficacy of nurse educators towards health policy. All modifications will continue to credit Dr. Hammon as the original creator and author of the Teacher Political Self-Efficacy Tool.

I am asking for permission to reproduce the modified tool in the appendix of my dissertation. After completion of my dissertation, the dissertation will be made available to the public through Indiana University of Pennsylvania's library. In addition, the dissertation will be microfilmed by ProQuest Information and Learning (formerly UMI), and copies of the dissertation will be sold on demand. If you agree to the above, please sign this letter with an original signature, granting me permission to use your work, modify the tool, and reproduce the tool in an appendix in my dissertation and email the letter to Rebecca Modene at QHVT@iup.edu.

Thank you for your help.

Sincerely,

Rebecca Modene PhD (c), RN
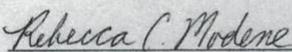
Rebecca C. Modene   *Mary Catherine Hammon*
Rebecca Modene   Mary Catherine Hammon

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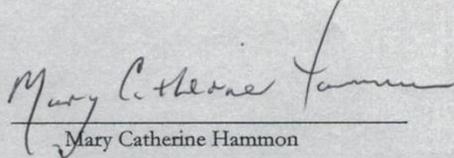
Appendix F

Political Astuteness Inventory*

Please indicate with a yes or a no response.

1. I am registered to vote.
2. I know where my voting precinct is located
3. I voted in the last general election.
4. I voted in the last two elections.
5. I recognized the names of the majority of candidates on the ballot at the last election.
6. I was acquainted with the majority of issues on the ballot at the last election.
7. I stay abreast of current health issues.
8. I belong to the state professional or student nurses' organization.
9. I participate (committee member, officer, etc.) in that organization.
10. I attended the most recent meeting of my district nurses' association.
11. I attended the last state or national convention held by my organization.
12. I am aware of at least two issues discussed and the stands taken at that convention.
13. I read literature published by my state nurses' association, professional magazines, or other literature on a regular bases to stay abreast of current health issues.
14. I know the names of my state senators in Washington DC.
15. I know the names of my representative in Washington DC.
16. I know the name of the state senator from my district.
17. I know the name of the representative from my district.
18. I am acquainted with the voting record of at least one of the above in relation to a specific health issue.
19. I am aware of the stand taken by at least one of the above on one current health issue.
20. I know whom to contact for information about health-related policy issues at the state or federal level.
21. I know whether my professional organizations employ lobbyists at the state or federal level.
22. I know how to contact the lobbyist.
23. I support my state professional organizations political arm.
24. I actively supported a candidate for the U.S. or state Senate or House of Representatives (Assembly)(campaign contribution, campaigning service, wore a button, or other) during the last election.
25. I have written regarding a health issues to one of my state or national representatives in the last year.
26. I am personally acquainted with a senator or representative or a member of his or her staff.
27. I serve as a resource person for one of my representatives on his or her behalf.
28. I know the process by which a bill is introduced in my state legislature.

29. I know which senators or representatives are supportive of nursing.
30. I know which House and Senate committees usually deal with health-related issues.
31. I know the committees on which my representatives hold membership.
32. I know of at least two issues related to my profession that are currently under discussion at the state or national level.
33. I know of at least two health-related issues that are currently under discussion at the state or national level.
34. I am aware of the composition of the state board that regulates the practice of my profession.
35. I knew the process whereby one becomes a member of the state board that regulates my profession.
36. I attend public hearings related to health issues.
37. I find myself more interested in public issues now than in the past.
38. I have provided testimony at a public hearing on an issue related to health.
39. I know where the local headquarters of my political party are located.
40. I have written a letter to the editor or other piece for lay press speaking out on a health-related issues.

*Used with permission from Dr. Mary Clark

Appendix G

Teacher Political Self-Efficacy – Modified Scale*

Using the response format below, rate your level of agreement by choosing one of the five responses for each item.

Strongly disagree	Disagree	Neutral/Undecided	Agree	Strongly agree
(1)	(2)	(3)	(4)	(5)

1. I state my opinions about health policy issues openly even in public and challenging settings.
2. I stay informed about national and state health policy initiatives.
3. I try to influence the health policy perspectives of my administrators.
4. I develop and maintain relationships with local and state government officials.
5. I respond to emails from or surveys sponsored by local, state or national professional nursing organizations that seek nurse educators' inputs.
6. I have made a formal presentation on an instructional best practice or a policy initiative at a profession specific meeting or conference.
7. I encourage and support other nurses and nurse educators who engage in health policy related activities.
8. I have participated in a deliberate information campaign in opposition to a particular health policy or position.
9. I solicit support for greater nurse involvement in health public policymaking from elected and appointed government officials.
10. I have distributed information for the purpose of informing and influencing the health policy perspectives of others.
11. I have served as a member of a work group or committee charged with researching and developing recommendations on a health policy issue.
12. I have served as a member of a committee or work group at the state or national level and sponsored by a specialized professional organization (e.g. Pennsylvania State Nurses Association, American Nurse Association, Academy of Medical-Surgical Nurses, etc.).
13. I use the means available to me to monitor the health policy positions and actions of elected government officials.
14. I try to influence the health policy perspectives of people or groups in my community.
15. I keep informed about the health policy related positions and actions of local, state or national affiliates of professional nursing organizations.
16. I have expressed in writing to government officials my perspectives on health policy matters.
17. I have provided assistance with routine school responsibilities to a peer in order to facilitate his/her greater involvement in health policy related activities.
18. I am positively supported by family and friends when I participate in activities of a political or civic or professional nature outside the usual work day or work week.

19. I have served as a representative on a community group looking at constructive ways to improve community health outcomes.
20. I have played a role in the selection of members/leaders of school sponsored committees or work groups dealing with health policy matters.

*Modified and used with permission from Dr. Mary Catherine Hammon

Appendix H

Demographic Questions

1. Please indicate your age to nearest whole number _____
2. Please indicate the state where you work – PA____ NY____ NJ____ DE ____ MD____
3. Please indicate your gender Male_____ Female _____ Prefer not to answer_____
4. Please indicate your highest earned degree in nursing MSN____ PhD_____
   DNP_____ (choose one)
5. Please indicate your graduation year from your pre-licensure nursing program
   _____ (free text)
6. Please indicate your graduation year from your BSN, if different than your pre-
   licensure nursing program _____, n/a_____ (free text)
7. Please indication your graduation year from your MSN _____ (free text)
8. Please indication your most recent graduation year from DNP or PhD program
   _____
9. Are you in a tenure track position yes ____ no____ (if no skip logic over next
   question)
10. Please indicate your current faculty rank instructor _____ Assisted professor _____
    Associated professor _____ Professor_____
11. Are you a member of a professional nursing organization? _____
12. Do you remember receiving formal health policy education in your pre-licensure
    program yes ____ no ____
13. Do you remember receiving formal health policy education in your BSN program
    yes ____ no ____ n/a_____
14. Do you remember receiving formal health policy education in your MSN program
    yes ____ no _____
15. Do you remember receiving formal health policy education in your PhD or DNP
    program yes_____ no _____ n/a _____
16. Do you remember having a nurse educator as a (formal or informal) health policy
    role model within any of your formal nursing education yes _____ no _____ (if yes
    skip logic to next question)
17. If yes, which level of education do you remember having a nurse educator as a
    (formal or informal) health policy role model. Pre-licensure _____ BSN_____
    MSN_____ PhD/DNP _____ (may chose more than one option)