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The political astuteness of the New Mexico registered nurse

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Abstract

The Political Astuteness of the New Mexico Registered Nurse

by

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MSN, University of New Mexico, 2001

BS, Lynn University, 1999

AS, Palm Beach College, 1991

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Public Policy and Public Administration

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Abstract

The United States spends the most per capita of all the developed countries on healthcare but demonstrates the worst healthcare outcomes. National agencies have turned to Registered Nurses (RNs) to improve healthcare outcomes through participation in healthcare policy development. Although the recommendation for participation in policy development exists, RNs, including those in the U.S. state of New Mexico have not participated at high levels. The purpose of this quantitative cross-sectional study was to measure the political astuteness of RNs in New Mexico and to determine to what extent nursing leaders have been successful in diffusing Institute of Medicine recommendations. Rogers's diffusion of innovations theory framed this study. Clark's Political Astuteness Inventory (PAI), which measures voting behavior, participation in professional organizations, awareness of policy issues, knowledge of the policy process, and elected officials, and involvement in political processes, was used to assess participants' political astuteness. A modified PAI was sent to a random representative sample of the population of licensed RNs in New Mexico. There were 411 responses. Secondary relationships between participants' demographics and PAI scores were analyzed using a t-test and linear-by-linear association. The findings revealed diffusion of the Institute of Medicine recommendations were not successful. The participants of this study mean scores revealed "beginning political astuteness." The results inform further research and can potentially be used to develop and test interventions to increase RNs' policy participation. Engaging more RNs in health care policy development may yield positive social change through improved health care outcomes.

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Dedication

I would like to dedicate this work to the contributors of my successful story. To my children, Mason and Joshua Doherty who have watched me learn their entire lives and put up with the emotional rollercoaster it all was. They made me laugh, smile, and enjoy my life. They give me purpose and drive. One can only hope modeling creates positivity in their children's lives. That they learn through watching your experiences, your mistakes, and your triumphs. They both became men I am proud of. I could not have hoped for more. They are each unique, special, caring, and genuine. Everything I aspire to be is for them.

Jacob and Dorothy Goodberg and Evelyn Wasserman were the prompters of my returning to school. My mother, Margaret Lew, always communicated education was the only way out of poverty and always pushed me to be better. Their love, encouragement, and support were more than any daughter or niece could ask for. They guided me and gave me support throughout my life. I wish they were still alive to see I finally accomplished what they dreamed. I hope they are proud as they watch over me.

Finally, this work would not have been possible if not for Phillip Clarke. His survey gave me the idea to look how to solve a problem I believed existed. This is a posthumous dedication. I would like to send gratefulness to Mary J. Clarke for granting me permission to use and modify the inventory her husband created.

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I would like to acknowledge the many strong women who have inspired me, kept me motivated, mentored, and believed in me. Amongst these mentors are Deborah Walker and Linda Siegle. My friends are my family and they sat with me many weekends as study buddies. I hope they benefitted from this bond as much as I did. A special thank you to Mickey Nunn who continues to stand by me through thick and thin. This work could not have been done without the support of Sheena Ferguson and Rosie Davis, who continue to provide challenges and never-ending hope. They gave me encouragement and drive to keep moving forward. They believed in me when I did not.

I also would like to thank Dr. David Milen, Dr. Karen Shafer, and Dr. James Mosko. Without their guidance and patience during turbulent times of my life, I would have wavered. I would also like to acknowledge Jeffrey Trujillo. He has taken me far and wide to experience things I have never experienced. He challenges my thoughts, ideas, opinions, and makes me think twice. He has been with me for this whole ride watching me drag my laptop and my work on every excursion without complaint.

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Chapter 1: Introduction to the Study

National healthcare reform continues to be on the forefront of the United States political agenda. Yet, despite changes in healthcare policy, there has not been an improvement in healthcare outcomes. The United States continues to spend the most per capita amongst developed countries and continues to display the worst outcomes (Institute of Medicine of the National Academies [IOM], 2013; The Commonwealth Fund, 2014, 2020). As a result, both national and international agencies have turned to RNs to assist in the development of health policy (IOM, 2011; World Health Organization [WHO], 2011). In the past, RNs had a significant impact on healthcare outcomes in the field of public health. The *Code of Ethics for Nurses* (American Nurses Association [ANA], 2015) implicitly states that the duty of the RN is to advocate for clients and includes provisions regarding heath care policy. Despite the calling and the duties of the RN, nurses still are not engaged in health policy development (Juma et al., 2014; Kunaviktikul et al., 2010; Mason, Keepnews, et al., 2012; Shariff, 2015; Shariff & Potgieter, 2012).

Nursing is the largest subset in the delivery of healthcare. As such, nurses are in a unique position to provide critical information to decrease healthcare disparities, increase the quality of healthcare, improve access and efficiency, and improve professional opportunities. Despite national and international recommendations calling for nurses to partake in policy development, there has been little success in increasing nursing participation. Researchers in several countries have examined the nurses' role in policy development has occurred in numerous countries (Juma et al., 2014; Kunaviktikul et al.,

2010; Mason, Keepnews, et al., 2012; Shariff, 2015; Shariff & Potgieter, 2012). The research suggests that RN non-participation is related to a lack of astuteness and subsequent skills related to the policy process. There is a gap in the literature on RNs's political astuteness in the United States. In order for nursing leaders, educators, and professional organizations to improve political astuteness, the current level of political astuteness must be determined and recommendations made. The level of success that nursing leaders, professional organizations, and other agencies of influence had in communicating and implementing the IOM recommendations must be measured and evaluated. The successful cascade of information and empowering education may lead to improvements in healthcare policy and delivery by RNs.

In this chapter, I provide background information regarding the ethical duties of the RN. The national and international recommendations for nursing are introduced. These items formulate the background of the study. The problem statement follows. I also present the purpose of the study and research questions (RQ) and hypotheses and explain the theoretical framework and the nature of the study. The chapter also includes definitions of key terms, discussion of the assumptions, scope and delimitations, limitations, and significance of the study, and a summary of key points.

Background

The Duty of the Registered Nurse

The *Code of Ethics for Nurses* (ANA, 2015) outlines the duties of the RN. The provisions of the code include discussion on the RN's primary commitment being to the patient. The patient is defined as an individual, family, group, community, or population

(ANA, 2015, p. 5). Through collaboration, it is expected that the RN will address the health of the public effectively. Even nurses in nonclinical roles need to work toward change through influence (ANA, 2015).

Provision 3 of the code further elaborates on the "professional responsibility in promoting a culture of safety" (ANA, 2015, p. 11). Nurses are to develop policies to promote the health and safety of the patient. The creation of the culture of safety includes acting on questionable practices and developing review processes to improve care both institutionally and beyond.

In Provision 5, discussion ensues around "the responsibility to promote health and safety, preserve wholeness of character and integrity…" (ANA, 2015, p. 19). Related to this premise, the RN is responsible for alerting authorities when the RN's integrity is compromised creating moral distress related to an erosion of an ethical environment that risks the safety or standards for patients receiving care. As a patient can also be defined as a community or a population (ANA, 2015, p. 5), this type of dilemma may occur with increasing frequency. The next provision continues to discuss the role of the RN in making sure the environment is "conducive to safe, quality health care" (ANA, 2015, p. 23). The nurse has an obligation to practice principles of beneficence, nonmaleficence, justice, fidelity, and respect.

Provision 7 specifically discusses the nurse advancing the profession "through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy" (ANA, 2015, p. 27). The generation of healthcare policy is part of advocacy. Nurses should be involved and lead in policy committees at the

institutional and agency level (ANA, 2015). Additionally, participation in civic activities related to health care is expected. Participation could be in the continuum of local through global initiatives.

Finally, Provision 8 discusses the nurse's role in collaboration "with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities" (ANA, 2015, p. 31). Healthcare is a universal right and includes political, social, and cultural dimensions (ANA, 2015). Through collaboration and advocacy, nurses understand that inequities contribute the global health deterioration. The nurse must address all socioeconomic determinants of health. Advocacy includes creating change in "structural, social, and institutional inequalities and disparities" (ANA, 2015, p. 32). Through groups and professional organizations, it is the nurse's duty to assist in educating the public and identifying contributors to illness, injury, and human rights violations. Nurses should respond through participation in public debate and legislative action.

In the United States, it is expected that RN's practice within ANA (2015) code of ethics. Nurses advocate for their patients with each day-to-day action in the work setting. However, it seems nurses do not have full access to decision making. These decisions effect both their practice and health care delivery and processes. In this era of diagnostic-related groups, the implementation of health policy effects the moral compass and ethical values of nurses as individuals and as a profession (Aroskar et al., 2004). With managed care organizations dictating practice and formulary (Heaton & Tadi, 2021), and creating quality issues, the nurse must speak out on impacts in equitable care delivery.

Recommendations

Nursing: A Unique Perspective

Nursing is the largest subset in the delivery of healthcare. There are more than 4 million nurses in the United States (National Council of the States Board of Nursing, 2020). Nurses provide care in a wide array of clinical and non-clinical settings. A nurse touches the life of every person from the time of conception through the time of death. As such, nurses are in a unique position to provide critical information to decrease healthcare disparities, increase the quality of healthcare, improve access and efficiency, and improve professional opportunities. Acknowledging this unique perspective and creating recommendations both nationally and internationally may assist nurses in developing meaningful healthcare policy.

Institute of Medicine

In 2011, the IOM, in conjunction with the Robert Woods Johnson Foundation, released a landmark report, *The Future of Nursing: Leading Change, Advancing Health.* This report provides recommendations based upon a 2-year study to assess the needs for transforming the nursing profession. The four main actions, according to the report, which need planning for implementation were:

- remove scope-of practice barriers
- expand opportunities for nurses to lead and diffuse collaborative improvement efforts
- engage nurses as full partners with physicians and other health care professionals in the redesigning of health care in the United States

- create an infrastructure for workforce data collection

The IOM (2011) offered recommendations for removing scope of practice barriers for Congress, state legislatures, the Centers for Medicare and Medicaid Services (CMS), the Office of Personnel Management, and the Federal Trade Commission and the Antitrust Division of the Department of Justice. The outline included expansion of CMS Medicare and Medicaid coverage for advance practice registered nurse (APRN) services to be the same as physicians. Similarly, the IOM recommended that state legislatures require third-party payers to provide reimbursement to APRNs. It was also recommended the conditions of participation for CMS include eligibility of APRNs for medical staff membership and for clinical and admitting privileges (IOM, 2011).

The IOM (2011) also made recommendations to professional organizations, private and public funders, education programs, and health care organizations to ensure there would be opportunities for nurses to lead and diffuse collaborative improvement programs with other healthcare disciplines (IOM, 2011, p. 2). These recommendations include the creation of educational programs and professional development ensuring success in program and business development aimed at improving health and health care. Schools of nursing should require basic competencies related to leadership theory and business practices within their curriculum. There was also a call upon nurses to “take responsibility for their personal and professional growth by continuing education and seeking opportunities to develop and exercise their leadership skills” (IOM, 2011, p. 5). Health care decision makers at every level were recommended to include representation from nursing for boards, executive management teams, and other leadership positions.

World Health Organization and World Health Assembly

The WHO also published recommendations for nursing (and midwives) to partake in health policy development in 2011. In *Strategic Directions to Strengthening Nursing and Midwifery Services 2011-2015,* the WHO spoke to the similarity in the health care goals of civil society and nursing as a discipline. The recommendations included contributing toward universal coverage, providing people-centered care, scaling up the national health care systems, and to meet global goals and targets (p. iv). The WHO incorporated resolutions of the World Health Assembly for nurses to improve health outcomes for "individuals, families and communities through the provision of competent, culturally sensitive, evidenced-based nursing and midwifery" (p. iv).

The WHO (2011) acknowledged nurses as the largest healthcare delivery group and the integral center to all care. Nurses were also recognized as a solution to saving lives and managing and preventing life-threatening conditions, through inexpensive, low tech interventions (WHO, 2011, p. 2). As a profession engaged in the core values of equity, solidarity, social justice, and community participation, nursing brings a crucial contribution. However, WHO (2011) noted that nurses remained unidentified as key stakeholders in the policy making process.

The recommendations from WHO's (2011) 2-year research of nursing and midwives were similar to those of the IOM (2011) report. WHO recommended that governments, civil society, and professional organizations work together with educational institutions, non-governmental organizations, and a range of international agencies to recognize nurses as a key stakeholder and seek the input of nurses with policy

development (p. 3). It was further recommended for nurses to lead every public health care reform effort and to address gaps in policy development. Nurses care for every facet of life and engage in emergency management. Policy makers were advised to create an "enabling environment" so nurses would have been able to meet the ever-changing health care needs that were in existence (p. 6). There was a call for equitable access to nursing and midwifery services.

WHO (2011) also identified that nurses were currently not involved in health policy development. WHO (2011) also reported the assumption that the nursing skill set for this level of advocacy (policy development) was lacking. As such, for nurses to help governments support the strengthening of health and healthcare delivery, professional organizations and other stakeholders must assist in empowering nurses to learn this role successfully.

United Nations

In 2015, the United Nations (U.N.) released the report *Survive, Thrive, Transform: Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030).* This report spoke to the lack of progress made with the previous global strategy for women's and children's health. The predecessor report called for improvement of health care indicators globally with a key mention of midwives, community healthcare workers, and all the healthcare workforce (United Nations [U.N.], 2009). The key policy proposals included the design of health care reform to maximize collaboration between nurses, midwives and community health workers (CHW), the creation of platforms for

nurses to voice their experience and share expertise, and improvements to the scope of nursing (Ameiva & Ferguson, 2012). These key messages have not been achieved.

The UN report combined with the WHO (2011) report provided an opportunity for the unique nurse perspective to be valued and listened upon. Yet, there has not been progress in terms of nursing professionals engaging in healthcare policy making.

Problem Statement

There is a problem in the U.S. health care delivery system despite the legislative attempt at improvement through the implementation of the Affordable Care Act. The United States continues to spend the most per capita on healthcare and demonstrates the worst outcomes when compared to other developed countries (IOM, 2013; The Commonwealth Fund, 2014; Sawyer & McDermott, 2019). A possible cause of this problem is the lack of RNs participating in policy development. Experts have recommended that RNs participate in the development of health policy to improve outcomes (IOM, 2011; WHO, 2011). However, there continues to be limited participation by nurses worldwide.

International research on nursing participation in health policy development reveals lack of participation by RNs due to lack of knowledge and skills related to policy process (Juma et al., 2014; Kunaviktikul et al., 2010; Mason et al., 2012; Shariff, 2015; Shariff & Potgieter, 2012). However, there was a lack of research for practicing nurses in the United States. I conducted this quantitative cross-sectional study to address this gap in the literature. Findings may provide nursing leaders with the knowledge necessary to develop programs to create successful RN participation in health policy development.

Currently, the level of political astuteness for this population is unknown. There are over 4 million RNs (National Council of the States Board of Nursing, 2020, p. S3) in the United States with expertise in every facet of healthcare. Using the unique insights of RNs, policies can be developed to improve healthcare outcomes. To address lack of participation, it is necessary to know more about the current level of political astuteness. A study measuring the level of political astuteness can help nursing leaders determine the interventions necessary to improve participation in health care policy development by RNs.

Purpose of the Study

The purpose of this quantitative cross-sectional study was to measure the political astuteness of RNs in New Mexico and to determine to what extent nursing leaders have been successful in diffusing IOM (2011) recommendations. Political astuteness represents an awareness and comprehension of policy and legislative processes and political skills (Byrd et al., 2012; Primomo, 2007, 2013). It is imperative to determine a baseline of political astuteness so that nursing leaders can develop interventions to improve RNs's political astuteness so successful participation in health policy development can occur. Furthermore, as is the case for descriptive studies, this study can stimulate exploratory research and the identification of hypotheses for further research (O'Sullivan et al., 2008).

Research Question and Hypothesis

RQ: Where on the diffusion of innovations curve has the cascading communication surrounding recommendations for increased nursing participation in

policy development are registered nurses in New Mexico as measured by the Political Astuteness Inventory (PAI, Clark, 2008)?

H_a: The communication on the need for the RN to participate in policy development is not in the critical mass phase as evidenced by the results of the modified PAI showing participants as being "totally unaware politically."

H_0: Alternatively, the communication on the need for the RN to participate in policy development was in the critical mass phase as evidenced by the result of the modified PAI showing participants as being "asset to nursing."

Theoretical Framework for the Study

Diffusion of innovations theory focuses on the stream of information and acceptance within a social system (Kaminski, 2011; Owen et al., 2002; Rogers, 2003). I used this theory to examine whether nursing leaders in New Mexico have been successful in furthering communication of the innovation. I determined the number of RNs in New Mexico and then assessed their level of political astuteness. Through an understanding of the definition and characteristics of each stage of the innovation and diffusion process, nursing leaders may be able to persuade colleagues to revise their strategies for engaging nurses in the policy process (see Lee, 2004). This application of the diffusion of innovations theory when paired with national recommendations, may lead to a resurgence of nursing recognition and value.

In 1962, Everett Rogers produced the Diffusion of Innovations theory to assess how, why, and at what speed new ideas spread through social systems. Rogers examined research on theory from six disciplines (Sullivan, 2009). This process begins with

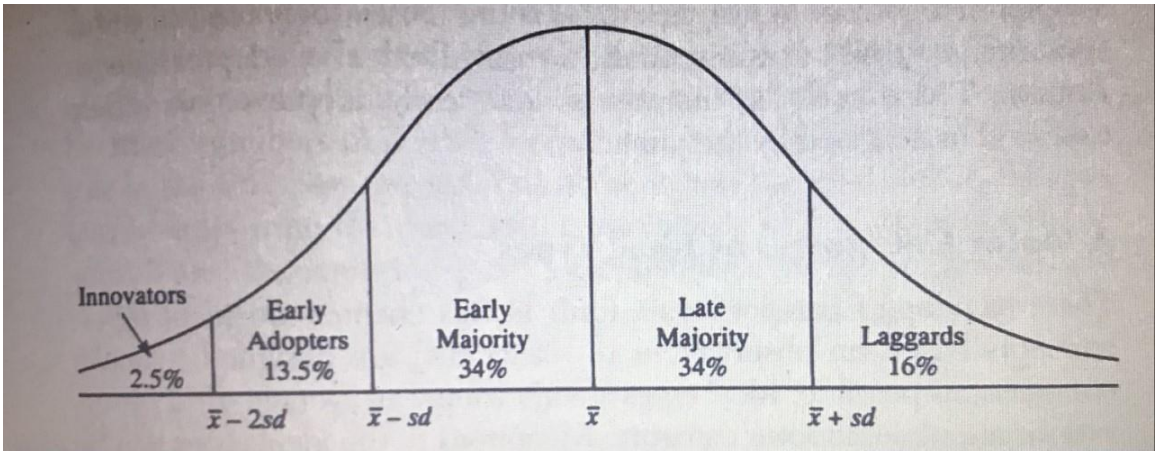
knowledge and ends with confirmation. Movement through each stage results in increased engagement and participation (Orr, 2003, Rogers, 2003). Diffusion is the process showing how an innovation spreads throughout a social system. Each member of the social system receives the communication and makes decisions following a 5-step process.

1. Knowledge: The member becomes aware of the innovation.
2. Persuasion: The member establishes an attitude on the innovation being favorable or unfavorable.
3. Decision: The member performs in activities to promote an in-favor or rejection of the innovation.
4. Implementation: The member puts the innovation to use.
5. Confirmation: The member evaluates the decision regarding the innovation.

This process is highly influenced by other members of the social system. The tide of acceptance is categorized by early adapters (Rogers, 2003). This group consists of 10-25% of the members of the system (Orr, 2003). Other members adopt at different speeds. Adoption is dependent upon the communication of the innovation. In this case, the innovation (healthcare policy participation) was the communication by nursing associations and nursing leaders. There was a lack of research regarding the successful communication of the IOM (2011) report calling on nurses to participate in policy and health care policy development at various levels. The nursing community must believe there is value in the innovation for it to be successful. This theory shows that there is an adopter distribution curve that is bell-shaped, and over time approaches normality

(Rogers, 2003; p. 281). The bell curve represents five stages of innovation adopters: innovators, early adopters, early majority, late majority, laggards (Kaminski, 2011).

Figure 1



Other researchers have applied the Diffusion of Innovations model to nursing leadership (Clement-O'Brien et al., 2011) and nursing innovations (Noyes, Lewis, Widdas, & Brombley, 2014; Robert et al., 2011). This theory has also been used to explore the diffusion of policy (Makse & Volden, 2011; Solingen, 2012; Strebel & Widmer, 2012). The lens has also been used to evaluate the spread of policy within healthcare (Ae-Sook & Jennings, 2012; Bouche & Volden, 2011; Burris et al., 2012; Sams et al., 2013).

In this study, I measure the New Mexico RNs political astuteness to determine if there was successful communication throughout the state regarding the IOM report and if there was policy participation. The distribution revealed where this social system lay

within the diffusion bell curve in New Mexico. The administration of the PAI (Clark, 2008) and customized survey questions, yielded three findings:

- the diffusion location of the innovation (RN policy participation) on the bell curve
- the methods necessary for nursing leaders to further communicate the innovation based upon a determination of the nursing social system being heterophilous or homophilous (Orr, 2003) and
- the need to equip nursing leaders with the knowledge of the skill level of the nurse in policy and politics.

Nurse leaders can now determine interventions necessary recommended based upon the levels in Dreyfus Model of Skill Acquisition. This model outlines different methods of teaching based upon the participant's level of skill (Chaffin & Cummings, 2012; Field, 2014). The PAI resulted in scores that correlate with novice to expert.

Nature of the Study

I used a quantitative cross-sectional survey research design. Survey research has been used frequently in federal level and nursing research (Keough & Tanabe, 2011). Researchers can administer surveys to exam what exists without manipulation of a variable or an intervention. By surveying participants using Clark's (2008) PAI, I was able to determine the level of political astuteness in the RNs of New Mexico. Clark's PAI is a self-report tool that is used to gain information about difficult-to-measure attributes of a population. Political astuteness is an awareness and comprehension of policy and legislative processes and political skills. Scores are derived from completion of the

survey. I piloted additional survey questions to ensure responses measured the concepts they were intended to measure. I administered the survey to five experts for their input and recommendations. The findings for these additional questions determined the level of success in the delivery of the message calling RNs to assist in health care policy and where in the diffusion this innovation has landed.

The New Mexico Board of Nursing list of RNs provided the population utilized to acquire the sample. Only RNs with New Mexico addresses were included to obtain the simple random sample.

Definitions

Diffusion bell curve: A figure representation displaying the distribution of an adoption of an innovation. Each member of the group is equal in "innovativeness" (Sahim, 2006). The category in which the member scored is related to the adoption of the innovation.

Early adopters: The category of people described in the DOI theory who rely upon the innovators' confirmation opinion before adopting the innovation. Also called *visionaries,* this group is looked upon as the informed decision-making leaders (Kaminski, 2011). Their opinion influences the early and late majority. In essence, the success of an innovation relies on the opinions of this group (Orr, 2003). This group represents Category 2 of the DOI diffusion bell curve.

Early majority: An influx of followers who, according to the DOI theory, represent the turning of the tide in the spread of the innovation. There is a flood of the

members of the social system adopting the innovation (Orr, 2003). This is Category 3 of the DOI adaptation. This category is also known as the *pragmatists* (Kaminski, 2011).

Innovation: A perceived new idea, product, practice, or behavior. The practice or idea may not be new but is perceived as new by the adopting group (Sahin, 2006). For the purpose of this study, the innovation was policy participation.

Innovators: A group of leaders who are eager to make the change. These people represent the first stage of the DOI spread of innovation. The innovators' opinion is formed in the confirmation stage and influences the subsequent decisions of other members of the system (Orr, 2003).

Laggards: The last category of adaptation; according to Orr (2003), includes members of the system who may be isolates or averse to adopting the innovation for many reasons. Individuals in this category are also known as the *skeptics* (Kaminski, 2011). If the member is an isolate, there is no social networking to be wary of the innovation. The member may also be fearful of what they must commit to adopt. This group represents the final stage of the diffusion bell curve in the DOI theory.

Late majority: In the DOI theory, people who comprise the fourth category of the innovation adaptation and represent the end of the tide. Members of the social system realize the social benefit of the innovation. There is understanding of the risk involved within the system if there is failure to adopt (Orr, 2003). The members of this group are also known as the *conservatives* (Kaminski, 2011).

Policy participation: For the purposes of this study, an active voluntary behavior by an individual independently or as part of group with the aim of effecting individual or

group concerns. The act targets either an entity, a state, national or global policy or services for societal change (Fox, 2014).

Political astuteness: A concept that includes constructs including awareness, involvement, influence, participation, and competence (Primomo, 2007, 2013). In this study, political astuteness was defined as policy awareness, the understanding of legislative processes, and political skills. I measured political astuteness by using the PAI developed by Clark (2008). This 40-item inventory measures concepts of voting behavior, participation in professional organizations, awareness of policy issues, knowledge of policy process and elected officials, and involvement in political processes (Byrd et al., 2012, p. 435).

Registered nurse (RN): A licensed professional who has at least an associate degree or hospital-based diploma, has successfully passed the National Council Licensure Examination (NCLEX-RN), and meets the qualifications or maintenance requirements of the nursing board and practice act of the specific state of residency ("RN," 2018).

Assumptions

I assumed that there would be a high non-response rate to the survey. This was accounted for by increasing the number of participants invited to take the survey. Additionally, I assumed that the participants would answer items honestly, though there was no way to determine if participant bias impacted the results. It was also assumed that the statistical tests chosen were able to have assumptions met. Furthermore, I assumed that each participant had a valid email address. This was not true in all cases, and additional disbursement of the survey occurred.

Delimitations

Delimitations of this study included bias of the researcher. This is a topic of high interest and passion for the researcher. To account for potential bias, I engaged in continuous self-reflection. The data were also analyzed by an expert in the field for additional confirmation of my findings. In addition, to truly explore the RQ posed in an area without previous research conducted, it may have been better to conduct a qualitative study to determine perceptions (see Creswell, 2013).

Limitations

Limitations to the study included cost. To improve the generalizability of the finding of this study, a sample of RNs across the United States needed to occur. This study was limited to RNs residing in New Mexico for cost reasons. Participation may have been influenced by the participant's educational level. Another consideration was active participation by the participant secondary to personally having acquaintance with the researcher.

Significance

There were 4,098,607 RNs in the United States (National Council of the States Board of Nursing, 2020, p. S3) at the time of this study. This sector of the healthcare force is closest to patients and practice in a wide array of settings. These attributes put nurses in a unique position to provide critical recommendations to improve health care delivery and decrease health care disparities. Without the input of this sector, the United States may continue to have an inefficient health care system with poor outcomes. Policy development will continue to be influenced by insurance companies and others without

global and practical insights from the largest sector caring for patients. If nurses were to participate in and influence policy, solutions could be attained in increasing the workforce size, decreasing cost, improving healthcare outcomes, modifying duties within the scope of practice, and improve education for nurses to participate in policy to bolster societal and patient outcomes (Arabi et al., 2014). Additionally, nurses would be able to assist in achieving healthcare for all in a patient-centered manner by developing policies affecting their practice, patient outcomes, cost containment, and health systems (WHO, 2011).

Determining the current political astuteness of RNs in New Mexico may provide knowledge that nursing leaders can use to develop programs and test outcomes to see if participation can be successfully increased in the future. In essence, this study is the first step to determine what is needed to increase nursing participation in health care policy development. Using study findings, nursing leaders may be able to develop education and mentoring plans for nurses based upon their level of astuteness.

This study may lead to positive social change by providing data that nursing leaders can use to increase nursing participation in health care policy development. Nursing leaders can study which interventions are successful in increasing nursing participation in policy making. Increased participation may allow for nursing expertise to assist in diminishing health care inequities and increasing access and quality of care for all. The array of healthcare outcomes in the life continuum may be improved through RNs' participation in healthcare policy development.

Summary

This chapter delineated the need to discover where on the IOM's (2011) diffusion continuum, as measured by the PAI (Clark, 2008), the population of New Mexico RNs stand in terms of having awareness of the need to participate in healthcare policy development and implementation. I also discussed the need for research on the study population's knowledge of the IOM report. As the largest subset of the health care delivery system, nursing has the unique perspective of care needs throughout the lifespan and in different socioeconomic scenarios. Findings from this study provide information for nursing leaders, educators, professional organizations, and other stakeholder entities to bring the New Mexico RN population to the critical mass portion of the diffusion of innovation curve. This study lays the framework for further studies to improve the levels of political astuteness necessary to be successful with this task. The information provided by this study may allow innovators and early adapters to better educate and mentor other nurses.

In the following chapter, I review the current literature on nursing political participation, barriers to participation, and RNs's history in healthcare reform. I also review E.M. Rogers 's Diffusion of innovations theory focusing on its application in similar studies conducted in other disciplines.

Chapter 3 includes an overview of the study's quantitative research design along with a rationale for its selection. In the chapter, the sampling strategy and procedure for the targeted New Mexico RN population is discussed. I also discuss procedures for recruitment, and ethical considerations, including consent. Finally, Chapter 3 reveals the

strategy for data collection and analysis along with discussion of the reliability and validity of the PAI.

Chapter 2: Literature Review

Introduction

Healthcare in the United States continues to produce the worst outcomes compared to other developed countries despite spending that is the most per capita (IOM, 2013; Murray, 2010; The Commonwealth Fund, 2014; Sawyer & McDermott, 2019). To address this issue, national and international agencies have called upon nurses to be engaged in developing healthcare policy (IOM, 2011; Press Ganey, 2015; Robert Wood Johnson Foundation [RWJF], 2013; The Advisory Board Company, 2014; United Nations [U.N.], 2010; WHO, 2011). Nursing leaders and educators have emphasized the need to become involved in healthcare policy development (Amieva & Ferguson, 2011; Barclay, 2010; Bryant, 2011; Chard, 2013; Donelan et al., 2010; Embree & Yueh-Feng Lu, 2016; Hashish & Kamel, 2014; Juma et al., 2014; MacDonald et al., 2012; Mund, 2012; Noyes et al., 2014; Vandenhouten et al., 2011; Webber, 2011). However, it was not known if the innovation of policy participation was diffused throughout the nursing community. The purpose of this study was to measure the political astuteness of RNs in New Mexico and to determine to what extent nursing leaders have been successful in diffusing IOM (2011) recommendations.

This chapter includes a review of the research on the topic of the political astuteness, nursing, and policy participation. It is divided into several sections that include the literature search strategy and the applicability of the theoretical framework. In the sections that follows, I synthesize the literature on the key concepts and variables related to nursing and political astuteness. This includes the barriers faced by, attributes

of, and the policy influence and advocacy of RNs. To conclude this chapter, a summary is provided highlighting the major themes found in the relevant literature. This includes what was discovered, what was known, and what was not.

Literature Search Strategy

I conducted a literature search using several databases, including Thoreau Multi-Database Search, CINAHL, and Medline, Political Science Complete, Sage Premier, and ProQuest, which I access from the University of New Mexico and Walden University online libraries. The key terms included *political participation and registered nurse, political participation and nursing, political astuteness and registered nurse, political astuteness and nursing, political skill and registered nurse, political skill and nursing, registered nurse and healthcare policy, nursing and healthcare policy, policy, participation and registered nurse, and participation, policy, and nursing*. Additional modifiers included scholarly journals, peer review, English language, and years of publication. I searched for articles published during the years of 2011 through 2018.

The topic of nursing involvement in public policy was a concept born from the early years of Nightingale and the influence of nurses in public health policy. The IOM (2011) report recommended and acknowledged the importance of the nursing lens in policy. This lens was recognized to be able to improve outcomes for the good. This landmark report stressed the necessary and expected behavior of the RN in policy participation. The innovation for this study was the participation of RNs in policy making. In conducting the study, I also addressed a gap in the literature. Much of the

literature reviewed was commentary (e.g., Brokhaw, 2016; Burke, 2016; Phillips, 2003) as opposed to work having a theoretical research base.

Theoretical Foundation

Rogers's (2003) diffusion of innovation theory. This theory explains how an idea gains momentum as it spreads through a social system (Kaminski, 2011; Owen et al., 2002). In this particular case, the social system was the nursing community. Essentially, the nursing community was summoned to participate in healthcare policy development. The DOI curve plot gives a visual of whether the community decided to support or resist the recommendation to become more engaged. This theory has been utilized and tested over 40 years (see Rogers, 2003)

In diffusion of innovation theory, each member of the social system is faced with decision-making to support or resist the innovation. This premise is also presented as a 5-step process. The process begins with knowledge and ends with confirmation. Movement through each stage represents an increase in engagement and participation (Orr, 2003). Ultimately, with the confirmation stage, the participant evaluates the decision made. The action of adaptation also has five stages. The stages range from the innovators to the laggards. It is the innovators, or opinion leaders, who determine the rate of adaptation. The method of communication is of utmost importance. This includes mass media and interpersonal methods (Orr, 2003; Owen et al., 2002; Rogers, 2003).

Theoretical Propositions

The DOI theory is an attempt to explain how an idea, a technology, a behavior, a product, or a practice gains momentum and spreads within a particular social system

(Orr, 2003; Rogers, 2003). There is an assumption surrounding the awareness of the need for the innovation. There are four main elements of the theory. These are a) innovation, b) communication channels, c) time, and d) social system.

An innovation "is an idea, practice, or project that is perceived as new by an individual or other unit of adoption" (Rogers, 2003, p. 12). An innovation does not necessarily need to be new, but the innovation must be perceived as new for an individual. The "newness" perception is a characteristic assumed within the adoption character. The interpretation and explanation of the innovation is integral in the speed of diffusion. Without overcoming uncertainty, barriers to implement the innovation may occur. The consequences of not implementing the innovation must also be strongly communicated to convince the social system to adopt it.

Rogers (2003) defined communication as "a process in which participants create and share information with one another in order to reach a mutual understanding" (p. 5). The communication channels are an important piece of cascading the information within and throughout the social system. An example of communication channels are mass media and interpersonal communication. As diffusion is a social process, the latter is considered more important to successful adaptation of the innovation (Makse & Volden, 2011; Sahin, 2006). The interpersonal exchange of information is more likely to create strong opinions and attitudes within the social system. Another assumption related to interpersonal communication is that the members of the social system share some attributes (Rogers, 2003).

A time dimension is included in the theory and is seen as one of its strengths (Sahin, 2006, p. 15). Time dimension is included within the innovation-diffusion process, adopter categorization and rate of adoption.

The social system can affect the innovativeness and is influenced by the structure of the system. An assumption of the social system is within the definition of the group being interrelated group and aiming toward achieving the same goal (Sahin, 2006).

According to the theory, a suggested behavior or idea is adopted over a period of time and is dependent upon the innovators. However, in this study, it was unknown if there was an awareness of the need to change.

Many researchers have used the diffusion of innovations theory. Its application has occurred for 40 years in behavioral studies, healthcare, sociology, education, political science, public health, communications, history, economics, and technology.

In health care, Cain and Mittman (2002) applied the theory in a study of the ever-evolving health care system which is known for introducing innovations from technology to treatments. Within the system, the authors identified 10 critical dynamics of innovation diffusion. These included relative advantage, trialability, observability, communication channels, homophilous groups, pace of the innovation or reinvention, norms, roles and social networks, opinion leaders, and compatibility and infrastructure (Rogers, 2003). There are examples of failed diffusion through each critical dynamic. The authors further delineate within the hierarchy of adopters and provide characteristics of each stage in which the adopters may fall.

Sanson-Fisher (2004) applied the theory to creating clinical change. The author applied the theory to creating change in clinical behavior as influenced by the role models, "the degree of complexity, compatibility with existing values and needs, and the ability to test and modify the procedure before adopting it" (Sanson-Fisher, 2004, p. S55)

Lee (2004) applied the theory to consider the perceptions of nurses in using the new innovation of computer charting and care plan system. She was able to apply the rate of adoption to the S curve of diffusion with limitations related to the specific population study. In her qualitative study, she also concluded that the concepts of complexity and observability may have a benefit of being interchanged with image, ease of use, results, demonstrability, and visibility (p. 237). The author stressed the dynamic nature of the innovation-diffusion process.

Owen, et al. (2002) applied the DOI theory to public policy. The unit of analysis in their study was an individual consumer, and the findings were characteristics of adopter categories (e.g., laggard and innovator). They further suggested that public policy enables or inhibits diffusion of an innovation for societal good. Owen et al. (2002) displayed disagreement with the focus on previous applications being based upon the success of the interpersonal communications. The article demonstrated the need to focus on innovators and opinion leaders, then early adopters and so forth to assist in expediting the implementation of the innovation along the curve. They further discussed the supposition that there should be a focus on the majority of those who resist an innovation at each stage. They cited research by Sheth in 1981 who displaced the focus lens on a particular segment of the population and more how there was perceived risk associated

with the innovation adoption. Owen et al. (2002) discuss Sheth's less developed concept in diffusion research, shows innovation as discontinuous and overcoming the obstacle of having a higher perceived risk. Owen et al. (2002) also extended the four proponents of the innovation to include marketing and competitive actions. The authors looked at the diffusion model to pose a benefit for keeping the diffusion of the idea controlled and slow.

Application to Dissertation Topic

Starting in 2011, international and national agencies began to emphasize nurses' participation in health policy decision-making. The IOM (2011) partnered with Robert Wood Johnson Foundation to present findings within a landmark report. The report provided a specific recommendation on how nurses can prepare to educate the profession and the expectation of nursing as a profession to be present in health care policy and development (IOM, 2011).

Through understanding the definition and characteristics of each stage of the innovation and diffusion process, implementation, and persuasion of colleagues to participate is achievable (Lee, 2004). This paired with national recommendations, brought strength to the message. The message included the resurgence of nursing recognition and value.

This study benefited from the application of diffusion of innovations theory in that it involved examination of the nursing community in the state of New Mexico as the study population and individual nurses as the unit of analysis. The innovation was the "call-to-action" for nurses to be at the table in the development of healthcare policy as

recommended by the IOM (2011). Specifically, I sought to measure the success of this innovation diffusing through the social system. I also subsequently measured the potential inhibitors/obstacles to the innovation in the political astuteness of the RN. There was an assumption that similar attributes existed between individuals who were part of the system and that being part of that system was a shared the goal of improving care. This theory provided the ability to identify and delineate the characteristics of the situation. A key finding is that, despite an innovation being valuable for the masses, resistance still occurs.

Literature Review Related to Key Variables and/or Concepts

Call to Action

The call-to-action stemmed from the IOM's (2011) report and work by other international and national agencies (Press Ganey, 2015; RWJF, 2013, The Advisory Board Company, 2014; U.N., 2010; WHO, 2011) that stated that nurses have the unique span of expertise across the lifespan to provide insight in developing policy to improve health care outcomes.

Nursing represents the largest portion of the health care delivery system (IOM, 2011; Khoury et al., 2011). National and international agencies recognize this population as having the knowledge necessary to assist in the development of health care policy and systems to improve quality effective care (IOM, 2011; Khoury et al., 2011; WHO, 2011). Nurses spend the most time with patients and navigating the systems. As such, the WHO (2011) suggested that nurses had the capacity to impact universal coverage, provide people centered health care, and create policies affecting their practice and working

conditions. Additionally, the agencies called on nurses to assist in the development of national health systems to meet the global goals and targets. The IOM and WHO recommended improvement in education for nurses to better prepare them to meet this calling.

Barriers to Participation/ Potential Obstacles

Although there have been increasing calls for their participation, nurses' role in committees and leadership has not changed perceptions on nursing as not being influential in health policy development, either in the United States or abroad (Arabi et al., 2014; Hughes, 2010; Juma et al., 2014; Khoury et al., 2011; Knight et al., 2015; Mason et al., 2012; Shariff & Potgieter, 2012; Toode et al., 2014). Health care organizations tend to have physicians on their boards (Mason et al., 2012; Shariff & Potgieter, 2012). When nurses have had the opportunity to participate in development of policy on boards, they have sometimes exhibited oppressed behaviors (Hughes, 2010). This was an obstacle similar to the one Sahin (2006) discussed.

Nursing historically was an oppressed group secondary to the medical hierarchy seen in institutions where they practiced (Arabi et al., 2014; Hughes, 2010; Mason et al., 2012). The public view also contributed to nonassertive behavior.

The Nightingale Pledge speaks to the need for advocacy. However, it also emphasizes the historically subservient role of the nurse. "With loyalty will I endeavor to aid the physician in his work…" (Gretter, 1893/2016, para. 1). This statement dates to the 1800s. Though the statement was revised in 1935, this portion remains. Since then, the profession has struggled with gaining an increase in autonomy and with the inability to

practice to the fullest extent of the scope of licensure (Committee, 2016). The IOM (2011) also recommends for each nurse to practice to the fullest extent of ability and licensure.

The concept of removing barriers to practice continued to be a theme in recommendations from the Institute of Medicine (Committee, 2016). Advanced practice registered nurses (APRNs) continued to face barriers related to not being able to meet this recommendation. At the time of the IOM report, 13 states met criteria for full practice authority. There are now 24 states with full practice authority (American Association of Nurse Practitioners, 2021). There were other states that have made small improvements but still barriers occur.

Physician organizations continue to create barriers and stand in opposition to APRNs practicing to the fullest scope of their education. This continued to occur despite the increase in collaboration between physicians and nurses (Committee, 2016). As a result, more diverse stakeholders were being sought to assist in removing these barriers. This included policy makers, business and corporations, and other health professions groups (Committee, 2016). The Centers for Medicare and Medicaid Services continued to create adjustments to legislation to allow for the ability of nurse practitioners to practice to the fullest extent of their education. For example, in 2012, regulations were amended to allow for APRN's to permit performance within hospitals to their fullest scope. The CARES act allowed independent practice of the nurse practitioner and parity in billing. Many of these changes will be permanent.

The Federal Trade Commission (FTC) also became involved in attempting to remove barriers to practice. The FTC participated to advocate for APRN scope of practice in many states through provision of letters, comments, and/or testimony (Committee, 2016; p. 5).

The IOM (2011) report recommended nurses to lead change, to participate in research toward evidence-based improvements, and to participate in ongoing reforms. However, nursing continues to be viewed as subservient, and must develop relationships to work collaboratively with other disciplines. Collaborating teams can be successful in delivering improved care with all members working to their fullest potential.

The recommendation for nursing to increase board membership also existed in the IOM (2011) report. Nurses have unique perspectives due to delivering care through the entire life continuum. At the time of the IOM (2011) report, 6% of board membership were held by nurses and 20% included physicians. Unfortunately, at the time of measuring progress, the percentage of board membership held by physicians remained the same while nursing dropped to 5% (Committee, 2016; p. 12).

Nursing ranked the highest in ethics and honesty by the Gallup Poll since 1999 (Brennen, 2017; Duff, 2019; Gallup, 2015, 2021; Reinhart, 2020; Riffkin, 2015). The exception was in 2001, the time of the 9/11 attacks where firefighters received the prestige (Mund, 2012). Despite this finding, top opinion leaders viewed health policy influence as being driven by the government and health insurance companies. The top opinion leaders acknowledged the nursing profession as being a knowledgeable resource regarding health information but did not view nurses as leaders in the development of

health policy or system delivery (Khoury et al., 2011). “Opinion leaders” felt nursing needed to overcome barriers to achieve more influence in health care; they (nurses) need to have their voices heard (Gallup, 2010, p. 3). According to the Gallup survey (2010), leaders which included university faculty, insurance leaders, corporate leaders, health services and government leaders, and industry leaders felt nurses could have an impact on reducing medication errors and improving patient safety. Interestingly, these leaders saw physicians being key decision makers as a barrier.

Lack of Skill Set

Throughout the literature reviewed, the discussions of barriers led to exemplifying that nursing did not have the skill set necessary to participate. This was both from the viewpoint of the participating nurse and other health care decision makers. It was just recently that health policy classes and mentoring have become part of the baccalaureate and masters level curriculum (Byrd et al., 2012). The currently practicing registered nurses did not receive this benefit.

When invited to the boardroom, many nurses did not take the challenge (Kunaviktikul et al., 2010). This was due to the lack of knowledge on processes and the perception that the nurse did not have the skill set to navigate. Nursing associations attempted to change this fear of the unknown and encouraged participation from its members in policy at local and national levels (MacDonald et al., 2012).

Attempts to overcome the lack of skill set occurred throughout the country through academics and professional organizations. The IOM (2011) report called for an increase in education entry level. The baccalaureate degree in nursing was considered

entry level. In 2011, about half of the nursing population held a baccalaureate degree. The goal was to reach 80% by 2020. At the time of the progress report (Committee, 2016), it was deemed as not measurable since there was not enough time for completion of degrees. However, enrollment did increase in both initial degrees being baccalaureate and in the associate degree to baccalaureate transition programs (Committee, 2016).

A barrier to the success of this recommendation revolved around the lack of increase in funding to support this goal. Funding has remained "flat for the past decade" (Committee, 2016; p.6). Though the number of programs grew, the salary for faculty did not. This created less interest in faculty positions.

Another success through the Campaign included an increase in the number of nurse residency programs to assist in the transition of a new nurse into the profession. However, ambulatory settings and population health lack residency programs. There were programs that assisted in transition to practice models for APRNs created. Outcomes from these residency programs included better retention and improved ability for the nurse to organize, manage and communicate (Committee, 2016).

Doctoral education also continued to be considered of high value. To meet the needs of the growing school programs, there was a need for more doctoral level prepared nurses. The IOM (2011) report recommended doubling the number of doctoral level prepared nurses by 2020. This was also immeasurable at the time of the Campaign's (2016) report. Recommendations still prevail for the achievement. The number of programs doubled. However, the predominance of these programs was for the Doctor of Nursing Practice (DNP). The recommendation from the IOM (2011) report was for an

increase in the numbers of PhD prepared nurses. This would assist in improving available faculty.

With all the improvement in level of education, literature on the successful inclusion of health policy varied. Much of the faculty did not receive policy education themselves. Many were not policy participants, nor have they had exposure. Others had success in engraining the importance of participation through including active participation in and development of policy (Committee, 2016).

Despite the findings, the Campaign continued to recommend that nurses lead health policy change. The strategy for implementation of this recommendation included targeting other stakeholders. This included insurance companies, health care systems, the National Academy of Medicine and other professional groups, and governmental bodies at all levels. The success of increased involvement revolves around seeking a consumer-oriented audience and grassroots level support (Committee, 2016; p. 13).

It was considered imperative that nurses continue to build competence in leadership and be mentored to formulate persuasive communications skills. Professional organizations must develop relationships with other organizations that represented other members of the health care community. Social workers, pharmacists, physicians, physician assistants, employers, and policy makers were suggested members (Committee, 2016; p. 14).

Attributes Necessary for Nurses to Engage in Policy Development

Nursing leaders who participated in policy development displayed certain attributes. The ability to communicate well was of utmost importance (Shariff, 2015).

Nurses understand how to communicate well. They speak with their colleagues, an interdisciplinary team, their patients, and the patient's families on a daily basis. Perhaps this would be a good point to encourage increased participation.

Other attributes included the ability to promote nursing and strategically think (Shariff, 2015). With this point, nurses must critically think in the care of the patients. They must use time management, teamwork, and handle information every day. The ability of the nurse leader to display professional credibility, collaborative practice, and conflict resolution skills were also considered attributes (Shariff, 2015). These are also skills displayed daily.

Attributes that needed to be grown included the ability to do research, be innovative, and to become politically astute (Shariff, 2015). These are attributes which must be groomed. This was also being addressed through nursing curriculums based on IOM (2011) recommendations that each curriculum include a policy class.

The Campaign encouraged nursing organizations, educational programs, and professional societies to assist the nurse in lifelong learning (Committee, 2016; p, 9). This included navigating the political field and collaborating with other disciplines to improve healthcare delivery systems and policy.

Policy Influence

Nurses participated at the hospital level in advocating for policy which effect their daily practice (Arabi et al., 2014; Kunaviktikul et al., 2010; Mund, 2012; Shariff & Potgieter, 2012). Their level of influence was perceived as minimal outside of the nurse's specific specialty. Nursing needs to develop the ability to advocate for rare resources

such as time, personnel, and materials in their facility. Often, policies created even in these institutions were unstable due to the lack of influence and the overarching medical hierarchy.

To improve policy influence, the nurse needed to take part in decision making, policy making, and policy involvement (Arabi et al., 2014). With more exposure both for the participating nurse and the other members of the advisement group, an increased comfort level will occur. In turn, the concept of 'power' will improve for the nurse. Power, or lack thereof, was a recurring theme in the literature reviewed (Arabi et al., 2014; Hughes, 2010; Juma et al., 2014; Knight et al., 2015; Shariff & Potgieter, 2012). In exhibiting power, Arabi et al. (2014) described three levels. The first being to vote, the second where the nurse looked at values, beliefs, and world views. In this level the nurse became a member of a group. This increased strength. The third level was to participate in the actual development of health policy.

Along the same lines, the attributes of policy influence are also in stages. Policy literacy, acumen, and competence lead to policy influence. The nurse beginner would look at hospital policies asking certain questions. Then the nurse analyzes the policy. Competence occurs with direct management in issues to challenges and opportunities. Policies are monitored for desired effects and outcomes. Finally, policy influence occurs when the nurse develops an important role in the development of a policy, not just the implementation (Arabi et al., 2014; MacDonald et al., 2012).

Diversity in the workforce is also of benefit. At the time of the IOM (2011) report, the workforce demographic did not meet the demographics of the people they

serve. There was a call for being able to provide entry for underrepresented populations throughout the country (Committee, 2016). It appeared community colleges assisted in providing easier entry into the profession for this group (Committee, 2016). The Committee (2016) looked to state coalitions to assist in this endeavor. A barrier to successful implementation of this recommendation included funding. The Josiah Macy Foundation assisted through providing grants for interprofessional educational collaboratives.

Workforce data was a key component to draw on individual nurse expertise. States must understand the number and type of health care professionals serve its constituents. We must know where they are employed and the roles they incorporate. The knowledge of workforce data was considered critical in the formation of improved health care delivery models (Committee, 2016; p. 14). This research will contribute toward determining the demographics, educational level, and political astuteness of the registered nurse in New Mexico. National agencies should assist in collecting and disseminating information regarding the health care work force throughout the country. An example given by the Committee (2016) is having HRSA do a combined National Sample Survey of registered nurses and a National Sample Survey of APRNs (p. 15).

Advocacy

Advocacy is acting to support a cause (Merriam-Webster, 2019). As part of the Nightingale pledge and the Code of Ethics (ANA, 2014), nurses are responsible for advocacy. This includes advocating to promoting healthy environments, policies of safety, and for patients and families. However, over the last decade, nursing seemed to

forget this role in social justice (Buettner-Schmidt & Lobo, 2012). Part of being an advocate includes the ability to look at policy and understand it in an open system (Arabi et al., 2014; Feetham & Doering, 2015). This includes understanding the many factors influencing and many effects the policy will have at a macro and micro level. The nurse must recognize when conflict could arise and be able to navigate.

Progress Toward Recommendation

The combined efforts of the RWJF and the IOM assess the progress toward the recommendations from IOM's (2011) report. The effort of meeting the recommendations has become to be termed the "Campaign" (Committee for Assessing Progress on Implementing the Recommendations of the Institute of Medicine Report: The Future of Nursing [Committee], 2016). The Committee (2016) continues to advocate for nursing to be involved in policy making, not just implementation. Additionally, with the progress report, the stress is made upon the need for collaboration within the disciplines for success to occur. The recommendations to be emphasized in the years to come include a) diversity in the nursing workforce, b) advancing education, c) leveraging nursing leadership, d) interprofessional collaboration, and e) accurate workforce data (Committee, 2016, p. 2).

The Campaign to advance the recommendations worked with the Center to Champion Nursing in America and communicate the efforts through state coalitions. New Mexico did not have an established coalition. However, through the New Mexico Nurses Association, attempts were made to cascade information, legislatively support advancing education through creation of community and university joint programs, and educate

nurses on legislative agendas and navigation from a grass roots perspective (D. Walker, personal communication, February 14, 2019). The Committee (2016) discusses other organizations who released literature calling for advancing the recommendations of the Future of nursing report. This includes The Carnegie Foundation, WHO, and the Tri-Council for Nursing (p. 3).

The IOM's (2011) report was based upon the knowledge of the Patient Protection and Affordable Care Act (ACA) being implemented. The ACA created the need for team-based care models and nursing had opportunity to play a significant role. This included care management of chronic diseases and a focus on population health. The system of healthcare delivery has been continuing to evolve.

The themes from which nursing should act for the Campaign to be successful were: a) building a broader coalition to increase the awareness of the nurses ability to play a full role in practice, education, collaboration and leadership, b) continuing to promote diversity, and c) improving workforce data (Committee, 2016; p. 4). The concept of removing barriers to practice also remained a key component of successful improvement in healthcare delivery (IOM, 2011).

In advocating for social justice and eliminating disparities, nurses can be involved with policy and procedural development at any level. Nurses should be involved in fund allocation decisions in a manner where he/she is supported in a sea of hierarchal power. The lack of knowledge on budget has been viewed as a weakness for nurses (Arabi et al., 2014; Juma et al., 2014; Khoury et al., 2011).

The Committee (2016) recognized that one profession cannot meet the complex needs of our country. Collaboration is key. In order for the nurses' unique perspective to be considered as worthy, they must be invited to the table. To be seen as an expert, much work needs to be done. In determining where on the diffusion curve the state of New Mexico sits regarding the level of implementation of the IOM's (2011) report, nurse leaders can partner with other professional and entities to overcome identified barriers and strengthen coalitions to improve the delivery of health care in this state.

Summary and Conclusions

Nursing has been recognized as a valued resource to contribute to development of health care policies and systems (Arabi et al., 2014; IOM, 2011; WHO, 2011). However, nurses displayed the perception of not having the skills necessary to participate (Hughes, 2010; Juma et al., 2014; Knight et al., 2015; Kunaviktikul et al., 2010; Shariff, 2015; Shariff & Potgieter, 2012). Attempts to overcome these barriers need to occur. These barriers include historical oppression and lack of skill set. Nurses' involvement in policy development will improve the profession while improving healthcare delivery. Ultimately, this will improve healthcare outcomes and decrease disparities. There could be work toward establishing an adequate workforce, modification of duties, improving education based on society's needs, improving retention and job satisfaction, and ultimately the improvement of patient outcomes (Arabi et al., 2014).

This study contributes to a body of literature determining the current level of political astuteness. It enables nurse leaders to determine if there has been success in current methods of cascading the message of the importance and need for nurses in New

Mexico to be engaged in developing health care policy. In addition, this study contributes to the limited research regarding the demographics of the current state of the nurse population. Finally, this study adds to the limited literature on policy participation of the RN. This study is limited in generalizability to the RN demographics of New Mexico. The method and procedures for this cross-sectional design are outlined in the next chapter.

Chapter 3: Research Method

Introduction

The purpose of this quantitative cross-sectional study was to measure the political astuteness of RNs in New Mexico and to determine to what extent nursing leaders have been successful in diffusing IOM recommendations. Political astuteness represents an awareness and comprehension of policy and legislative processes and political skills. It was imperative to determine a baseline of political astuteness so nursing leaders can develop interventions to improve RNs' political astuteness so successful participation in health policy development can occur. Furthermore, as is the case for descriptive studies, this study can stimulate exploratory research and the identification of hypotheses for further research (O'Sullivan et al., 2008).

In this chapter, I provide an overview of the research method for this study. First, the research design and rationale are presented. The methodology of the study that follows is described in such a manner that future researchers can replicate the study. Within the discussions of the methodology, the population and the sampling and sampling procedures are described. I then discuss the procedures for recruitment, participation, and data collection. In the section that follows, I introduce the survey I used. Finally, the threats to validity are explored. A summary concludes this chapter.

Research Design and Rationale

I conducted this study to determine where on the diffusion of innovation curve the innovation of policy participation was cascaded through a modified PAI. The independent variable was the RN participating in policy making as recommended by the

IOM (2011) report recommendation. The dependent variable was the participants' knowledge of the IOM report. Another dependent variable in this study was participants' political astuteness as measured by the PAI. Political astuteness was measured to determine how prepared RNs in New Mexico were to participate in healthcare policy development. The survey was further modified to see if there was a health policy course in the participants' education and for demographics.

The research design was a non-experimental descriptive design utilizing survey research. Survey research is used frequently at the federal level and in nursing research (Keough & Tanabe, 2011). Researchers use this method to look at what currently exists without manipulation of variable or an intervention. There is not a determination of causal relationship (Laureate Education, 2010). The survey in this study was a self-report tool to gain information about difficult-to-measure attributes of a population.

In using a cross sectional design, I aimed to measure the political astuteness and other attributes of participants' at the time the study was conducted.

Resource constraints were also considered. Though direct mail is known to have a better response rate (Shannon & Bradshaw, 2010), the cost and time involved with mailing and including a self- stamped, self-addressed envelope was cost prohibitive. The list from the Board of Nursing had an affiliated cost.

Web-based survey research typically does not have any costs affiliated with it. I used SurveyMonkey with a nominal cost. SurveyMonkey was used to enter the survey questions, enter the electronic mail addresses from sample, send the electronic mail, and

collect responses. The responses were entered into Statistical Package for the Social Sciences (SPSS) program, which, for Walden students, is free.

Methodology

I intended this quantitative cross-sectional survey to measure the successful communication of the IOM (2011) report to the RNs of New Mexico (NM). I used Rogers's diffusion of innovations theory in designing the study. Rogers studied six different disciplines (Sullivan, 2009) and focused on the stream of information and acceptance within a social system (Kaminski, 2011; Owen et al. 2002). I used a modified version of the PAI to determine where participants were situated on adaptation of the IOM recommendations. Additionally, I measured the level of political astuteness of participants by obtaining the score from the PAI. Using findings from this study, nursing leaders can develop interventions to improve the astuteness of the RN based upon demographics and evaluation of each item on the survey.

Population

The population chosen for this study was RNs in New Mexico. According to the New Mexico Board of Nursing, there are 24,821 RNs licensed in New Mexico in 2020, of which 18,360 had New Mexico addresses. This population, because there was a definitive countable number of sampling units, was finite (Frankfort-Nachmias et al., 2015). The sampling frame contained a complete listing of the population.

Sampling and Sampling Procedures

The goal of the sampling design was to obtain a representative sample (see Frankfort-Nachmias et al., 2015). Because each member of the population had an equal

chance of being invited to participate in the study, a probability sample was appropriate. The probability sample design chosen was the simple systemic random sample.

I randomly assigned each member of the population a number (see Frankfort-Nachmias et al., 2015). This was generated through a computer program. Each member of the population randomly chosen within the determined sample size was invited to participate in the study. This method allowed for estimation of parameters that were representative of the population (Frankfort-Nachmias et al., 2015).

Using a systemic simple sample, I gave each member of the RN list attained from the New Mexico Board of Nursing a random number with Excel. All members of the registry were considered eligible if their address was in New Mexico. RNs with an address outside of New Mexico were excluded. Participants were randomly chosen to achieve a number to account for a presumed 40% non-response rate. An additional random selection occurred after further literature revealed a lower response rate in healthcare professionals (Hai et al., 2019). The first group of emails did not elicit the number of responses necessary to conduct analysis to achieve a 95% confidence level with a 5% margin of error.

There were 18,360 RNs with addresses in New Mexico. To obtain a representative sample that could be generalized to the overall population of licensed RNs in New Mexico, a sample of 379 nurses needed to participate to attain a 95% confidence level with a margin of error of 5%.

Procedures for Recruitment, Participation, and Data Collection

I sent invitations to participate in the study to licensed RNs in New Mexico with a New Mexico residential address. Recommendations for participant recruitment from the Agency for Healthcare Research & Quality (n.d.) were considered. The contact was solely with the use of emails provided from the New Mexico Board of Nursing list of licensed RNs. An email was sent out to eligible randomly selected participants that provided an introduction and information about the study (see Appendix A). The email also contained a link to the survey (see Appendix C). An email that was returned or unopened rendered the invited participant ineligible at the close of the survey.

To be respectful of the participants time and efforts, I explained in the email how long it would take to complete the survey. Ethical standards were maintained and are discussed later in this section. Informed consent was obtained by the participant clicking the link to initiate the survey.

Informed consent can be challenging in survey research. Internet surveys pose challenges in general (O'Sullivan et al., 2008; Rudestam & Newton, 2015). There was not a way for the participant to ask questions during the taking of the survey. I had to reflect and consider every possible scenario of risk to the participant when I formulated the consent form. For this study, the concept of inconvenience and time loss came to the forefront of potential risks to the participants. However, in consideration of the nurse's obligation to advocate for the patients they serve and to develop, implement, evaluate, and promote policies for safety (American Nurses Association [ANA], 2014), there could have been some distress in answering questions during administration of the modified

PAI. Contact information was provided in the introduction email with contact information in case the participant experienced such distress. Additionally, the participant had the ability to stop taking the survey at any time.

The inventory sought answers regarding the participant's level of engagement in politics. Engagement in politics stemmed from simply being registered to vote to having served as a resource on a health-related issue and involvement with their legislators (Byrd et al., 2012). Although the survey was meant to be anonymous, there was a risk, due to the demographic questions, that it could be determined who a participant was. I took steps to ensure confidentiality. A participant was invited to submit their contact information to my personal email if they were interested in seeing the results of the study.

On the consent, located in the email, I listed my personal contact information so that the participant could contact me with any questions they may have had. As far as the emotional distress, it was discussed in the informed consent prior to the participant providing the consent by clicking the link to the survey. As Rudestam and Newton (2015) discussed, the participant should emerge from this project unharmed (p. 314).

Demographic questions that were added to the survey include:

- gender
- age
- educational level
- number of years licensed as an RN
- geographic area
- membership of professional nursing organization

A participant had the ability to exit the study at any given time. Exit was considered with incomplete survey responses. A selected candidate had the ability to choose not to participate by not taking the survey.

The data collection was through the SurveyMonkey site. I transferred the information received from the survey platform to SPSS for analysis. The analysis included descriptive statistics. This included percentages, and frequency distribution. Secondary findings from subsequent correlations related to PAI scores are listed in Appendix E. Secondary findings suggested correlations between certain demographic qualities impacting the scores of political astuteness. For example, those with more years of practice had higher scores. This finding allows for targeting certain demographics with programs designed to improve political astuteness in follow-up interventions or future research.

There were no follow-up procedures necessary unless a participant requested results of the study.

Instrumentation and Operationalization of Constructs

The PAI is a 40-item tool developed by Clark (2008) to measure the level of political astuteness. I obtained permission to use this inventory from the author's wife, Margaret Clark (see Appendix B). The concepts covered in the tool include voting behavior, participation in professional organizations, awareness of policy issues, knowledge of policy process and elected officials, and involvement in political process (Byrd et al., 2012, p. 435; Clark, 2008). This inventory takes approximately 10 minutes to complete. The responses are dichotomous with a choice of "yes" or "no." All "no"

responses are given a representative number of 0. All “yes” responses are given a representative number of 1. The scores are added to provide a sum of 0-40. The scores are categorized (Byrd et al., 2012, p. 435) and represented in Table 1.

Table 1

Political Astuteness Inventory Score Interpretation

Score	Interpretation
0-9	Totally unaware politically
10-19	Slightly more aware of implication of political activity for nursing
20-29	Beginning political astuteness
30-40	Asset to nursing

I added other demographic questions. These included age, gender identity, geography, number of years practicing, and level of education. Supplemental survey questions included:

- Are you aware of the IOM’s report *The Future of Nursing: Leading Change, Advancing Health?*
- Do you believe it is important that nursing assist in development of healthcare policy?

- Do you believe nursing can have an impact in healthcare policy development?
- How would you rank you level of proficiency in the policy process? (Likert scale)
- How would you rank your level of participation in policy? (Likert scale)
- Do you feel you have the skills necessary to be successful in participation?
- Are you intimidated by the policy process?
- Do you believe participating in a mentoring program to improve skills would be beneficial?
- Would you participate if such a program existed in New Mexico?

A panel of experts in political science and nursing assessed the PAI and the additional questions for content face validity.

Threats to Validity

I considered the ethical aspects of the research. There were numerous considerations in both the ethical tenets of research and the scientific integrity of survey research when designing and conducting the study. Hammer (2017) discussed the process to ensure that both elements are considered when using a survey as a research instrument.

The reliability and validity of the PAI were established through its use in numerous studies (Byrd et al., 2012; Primomo, 2007; Primomo & Bjorling, 2013). This includes the internal consistency of the survey. The instrument was only administered to the nursing population. Selection bias was obviated through the random selection of

participants from a complete list of RNs in New Mexico as provided by the New Mexico Board of Nursing.

Threats to validity were identified and mitigated through five experts who lead and participate in health policy review the survey. This assisted to establish the additional questions as maintaining the construct validity of the survey in its entirety. Additionally, this served as a pilot. Piloting the survey also demonstrated continued convergent and divergent validity of the constructs that were measured (Etchegray, 2011).

Ethical Procedures

Survey research provides a conundrum of issues related to informed consent. I reflected throughout each step of the research. I identified the concept of inconvenience and time loss as the highest potential risks to the participants. I also considered the risk of potential distress in answering the questions of the PAI as nurses are obliged to advocate for the patients they serve and to develop, implement, evaluate, and promote policies for safety (ANA, 2014). The inventory sought answers regarding the participant's level of participation in politics. This stemmed from simply being registered to vote to serving as a resource on a health-related issue and being involved with their legislators (Byrd et al., 2012).

Consent was acknowledged through the participant completing the survey. Obtaining informed consent required the ability for the participant to be able to ask questions. On the consent, my personal contact information was included so a participant could contact me if there were any questions. The risk of emotional distress was

discussed in the informed consent. As Rudestam and Newton (2015) discuss, the participant should emerge from this project unharmed (p. 314).

The electronic mail that was sent to the participants outlined the purpose of the study and how the information was to be used and disseminated. The introduction discussed the concept of implied consent through participation. I also explained in the electronic mail to the participants that they were able to not to answer any demographic questions and that they could exit the survey at any time.

Summary

The preceding chapter provided information on this non-experimental cross-sectional descriptive design using survey research to determine if the RNs of New Mexico received messaging from nursing leaders to engage in policy-making from the IOM (2011). The use of the PAI determined to what extent the participant was participating in policy.

Chapter 4: Results

Introduction

The purpose of this quantitative cross-sectional study was to measure the political astuteness of RNs in New Mexico and to determine the extent nursing leaders have been successful in cascading the IOM (2011) recommendations. Political astuteness represents an awareness and comprehension of policy and legislative processes and political skills (Byrd, 2012; Primomo, 2007). The findings from this study may allow nursing leaders to develop interventions to improve RNs' political astuteness and the ability to successfully participate in health policy development. Another goal of the study was to stimulate exploratory research and the identification of hypotheses for further research (see O'Sullivan et al., 2008). The RQ and hypotheses for the study were as follows:

RQ: Where on the diffusion of innovations curve has the cascading communication surrounding recommendations for increased nursing participation in policy development are registered nurses in New Mexico as measured by the Political Astuteness Inventory (PAI, Clark, 2008)?

H_a: The communication on the need for the RN to participate in policy development is not in the critical mass phase as evidenced by the results of the modified PAI showing participants as being "totally unaware politically."

H_0: Alternatively, the communication on the need for the RN to participate in policy development was in the critical mass phase as evidenced by the result of the modified PAI showing participants as being "asset to nursing."

I described the data collection process, implementation fidelity, and methodology in Chapter 3. The survey was modified from its original form with the permission of the originator's estate (see Appendix B). To determine construct validity of the revised material, it was reviewed by a panel of experts in healthcare policy. I also conducted Cronbach's alpha test to ensure validity. This chapter presents the tool validity, intervention fidelity and data collection details. The chapter also presents the demographics of the participant group. The results and analysis of the data are also included.

Tool Validity

The PAI is a tool that has been used in numerous nursing studies with a pre-test post-test design (e.g., Byrd et al., 2012; Primomo, 2008; Primomo & Bjorling, 2013). The tool was modified with the permission of the author's widow (see Appendix B). Because I modified the inventory, I sent it to five experts to achieve construct validity for the current administration. The experts provided recommendations to update wording. For example, professional nursing organizations are no longer in districts. A recommendation to change nursing organization "district" to "local nursing association" was made. All recommendations were incorporated apart from adding additional questions. The accepted recommendations were contained in the final survey used for this study (see Appendix C). The recommendations for the changes made to the survey can be found in Appendix D.

The modified PAI had a high level of internal consistency as determined by Cronbach's alpha of 0.91. There were no items identified within item-total statistics that

lowered the Cronbach's alpha score, suggesting each item is appropriately associated with the remainder of the items. Question 37 resulted in a small increase with deletion that was not significant. Question 37 queried participants on whether they were more interested in public issues compared to the past. Excluding Question 37 from the survey would have increased the Cronbach's alpha score from .907 to .909. Both these scores round to .91, therefore leading to the retention of the question.

Data Collection

I purchased a list of actively licensed RNs from the New Mexico Board of Nursing to recruit participants to take the survey, which I had loaded into SurveyMonkey. The list was altered for uploading potential participants' contact information to send invitation by email within SurveyMonkey. Any RNs with addresses outside of New Mexico were excluded. Between August 18 and September 24, 2020, a total of 14,490 emails were sent using simple randomization. Of these invitations, 5,757 were opened. Many invitations were not deliverable for several reasons. First, the email provided was incorrect. This occurred with 879 emails. Second, there were approximately 116 emails that "opted out" of receiving surveys via Survey Monkey. There were 890 emails that were returned undeliverable. Lastly, the email invitation might have landed in the recipient's spam mailbox. A total of 7,738 emails remained unopened for any of the preceding reasons. The remaining number of opened emails showed that the potential participant clicked through without participating. A response rate of 7.5% occurred from the opened emails. This is a low response rate and has the potential to create bias, though since there was a representative sample, the non-responders can be considered "missing

at random" (Parashos et al., 2005; p. 9). In the time of pandemic, nurses worked more hours and were under more stress (Arnetz et al., 2020; Moore et al., 2021) This could have, at least in part, contributed to the low response rate.

In order to achieve a 95% confidence interval with a 5% margin of error, 379 participants were needed in the sample size. A total of 411 surveys were completed in entirety. Surveys not completed in their entirety were excluded from data analysis

Intervention Fidelity

The study implementation occurred as planned. There were several emails received from participants interested in learning more about the study. One participant expressed an opinion about "Yes/No" choices being inadequate without the ability to write open-ended responses. This participant did complete the survey in entirety. I was not contacted by any participant who had an adverse event related to bad or other unexpected untoward feelings.

Results

The goal of this study was to determine where RNs are on the diffusion of innovation curve in terms of engagement in policy participation as measured by the modified PAI.

Baseline Demographics and Descriptive Characteristics of Sample

Gender

Table 2 reflects the gender identity of the participants (N = 411). The number of female respondents was 336 (81.8%). Male participants accounted for 17.3% of responses (N = 71).

Table 2

Gender Identity of Participants

Gender	*N*	%
Female	336	81.8
Male	72	17.5
Nonbinary	1	0.2

Age

The majority of participants were between the ages of 45-54 (*N* = 102, 24.8%) and 55-64 (*N* = 110, 26.8%) representing 51.6% of the total participants. For analytical purposes and to prevent potential identifier, the age group of 18-24 was combined with the 25-34 age group.

Table 3

Age of Participants

Age	*N*	%
18-24	1	0.2
25-34	41	10
35-44	79	19.2
45-54	102	24.8
55-64	110	26.8
65+	75	18.2
Failed to answer	3	.07

Ethnicity

Of the 411 participants, two did not respond to the question about ethnicity. Native Americans made up 3.4% of the respondent population; Asian or Asian American comprised 1.7%, Black or African American comprised 1.2%, Hispanic or Latino made

up 16.5% of the population and those identifying as White or Caucasian represented 75.7% of the population. A breakdown of respondents' ethnicity is found in Table 4.

Table 4

Ethnicity of Participants

Ethnicity	*N*	%
American Indian or Alaska Native	14	3.4
Another Race	4	1
Asian or Asian American	7	1.7
Black or African American	5	1.2
Hispanic or Latino	68	16.5
White or Caucasian	311	75.7
Failed to answer	2	0.5

Years of Practice

The largest percentage of respondents practiced for 31 years or more (*N* = 122; 29.6%). This time in practice is congruent with literature showing an aging nursing population (American Nurses Association, n.d.; Haddad et al., 2020). Participants' years of practice can be seen in Table 5.

Table 5

Participants Years of Practice

Years of Practice	*N*	%
0-5	53	12.9
6-10	59	14.4
11-15	55	13.4
16-20	46	11.2
21-25	42	10.2
26-30	34	8.3
31+	122	29.7

Education Level

There were 20.2% of registered nurses practicing with an ASN/ADN education (*N* = 83). Baccalaureate nurses accounted for 35.3% of the respondent population (*N* = 145). Master's degrees were held by 31.1% of the participants (*N* = 128) and doctoral degrees by 8.1% of the respondent population (*N* = 33). Five respondents held post master's degree certificates (1.2%). For analytical purposes in correlations and due to their small number, those with post master's degree certificates were assigned to the MSN category and PhD and DNP categories were combined.

Table 6

Education Level of Participants

Education Level	*N*	%
ASN/ADN	83	20.2
BSN	145	35.3
MSN	128	31.1
Masters/Doctorate non-nursing	17	4.1
Post-Master's Certificate	5	1.2
DNP	22	5.4
PhD	11	2.7

The descriptive statistics representing the characteristics of the sample are in Tables 2-6. I produced other descriptive statistics and analyzed correlations using one-way ANOVA, independent t-test, and Spearman's rho to evaluate relationships between demographics and the PAI. As these correlations were secondary to the RQ, the results are presented in Appendix E rather than in the narrative.

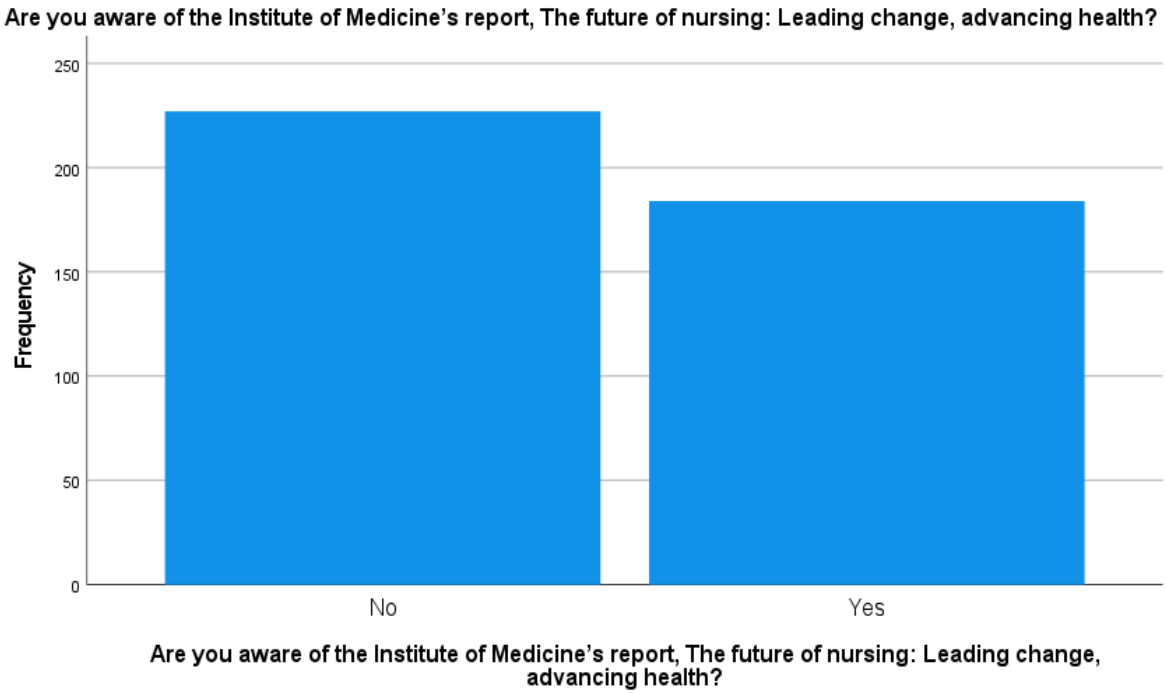
Knowledge of Institute of Medicine Report

The IOM (2011) is the agency within the United States that recommended that RNs increase their policy participation. Nursing leaders and educators have been responsible for disseminating this recommendation.

The majority (55.1%, $N = 227$) of the participants reported not having knowledge of the IOM report; the remaining 44.7% ($N = 184$) did have knowledge of the report (see Figure 1). These data alone did not answer the question regarding nurse leaders being successful in disseminating the IOM's report on the future of nursing. I ran correlations to determine if there was a relationship between the awareness of the IOM and belonging to a professional nursing organization. It would be expected that the leaders of these organizations would communicate the report and its recommendations to members. They would be considered the innovators in the DOI theory.

Figure 2

Awareness of IOM Report



As seen in Figure 2, only 55.1% of the respondents reported having knowledge of the report. According to the diffusion of innovation theory, this would not have been considered a meaningful innovation by the innovators (nursing leaders) and therefore would not have completed the diffusion of innovation bell curve or the steps of accepting the innovation.

A measure of political participation within the RN community of New Mexico may indicate that there was policy participation without having knowledge of the IOM report.

***Political Astuteness Inventory Scores*:**

The respondents (N = 411) PAI score had a mean of 20.21, a mode of 26, and a median of 20 with a standard deviation of 7.78. A score of 20 is the equivalent of beginning political awareness.

The PAI score indicates there is a beginning political awareness amongst the respondents of the survey. However, there is a standard deviation of 7.78. With a score of 12, this would suggest that the RN of New Mexico is slightly aware of the implications of political activity for nursing.

Table 7

Political Astuteness Inventory Scores

Score	*N*	%
Totally Politically Unaware		
0-9 Points	39	9.5
Slightly Aware of Implications		
10-19 Points	149	36.3
Beginning Political Awareness		
20-29 Points	174	42.3
Politically Astute		
30-40 points	49	11.9

The mean score of 20.21 reflects a beginning political awareness of the registered nurse in New Mexico. This score supports rejecting the null hypothesis the RN in New Mexico being an asset to nursing as measured by the PAI score.

Diffusion of Innovation

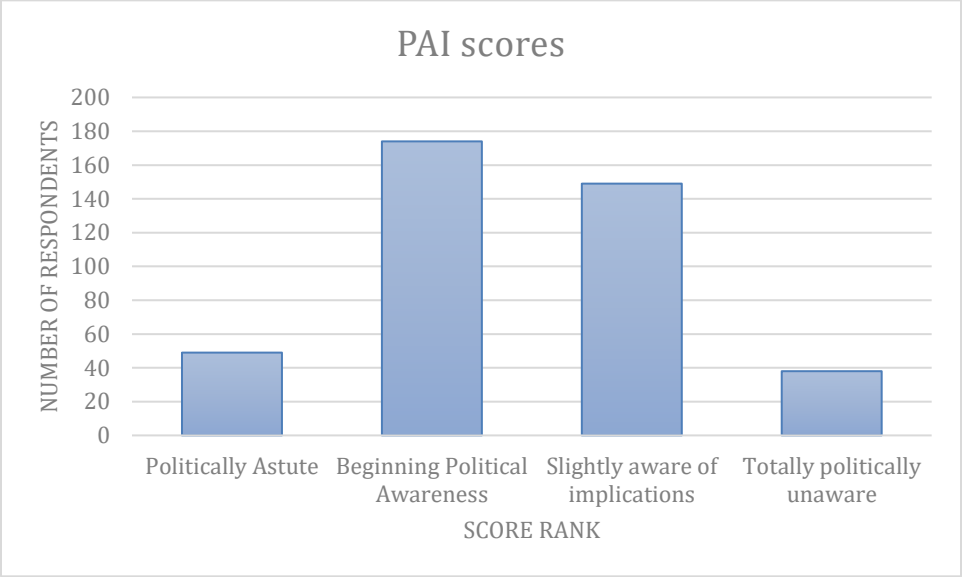
This study was guided by the RQ, where on the diffusion of innovations curve has the cascading communication surrounding recommendations for increased nursing participation in policy development are nurses in New Mexico as measured by the modified Political Astuteness Inventory (PAI, Clark, 2008)? Only 44.7% of the

population acknowledged awareness of the IOM (2011) report. Of those belonging to professional organizations, 55.2% acknowledged awareness of the IOM (2011) report. The PAI score was used to measure the political astuteness of the NM registered nurse.

The scores, placed within the diffusion graph (see Figure 2) show the innovation to increase engagement in political and policy development demonstrates a normal diffusion bell curve. Interpreted, less than half the nursing community still needs encouragement to increase policy participation.

Figure 3

PAI Score Rank



Summary

In summary, the communication diffusion of IOM's recommendation for RNs to increase policy participation did not hit critical mass on the diffusion of innovation curve based upon PAI scores of a representative RN sample in New Mexico. Chapter 5 will

provide insights into the interpretation of the findings and the limitations of this study. In addition, the upcoming chapter will provide recommendations for further research and the implications of the findings. A conclusion is also given in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative cross-sectional study was to measure the political astuteness of RNs in New Mexico and to determine to what extent nursing leaders have been successful in diffusing IOM (2011) recommendations. The innovation was political participation. The social system was the New Mexico RN community. I used a modified Political Astuteness Inventory (Clark, 2008) to measure political astuteness of the RN participants. Surveys were sent to a simple randomized group from the entire licensed RN population residing in New Mexico. The total number of participants was 411.

Using SPSS, I analyzed the results of the survey were analyzed using descriptive statistics. The key finding of this study was the innovation of policy participation has not been disseminated throughout the nursing community. In other words, the innovation of RNs to participate in policy has not hit critical mass as defined in the DOI theory. Critical mass in the DOI theory represents a sufficient number of adopters of a new idea or innovation (Rogers, 2003). This finding led me to reject the null hypothesis. The innovation of the RN to participate in policy development was not in critical mass phase as evidenced by the scores of the modified PAI. The measurement of the political astuteness score revealed a mean score of 20 amongst the 411 participants. According to Clark (2008) this score translates to beginning political astuteness.

In this chapter, I discuss the findings in relation to previously published literature reviewed. Additionally, findings are reviewed within the context of the diffusion of

innovation theory. I also consider the limitations of the study, offer recommendations for practice, and potential future studies, and discuss the implications of the study.

Interpretation of the Findings

Nursing leaders and educators have sought to emphasize the need for nurses become involved in healthcare policy development (Amieva & Ferguson, 2011; Chard, 2013; Embree & Yueh-Feng Lu, 2016; Hashish & Kamel, 2014; Juma, Edwards, & Spitzer, 2014; MacDonald et al., 2012; Mund, 2012; Noyes et al., 2014; Vandenhouten et al., 2011; Webber, 2011). Based on the findings of this study, nurses have not heeded the call for policy participation. In responding to the question of whether the participant believed nursing could make a difference by becoming involved in policy making, 99% of the respondents chose “yes” (see Appendix E). When asked if the participant felt intimidated by the process, 42.8% of participants answered “yes” (see Appendix E). These findings affirm the body of literature that showed nurses lacking skills necessary to participate in healthcare policy (Arabi et al., 2014; Hughes, 2010; Mason et al., 2012). Nursing associations have attempted to change this fear of the unknown through encouraging participation in policy from its members at the local and national level (MacDonald et al., 2012). The literature also revealed that nurses can have an impact on improving patient safety (Gallup, 2010) but that barriers needed to be overcome. Although RNs remain the most trusted and ethical profession in the view of the U.S. public (Gallup, 2021), the population remains nonassertive. The results of this study lead to the conclusion that RNs need to overcome the lack of skill barrier to influence healthcare.

This study supported the findings of previous literature, specifically, the literature revealing the RN as being ill-prepared and lacking the skill set to participate in policy development (see Gallup, 2010; Juma et al., 2014; Khoury et al., 2011; Kunaviktikul et al., 2010; Mason, 2012). A question within the survey regarding whether the participant had a healthcare policy class in their curriculum revealed that 44.3% of the participants did not. The concept of mentoring and engagement in a health policy class remains in its infancy and began in 2011 (Byrd et al., 2012). The faculty themselves may not be adept in instructing and cultivating the skills needed to navigate the political field. Although strategic and critical thinking are part of nursing skills, to expand them away from the patient bedside and into policy participation remains to be achieved. The fact of the matter is as a nurse, one works with an interdisciplinary team, their patients, their families, and colleagues daily (Shariff, 2015). The communication skills are there. The skills just need to be honed and grown to reach outside of the bedside arena.

Regarding the perceived level of proficiency in policy, 60.3% of the participants self-ranked at average or above average proficiency. Despite this, 66.4% of respondents ranked themselves as participating “none at all” or “a little” in policy participation (see Appendix E).

According to the diffusion of innovation theory (Rogers, 2003), an innovation being diffused through a social system occurs only when the innovators find the innovation to be meaningful. Further research has shown that nurses lack the skill set necessary to participate in policy successfully. If the leaders (innovators) believed policy participation was meaningful, the diffusion curve would have shown a critical mass of

acceptance. The acceptance, measured by the PAI, would have had higher scores. The DOI curve plot provided a visual of whether the social system decided to support or resist the innovation of policy participation. In plotting scores, the laggards and late adapters outnumbered the innovators and early adapters. This meant that the innovation of policy participation had not disseminated throughout the RN population. The community was resisting policy participation.

The five-step process of diffusion begins with knowledge and ends with confirmation. In each stage there is increased engagement and participation occurs (Orr, 2003). The adaptation of the innovation also has five stages. It is the innovators, or opinion leaders, who determine the rate of adaption. As only 50% of the participants having heard of the innovation, nursing leaders and other disciplines who can assist in mentoring, must step up to ensure that nurses' policy participation can become reality. The communication channels used failed to disseminate necessary information to the social system (nursing community).

Arabi's (2014) discussion of power to have an influence in policy includes three levels. The first level includes being able to vote. In this study, close to 100% of the participants actively vote. In the second level, the nurse looks at values, beliefs, and world views. Within the third level, the nurse becomes a member of a group, increasing strength and participation in the development of healthcare policy. With a mean score of 20 (+/-7), the nursing community in New Mexico is still gathering their values, beliefs, and world views. The innovation of policy participation has barely started.

Though the call to RNs to participate in policy was given less than a decade ago, as findings illustrate, nursing leaders and educators have a long way to go to ensure that this profession can have a positive effect on healthcare delivery and outcomes.

Limitations of the Study

This study had several limitations. First, the assumption that nursing leaders specifically attempted to disseminate the recommendation from the IOM report was a broad generalization. Educators and leaders may have engaged in programs to develop the political astuteness of the RN without mentioning the groundbreaking IOM (2011) report.

Another limitation of this study includes the inability to generalize to other states. This study was limited to RNs with New Mexico addresses. The demographics of the sample populations were congruent with the *New Mexico Board of Nursing Annual Report* (New Mexico Board of Nursing, 2020) and the *New Mexico Healthcare Workforce: 2019 Annual Report* (Farnbach-Pearson & Reno, 2020). It was a representative sample. As such, the secondary data acquired from the participant responses were able to be analyzed for future studies and interventions.

Although the internal consistency and construct validity were achieved with the modified tool, in the past, this tool was used in pre-post intervention settings (Byrd et al., 2012, Primomo, 2007, Primomo & Bjorling, 2013). In the case of this study, the tool was used before intervention, but after the landmark study release.

Another limitation concerns the PAI tool. The tool looks specifically at participation in policy and politics outside of the workplace (Clark, 2008). This skewed

policy participation as specific to state, or national participation. The attributes of policy influence also have stages. Policy literacy, acumen, and competence lead to influence (Arabi, 2014). The nurse beginner may have scored low within the framework of the PAI without having the questions related to institutional policy analysis and cognizance. If local or institutional policy questions were added, the scores may have been different.

This study revealed the RN population in New Mexico as having "beginning political astuteness" based upon the mean score of 20. Though the SD was =/-7, there was no difference in category for a score of 27 or 20. However, a score of 13, changes the category rank to the NM RN being "slightly aware of political implications."

Recommendations

The following section includes significant findings and recommendations. The PAI score mean for the RN population in New Mexico was 20. The score fits into the "beginning political awareness" category. The sample attained was representative of the New Mexico RN population.

The recommendations for further research are limited to the RN population in New Mexico. The survey scores can be correlated to determine interventions to improve political astuteness based upon weaknesses and strengths within demographic subgroups. Future researchers can use the responses of this survey as a baseline to determine success of interventions.

In addition, researchers may want to partner with colleges of nursing in New Mexico to ensure that the professors teaching the now-required health policy course have the skills and knowledge necessary to successfully instruct students.

Implications

Positive social change includes "empowering the greater good" (Subocz, 2020, para. 1). Walden University (2020) defines social change as a deliberate process of applying ideas; "Positive social change results in the improvement of human and social conditions" (Social Change section). This study addressed the ineffectiveness of healthcare delivery and its direct negative impact on healthcare outcomes. The United States continues to demonstrate poor outcomes when compared to other developed countries (IOM, 2013; The Commonwealth Fund, 2014, 2020). The state of New Mexico remains at the bottom of national metrics with positive outcomes and at the top of the list for national metrics with negative impact. For example, New Mexico is at the top of the list measuring poor outcomes related to diabetes and well-being (Sharecare, 2021) and at the top of list for substance abuse (Kiernan, 2021) and violence per capita (Statista Research Department, 2020).

In addition to attaining a baseline for political astuteness of the RN in New Mexico, this study contributed to filling a gap in the literature on RNs and political participation and provides the framework needed to improve the political astuteness of the RN in New Mexico.

The achieved sample was congruent with the RN population in New Mexico. This will enable future researchers to target specific demographics for interventions. These interventions would create a RN armed with the tools to participate in healthcare policy development successfully. Barriers to care and socioeconomic inequities can be overcome through the development of healthcare policy that addresses them. With the

RNs' unique perspective, healthcare policy development can improve the health care delivery systems and health care outcomes.

Conclusion

This quantitative cross-sectional study did not support the null hypothesis of policy participation in critical mass phase and the RN in New Mexico being politically astute as an asset to nursing. However, it did not support the hypothesis of the RN in New Mexico being politically unaware either. This study far from answered the question of whether RNs are participating in healthcare policy development within the healthcare delivery systems they may practice and instead focused on state and federal policy participation.

The take-home message from this study is for RN leaders and educators. Nurses' unique lens, knowledge, and perspectives can improve healthcare delivery and ultimately outcomes. Each nurse must be equipped with the skills necessary to engage and influence policy makers and overcome the challenges of a medical hierarchy stifling the nurses' voice and opinion. It is up to each nurse to mentor another nurse, to share knowledge and information and to encourage growth and stretching beyond the comfort zone. Education is a lifelong endeavor for the RN. The learning curve may involve mastering ever-changing technology or figuring out how to analyze policy. The skills are there. They need to be honed and grown to achieve success in influence. The United States must improve healthcare delivery and abolish healthcare inequities and rise from having the worst outcomes of the developed countries. RNs are a key component to finding these

improvements and solutions. This generation of registered nurses must be trained to successfully influence and develop healthcare policies.

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Appendix A: Participant Invitation

Subject line: You are invited

Greetings!

My name is Gloria Doherty. I am reaching out to you as a researcher to participate in a study being conducted in partial fulfillment in attaining a Doctor of Philosophy in Public Policy and Public Administration at Walden University. You may know me as a registered nurse or a nurse practitioner, but this study is separate from that role.

The purpose of this study is to determine if the call to action for nurses to participate in healthcare policy development has cascaded throughout the nursing community as measured by a modified survey.

The hope for this study is to determine a baseline of information to create further exploratory studies. The baseline will assist in the nursing community, educators and leaders to help improve political astuteness. For the purpose of this study, political astuteness is defined as policy awareness, the understanding of legislative processes, and political skills.

You are invited to participate in this study through randomization from a list of actively licensed registered nurses residing in New Mexico. Your participation is completely voluntary. You have the right to not participate or withdraw from participation at any time. You may know me professionally or as a leader in professional nursing organizations. My role for this study is as a researcher. Our relationship will not be effected favorably or unfavorably based upon your participation choice. Responses to this survey are anonymous. Research should only be done with those who freely volunteer. The data gathered from this survey will be kept secure and password protected for 5 years, at which point it will be destroyed. The data analysis and reporting will be done in aggregate preventing identification from occurring.

Participating in this survey could involve some risk of minor discomforts that can be encountered in daily life. With protections in place, this study poses minimal risk to your well being. You may stop participation at any time should you experience any discomfort. There is no direct benefit to you through participating. However, the results of this study can assist in social change by informing the nursing community and its leaders on how to improve policy skills to improve healthcare.

The survey will take approximately 15 minutes to complete. There are 57 multiple choice answers which include demographics. Participation is completely voluntary and there is no compensation for your participation.

If you have questions regarding the survey, you may contact me at any time. You may reach me by cell phone (505) 350-2291 or by email gloria.doherty@waldenu.edu.

If you have questions regarding your rights as a participant, you may contact the University Research Participant Advocate by calling (612) 312-1210.

Examples of questions in this survey:

· What is your highest level of education in nursing? (Multiple choice)

· Do you believe that nursing participating in healthcare policy development is important?

· How would you rank your level of proficiency in the policy process? (Likert scale: 1-5)

· I voted in the last general election. (Yes/No)

· I stay abreast of current health issues (yes/No)

I am looking forward to the results of this survey. If you would like an update with results, please email me at gloria.doherty@waldenu.edu and I will provide the update.

Please keep or print this email as a copy of your consent form.

By clicking the survey link below, you are acknowledging your understanding and providing informed consent to participate.

Thank you very much,

Gloria Doherty MSN, RN, ACNP-BC

Appendix B: Permission to Use the Political Astuteness Inventory

Mary Jo CLARK

Wed 4/18/2018 5:19 PM
To: Gloria Doherty;

Most dissertation advisors accept an email. If you need a formal letter or permission, it would be helpful if you could draft one that I could then edit as needed. Yes, please keep me apprised of what you are doing. Since I retired, I don't always check my email everyday, but I will get back to you as soon as I do.

Sincerely,

Mary Jo Clark

On April 18, 2018 at 11:05 AM Gloria Doherty wrote:

Oh my! Mary Jo!
I am so sorry for your loss. I will keep you and your family in my prayers!!!
Will it be okay if I need to reconnect with you for a formal letter? Unfortunately, I have not received formal instructions and am unsure if this email will suffice. I hope this doesn't cause you any angst. I understand how sensitive this could be :(
I would also love to include you as I go through each step of the process if you would like :)
Thank you so much for returning my correspondence:)
With sincerity
Gloria
Sent from my iPhone

On Apr 17, 2018, at 6:25 PM, Mary Jo CLARK wrote:

Gloria,

He was my husband, but died in January. He routinely had me give permission for the use of the tool, so you are welcome to use it. Good luck with your dissertation. Let me know how it works out.

Sincerely,

Mary Jo Clark

On April 16, 2018 at 4:32 PM Gloria Doherty wrote:

Hello Dr. Clark!

My name is Gloria Doherty and I am a doctoral candidate. I have been attempting to receive permission to use the *Political Astuteness Inventory* written by Philip Clark in one of your text books.

The reference is below. I have had no luck in locating Mr. Clark for permission. I had many librarians assist in the search. The Health Sciences Center librarian suggested I contact you since you are the editor of the publication.

I greatly look forward to hearing from you so I can begin the research on my dissertation!!!

Clark, P. E. (2008) Political astuteness inventory. In: Clark, M. J. (ed.) Community assessment reference guide for community health nursing, 1–2Upper Saddle River, NJ: Pearson Prentice Hall.

Thank you so much for any assistance you can offer!!! My cell is the best way to reach me.

Gloria Doherty PhDc, MSN, Adult Health Nurse Specialist, ACNP-BC
Executive Director Inpatient Providers, Pulmonary Diagnostics and Respiratory Therapy
Intensivist NP Trauma Surgical Critical Care Services

Appendix C: Survey

Part I provides demographics and baseline perspective. Part II is exclusively dichotomous with Yes or No answers.

Part I: Demographics and Perceptions

1) What is your age group?
2) To which gender identity do you most identify with?
3) What ethnicity do you identify with?
4) What county do you practice in?
5) What is the highest level of education you have completed?
6) How many years have you practiced?
7) Are you aware of the Institute of Medicine's report, *The future of nursing: Leading change, advancing health?*
8) Do you believe it is important that nursing assist in the development of healthcare policy?
9) Do you believe nursing can have an impact in healthcare policy development?
10) Did you have a health policy class in your formal training?
11) Do you feel you have the skills necessary to be successful in participating in healthcare policy development?
12) Are you intimidated by the policy process?
13) Do you believe participating in a mentoring program to improve skills would be beneficial?
14) Would you participate if such a program existed in New Mexico?
15) Do you participate on a board of any organization or governmental agency?
16) How would you rank your level of proficiency in the policy process? (Likert scale 1-5)
17) How would you rank your level of participation in the policy process? (Likert scale 1-5)

Part II: Political Astuteness Inventory: used with permission.

1) I am registered to vote
2) I know where I can vote.
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
6) I was acquainted with the majority of items on the ballot in the last election
7) I stay abreast of current health issues
8) I belong to the state professional nursing or specialty organization
9) I participate (as a committee member, officer, etc.) in this organization.
10) I attended the most recent meeting of my nursing association.
11) I attended the last state or national convention/conference held by my organization.

12) I am aware of at least two issues discussed and the stands taken at that convention/conference.
13) I read literature published by my state nurses association, a professional magazine, or other literature on a regular bases to stay abreast of current health issues.
14) I know the names of my state (Federal) senators in Washington D.C.
15) I know the names of my state (Federal) representatives in Washington D.C.
16) I know the name of the (New Mexico) state senator from my district.
17) I know the name of the (New Mexico) state 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 the information about health-related policy issues at the state or federal level.
21) I know whether my professional organization employs a lobbyist at the state and federal level.
22) I know how to contact that lobbyist.
23) I support my state professional organizations political arm
24) I actively supported a candidate for US Senate, House of Representatives, or state unicameral (campaign contribution, campaigning service, wore a button, or other) during the last election.
25) I have written regarding a health issue 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 or his or her staff.
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 of 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 (New Mexico Board of Nursing).
35) I know the process whereby one becomes a member of the state board that regulates my profession.

36) I attend public hearings (town halls, meetings, or legislative) related to health issues
37) I find myself more interested in public issues now than in the past
38) I have provided testimony or express expert opinions at a public hearing (town halls, meetings, or legislative) on an issue related to health.
39) I know where the local headquarters of my political party is located.
40) I have written a letter to the editor or other piece for the lay press speaking out on a health related issue.

For each question '1' point is given for each "yes" and '0' points for each "no." The Political inventory score is the above. Look for the number of points. For example, 21/40 reflects a beginning in political awareness. Your inventory score = 0-9 points: Totally politically unaware 10-19 points: Slightly aware of the implications of political activity for nursing 20-29 points: Shows a beginning political awareness 30-40 points: Politically astute and an asset to the profession

Appendix D: Recommendations

	Recommendation	Used
Expert 1	Federal vs State in terms of elected officials	Updated in questions
	Conference vs conventions	Updated in question
	an option that they rely on professional associations vs personal direct engagement	Not added
Expert 2	many people do not know what a precinct is	18. knowledge of where I can vote.
	We have constitutional changes on the ballot but not initiative issues	22: 'majority of items'
	Federal representatives	30/31.Federal as suggested
	Federal senators	55 Have expressed expert opinion
	More explanation on public hearings	
	Testify at legislative hearings	
	Precincts move	
Expert 3	Include ethnicity	Included in demographics
	Tool and practice parameters are spot on	
Expert 4	Changes in demographic question wording	
Expert 5	Recommendation to strike two questions	Did not incorporate due to the inventory being used. Words changed as recommended from another expert.

Appendix E: Permission to Use Rogers' (2003) Image (Figure 1)

Gloria Doherty
Fri 5/28/2021 1:14 PM

Greetings to your department!!
I had the wonderful pleasure to speak with Gabrielle this afternoon. She was able to direct me to your area.
I am currently working on obtaining a PhD in Public Policy and Public Administration. As part of the requirements to successfully achieve the PhD, a dissertation is required. The theory I have worked with is Everett M. Rogers's diffusion of innovations. As part of the body of work for my dissertation, I would like to include an illustration of the diffusion's curve as illustrated in his 2003 edition. This can be found on page 281. I am very familiar with Rogers's background (we were both part of the University of New Mexico). Unfortunately, Dr. Rogers passed in 2004. As such, I believe the permission to use a likeness to an his image falls to you, the publisher. I am hoping to receive permission for the use of the adopter categorization on the basis of innovativeness figure. I greatly look forward to your communication.
Rogers, E.M. (2003). Diffusion of Innovations (5th Ed.). Simon and Schuster; New York, New York.
Page 281; Figure 7-3
Thank you for any assistance you may offer. I may be reached with further questions by cell phone
Of note, I am going camping and will have intermittent service through Sunday.
Gloria Doherty

Milunic, Laura
Wed 6/2/2021 1:52 PM
To: Gloria Doherty

Dear Gloria Doherty:

In reply to your request, you have Simon & Schuster's permission to use p.281, Figure 7-3: "Adopter Categorization on the Basis of Innovativeness" as specified in your request from the book "**DIFFUSION OF INNOVATIONS, 5E**" by Everett M. Rogers in your Doctoral degree dissertation. New permission is required for all subsequent uses.

The following acknowledgment is to be reprinted in all copies of your dissertation:

This permission applies to all copies of your thesis made to meet the Doctoral degree requirements at Walden University.

Please re-apply to this department if your dissertation is later accepted for commercial publication and you wish to retain our material at which time there will be a fee.

Best wishes for the successful completion of your work.

Sincerely,

Laura Milunic
Assistant Permissions Manager

Appendix F: Secondary Data Analysis

The tables to follow show secondary data analyses. I hope that the findings in this Appendix can provide nurse leaders and educators with sufficient baseline information on the New Mexico RN community to allow for further research and/or interventions to improve political astuteness.

Population Comparison to New Mexico Licensed Registered Nurses

The annual report from the New Mexico Board of Nursing (BON_1, 2020) reveals females comprising 85% of the registered nurses. Additionally, Hispanic/Latino ethnicity is identified in 24.79% of the registered nurses licensed in the state of New Mexico. The education demographics reveal ASN/ADN/Diploma nurses comprise 32% of the registered nurse population, baccalaureate in nursing is 41%, masters 16% and doctoral degree 18%.

According to the *New Mexico Healthcare Workforce: 2019 Annual Report* (Farnbach & Reno, 2019), the age of the population of nurses is also congruent with this study's participants. This report has age broken out by APRN and RN (p.77). They are combined and reconfigured in percentages and total numbers in the table below (table 8).

Table 8

Age from 2019 state data survey N = 19068

Age Demographics

	N	%
18-24	347	1.8
25-34	3761	19.7
35-44	4596	24.1
45-54	3904	20.5
55-64	4383	22.8

65+	2077	10.9

In looking to see generalizability for the national RN population, The National Council of State Boards of Nursing conducted a study on characteristics of nurses partnered with The National Forum of State Nursing Workforce Centers (2018). The characteristics presented include ASN/ADN entry level is 7.5% with diploma nurses being 2.5%. Baccalaureate degrees for nurses account for 45% of the workforce. Master's degrees account for 17% and doctoral prepared in nursing accounts for 3% of the population. When compared to the national data, NM has fewer BSN but more masters and doctoral prepared RNs. The average age of the RN is 51 years of age. This is congruent with the age group of the participants of this study. The national characteristics of RNs by gender show the percentage of males growing. Males accounted for 9.1% of national data. There were 17.8% of the survey participants being male.

PAI score correlation

I analyzed to see if there was a correlation between PAI score and age. There was a positive correlation between PAI score and age. Spearman's correlation shows a positive, medium effect size (rho = .31), statistically significant ($p < .001$) relationship between age and PAI score. The one-way ANOVA shows a similar pattern and, overall, a statistically significant relationship, $F(4, 399) = 11.94$, $p < .001$.

Correlations between gender and PAI scores was conducted. Male respondents had a small effect size ($d = 0.24$) statistically non-significantly ($t(405) = 1.80$, $p = .07$) lower mean PAI score than female respondents.

T Test

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Quiz Results	female	336	20.50	7.776	.424
	male	71	18.68	7.716	.916

Independent Samples Test

	Levene's Test for Equality of Variances		t-test for Equality of Means						
								95% Confidence Interval of the Difference	
Quiz Results	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Equal variances assumed	.013	.910	1.798	405	.073	1.824	1.014	-.170	3.818
Equal variances not assumed			1.807	102.288	.074	1.824	1.009	-.178	3.826

Independent Samples Effect Sizes

			95% Confidence Interval	
	Standardizer[a]	Point Estimate	Lower	Upper

Quiz Results	Cohen's d	7.766	.235	-.022	.491
	Hedges' correction	7.780	.234	-.022	.490
	Glass's delta	7.716	.236	-.023	.495

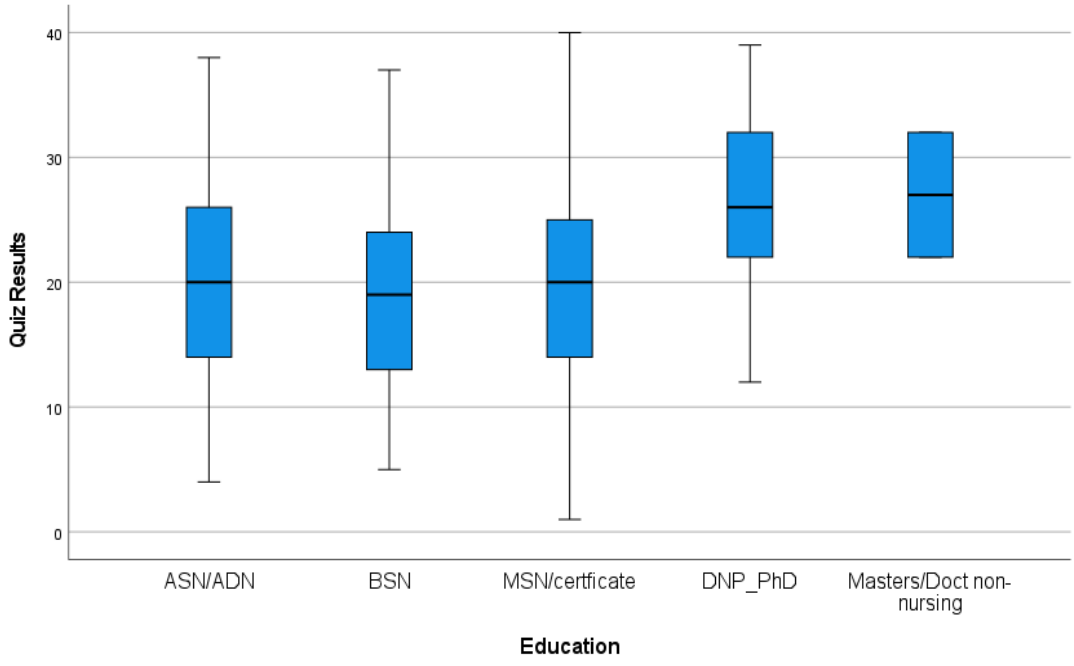
a. The denominator used in estimating the effect sizes.

Cohen's d uses the pooled standard deviation.

Hedges' correction uses the pooled standard deviation, plus a correction factor.

Glass's delta uses the sample standard deviation of the control group.

I explored to see if there was a relationship between education level and PAI scores. Findings revealed that those who were doctoral prepared scored higher on the inventory. Another notable finding showed baccalaureate prepared nurses scored lowest on the inventory.



These relationships suggest to nursing leaders that programs should be implemented for younger nurses. Those achieving associate through master degrees need to achieve improved skills in policy participation in order to successfully participate, influence and shape New Mexico's health care delivery and improve outcomes.