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Political Efficacy and Political Participation of Nurse Practitioners: A Dissertation

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A Dissertation Presented

by

NANCY C. O'ROURKE

Submitted to the Graduate School of Nursing

University of Massachusetts Worcester

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Graduate School of Nursing


Political Efficacy and Political Participation of Nurse Practitioners


A Dissertation Presented


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Abstract

In many states, outdated rules and regulations restrict nurse practitioners (NPs) from practicing to their full potential, often limiting patients' access to primary care. Modernizing NP state scope of practice laws and allowing patients greater access to NPs services is a priority. Unlike other professions, nurse practitioners have been unable to consistently influence legislative changes to health policy. This study examined the political efficacy and participation of nurse practitioners in the United States today (N=632). A descriptive cross sectional design, in conjunction with a political efficacy framework, evaluated nurse practitioners' participation in political activities and their internal and external political efficacy. Increased internal political efficacy was significantly ($p < 0.001$) associated with NPs who were older, had specific health policy education, and have been mentored in health policy. Our findings show that NPs vote at consistently higher rates (94%) than the general population and almost 50% report contacting legislators via mail/email/phone. As a group however, NPs report limited participation in other political activities, especially grassroots efforts. These findings hold significant implications for the profession as we strive to make policy changes across the country. It is important that educators assess our current methods of educating NPs about politics and health policy. Professional organizations and policy makers must re-examine outreach and strategies to inspire greater grassroots engagement of NPs.

Political Efficacy and Nurse Practitioners

Dissertation Proposal

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Submitted July 1, 2015

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Political Efficacy and Nurse Practitioners

Introduction

Political efficacy, first conceived as an explanation for voter participation in the electorate process, continues to be a topic of significance in political research (Campbell, Gurin & Miller, 1954; Caprara, Vecchione, Capanna, & Mebane, 2009; Morrell, 2003; Sharoni, 2012). One's sense of being able to influence the political process is consistently associated with political participation. Unlike other professions, nurse practitioners (NPs) have been unable to consistently influence legislative changes to health policy (Craven & Ober, 2009, Smith, 2011;Teixiera, 2011). Whether this is related to their political efficacy, or to other reasons, is not known.

Historically, nursing has had limited political influence in health policy (Cohen, Mason, Kovner, Pulcini & Sochalski, 2011; Cohen, Muench & Sochalski, 2010). In many states, outdated rules and regulations restrict NPs from practicing to their full potential, limiting patients' access to primary care. Modernizing NP state scope of practice laws allows patients greater access to NPs services. To improve access to healthcare, the Institute of Medicine's (IOM) 2010 report *The Future of Nursing: Leading Change, Advancing Health* called on the profession to develop greater competency and presence in the policy arena. With this call to action, NP organizations across the country are working to change state rules and regulations through legislation that includes the IOM's recommendation that NPs practice to the full extent of their education and training (IOM, 2010). However, Smith (2011) and Teixeira (2011) contend that nursing's political "voice" continues to be silent. In the 2012-2014 legislative session, over a dozen states introduced legislation that would have modernized licensure laws

for NPs. Only three of these states however, were successful in making changes that led to full scope of practice (Phillips, 2015).

At a time when primary care practitioners are already in demand across the country, the Patient Protection and Affordable Care Act (PPACA) brought over 10 million newly insured individuals into the United States (US) healthcare system (Sommers, Musco, Finegold, Gunja, Burke, & McDowell, 2014). The American Association of Medical Colleges (AAMC) predicts a shortage of 90,000 physicians by 2020 and one half of these shortages are for primary care physicians (Kirch, Henderson & Dill, 2012). To meet a target of one provider for every 2,000 patients and to care for an aging population, another 35,000 to 44,000 adult primary care providers will be needed by 2025 (U.S. DH&HS, 2013). As newly developed models of care depend heavily on NPs to fill gaps in the primary care workforce (Auerbach, 2012; Bauer, 2010), optimizing the role of NPs requires the revision of state rules and regulations that currently limit NP practice.

In 2006, the American Association of Colleges of Nursing's (AACN) adopted the *Essentials of Doctoral Education for Advanced Practice Nurses*. Among other things, this document required additional coursework in health policy, with a goal of increasing political efficacy and engagement through political socialization and education. Studies conducted after the incorporation of this requirement reveal that less than one third of NPs report consistently engaging in any political activities other than voting (Kung & Rudner-Lugo, 2014; Moran, 2014). Imperative to the profession's future is understanding how to increase engagement, especially with regard to rules and regulations that directly impact advanced practice nursing (APN).

Specific Aims

Using a political efficacy framework, the purpose of this study is to evaluate the current political efficacy and political participation of NPs across the US, to better understand factors associated with political interest, knowledge and engagement. The specific aims of this study are to:

1. Describe internal and external political efficacy of NPs in the US.
2. Examine the association of select NP characteristics (age, gender, race, ethnicity, education, income, NP population foci, full practice authority, relationship with a health policy mentor or role model), and health policy education in non-political environments (academic coursework or continuing education offering on health policy) with internal political efficacy.
3. Examine the association of select NP characteristics (age, gender, race, ethnicity, education, income, NP population foci, full practice authority, relationship with a health policy mentor or role model) and previous political participation (direct political participation or mentoring by another with this experience) with external political efficacy.
4. Examine the relationship between internal and external political efficacy and NP political interest, knowledge, participation and likelihood to vote.

As the healthcare system evolves through legislation and regulation, it becomes paramount for NPs to understand the importance of political participation and engagement in health policy, as it will shape the future of their profession. Understanding factors associated with NP political efficacy and participation is important for educators, political activists and

professional nursing organizations in order to serve the needs of the NP profession through enhanced political education and engagement. This study is undertaken to provide current information on the political efficacy and participation of NPs in political and health policy activities nationally. I aim to identify factors associated with political efficacy and to identify potential factors that can be modified to motivate the profession towards a stronger political position.

Background and Significance

Addressed in this review of the literature are conceptualizations and definitions of political participation (conventional and unconventional) and factors influencing political participation. I also examine what is currently known about NP political participation and political efficacy.

Political efficacy. Political efficacy has two distinct constructs: a personal sense of efficacy (internal) and a system oriented component of efficacy (external) (Balch, 1974; Neimie, Craig & Mattei, 1991). Verba, Schlozman, Brady and Brady (1995) defined political efficacy as “an activity that has the intent or effect of influencing government action – either directly by affecting the making or implementation of public policy or indirectly by influencing the selection of people who make those policies” (p. 38). Activities include voting, campaigning, contacting public officials, protests, membership on a local board, affiliation with political organizations and informal community work. This definition prevails throughout political research and is used in this study. Sharoni’s (2012) identification of political socialization and education in a non-governmental environment as factors that influence political efficacy and participation are also incorporated in this research.

Conventional and unconventional political participation. The American system of government allows for many forms of participation, while emphasizing the freedom of individuals and groups. Since the 1970s, research has described political participation as conventional or unconventional. Voting, discussing politics, forming interest groups, lobbying, campaigning or running for office are all considered examples of conventional political participation (Henn & Foard, 2012). Engaging in protests, sit-ins, boycotts or marches are considered unconventional political participation (Munroe, 2002; Henn & Foard, 2012). Unconventional political participation appeals to those who distrust the political system and tends to create a strong sense of political efficacy and group consciousness (Bourne, 2010). Historically, Americans are more likely to engage in unconventional activities than citizens in other democratic countries (Roberts, 2009; Bourne, 2010; Ekman & Amnå, 2012). Of late however, the distinction between conventional and unconventional activities has become more controversial, as activities like demonstrations are becoming more acceptable in the public's eye (Inglehart & Catterberg, 2002; Norris, Walgrave & Van Aelst, 2005; Dalton, 2008a; Linssen, Schmeets, Scheepers & te Grotenhuis, 2014).

Voting and political participation. While voting is not the only form of political participation, Putnam (2000) states "electoral abstention is even more important as a sign of deeper trouble in the body politic..." (p.35). Compared to other industrialized countries, voter turnout in the U.S. is low and has continued to decline over time (Putnam, 2000; Roberts, 2009; Bourne, 2010; Teixeira, 2011). One reason for the decrease in voter turnout is the growing belief that the government is unresponsive to citizens (Roberts, 2009; Jones, 2014). Links between political parties and groups often help to mobilize voters, yet in the U.S., political parties are not as closely linked to specific groups as are parties in other democracies (Norris et

al. 2005; Dalton, 2008b). It is also more difficult to vote here than in other countries. In the U.S., citizens are usually required to register in advance, leaving the initiative up to the individual citizen (Norris et al. 2005; Roberts, 2009). Although the act of voting is relatively simple, learning about candidates requires a great deal of initiative and many eligible voters may feel inadequate to the task (Burden & Neiheisel, 2011).

Age and political participation. Another proposed explanation for the decrease in voter turnout is the influx of young citizens who choose to engage in less conventional methods of political participation than voting. Zukin, Keeter, Andolina, Jenkins and Del Carpini, (2006) reported that political and civic engagement initially increases with age and then falls sharply by age 65. They found young voters are less likely to vote, reporting only 34% of GenXers (born between 1961 and 1981) and 24% of DotNets (age 20 and older) consistently vote in elections (Zukin et. al., 2006). An intergenerational decline in party association among Americans is also proposed as a reason for the decline in voting (Schlozman, Verba & Brady, 2012; Zukin et al., 2006; Keeter, Zukin, Andolina & Jenkins, 2002; Putnam, 2000). Younger voters reported feeling isolated or excluded, as political parties have been reluctant to engage and represent the interests of the younger voters (Keeter et al., 2002; Zukin et al., 2006).

Socioeconomic status (SES) and political participation. In a study of 1353 participants, Vecchione and Caprara (2009) did not find a significant relationship between political participation and income. However, Schlozman et al., (2012) evaluated data from numerous surveys of the American public over the last 25 years and found income a significant determinant of political participation. Those earning higher incomes were more involved in political activity than those of lower income (Schlozman et al., 2012). The greatest disparity was noted in monetary donations, while activities like working on campaigns showed some

disparity (Schlozman et al., 2012). This infers an imbalance of political voice and power in the American democracy, as the more affluent and educated citizens are more likely to participate in political activities (Schlozman et al., 2012). These findings are consistent with the results of a mixed methods study of 32 young British women with lower SES who reportedly felt under represented and without significance within the political system (Geneits, 2010). Geneits (2010) contends young women from lower SES are unaware of political processes and least likely to participate in political activities when compared to other groups.

Gender, race and political participation. Since 1964, a majority of U.S. voters are women. In the 2012 national elections, 63% percent of women surveyed reported they voted compared to 48% of men (Census Bureau, 2012). In a seminal work, Schlozman, Burns and Verba (1994) explored gender disparity in political participation (n=2715). They included non-traditional political activities in which women typically engaged (organized protests, community volunteerism, church groups). Despite the accommodation, women tended to be less engaged than men. While differences were relatively small, they were statistically significant. Schlozman, Burns and Verba (1994; 1999) determined this was more an issue of political resources (financial, time, family responsibilities and early political socialization) and organizational participation (political socialization at work). Conway (2001) suggests the gender gap is starting to close, however, in all aspects of political participation other than voting, men are still participating in political activities at higher rates than women (Schlozman et al., 2012). The racial demographics of voters are also changing. In the 2012 elections, the number of non Hispanic whites who voted were 64.1%, while Blacks represented 66.2% and Hispanics represented 48% (Census, 2012). Schlozman et al., (2012) note the inequalities of race and gender may be explained by disparities in SES.

Political participation and nursing. In a study of 205 nurses, Barrett-Sheridan (2009) found voting the most frequent form of political participation. She also reported a positive relationship between political participation and older age, increased years of experience in nursing and previous experience in health care policy. In her study, 47.9% of participants were associate degree or diploma nurses and 84.9% were women. However, she found neither gender nor education significantly related to political participation (Barrett-Sheridan, 2009).

Using engagement in a professional organization as the measure for political participation, Cramer (2002) studied political participation of 118 RNs and found resources, defined as free time, money and civic skill to predict political participation in organizations 61% of the time. Engagement in the organization's political activities and networking (defined as requests to participate) were predictive of political participation only 59% and 51% respectively (Cramer, 2002). Vandenhouten, Malakar, Kubsch, Block and Gallagher-Lepak (2011) found statistically significant differences in nurses' mean political participation when related to political views, party affiliations, age, education, years as an RN and income (n=440). When asked about barriers to participation, 80% of the respondents in this study reported having no time to engage in political activities and 92% reported limited financial ability to contribute to political campaigns or causes (Vandenhouten et al., 2011). However, they found statistically significant correlations ($p = 0.001$) between political interest, political efficacy and engagement. In this study, 40% felt their participation would have political impact in decision-making, while only 32% felt they could affect change at the state or national level. The majority (80%) indicated that nursing education had not adequately prepared them for political participation (Vandenhouten et al., 2011).

Examining the participation of RNs (n=315) in health policy activities, Salvador (2010) found over one-fourth (26.5%) had no participation in health policy activities. Sixty-nine percent felt health policy education was lacking and 68.8% rated their policy skills as poor. Nurses who received health policy education were significantly more involved in health policy compared to those who did not receive health policy education ($p=.01$) (Salvador, 2010). In a study of 364 nurse midwives, Gesse (1991) looked at political participation and found 77% reported voting as the predominate mode of political participation. Only a small number consistently engaged in other political activities. In 2009, Casey studied political participation of 203 certified registered nurse anesthetists (CRNAs) in North Carolina. Eighty-one percent cited work as a barrier to political engagement. Family obligations were identified as a barrier by 78.3%. Sixty four percent had a general lack of interest in politics with more than one half of respondents stating lack of time as a factor (55.2%) (Casey, 2009). Of note, 48.3% cited lack of efficacy and knowledge of the legislative process (42.9%), financial resources (42.3%), political education in nurse anesthesia programs (37.9%), knowledge of current political issues (34.5%), and mentoring by the state CRNA organization (NCANA) (25.6%) as significant barriers to participation (Casey, 2009).

In Florida, Kung and Rudner-Lugo (2014) surveyed 884 advanced practice nurses (APNs) examining factors that influenced advocacy and political participation. Although the study included all APNs, 84% of the respondents were NPs. Older age, association with a professional organization and perceived barriers to full practice (restricted prescriptive authority, physician supervision) were positively correlated with political activity ($p=.001$) (Kung & Rudner-Lugo, 2014).

Moran (2014) examined the political participation of 170 APNs in Louisiana. She found

the strongest predictor of political participation was engagement in organized activities ($\beta = .392$; $p < .001$). In her survey, APNs reported being very interested in politics related to their profession and having strong partisanship connections. However, recruitment (being asked to participate) did not significantly influence political participation in this group. Again, voting was identified as the most frequent form of political participation.

Only three studies specifically examined the political participation of NPs. In 1983, Frenkel and Pickett surveyed New England NPs ($n=79$) and found that most felt their education did not prepare them for participation in the political process. In this study, 56 % reported limited or no involvement in health policy or political activities. Only two respondents felt participation in health policy and political activities were a responsibility of the profession (Frenkel & Pickett, 1983).

In 1984, Sweeting evaluated the political effectiveness, knowledge and political participation of NPs in North Carolina ($n=209$). In this study, 57% felt money was more important to candidates than public opinion and 53% felt government represented only the interests of a few organized, well-funded groups (Sweeting, 1984). Passive activities were the most common form of political participation. Of note, 84% stated they never donated to campaigns (Sweeting, 1984).

Using Bandura's self-efficacy model of behavior change and political efficacy, a 2000 survey examined 440 U.S. NPs' involvement over a four-year period (Oden et al., 2000). These authors reported a strong positive correlation between self-rated involvement in political activities and political efficacy ($p < .001$) (Oden et al., 2000). Despite the majority having had some educational content on public policy, the participants reported limited knowledge about

how to effect changes to public policy. The bulk of the education, however, was from professional organizations and journals, rather than formal coursework (Oden et al., 2000).

Summary of the literature. Based on extensive research of the general population, we know that gender, age, SES, race, education and political socialization influence one's political participation. The more affluent and educated vote and participate in political activities more frequently than do the less educated, lower income populations. In activities other than voting, men consistently participate in political activities at greater rates than women. Research also shows that political participation and voting declines in the older age groups (age > 65). Some suggest that political education and socialization increases one's sense of political efficacy, increasing the likelihood of political participation. The extant literature examining RNs and NPs agree that age, income, education and political socialization are influential predictors of political participation. Gender has not been specifically evaluated in most of the nursing studies.

Factors, such as the general decline in political participation could have significant implications for NPs. The average age of NPs is 49years. Research shows political participation decreases as one ages. Although men are more prevalent in the profession over the last few years, NPs continue to be predominately female. We know that aside from voting, women participate in political activities less often than men. We have limited understanding of the impact of adding health policy content into NP curriculum and whether or not it has successfully socialized the younger generation of NPs, increasing their sense of political efficacy or trust in government. The two studies conducted since the addition of health policy to the curriculum do not show a significant increase in participation or efficacy; however they were small and limited in their scope of assessment. The NP profession was established in the

early 1970's, yet still faces major challenges to professional practice. As legislation continues to drive changes to healthcare delivery, it is imperative NPs have a political voice. The majority of studies to date have examined the political participation of RNs, with only three studies specifically evaluating NP political participation. While these studies and others that look at the general population provide some knowledge of the issues, further research is needed to understand the political efficacy and competence of NPs. Given the rapidly changing legislative face of healthcare, the limited research of the professions' political engagement is inadequate. It does not provide the depth of information required to more successfully engage the NP population in political activities and advance the political agenda of the profession.

Theoretical Framework

Recognized as an important motivational variable, self-efficacy is an appropriate concept to frame this study on political engagement. Initially described by Bandura (1977), self-efficacy is a person's belief that he or she can be successful with a specific task or in a specific situation. Bandura's theory has been extensively used to understand human motivation. Sharoni (2012) built upon these concepts and developed a model of political efficacy that will serve as the framework to guide this study. Sharoni (2012) describes internal and external political efficacy and defines them respectively as "the average American's feelings of political empowerment and his or her perception of the government's receptiveness to public political participation" (p.119). This framework denotes characteristics predictive of internal and external political efficacy which lead to political interest, knowledge, engagement and trust in the government.

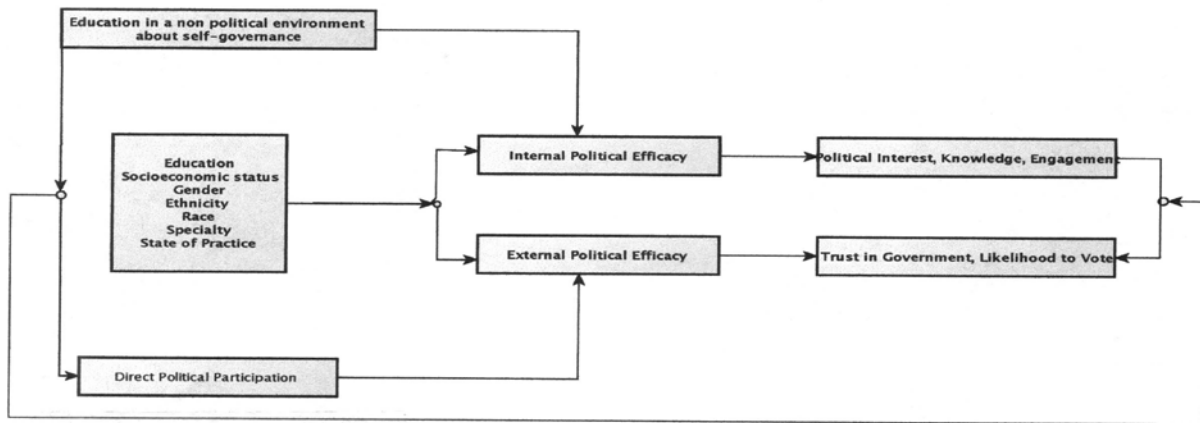


Figure 1. Adapted from Sharoni, 2012.

Personal characteristics (age, gender, socioeconomic status (SES), race, ethnicity and education, as well as educational experiences in non-political environment about self-governance) are factors associated with achieving internal political efficacy (Sharoni, 2012). Specifically, higher education, higher SES, older age (>65), race (white) and gender (male) are predictive of a higher sense of political efficacy (Schotzman et al., 2012; Zukin et al., 2006). Sharoni's (2012) conceptualization that education about self-governance in a non-political environment is a form of political socialization which leads to a sense of increased internal efficacy is supported by others (Riedel & Sullivan, 2001; Zukin et al., 2006; Schotzman et al., 2012). In addition to variables included by Sharoni, in her model (Figure 1), NP specialty or foci of practice and practice setting (State of practice to reflect degree of full practice authority) have been added, as they are hypothesized characteristics that may impact NPs internal political efficacy, specifically in participation in health policy. Reidel and Sullivan (2001) have also shown that external political efficacy is influenced by one's direct political activity. Mentoring by someone more knowledgeable in health policy and political participation is added to the characteristic direct political participation, as it is hypothesized to be a factor that may impact external political efficacy as well.

Use of this framework will yield valuable insights into the political efficacy and political participation of NPs. Engaging NPs in key political issues will have significant implications for the profession. Ultimately, the goal of this study is to provide the foundation to spur further research to improve the political position of the NP profession.

Methods

Design, sample and setting. This study employs a descriptive cross-sectional design to explore the political efficacy and participation of a random national sample of nurse practitioners. The sample, purchased from the American Association of Nurse Practitioners (AANP) database, includes all NPs licensed in the U.S. who are AANP members and is inclusive of all specialties (acute care, adult, family, geriatric, neonatal, pediatric, women's health and psychiatric NPs).

Sample size was calculated based on a confidence level of 95%, confidence interval of half-width 0.05, standard deviation of 0.5 and population of 182,000, based on a 40 % or less response rate. Calculations produced an ideal sample of 385. This sample size permits estimation of mean efficacy to within ± 0.05 points and provides sufficient precision that a correlation of at least 0.14 between efficacy and age (or any other continuous predictor) is detectable, i.e., is statistically significant with 80% power.

With a goal of 385 completed surveys, 2020 NPs will be invited to participate via a mailed survey conservatively estimating a 20% response rate. This will allow us to detect a correlation between efficacy and continuous predictor (such as age) of at least 0.14. If we have 2 approximately equally-sized groups, we will be able to detect a mean between-group difference in efficacy of 0.3 standard deviations. As 21 states and the District of Columbia now have full practice authority (AANP, 2015), we think 40% of the 385 participants will work in a

state with full practice authority. Therefore, an approximate 0.3 standard deviation was calculated as well based on that assumption.

The AANP database allows for systematic sampling, minimizing sampling error and supporting the generalizability of the findings. Ease of obtaining the list, along with it being representative of the U.S. NP population, is a benefit. The list can be stratified by a number of variables, including specialty and geographic location. This study will use geographically stratified data, as we seek to identify a relationship between political efficacy and states with full practice authority as well as having NPs representative of all fifty states.

Inclusion and exclusion criteria. Participation in this study will require: (a) current licensure as an NP in the U.S., (b) ability to read and write English (evidenced by successful passing of NCLEX exam), and (c) inclusion in the AANP database. There are no additional exclusion criteria.

Procedures. The names and addresses of a geographically stratified random sample of 2020 nurse practitioners will be purchased from the AANP. In order to increase response rates, a pre-survey postcard (Appendix A) announcing the delivery of the survey will be sent one week prior to survey mailing (Dilman, 2009). The survey mailing will contain a Letter of Introduction (Appendix B), the survey containing the Political Efficacy and Trust in Government Indices, as well as demographic questions (Attachment A), a postage paid return envelope and an Opt-Out postage paid postcard (Appendix C) for those who choose not to participate. The opt-out postcard contains 6 demographic questions, in hopes of determining if NPs in full practice states are more or less likely to not participate in political research. Upon UMMS IRB approval the researcher will pilot the survey by mail with a random sample of 20 nurse practitioners to evaluate the survey instruments for ease of use, understandability of the

directions, time for completion, and overall acceptability. If any issues are identified, they will be addressed and revised prior to mailing to the targeted participants.

All data will be collected via the survey instrument (Attachment A) which includes questions from Sharoni's (2012) Political Efficacy Index Survey, Sharoni's (2012) Trust in Government Index Survey and researcher developed demographic questions which includes questions about the characteristics of the participants and their NP practice. Anticipated time to complete the survey is less than 15 minutes. Completed surveys will be accepted up to six weeks after the initial mailing.

Measures

The Efficacy Index (a measure of internal efficacy) and Trust in Government Index (a measure of external efficacy) developed by Sharoni (2012) will be used to assess political efficacy. Other characteristics of the subjects will be obtained through a general demographic questionnaire. All measures are found in Attachment A.

The Efficacy Index. The Efficacy Index (Sharoni, 2012) will be used to assess internal political efficacy. Sharoni (2012) tested this index in a study on internet use and trust in government with a sample of 924 adults. It is comprised of 13 questions, derived from the American National Elections Study and political efficacy theory. This index uses a Likert scale and ranks agreement or disagreement with each statement. An overall higher score indicates a higher sense of internal political efficacy. Analysis of the data showed a range from 0-44, mean scores of 34.3, skewness of -.389 and Chronbach's alpha of 0.775, demonstrating high reliability.

The Trust in Government Index. The Trust index includes ten scale questions, based on a Gallup poll on "Trust in Government." These ten questions were designed to evaluate an

individual's trust and confidence in government. The Likert type scale has participants rate their opinions on a scale of 1-5. Greater trust in government is demonstrated by high overall score. Sharoni (2012) tested the scale in a study on internet use and trust in government (n=915). In her study, the scale had a range of scores from 0-41, a mean score of 17.6, skewness of -.034 and a standard deviation of 7.2. Chronbach's alpha of 0.881 indicated high reliability.

Demographic Questionnaire. Researcher developed demographic questions will be used to elicit information about characteristics thought to influence political efficacy, as described in Sharoni's framework of political efficacy. Characteristics of interest are: age, gender, ethnicity, socioeconomic status, race, and education. In addition, to better describe the sample population, participants will also be asked to record their NP population foci and years of NP practice. Three additional variables were added as the literature also supports their potential likelihood of predicting enhanced political efficacy. These variables are: relationship with a politically active mentor or role model, specific education either during initial NP education program or focused continuing education on health policy, and state where employed, which reflects rules and regulations of NP practice.

Statistical Analysis

IBM PASW 20v statistical software package will be used to analyze the data. Descriptive statistics (frequencies, means, standard deviations, and percentages) will be calculated for all study variables as appropriate to the level of data. For continuous variables, mean, median, skewness, standard error of the mean, standard deviation, and histograms will be calculated. Frequencies will be run on all categorical variables. All continuous variables will be checked for normal distribution by calculating Fisher's measure of skewness. Internal

consistency reliability will be evaluated using Cronbach's alpha for all multi-item scales. Missing data will be analyzed by ANOVA against other variables to assess for significant differences to assess randomness. The mean differences in the groups with missing data compared to those with non-missing data will be assessed.

To address Specific Aim # 1 and Specific Aim #4, descriptive statistics will be used to describe overall internal and external political efficacy with a higher score reflecting greater political efficacy. To describe the association of select characteristics (age, gender, ethnicity, race, education, specific education on health policy content, NP population foci, income, employment in state with or without full practice authority, and relationship with a health policy mentor or role model) to internal political efficacy, I will use ANOVA. Formal education on health policy is a dichotomous variable (yes/no), with a yes denoting health policy content during initial NP education or participation in a health policy continuing education program. The relationship between NP internal political efficacy and formal education on health policy will be evaluated using a 2-sample t-test to compare mean political efficacy for those with and without formal education on health policy.

Specific Aim # 2 will be addressed by using descriptive statistics to describe current political interest, knowledge and engagement in health politics of NPs in the US. To examine the association of select characteristics to political interest, knowledge, and engagement in politics I will use one's self-report of "Have you participated in political activities other than voting in the past 5 years?" (campaigning, contacting legislators, committee work, fundraisers, etc.) with a yes/no dichotomous response. I will look at associations of the binary outcome with each predictor separately using a cross tabulation and chi-square test for categorical predictors

and an independent-samples t-test for continuous predictors. Subsequently I will examine multiple predictors using logistic regression analysis.

Specific Aim #3 examines the association of select NP characteristics (age, gender, ethnicity, race, education, income, NP population foci, full practice authority) and previous political participation (including relationship with a health policy mentor or role model) to external political efficacy, using Sharoni's (2012) Trust in Government survey. For continuous variables I will use analysis of covariance (ANCOVA) for multivariate analyses. I will also look at associations with predictors one at a time using ANOVA for categorical predictors and Pearson correlations for continuous predictors.

Data Management

Each survey will be assigned a unique research ID number to track only the number of respondents. The ID number will not be linked to any personal identifiers. All study data sheets will be kept in a locked cabinet in a locked office, and only the PI and dissertation committee will have access to the data. All data will be double entered to ensure accuracy of the data onto a password protected research designated drive at UMMS, which is backed up nightly. The two data sets will be merged, and correlations run on each variable to identify errors in data entry. Any variable that does not have a correlation of one will be reviewed and any data entry errors corrected. Correlations will be rerun between the two data sets to ensure that all errors are corrected. A clean data set file will be saved and used for the remainder of the data analyses of the study. In accordance with UMMS policy, original data and data on the research drive will be maintained for a period of three years after the completion of the research.

Human Subject Considerations

Institutional Review Board (IRB) approval will be obtained from the University of Massachusetts Medical School (UMMS) IRB. All surveys will be anonymous to protect the identity of the participants. Given the study involves minimal risks and involves no procedures that require a signature, agreement to participate in the study and complete and return the survey will be the surrogate for written consent. An introductory letter (Appendix B) explaining the survey purpose and aims will be included in the mailing. The letter will explain that the survey is voluntary and anonymous, will take approximately 15 minutes to complete, participation has minimal risk, and there are no direct benefits to the participants. The researcher's name and contact information, as well as that of the UMMS IRB, will be included should any participant have questions or concerns.

As an incentive to participate, three strategies will be employed. First, a tea bag will be included in the mailing, encouraging participants to "have a cup of tea on me" while completing the survey. Second, a link to a survey account will be provided and participants can register in a drawing for a \$100 dollar Amazon gift card. The subjects who wish to participate in the random drawing may register at

<https://survey.zoho.com/editor.do?surveyid=115022000000008027>

The drawing will occur after the data has been collected and analyzed. Last, I will offer to share results of the research to any interested participants. Participants may send an email request directly to me so that it is not related to their survey results.

Limitations

There are limitations to this study. Using a cross sectional design provides information only specific to this population at this point in time. Determining causal relationships is not

possible. The survey relies on self-reporting. Under reported or over reported political participation due to inaccurate recall could pose a threat to the internal validity of the findings. External validity may be affected by non-response. Those choosing to respond to a mailed survey may be different in some ways from the non-respondents. AANP's database could potentially be inaccurate or incomplete, contributing to a lower response rate and to the sample not being truly representative of the NP population thus limiting generalizability. Lastly, a percentage of the AANP database are NPs who are members in a professional organization and may be more likely to be politically engaged and have a higher sense of political efficacy than those who are not. This potential bias should be minimized with the random sampling of the database, which is just as likely to include NPs who aren't members of professional organizations.

Potential challenges

Recruitment via survey can be challenging. Dillman, Smyth, and Christian (2014) suggest using different modes to contact participants when possible. However, the AANP will only provide mailing addresses and thus this will be the only mode used to invite participation in this study. This is a recognized limitation with this study design. Although historic response rates in mailed surveys are approximately 40% (Dillman, 2000), we chose a more conservative response rate (20%).

To increase my response rate I have included 3 strategies as described. Although Dillman et al., (2014) suggests a third or fourth mailed contact might not yield an increase in the response rate, if the response rate is unacceptable consideration will be given to a third mailing. Statistical analysis can be affected by a low response rate or non-response from certain geographic regions. If this occurs, a third, geographically targeted mailing will be considered.

Another challenge will be data entry. As this is a paper survey, all data must be manually entered into the statistical software system. This is labor and time intensive and creates opportunities for errors in data transcription. To minimize these issues, I will double enter the data and run correlations to ensure accuracy. To minimize any statistical analysis errors, an experienced statistician has agreed to serve on my committee and will oversee all data analysis.

Conclusions

The extant research on NP political participation and efficacy is largely outdated and does not provide insights into the current political situation of NPs across the country. To more adequately address the issue, this study provides an opportunity to examine a random national sample of NPs and examines the current levels of political participation and political efficacy. Determining which variables impact political efficacy and participation will provide valuable data to both NP organizations seeking to change the legislative landscape for NPs and to educators in designing and updating educational programs in health policy. This study seeks to provide will provide an in-depth analysis to assess the extent of NP political engagement and participation, and to identify potential foci for increasing internal and external political efficacy.

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Executive Summary

Political Efficacy and Participation of Nurse Practitioners in 2016

This study assessed internal and external political efficacy among nurse practitioners throughout the U.S. and association with select demographic, practice, and educational variables. The table below summarizes the changes made to the original research proposal approach and rationale for the changes.

Summary of changes to dissertation proposal

Original Proposal	Change	Rationale for the Changes
A pilot was conducted to assess clarity of survey mailings and instructions with the intent to modify based upon feedback.	Responses to “pilot” study were included in final analysis as no feedback was provided to suggest the need for any changes to the process or mailing.	Only 6 respondents and no specific questions or feedback provided. Thus, no modifications were made and their responses to the survey were included with the study data.
The proposed plan was to conduct univariate analysis of association of select variables to internal and external efficacy and political participation.	To estimate the effect of the statistically significant predictors on the dependent <i>variable</i> with <i>other predictors</i> held constant, we ran <i>multivariate</i> statistical analyses.	We wanted to control for predictors and see which variables remained statistically significant.

Political Efficacy and Participation of Nurse Practitioners

Nancy C. O'Rourke, MSN, ACNP, ANP, FAANP

September 22, 2016

What's the Issue?

Nurse Practitioner (NP) profession established early 1970's

Still major challenges

NPs unsuccessful in creating or sustaining political change

NPs not politically engaged

Legislation driving changes

Delivery model

Reimbursement

Scope of practice

(Cohen, Mason, Kovner, Leavitt, Pulcini & Sochalski, 1996; Cohen, Muench & Sochalski, 2010; Craven & Ober, 2009; Oden, Price, Alteneider, Boardley & Ubokudom, 2000; Kung-Rudner-Lugo, 2014; Moran, 2014).

Background

- In the 1980's there was an initial push for Full Practice Authority (FPA)
- Alaska, New Hampshire, Oregon and Washington were the first states to adopt broader licensing authority for NPs, creating increased supply of primary care providers, especially in remote areas. A few other largely rural states, many with severe physician shortages, followed in the 1990s.
- Until the IOM report, FPA was not a priority, as reimbursement took center stage. Now, FPA for NPs is a key determinant of access to care for millions of patients.
- Although we are making progress, many states still have outdated rules and regulations that restrict NPs from practicing to their full potential, limiting patients' access to primary care.

Background

- At this time, 44% of states have full practice authority. This **leaves 28 states that need to modernize their state practice act**, and/or rules and regulations governing NP practice in order to meet the IOM's recommendation for full practice authority.
- **In the 2012-2014 legislative sessions, over a dozen states introduced legislation to modernize licensure laws for NPs. Only three of these states were successful in making changes that led to full scope of practice (Phillips, 2015).**
 - **Active campaigns to revise outdated laws and regulations;**
 - **These efforts will requires NPs active engagement in policy**
 - **To date unable to mount consistent and effective grassroots activities that creates and sustains policy changes.**

Political participation and the general public

- Older adults have a higher rate of voting (69.7%) compared to 18-24 years old (38%) and 25-44 years old (49.5%) (File, 2013b).
- 64.1% of the eligible non-Hispanic whites, 48% of the eligible Hispanics and 66.2% of the eligible Black voters cast ballots (File, 2013a).
- While women are more likely to vote than men (63.7 % versus 59.8%), in all other aspects of political participation, men are consistently participating at higher rates than women across all types of political activities (Dittmar, 2015; Dittmar, 2014; Schlozman et al., 2012).
- Higher education leads to higher rates of voting, with the rate of college graduates as high as 70%, compared to those with high school education (27%) ("Voting", n.d.)
- Education targeting the development of civic skills strongly predictive of political participation

- Age
- Gender
- Race
- Income /SES
- Education
- Political socialization

Background

- Factors associated with RN political engagement (Barrett-Sheridan, 2009; Cramer, 2002; Vandenhouten, Malakar, Kubsch, Block & Gallagher-Lepak, 2011)
 - Time
 - Money
 - Civic Skill
- Advanced Practice Nurses and political engagement
 - Similar issues to RNs
 - Recent studies show conflicting findings in political engagement other than voting which is consistent
 - Oden et al., 2000
 - Kung & Rudner-Lugo, 2014
 - Moran, 2014
 - Ryan, 2015

Purpose of study

- Assess political efficacy and political engagement of U.S. nurse practitioners
- Gain insight into factors associated with political interest and engagement
- Identify areas for further investigation

Specific Aims

1. Describe internal and external political efficacy of NPs in the US.
2. Examine the association of select **NP characteristics** and **health policy education** in non-political environments with **internal political efficacy**.
3. Examine the association of select **NP characteristics** and **previous political participation** with external political efficacy.
4. Examine the relationship between internal and external **political efficacy** and NP **political interest, knowledge, participation and likelihood to vote**.

NP Characteristics

- Age
- Gender
- Race,
- Ethnicity
- Education
- Income
- NP population foci
- Practicing in a state with full practice authority
- Relationship with a health policy mentor/role model

Political Efficacy

Political efficacy is “an activity that has the intent or effect of influencing government action – either directly by affecting the making or implementation of public policy or indirectly by in It is associated with political participation and often referred to as one’s sense of being able to influence the political process (Campbell, Gurin & Miller, 1954; Caprara, Vecchione, Capanna, & Mebane, 2009; Morrell, 2003; Sharoni, 2012).

Political efficacy has two distinct constructs: a personal sense of efficacy (internal) and a system oriented component of efficacy (external) (Balch, 1974; Neimie, Craig & Mattei, 1991; Van Stekelenburg & Klandermans, 2013).

Political Efficacy

Internal efficacy:

one's sense of being able to understand and participate in politics.

External efficacy:

one's trust that the government will be responsive to the demands of citizens

Theoretical Framework

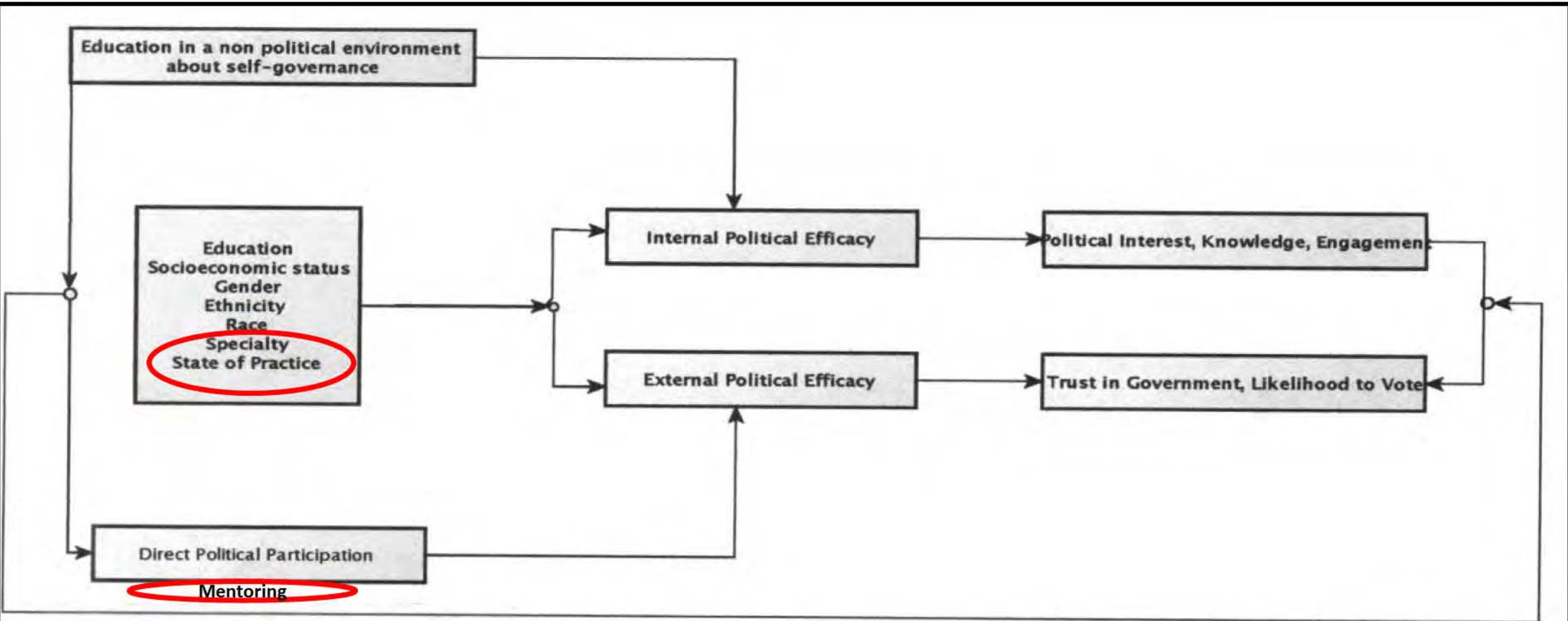


Figure 1. Adapted from Sharoni, 2012.

Study Design

- Descriptive, cross sectional survey
 - Random, geographically stratified
 - Representative of U.S. NPs
 - Inclusive of all specialties
 - Include Full Practice (FP) and non FP states
 - UMass IRB approval
 - AANP database
 - Desired sample 385
 - Mailed survey
- Inclusion
 - Be able to read and write English
 - Licensed in U.S.
 - Included in AANP database
 - Exclusion
 - No additional exclusion criteria

Procedures and Measurement

- Piloted with 20 NPs
 - Postcard announcement one week prior to mailing of survey
 - Mailing contents
 - Introductory letter
 - Survey instruments
 - Demographic questions
 - Postage paid envelope
 - Opt out post card
- 1. Efficacy Index (Internal Political Efficacy)**
 - 13 items
 - 1-5 Likert scale ranking agreement/disagreement
 - Higher score reflects higher internal political efficacy
 - Reported Cronbach's alpha of 0.65
 - 2. Trust in Government Index (External Political Efficacy)**
 - 10 items
 - 1-5 Likert scale
 - Higher score reflects greater trust in government
 - Reported Cronbach's alpha of 0.89
 - 3. Demographic survey**

Survey Response

- 31% response rate (N=632)
- 49 states represented (excluding Hawaii)
- All 11 AANP regions represented
- All NP certifications represented

Statistical Analysis

- IBM PASW 22v statistical software package.
- Descriptive statistics were calculated for all study variables as appropriate to the level of data.
- For continuous variables, mean, median, skewness, standard error of the mean, standard deviation, and histograms were calculated.
- Frequencies were run on all categorical variables.
- All continuous variables were checked for normal distribution by calculating Fisher's measure of skewness.
- Internal consistency and reliability were evaluated using Cronbach's alpha for all multi-item scales.
- Multivariate analysis to eliminate confounders was performed on all statistically significant variables.

Characteristics of NPs (N=632)

Characteristic	n	%
Age		
20-35 years	102	16.9
36-45 years	137	22.7
46-55 years	160	26.5
56-65 years	176	29.1
> 65 years	29	4.8
Female	572	91.4
Non-Hispanic	601	97.1
White	549	87.3
Master's or Doctoral degree	622	98.4
Annual income > \$80	498	87.2

Characteristic	n	%
NP Certification		
Family	458	72.5
Adult/Adult-Gero Primary Care	155	24.5
Other (Pediatric, Psych, Specialty)	60	9.5
Gerontology	37	5.9
Adult/Adult-Gero Acute Care	29	4.6
Not certified	9	4.6
Practice in state with Full Practice Authority	142	23.5
"Formal" Health Policy education	436	72.3
Voted in 2012 Presidential Election	593	93.8
Contact with legislator	302	47.9
Worked with/donated to PAC	147	23.3

Low Political Efficacy of NP's suggests "politically alienated Americans" using Sharoni's (2012) typology

Internal Efficacy	
Cronbach's Alpha	0.65
Score mean (SD)	44 (+/- 6)
Range	26-51
Median	45

External Efficacy	
Cronbach's Alpha	0.89
Score mean (SD)	29 (+/- 7)
Range	10-50
Median	30

To be considered an "empowered American" the mean needs to be \geq the median

Variables Associated with Internal Political Efficacy

Characteristics	Univariate <i>p</i> value
Age	<0.001
Gender	.141
Race	.798
Ethnicity	.272
Income	.115
Highest Education	<0.001
Health Policy Mentor	<0.001
Health Policy Education	<0.001
Full Practice State	.932 ₅₀

No significant association of select characteristics to external political efficacy

Characteristics	<i>p</i> value
Age	.091
Gender	.15
Race	.259
Ethnicity	.481
Ann Income	.707
Highest Education	.082
Health Policy Mentor	.399
Health Policy Education	.973
Full Practice State	.679

Political Activities all Associated with Internal Efficacy

Political Activity	Yes n (%)	No n (%)	Internal Efficacy <i>p</i>	External Efficacy <i>p</i>
Anticipate voting 2016 Presidential election	603 (95.6)	28 (4.4)	.000	.191
Voted in 2012 election	584 (93.7)	39 (6.3)	.004	.439
Contacted legislator(s) via mail/email/phone	297 (47.8)	325 (52.3)	.000	.599
Attended Health Policy Conference	169 (27.2)	453 (72.8)	.000	.361
Worked on political campaigns	160 (25.8)	461 (74.2)	.000	.612
Worked or donated to Political Action Co.	144 (23.2)	478 (76.8)	.000	.324
Met with legislator	129 (20.7)	493 (79.3)	.000	.817
Relationship with health policy mentor	110 (18.3)	492 (81.7)	.000	.399
Attended political fundraiser/ town meeting	105 (16.9)	515 (83.1)	.000	.252
Worked on political issues with organizations	94 (15.1)	527 (84.9)	.000	.901
Provided education to legislator(s)	55 (8.9)	565 (91)	.000	.845
Public speaking re: political issues	30 (4.8)	591 (95.2)	.008	.274

Implications for Legislation

- NPs vote at higher rates than general public.
- Limited political engagement of NPs beyond voting and letter writing.
- In the legislative arena, being able to organize and mobilize grassroots is key to advancing the profession's political agenda.
- Limited effect on policy may be due to lack of grassroots engagement.
- Strategies to identify barriers to engaging NPs in grassroots activities and addressing those issues are needed.

Implications for Professional Organizations

- Professional organizations are uniquely positioned to develop programs that focus on and foster leadership and mentoring
 - 35% of the NPs were interested in participating in such a program (Ryan, 2015)
- Potential to creating and fund fellowship opportunities
- Utilize existing programs and policy leaders to foster professional development in health policy

Implications for Education

- With less than half of NP participants in this study (47%) reporting having received health policy education during their initial NP program, consistent with Ryan's (2015) reporting of 43% recalling receiving health policy education in their NP educational program, more needs to be done.
- Ryan (2015) reports that 81% of participants wanted more formal educational opportunities on political activism.
- Educators need to examine current educational practice and determine if the goal is for NP graduates to be knowledgeable about health policy and the impact the profession could have and/or to actually become politically active and engage in the creation of health policy?
- Warrants further review

Strengths & Limitations

- Demographics consistent with AANP and other national data.
- Good generalizability
- Random geographically stratified sample
- Reliable measures of political efficacy
- Cross sectional design
- Self reporting
- Non response
- Participants all AANP members

Conclusion

- NPs do not have high political efficacy
- Higher age and exposure to health policy education and mentoring are all significantly related to internal political efficacy
- Voting and letter writing campaign support are the predominate political engagement activities of NPs in the U.S.
- Lack of engagement by NPs in grassroots efforts that influence policy

Further research needed

- Political efficacy may not be the driving force for political engagement in grassroots efforts.
- High voting may reflect *civic responsibility* more than efficacy or desire for political engagement.
- The outcome/contribution of education on health policy during NP education yet unknown
- Reasons for lack of grassroots participation requires further investigation

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DISSEMINATION PLAN

The primary description of this dissertation work was submitted as a manuscript on November 7, 2016 to *Policy, Politics and Nursing Practice* for review and consideration for publication.

Appendix A: Announcement Postcard

My name is Nancy O'Rourke and I am a PhD student at the University of Massachusetts. Because you are a licensed NP, I will be inviting you to participate in my dissertation research. Please watch your mail, as the survey will arrive in about one week. Thankyou in advance for your willingness to participate!

Sincerely,
Nancy C. O'Rourke, NP

Appendix B: Letter of Introduction

Date

Greetings,

My name is Nancy O'Rourke and I am a PhD student at the University of Massachusetts in Worcester, Ma. My dissertation examines Nurse Practitioners' (NP) political participation and political efficacy. I am inviting you to participate in this research study because you are a licensed NP.

Participation is voluntary and involves completing a 15-minute survey. Your responses will be completely anonymous. If you choose to participate, please answer all questions as honestly as possible and return the completed questionnaires promptly. I have enclosed a self addressed stamped envelope for your convenience in returning the completed surveys to me. While completing the survey, please enjoy a "cup of tea on me." I have enclosed a teabag for your pleasure. If you wish to participate in the random drawing for a \$100 dollar Amazon giftcard you may register at: <https://survey.zoho.com/editor.do?surveyid=115022000000008027>

Thank you, in advance, for taking the time to assist me in my educational endeavors. The data collected should provide valuable information regarding the political participation of NPs in the United States. My hope is this research will aid in developing educational tools and programs that can increase our sense of political efficacy.

If you require additional information or have questions, please contact me at the number/email listed below.

I truly value your input and thank you for participating.

Sincerely,

Nancy

Nancy C. O'Rourke, MSN, ACNP, ANP, FAANP
(603) 305-8929 or nancyc.orourke@gmail.com

Dr. Nancy Morris, Chair of Dissertation Committee
Nancy.Morris@umassmed.edu

Political Efficacy and Nurse Practitioners

Trust in Government

Please check off the most appropriate answer. Some require you to write in the most appropriate response.

1. How much confidence do you have in the federal government in Washington when it comes to handling:

	1 = A great deal	2 = A fair amount	3 = Somewhat	4 = Not very much	5 = Not at all
A. International problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Domestic problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How much trust and confidence do you have at this time in:

	1 = A great deal	2 = A fair amount	3 = Somewhat	4 = Not very much	5 = Not at all
C. The Executive Branch headed by the President?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. The Judicial Branch headed by the U.S. Supreme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. The U.S. Senate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. The U.S. House of Representatives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Washington to do what is right?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. The government of the state in which you live, when it comes to handling state problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. The local government of the area in which you live, when it comes to handling local problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. The men and women in political life in this country who either hold or are running for public office?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Efficacy Questions

	1= Completely agree	2= Somewhat agree	3 = Do not agree or disagree	4 = Somewhat disagree	5 = Completely disagree
A. When reading the political news I understand almost all of what I read.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. I have strong political opinions/outlook/ideology.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. In NP school I received a good education of U.S. government and politics.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. I never speak about politics with my family, friends, and/or colleagues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. If I had the opportunity to engage directly with a government official or politician I would have a lot to speak about.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. If given the opportunity to participate in an online town hall I would participate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. If given the opportunity to vote on a referendum online I would participate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. If given the opportunity to vote on any bill in Congress, I would participate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. If invited to, I would join a group online that tries to influence government policies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. If and/or when I write to a government agency, official, or politician, my views are not considered.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. If and/or when I publicly express my opinion (such as in an op-ed, blog post, or in a T.V. interview) the government will consider my opinion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. My vote matters.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. If and/or when I petition my representative, I am unsure that he/she will act in my best interest.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. What is your age?

5. What is your gender?

- 1. Male
- 2. Female
- 3. Transgender

6. What is your ethnicity?

- 1. Hispanic
- 2. Non - Hispanic

7. What is your race? Select all that apply.

- 1. American Indian / Alaska Native
- 2. Asian
- 3. Black / African American
- 4. White
- 5. Native Hawaiian or Other Pacific Islander

8. Do you have a current NP license?

- 1, Yes
 - 2. No
-

9. Are you currently working as an NP?

Yes

No

10. If you answered yes to Question 9, in what State do you practice?

11. Have you ever participated in an education session or class about health policy and political processes? y

1. Yes

2. No

12. If you answered yes to Question 11, where did you receive education about health policy? Please select all that apply.

1. Initial NP Education Program

2. Continuing Education Program

3. State NP Organization

4. National NP Organization

5. Other formal education program (non-NP)

6. I was mentored by a colleague with Health policy experience

7. I have not received any formal education about health policy

8. Other

Other (Please Specify)

13. Did you vote in the last Presidential election?

- 1. Yes
 - 2. No
-

14. How likely are you to vote in the next national election?

- 1. Very likely to vote.
 - 2. Probably likely to vote.
 - 3. Unsure
 - 4. Unlikely to vote.
 - 5. Definitely not likely to vote
-

15. Select the response that best describes your INITIAL NP program: If you hold degrees from multiple NP programs, select the response that describes your initial NP program.

- 1. Certificate
 - 2. Master's
 - 3. Post-Master's Certificate
 - 4. Doctoral
-

16. Select your highest level of education:

- 1. Certificate
 - 2. Master's
 - 3. DNP
 - 4. Nursing PhD
 - 5. Other Nursing Master's
 - 6. Other non- Nursing Doctorate
-

17. Did you have a degree in a field other than nursing prior to becoming a NP?

1. Yes
2. No
-

18. If you answered yes to # 17, what degree and in what field of study?

19. In what year did you complete your first NP program? If you hold multiple degrees from multiple NP programs, enter the year that you completed your initial program (YYYY)

20. What is your area of certification? (Specialty or population foci). Please select all that apply:

- 1. Adult
- 2. Acute Care
- 3. Gerontologic
- 4. Pediatric
- 5. Family
- 6. Psychaitric
- 7. Adult - Gero - Acute
- 8. Adult -Gero- Primary
- 9. Adult - Psychiatric
- 10. School NP
- 10. None of the above
- 11. Other

Other (Please Specify)

21. What is your compensation arrangement for your main NP work site?

- 1 = Salaried
 - 2 = Hourly
 - 3 = Self- employed
 - 4 = Contracted (1099)
-

22. What is your total annual income from all employment, to the nearest thousand dollars (e.g. if 104,999 please enter 105).

23. What is your annual base salary from your main NP work site? Please round to the nearest thousand dollars (e.g. if 94,999 enter 95).

24. Have you had a relationship with a health policy mentor or role model?

- 1. Yes
 - 2. No
-

25. If you answered yes to Question 24, please check the most appropriate answer to describe the relationship with mentor.

- 1. Formal mentoring program.
- 2. Informal mentoring with colleague or friend who is politically active.
- 3. Mentoring through State NP organization.
- 4. Mentoring through National NP organization.

Other (Please Specify)

26. Have you participated in political activities other than voting in the past 5 years? Please check all that apply.

- 1. Worked with or donated to Political Action Committee.
 - 2. Donating to campaigns.
 - 3. Attending political fundraisers, town hall meetings or other politically focused meetings.
 - 4. Met with legislators.
 - 5. Contacted legislators through email, regular mail or telephone.
 - 6. Provided education materials to legislators.
 - 7. Public speaking engagements regarding political issues affecting NP practice.
 - 8. Attended an educational event or conference focused on health policy.
 - 9. Worked with State or National NP organizations around political issues.
-

Appendix D: Opt Out Postcard

I choose not to participate in the survey “Political Efficacy and Nurse Practitioners”

Please fill in or circle the best response for each question.

1. What is your age? _____
2. What is your gender? Male / Female / Transgender
3. What is your ethnicity?
 - a. Hispanic
 - b. Non – Hispanic
4. What is your race?
 - a. American Indian / Alaska Native
 - b. Asian
 - c. Black / African American
 - d. White
 - e. Native Hawaiian or other Pacific Islander
5. Do you have a current NP license? Y / N
6. In what State do you practice as a nurse practitioner?

Thank you