Implementation of an Evidence-Based Experiential Learning Program to Improve Nursing Engagement in Health Policy and Advocacy

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Author Note

"On my honor as a student, I pledge I have neither given nor received aid on this assignment."

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Abstract

Not only are nurses qualified to participate in health policy and advocate for social justice, they are called to do so by the ethical tenets of the nursing profession. Despite their duty to act, nursing engagement in health policy and advocacy remains low, and many nurses report feeling inadequately prepared for policy involvement by their educational programs. Experiential learning is widely utilized in nursing education to bridge the gap between theory and practice; however, it has not been fully integrated into the nursing health policy curriculum. This project utilized an evidence-based practice framework to pilot an experiential learning program in health policy and advocacy for nursing students at the University of Virginia, which was centered on the concept of social justice, and aimed to promote emancipatory nursing praxis among participants. The two-day program coincided with the 2021 legislative session of the Virginia General Assembly, and students were immersed in the legislative process by observing live legislative sessions and discussing policy issues with elected officials. Students interacted with health policy experts, lobbyists, attorneys, nurse executives, and leadership from professional nursing organizations. The program utilized local public health data to highlight health disparities, and students engaged in critical analysis of legislative initiatives as a means to advocate for vulnerable populations. Levels of political astuteness increased for all participants after program attendance, and student reflections indicated positive changes in perceptions related to social justice and the nurse's role in health policy and advocacy. Results demonstrate the effective integration of evidence into program design and implementation, and support the benefit and feasibility of program adoption within the nursing health-policy curriculum.

Keywords: social justice, experiential learning, political astuteness, emancipatory nursing praxis, enact

Dedication

This project is dedicated to the nurse I love most in this world, my mother. I couldn't have asked for a better role-model, cheerleader, or ally. Thank you for always lighting the path so I could find my way.

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I am immensely grateful to my wife, Aisha, and our children, Gavin and Stella, for their endless love and support through this incredibly meaningful journey. None of us anticipated a life-altering diagnosis, a deadly pandemic, or massive civil unrest during my doctoral program, but through every obstacle, they never stopped cheering me on. Thank you for believing in me.

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Finally, I'd like to thank the nurse-educator who taught me that social justice was well within my scope of practice, Dr. Camille Burnett. That knowledge was a tremendous gift, and I'm doing my best to pay it forward.

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Nurses are trained to holistically care for patients at the individual, systems, and population levels. As nurses gain experience and education, they become increasingly knowledgeable about the systemic dysfunction that contributes to poor health outcomes, hinders professional nursing practice, and perpetuates health disparities among vulnerable populations. Not only are nurses qualified to influence health policy and advocate for patients at every level, they are called to do so by the ethical tenets of the nursing profession, and encouraged to do so by educational and professional nursing organizations in the United States. (American Association of Colleges of Nursing [AACN], 2006; AACN, 2008; AACN, 2011; American Nurses Association [ANA], 2011).

Background and Significance

Despite many initiatives to increase participation, nursing involvement in health policy and advocacy is lacking (Lewinski & Simmons, 2018). Political involvement among nurses is declining, with the number of nurse-voters decreasing from 75.9% in 2016 to just 70.4% in 2018; additionally, the number of registered nurses in the United States Congress fell from seven in 2014 to just two in 2018 (VandeWaa, Turnipseed, & Lawrence, 2019; ANA, 2019). Some of the perceived barriers to policy involvement among nurse leaders are: lack of knowledge, skills, and support, lack of opportunity or connections, perceived devaluing of nurses' contributions to policy development, the belief that health policy is initiated at the federal level in a top-down approach, gender bias against women in policy positions, and lack of financial resources (Shariff, 2014). There is also an historical perception within the nursing profession that political involvement might be viewed as divisive and incongruent with caring, potentially threatening the

respectability possessed by the profession as a whole (Albarran, 1995). This perception has gradually abated; however, curriculum frameworks utilized in many nursing education programs continue to model a subdued role for nurses in health policy-related social action (Boswell, Cannon, & Miller, 2005). One study revealed that eighty percent of nurses felt inadequately prepared for political involvement by their educational programs, despite the widespread calls for increased nurse participation in health policy and advocacy work (Vanderhouten, 2011).

In 2010, the Institute of Medicine (IOM) partnered with the Robert Wood Johnson Foundation (RWJF) to conduct a thorough review of the nursing workforce and make evidence-based recommendations to best meet the increasingly complex healthcare needs of the American public (Institutes of Medicine [IOM], 2010). The IOM report recommended the removal of regulatory barriers that prevent advanced practice registered nurses (APRNs) from practicing to the full extent of their training and education, and asserted that nurses should be equal partners with physicians in the process of redesigning the U.S. healthcare system. Fueled by the momentum created by the IOM report, state and national nursing organizations partnered with lawmakers and successfully won full-practice authority for nurse practitioners in 28 states and the District of Columbia, and continue to make progress elsewhere in the nation. As America's most trusted and ethical profession for the past 18 years (Reinhart, 2020), nurses are uniquely positioned to leverage their collective strength and expertise to influence health policy, and the success of recent legislative victories could help to grow momentum.

In addition to removing regulatory barriers to advanced practice, the IOM report also called for nursing education programs and professional nursing organizations to prepare the nursing workforce to assume leadership positions in the public, private, and government sectors. Furthermore, the report recommended that decision-makers in these settings work to ensure that

nurses have a seat at the table. In contrast to the successful policy campaign that expanded the legal scope of advanced nursing practice, efforts to increase nurse leadership in public health policy, and entice nurses into formal policy-related positions, have produced mixed results.

The American Association of Colleges of Nursing (AACN) partnered with nursing education programs to prepare the nursing workforce for leadership in a variety of sectors, as outlined in the IOM report. The AACN identified the basic competencies in health policy that should be integral to each level of nursing education, and these competencies continue to inform the content and focus of nursing health policy education throughout the nation.

The Essentials of Baccalaureate Education for Professional Nursing Practice (2008) necessitates that baccalaureate programs provide nurses with a basic knowledge of policy issues and facilitate their ability to describe the U.S. healthcare system, as well as compare the benefits and limitations of the financial structure it is based upon, including the delivery and reimbursement of healthcare services (AACN). Baccalaureate education provides an introductory examination of legislative and regulatory processes related to the provision of care. The Essentials of Master's Education in Nursing (2011) outlines increasingly complex competencies related to health policy and advocacy, including: the ability to analyze the structural influence of health policy on patient outcomes, participate in development and implementation of policy up to the federal level, examine the impact of legal and regulatory processes on nursing practice, interpret research and inform policy makers and stakeholders, and advocate for policies that improve public health and the nursing profession as a whole (AACN). The Essentials of Doctoral Education for Advanced Nursing Practice (2006) describes the highest level of preparation for nurses in the health policy arena, and endorses competencies that demonstrate the clinical and academic expertise required to develop, evaluate, and provide leadership from the local to

international level. These competencies include the ability to: critically analyze policy proposals and related issues from the perspective of all stakeholders, develop and implement health policies that shape healthcare financing, regulation, and delivery, influence and educate policy makers and the public, and advocate for social justice through promotion of ethical and equitable public policy.

Based on the academic preparation at each level of nursing education, nurses with advanced degrees may be the most qualified to take an active role in the policy process. According to the AACN (2006), APRNs possess specialized training in the critical evaluation of evidence, and thus are capable of creating or endorsing evidence-based policies at the systems-level; however, a pilot study found that among nurses, the majority of whom held advanced degrees, only about 1/3 were currently involved in any type of health policy or advocacy work (Lewinski & Simmons, 2018). Bridging the gap between educational preparation and professional practice in the policy arena remains an ongoing challenge for the nursing profession.

In direct response to recommendations made in the IOM report, professional nursing organizations also stepped up to the plate. The American Nurses Association (ANA) launched the American Nurses Advocacy Institute (ANAI), a program designed to improve nurses' ability to engage in policy and advocacy, and increased their support and guidance for state nursing associations regarding local policy, advocacy, and leadership opportunities (ANA, 2011). Despite significant commitment and investment by the ANA, as well as countless other professional nursing organizations, additional avenues to increase nursing involvement and leadership in health policy are likely needed. Professional organizations, while possessing the ability to be highly effective policy influencers, are not recruiting and retaining enough nurses

into membership. Of the estimated 3.8 million nurses in the United States, only about 10% are active members of a professional nursing organization (Black, 2014).

If the vision of the IOM report is to come to fruition, strategic initiatives should be implemented that complement the efforts of the AACN and professional nursing organizations, with the goal of recruiting and retaining nurses in health policy and advocacy. More specifically, an evidence-based approach should be utilized that seeks to address the perceived barriers preventing involvement in policy work, while taking into consideration the varying levels of expertise and academic preparation of the nursing workforce.

Evidence Based Practice Implementation Framework

The implementation framework utilized for this project was the Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care ([Iowa Model]; Appendix H). This model provides a systematic, step-wise approach to the evidence-based practice (EBP) process, with the goal of answering important clinical questions and ultimately improving quality of care (Iowa Model Collaborative, 2017). The Iowa Model includes seven major steps, many of which are buffered with opportunities for reflective analysis and decision-making. Decisions made at these checkpoints facilitate progression through the model, or divert to a feedback loop that requires revision of a previous step. The evidence produced by successful navigation through this model can be utilized in clinical decision-making and implementation of evidence-based practice changes at both the individual and systems levels (The Iowa Model Revised, 2016).

The Iowa Model begins with a triggering issue or opportunity, which can include: a clinical or patient-identified issue, an initiative at the organizational, state, or national level, new data or evidence, accrediting agency requirements or regulations, or a philosophy of care. After a

triggering issue or opportunity occurs, a question or purpose for the EBP process is identified, and the first checkpoint for analysis and decision-making occurs: Is this topic a priority? If so, a team is formed, including stakeholders and individuals with relevant skill-sets, for varying levels of involvement in the project. Once the team is established, the process is begun to systematically assemble, appraise, and synthesize evidence while also weighing quality, quantity, consistency, and associated risk.

The second checkpoint for analysis and decision-making requires a determination of whether sufficient evidence exists to warrant a practice change. After a thorough review, if evidence is sufficient, the next step is to design and pilot the practice change with consideration for patient and family preferences, available resources, constraints, and any necessary approvals. Components of the pilot design include: a collection of baseline data, a localized protocol, implementation and evaluation plans, and a strategy to acquire materials, prepare clinicians, and promote adoption of the practice change. Post-pilot data should be collected and reported for further review, which creates a valuable archive of information if the practice change becomes widely adopted.

After the pilot is complete, another checkpoint for analysis and decision-making is presented: Is the change appropriate for adoption into practice? If adoption is feasible, the next step is to integrate and sustain the practice change. Identifying key personnel, creating linkages with the governance structure, and gaining buy-in from senior leadership, is necessary so that the practice change can be hard-wired into the system as the default approach. By auditing feedback and monitoring key indicators and outcomes identified during the pilot, evidence-based quality improvement is facilitated, and additional support can be re-infused, as needed.

The Iowa Model encourages interdisciplinary collaboration and teamwork throughout the process, and that theme continues through the final step of the algorithm: dissemination of findings. Dissemination can occur both internally within the governance structure, and externally in the form of peer-reviewed publications, communication with policymakers, posters, podium presentations, and media interviews, among others (Hanrahan, Marlow, Aldrich, & Hiatt, 2010).

The Iowa model has a few weaknesses. Though the process algorithm is concise, it requires many steps, each with specific criteria for progression. This may appear too complex or time consuming for clinicians interested in a more expedient process. Furthermore, because no step-by-step instructions are provided for critical tasks such as assembling a team, obtaining approvals, or designing a pilot practice change, there is room for error or external influences that could potentially jeopardize outcomes. Despite these weaknesses, the Iowa model offers a clear, concise, and systematic approach to EBP, with an algorithmic process that is logical and fairly straightforward to navigate. The model is dynamic, with updates and revisions that reflect the evolution of EBP as well as feedback from users, most recently in 2017 (Iowa Model Collaborative). These features, combined with the step of piloting the pilot practice change to collect data and determine feasibility, make the Iowa Model an excellent framework with which to explore the role of experiential learning in health policy and advocacy education for nurses.

Triggering Issues and Opportunities

Nurses have a professional obligation to be involved in health policy and advocacy, work to eliminate health disparities and inequities, and promote social justice (AACN; ANA; International Council of Nurses). In response to the recent calls to action at the organizational, state, and federal levels, there exists a unique opportunity to try innovative approaches to nursing education and close the practice gap that exists for nurses in health policy and advocacy work.

Immersing students in experiences, and encouraging focused reflections on those experiences, has proven to be an effective adjunct to didactic coursework across disciplines (Miano, n.d.; Association for Experiential Education, n.d.). Experiential learning is a pedagogical methodology that aims to integrate theory and practice within nursing education (Murray, 2018). Experiential education has been shown to improve nursing judgement and competency in performance of skills in the setting of clinical simulations (Chmil et al., 2015). Role playing, clinical experiences, and problem or inquiry-based learning are activities of experiential learning commonly used in nursing education, and these activities can take place in the field, the classroom, or both (Murray, 2018). Despite the use of experiential learning throughout clinical nursing education, the practice has not yet been widely adopted for use in the nursing health policy curriculum.

Active learning experiences specifically related to health policy have been demonstrated to improve knowledge, skills, and political astuteness among nursing students (Byrd et al., 2012). A qualitative analysis found that, after a health policy related experiential learning event, students reported a significant improvement in their understanding of the legislative process and law-making; additionally, students reported an increased likelihood of becoming involved in policy-related activities or running for public office in the future (McGuire et al., 2017).

The potential success of efforts to increase nurses' participation in health policy and advocacy hinges on effectively reducing the perceived barriers that prevent nurses from becoming involved, and providing them with the knowledge and skills necessary to be successful. Experiential learning is an evidence-based pedagogical approach that has been successfully used to complement didactic coursework across disciplines (Association for

Experiential Education, n.d.), and it may be particularly useful for nursing education in health policy and advocacy.

Project Purpose and Question

The purpose of this project is to review existing evidence related to experiential learning in nursing health policy education and utilize findings to pilot an evidence-based experiential learning program for nursing students, in an effort to promote effective and sustained involvement in health policy and advocacy work.

A systematic review of literature was conducted to answer the following question: *Among graduate nursing students, does an experiential learning program increase the likelihood of future professional involvement in health policy and advocacy?*

The secondary aim for the systematic review of literature included answering the following question: *What curricular design themes, pedagogical goals, and activities were utilized in effective experiential learning programs?*

The Team

The team assembled for this project included content experts, as well as nursing faculty from the University of Virginia, including: Terri Yost, PhD, RN, FNP-BC, primary project advisor and content expert for qualitative data analysis; Kimberly Acquaviva, PhD, MSW, CWE, second reader and content expert for policy and advocacy; Becky Bowers-Lanier, EdD, Virginia Nurse Advocate Health Policy Fellowship coordinator and legislative content expert; Ha Do Byon, PhD, MS, MPH, RN, content expert for statistical methodology and data analysis; Dan Wilson, MLS, nursing librarian and content expert for the systematic review process.

Assembly, Appraisal, and Synthesis of Evidence

Review of Literature

A systematic review of literature was conducted, and the following keywords and Boolean operators were combined to create a search phrase for all databases: experiential learning AND ("health policy" OR "policy" OR "legislative" OR "advocacy") AND ("nurse" OR "nursing" OR "nurses"). Results of all searches were limited to those published in the English language. Due to the highly specific subject matter in this review, and the goal of exploring all relevant evidence, no limitations of publication date were utilized.

Relevant Medical Subject Headings (MeSH) were generated by the PubMed database, then a search was performed among titles and abstracts only, producing a total of 71 results. The Cumulative Index to Nursing and Allied Health Literature (CINHAL) database was searched using equivalent subjects-expanders within the basic search feature, and limiting results to academic journals, which produced a total of 76 results. Web of Science (WOS) was utilized to search all included databases, producing 56 results. Finally, the Elton B. Stephens Company (EBSCO) host was utilized to search the following educational databases: Education Resources Information Center (ERIC), Teacher Reference Center, SocINDEX, Women's Studies International, Education Research Complete, SPORTDiscus, Education (H.W. Wilson), eBook Collection, Education Index Retrospective: 1929-1983 (H.W. Wilson), Gateway to North America: People, Places, and Organizations of 19th-Century New York. Results were expanded to include all related topics, which produced a total of 90 articles from the included databases. Exact duplicates were automatically removed by EBSCO, leaving a total of 70 results for review.

Screening Process

The total number of articles retrieved for review from all database searches was 273. After the removal of duplicates, 173 unique articles remained. Titles and abstracts from each article were screened for relevance to the PICOT question. All articles were included for review if they met all of the following criteria: subject matter was related to public health policy or advocacy, an experiential learning process was identified or described, nursing students were the primary focus, and the article was subjected to peer-review at time of publication. A total of 152 articles were excluded due to failure to satisfy all inclusion criteria. After title and abstract screening, a total of 21 articles were retained for full-text review. Upon review, one article was removed due to irrelevance to the PICOT question. One article was removed because the full-text article was no longer available in any format, likely related to the publication date in 1992. All remaining articles were included for final analysis if they were rated a level III or higher, with a quality rating of "A" or "B" on the Johns Hopkins Nursing Evidence Based Practice (JHNEBP) scale. Among the articles retained for final analysis, references were screened for eligibility using the same criteria as the primary evaluation. Two articles were added to the final analysis, and several articles that did not meet criteria for formal inclusion were retained to inform the background analysis. Figure 1 shows the search process, using a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram.

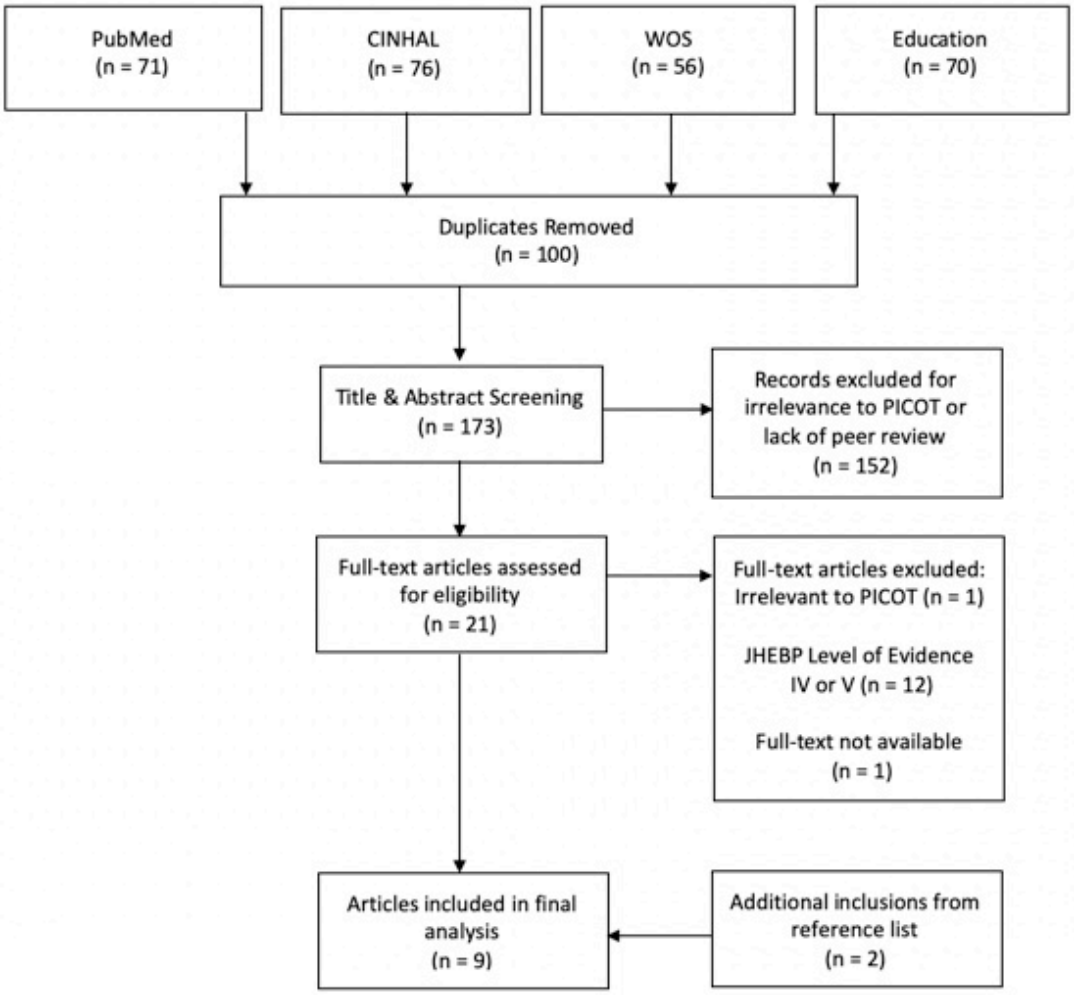

Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram for the systematic literature search process. CINAHL = Cumulative Index to Nursing and Allied Health Literature; WOS = Web of Science; Education = Education Resources Information Center, Teacher Reference Center, SocINDEX, Women's Studies International, Education Research Complete, SPORTDiscus, Education (H.W. Wilson), eBook Collection (EBSCOhost), Education Index Retrospective: 1929-1983 (H.W. Wilson), Gateway to North America: People, Places, and Organizations of 19th-Century New York. JHNEBP = Johns Hopkins Evidence Based Practice.

Level of Evidence

A literature table was created to evaluate the key components of each full-text article that was screened for eligibility. The purpose of each article was identified, as were the study type, sample characteristics including size, independent and dependent variables, if applicable, as well as a brief synthesis of study findings. Each article was systematically evaluated using the JHNEBP scale to identify the level of evidence, and to assign an overall quality rating. Articles with a JHNEBP rating of III or higher, and a quality of "A" or "B", were screened for references that satisfied primary search inclusion criteria, but that were not previously identified. As a result of this screening, two additional articles were included in the final analysis, for a final total of 9 articles. Two articles were rated JHNEBP level IIA, three articles were rated JHNEBP level IIB, one article was rated JHNEBP level IIIA, and three articles were rated JHNEBP level IIIB.

Analysis and Synthesis of Evidence

The highest level of evidence included for analysis was JHNEBP level II, with two studies rating as "A" quality and three studies rating as "B" quality. All five studies utilized quasi-experimental pre-test/post-test designs, and evaluated the influence of experiential learning interventions on various characteristics of interest related to health policy education. Three studies measured changes to political astuteness (Primomo, 2007; Byrd et al., 2012; Primomo and Bjorling, 2013), one study measured changes in health policy engagement (Garritano & Stec, 2019), and one study measured changes in civic engagement (Nokes et al., 2005). Despite the variation in specific characteristics of interest, all study results favored experiential learning activities.

The experiential learning intervention was operationalized somewhat variably among studies measuring political astuteness. Primomo (2007) sampled graduate nursing students (n =

40), measuring political astuteness before and after a 10-week health policy course that featured either a guest lecture and discussion with one of Washington State's eight nurse legislators, or a trip to the Washington state capitol during the legislative session to meet with legislators and discuss policy issues. Byrd et al. (2012) implemented a series of health policy-related experiences including: information sessions at the Department of Health and State House, dialogue with professional and community advocates and public health leaders, and a group public health policy project to analyze and address a problem, then present the recommended policy changes to the college community. The sample size was large (n = 300) and included both pre- and post-licensure senior nursing students in a baccalaureate program. Primomo & Bjorling (2013) evaluated two groups attending a Nurse Legislative Day (n = 80; n = 34), each comprised of nursing students representing every level of nursing education. Despite providing experiential learning opportunities in a myriad of settings, these studies all produced similar results.

The Political Astuteness Inventory (PAI) is a 40-question, validated instrument that evaluates related factors such as voting behavior, participation in professional organizations, awareness about health policy issues, knowledge of the legislative and policy processes, knowledge of legislators, and involvement in the political process (Clark, 1984). All three studies that utilized the PAI demonstrated a significant increase in political astuteness after implementation of an experiential learning intervention (Primomo, 2007; Byrd et al., 2012; Primomo and Bjorling, 2013). Increases were noted in almost all of the individual factors assessed by the PAI. The factors with little or no increase were typically those rated highest at baseline. For example, if participants were already active voters prior to the intervention, there was little ability to improve at follow-up. Byrd et al. (2012) found that knowledge of legislators, and knowledge of legislative and policy processes, demonstrated the greatest improvement after

a series of health policy-related experiences. Regression analysis indicated that knowledge of the legislative process was a significant predictor of post-test political involvement (Byrd et al., 2012).

Primomo (2007), Byrd et al. (2012), and Primomo & Bjorling (2013), utilized a fairly heterogenous pooled sample population in terms of age and educational rank, though all studies consisted predominantly of women. Primomo (2007) initially found that age, years in practice, and basic nursing education did not influence political astuteness; however, Byrd et al. (2012), reported that basic nursing education actually did impact political astuteness, with RN to BSN students demonstrating higher PAI scores than traditional BSN students, both before and after the intervention. The dynamic influence of education level on political astuteness was reinforced by Primomo & Bjorling (2013), who noted that participants with higher educational ranks had larger increases in PAI scores after a nurse legislative day than those with lower educational ranks.

The two remaining JHNEBP level II studies utilized experiential learning methodologies to complement didactic coursework, and both successfully integrated technology to amplify the experience for students. Nokes et al. (2005) implemented a service-learning intervention using classroom instruction, internet-based assignments, and a Blackboard 5.0 interactive program to connect service-learning hours with structured student reflections and evaluations. Garritano & Stec (2019) utilized an iPad-based program to facilitate immersive experiences related to cultural competence, health equity, and social awareness, with a focus on health policy at the institutional, community, state, federal, and global levels. Participants used iPads to create a video presentation documenting their experience when meeting with a local or state representative, and shared the presentation with the class.

Both studies measured changes in levels of engagement among participants. Nokes et al. (2005) analyzed civic engagement using an adapted instrument, consisting of 12 items scored on a 5-point Likert-type scale. Garritano & Stec (2019) measured health policy engagement using a survey which included yes or no questions, as well as 5-point Likert scale ratings. Both civic engagement and health policy engagement scores significantly improved after participating in an intervention incorporating experiential learning (Nokes et al., 2005; Garritano & Stec, 2019).

Nokes et al. (2005) reported a fairly heterogenous sample of undergraduate and graduate level nursing students, which included registered nurses, adult nurse practitioners, and advanced practice public health nurses (n = 15). Though the sample was somewhat racially diverse, all participants identified as female. Garritano & Stec (2019) reported a much larger sample (n = 102), which was homogenous in terms of educational rank, consisting entirely of Doctor of Nursing Practice (DNP) students over the course of 5 semesters. Neither study analyzed the association between demographics and outcome measures.

Four studies included for final analysis were rated III on the JHNEBP level of evidence scale, with one rated as "A" quality, and three rated as "B" quality. One study used a non-experimental quantitative pre- and post-test design (DeBonis, 2016), while the other three utilized qualitative study designs. McGuire et al. (2016) performed a retrospective, reflective analysis of major themes, which was quantified using triangulation among multiple researchers to ensure an accurate distillation of meaning from verbatim student feedback. DiCenso et al. (2012) utilized an independent researcher to thematically code participants' survey responses, which were presented using reflective analysis, as well as participant verbatims. Garner et al. (2008) performed interpretive analysis of dynamic student interactions based on a conceptual

model rooted in advocacy, activism, and professional accountability, a model which also informed the intervention design.

Using an existing service-learning requirement for graduate nursing students at a free-clinic, DeBonis (2016) measured changes in civic engagement, and desire for involvement in work related to social justice and health disparities after completion of the activity. DeBonis found that participation in service-learning was associated with a significant increase in every measured aspect of civic engagement, including the belief that healthcare professionals have a duty to volunteer for community service ($p = .0001$) and plans to be involved in community service in the future ($p = .0495$). Related to social justice and health disparities, program participants were more likely to feel that volunteering could have a positive impact on the community ($p = .0001$) and that being involved in community improvement was important ($p = .0023$). Additionally, participation in the service learning program was associated with improved knowledge and understanding about the impact of socioeconomic status on health ($p = .0001$), and barriers to receiving care ($p = .0001$).

All three qualitative studies operationalized the concept of experiential learning by crafting interventions that established new professional relationships and immersed participants in non-clinical settings outside of the classroom. McGuire et al. (2016) utilized experiential activities such as interviewing public policy-makers, attending policy meetings, and spending a day at the State Capitol. Garner et al. (2008) created virtual, web-based classrooms to connect students in the United States and the United Kingdom, and featured international travel to facilitate exchange of ideas and global health nursing leadership. Finally, DiCenso et al. (2012) incorporated a 90 – 120-hour health policy practicum for Canadian students to gain practical experience working with policymakers in provincial, federal, and international organizations.

McGuire et al. (2016) identified four major themes observed in participants' reflections, including feelings about the experience, reported changes in attitude, educational value, and intent to act in the future. The largest benefit was seen in attitudinal changes, with students reporting that witnessing a live legislative session at the State Capitol brought clarity to their understanding of the law-making process, as well as the importance of nursing involvement. Notably, the majority of participants reported intention to become more involved in the legislative process after an experiential activity. Garner et al. (2008) noted themes of cultural awareness, the impact of politics on healthcare provision, and similarities in nursing issues in the United States and United Kingdom, in participants' reflections. Overall, students demonstrated growth in leadership competencies, with improvements to communication skills and self-confidence being most prominent. DiCenso et al. (2012) outlined the areas of greatest learning identified by students, which included: learning how government and policy-making work, broadening understanding of policy issues, informing each other's worlds, and communicating with policy makers. Students indicated that the policy practicum solidified their interest in policy research, and reported gaining knowledge and experience that was well beyond the boundaries of classroom instruction.

All participants in the JHNEBP level III studies were both students and registered nurses, with the vast majority being enrolled in graduate programs. The sample recruited by DeBonis consisted entirely of advanced practice nursing students (n = 152). McGuire et al. included both master's students (n = 134) and doctoral students (n = 59). Garner et al. included master's students (n = 3), PhD students (n = 9), and one DNP student (n = 1). Garner, Metcalfe, and Hallyburton sampled all RN-to-BSN students (n = 15). None of the JHNEBP level III studies explored demographic data or educational rank as compared to outcomes, with the exception of

DeBonis (2016) who noted that doctoral students were more likely to offer their expertise to elected officials, and master's students were more likely to contact their elected official to express their opinion on a piece of legislation. This phenomenon mirrors the stepwise academic preparation of master's and doctoral students, with doctoral students receiving expanded training in the evaluation and implementation of evidence-based practice.

Limitations

Some of the studies had small sample sizes, and demographics were fairly homogenous, with women making up the majority of participants. Racial demographics were only provided in one study, which leaves much unanswered about how policy-related learning activities are experienced by minorities and historically marginalized groups.

A few of the studies had incomplete data sets due to technical difficulties (Primomo & Bjorling, 2013; Garner, Metcalfe, & Hallyburton, 2008), which limited some aspects of analysis. All studies used convenience samples, and most were limited to one university or educational program, which may reduce generalizability of findings to other academic settings. And finally, most studies lacked long-term follow-up after participation in experiential learning programs. Anecdotal updates were provided about the policy endeavors of participants after study completion (Garritano & Stec, 2019), but additional research is likely needed to fully assess the long-term benefit of policy-related experiential learning programs.

Strengths

Despite the described limitations of included studies, valid data was produced that can reliably inform future research. Samples included subjects with a wide variety of educational backgrounds, areas of professional practice, years in nursing, and levels of previous exposure to health policy and advocacy work, making overall findings adequately generalizable to graduate

nursing students. Several of the studies had fairly large sample sizes, which improved internal and external validity; however, even studies with small sample sizes were able to detect statistically significant results. The broad array of settings in which experiential interventions were conducted, allows for a thorough comparison of program styles, as well as their associated level of efficacy. Overall, the body of evidence generated in this systematic review of literature was sufficient to draw conclusions about the benefits of experiential learning in nursing health policy education.

Discussion and Recommendations

The overall quality of evidence included for analysis was good. A total of three articles were rated as "A" quality, and six rated as "B" quality. No JHNEBP level I articles were found that related to the PICOT question, but five JHNEBP level II and four JHNEBP level III articles were included for analysis. The initial literature search revealed a large number of program evaluations and expert opinions related to experiential learning program design and nursing health policy education, but there was less available research data pertaining to measurable outcomes of experiential learning programs. Experiential learning has already been widely adopted across various disciplines (Miano, n.d.), which may reduce incentive to conduct research on this pedagogical approach in the highly specific context of nursing and health policy. Even still, an adequate amount of good quality evidence exists related to experiential learning, and findings support the use of this pedagogical approach in nursing health policy education.

General Outcome Measures

The studies included for analysis utilized various approaches to experiential learning, and measured a range of characteristics and outcomes. The results, when viewed in totality, create a multifaceted description of how experiential learning affects nursing involvement in health

policy and advocacy. Every study produced results that favored experiential learning activities. Participation in experiential learning is associated with significant positive improvements in various characteristics of interest, including: political astuteness (Primomo, 2007; Byrd et al., 2012; Primomo & Bjorling, 2013), civic engagement (Nokes et al., 2005; DeBonis, 2016), health policy engagement (Garritano & Stec, 2019), desire to be involved in social justice and health disparities work (DeBonis, 2016), knowledge of the legislative process (DiCenso et al., 2012), changes in attitudes or perceptions about the role of nurses in health policy and advocacy (McGuire et al., 2016; DiCenso et al., 2012), communication skills (DiCenso et al., 2012; Garner, Metcalfe, & Hallyburton, 2008), and self-confidence (Garner, Metcalfe, & Hallyburton, 2008). All of these improvements could benefit nurses involved in health policy and advocacy. For this reason, experiential learning activities should be tailored to improve one or more of these measures.

Future Policy Involvement

The review of literature was prompted by the following question: *Among graduate-level nursing students, does an experiential learning program increase the likelihood of future professional involvement in health policy and advocacy?* The evidence suggests that this pedagogical approach does increase the likelihood of future policy involvement. Experiential learning provides improved knowledge of the legislative process (DiCenso et al., 2012), which is a significant predictor of political involvement (Byrd et al., 2012). Experiential learning is associated with increased intentions of becoming more involved in the legislative process (McGuire et al., 2016). Students who engage in experiential learning report an increased desire to engage in advocacy (DeBonis, 2016), an increased belief that engagement in policy and advocacy work is important for nurses (McGuire et al., 2016), and an increased belief that

advocacy can have a positive impact on the community (DeBonis, 2016). Because the evidence suggests that experiential learning activities increase the likelihood of nurse participation in health policy and advocacy, this evidence-based pedagogical approach should be used to complement to didactic coursework, whenever possible.

The best proxy found in the literature for increased likelihood of participation in health policy and advocacy, was the measure of political astuteness, which was assessed using a validated instrument called the Political Astuteness Inventory (Primomo, 2007; Byrd et al., 2012; Primomo & Bjorling 2013). According to regression analysis, some factors related to political astuteness are predictive of future involvement in the political process (Byrd et al., 2012). This tool is specific to the nursing profession, and information collected, such as knowledge about elected representatives, the process by which a bill becomes law, and level of participation in professional organizations, among others, can be used to tailor health policy education to the specific level of political astuteness for an individual or group. For this reason, the PAI is a valuable tool for implementing and evaluating experiential policy education, and should be utilized when feasible.

Educational Rank

Byrd et al. found that higher levels of nursing education correlated with higher levels of political astuteness (2012), and nursing students with higher educational rank had larger increases in political astuteness after participation in a legislative day, as compared to students with lower educational ranks (Primomo & Bjorling, 2013). Primomo (2007) demonstrated higher baseline PAI scores for graduate students (M =13.6) than were found among undergraduate nursing students by Byrd et al. in 2012 (M =10.5). After participation in an experiential learning intervention, doctoral students were more likely to offer expertise to elected officials, whereas

master's level students offered opinions on specific legislation (DeBonis, 2016). These findings suggest that engaging graduate nursing students, particularly doctoral students, in health policy and advocacy-related experiential learning activities, may be a particularly effective strategy for increasing both the quantity and quality of nursing contributions to health policy and advocacy.

Experiential Learning, Operationalized

The secondary aim for the systematic review of literature included answering the following question: *What curricular design themes, pedagogical goals, and activities were utilized in effective experiential learning programs?*

The review of literature revealed several major curricular design themes among health policy-related experiential learning programs, including: immersion in the legislative process (Primomo, 2007; Primomo & Bjorling, 2013; Byrd et al., 2012; McGuire et al., 2016), interdisciplinary communication or collaboration (Garner, Metcalfe, & Hallyburton, 2008; Byrd et al., 2012; DiCenso et al., 2012; McGuire et al., 2016; Garritano & Stec, 2019), service-learning (Nokes et al., 2005; DeBonis, 2016), use of personal reflection to connect concepts and experiences (Nokes et al., 2005; Garner, Metcalfe, & Hallyburton, 2008; DeBonis, 2016; McGuire et al., 2016), and a focus on sociopolitical issues such as the social determinants of health, cultural competence, vulnerable populations, health disparities, and social justice (Nokes et al., 2005; Primomo, 2007; Garner, Metcalfe, & Hallyburton, 2008; Byrd et al., 2012; DeBonis, 2016; Garritano & Stec, 2019). These themes appear to reinforce two major pedagogical goals: to build the technical knowledge and practical skills necessary for effective involvement in health policy and advocacy, and to cultivate an impetus for sustained engagement and action.

The experiential learning activities used to convey technical knowledge and practical skills were clearly described in the literature, and included: meeting with lawmakers, attending

legislative sessions, performing policy analysis, and collaborating with stakeholders. Increased levels of political astuteness were most often reported as the quantitative measure of success. The experiential learning activities specifically used to motivate students for sustained engagement and action were slightly more ambiguous in the literature. Activities geared towards building civic and social responsibility used a service-learning approach to explore sociopolitical issues such as health disparities and inequity. Success was most often measured using qualitative data generated from surveys and personal interviews.

Based on the studies included for analysis, health policy and advocacy-related experiential learning activities appear to be feasible and reproducible. The literature provided an adequate amount of detail to create an effective roadmap for the design of this project.

Design and Pilot the Practice Change

Design Strategy

The curricular design themes, pedagogical goals, and experiential learning activities found in the literature served as a template for this pilot project, which utilized an evidence-based practice implementation framework with a mixed-methods approach to data collection and analysis. The experiential learning program was formally named, "Empowering Nurse Advocates to Cultivate Transformation," and the acronym "ENACT," a word which implies putting something into action, and more specifically, acting through legislation. This name embodies not only the essence of the project itself, but also the broader project aims of putting nursing expertise into action through health policy and advocacy work.

Theoretical Framework: Emancipatory Nursing Praxis

Emancipatory Nursing Praxis (ENP) served as the theoretical framework to guide the learning process and delivery of the ENACT program (Appendix I). Although no study in the

review of literature explicitly utilized this framework, all studies incorporated curricular design themes, pedagogical goals, or experiential learning activities that are consistent with ENP, making it an appropriate and well-suited framework for this project. The goal of incorporating this framework was to create an engaging and transformative learning experience for students, based on the evidence found in the literature review.

Curriculum Content

Emancipatory nursing praxis is centered on two major underlying concepts, emancipatory knowing and emancipatory thinking. In order to best utilize the ENP framework for program delivery, both concepts were integrated into the ENACT curriculum.

Emancipatory Knowing. Emancipatory knowing is a concept rooted in critical social theory, a perspective which examines the social, historical, and ideological contributors to injustice and inequity. In the nursing literature, emancipatory knowing has been described as the ability to critically evaluate social and political structures, and recognize that injustice is a product of human action that can be corrected when emancipatory knowledge is translated into praxis (Chinn, 2011; Snyder, 2014). In effect, emancipatory knowledge reconciles technical and practical knowledge by translating the way social relationships are shaped by power and privilege (McLaren, 2016).

Emancipatory knowing is an integral component of emancipatory nursing praxis; for students to be inspired into action, they must first understand the sociopolitical context of injustice and inequity (Canales & Drevdahl, 2014). Further distilled, emancipatory knowing helps to cultivate impetus for engagement and action, a pedagogical goal represented throughout the literature. As such, the ENACT program sought to explore the sociopolitical context of health

disparities in Virginia, and engage students in critical analysis and reflection as a means to support emancipatory knowing.

Snyder (2014) identified several strategies to support emancipatory knowing in nursing education, all of which are closely aligned with the curricular design themes, pedagogical goals, and experiential learning activities identified in the literature review. Snyder posited that, if nurse educators embraced emancipatory pedagogy, students would be much more likely to engage in emancipatory nursing praxis after graduation (2014).

Some of the learning activities that cultivate emancipatory knowing, and thus lay a foundation for emancipatory nursing praxis, include: attending legislative sessions, communicating with state legislators about matters of healthcare and professional practice, participating in focus groups, and participating in self-reflection (Snyder, 2014). All of these activities were supported in the review of literature, and were thus integrated into the ENACT program.

Emancipatory Thinking. In 2009, Kagan, Cowling, & Chinn called for emancipatory nursing education within the dialogue and praxis of social justice, and in 2011, Chinn outlined several ways in which emancipatory thinking can be operationalized using the *Essentials of Doctoral Education for Advanced Nursing Practice* (AACN, 2006). Regarding *Essential V: Healthcare Policy for Advocacy in Healthcare*, Chinn exemplified an emancipatory approach to policy evaluation by posing five critically reflective questions: Who benefits? Who is disadvantaged? Which social value does this policy reflect? From which motives does this policy arise? Is this policy good for the health of all members of our community? Chinn (2011) also described the ways in which emancipatory thinking is consistent with *Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health,* and the following

critically reflective question was posed: What is happening upstream to create patterns of injustice, discrimination, and disadvantage? This series of questions integrates the critically reflective process that is fundamental to emancipatory knowing, with the pedagogical goals of graduate nursing education set forth by the AACN, and thus Chinn's approach served as a starting point for discussion and policy analysis during the ENACT program.

Learning Process

Emancipatory Nursing Praxis. Emancipatory Nursing Praxis (ENP) is a middle-range nursing theory that describes the transformational learning process by which nursing engagement in social justice is determined (Walter, 2017). Emancipatory nursing praxis was conceptually described in the aforecited literature as being the actionable result of emancipatory knowing, and the ultimate goal of emancipatory nursing pedagogy. ENP, as a theoretical framework, was operationally defined using a constructivist grounded theory study to evaluate the experiences of those directly engaged with the phenomenon, including two aforecited authors, Chinn and Kagan (Walter, 2017). The ENP framework can be utilized to inform nursing education, research, and the practice of social justice (Walter, 2017) which makes it particularly well-suited to address the education-practice gap that exists for nurses in the health policy and advocacy arena.

Walter (2017) identified four dynamic and inter-related conceptual categories within the framework of Emancipatory Nursing Praxis: becoming, awakening, engaging, and transforming; Two contextual categories were also identified: relational and reflexive (Walter, 2017). These concepts and contexts are non-linear, and can occur in simultaneous or overlapping succession, as transformational learning occurs over the course of a lifetime. The four main concepts, and the processes by which they occur, explicate a wide range of potential starting-points for students. In other words, each student brings with them a unique worldview, with varying levels of

knowledge and experience that impact the ways in which they experience the ENP learning process. Because the ENP framework is conceptually inter-related and non-linear, it is generalizable to a wide audience, and provides an opportunity for transformational learning, regardless of an individual's baseline positioning within the framework.

Becoming describes a person's initial experiences and perceptions related to injustice, and is typically informed by intrapersonal characteristics and socioenvironmental factors, often subconsciously. Baseline perceptions about injustice significantly impact the way an individual experiences the transformative learning process of ENP.

Awakening refers to a shift in a nurse's self-perception as related to the health and wellbeing of others. It can be stimulated by a single significant event, or by a gradual evolution. The processes that bring about awakening are: positioning, confirming, dialoguing, and dismantling. Positioning requires an introspective evaluation of formerly held beliefs in comparison to a different or new way of thinking, so that a deeper understanding of one's position in the world is gained. Confirming is the ongoing process by which a person's new world view is challenged or reinforced. Dialoguing is a process of self-education that occurs primarily through discussion and interaction with people whose lived experience is different than one's own. Dismantling, or breaking down attitudes and perceptions that function as barriers to an authentic life, marks the emergence of emancipatory reflective practices.

Engaging occurs when a nurse is compelled into action by specific, transformative goals. The four processes that produce engagement are: analyzing power, collective strategizing, praxis, and persisting. Analyzing power helps to identify various stakeholders, and compare the benefits and injustices imposed upon them by the status quo. Collective strategizing is the process by which personal and professional collaboration occur, in order to perform an assessment, gather

support, and plan interventions that seek to accomplish common goals. Praxis, as a process component of ENP, describes the simultaneous engagement in both self-reflection and action, in order to enhance collective efforts to bring about change. Persisting is the process of sustaining praxis long-term, and when necessary, mitigating risks in order to do so.

Finally, *Transforming* embodies the essence of social justice, and is experienced as a fundamental restructuring of thoughts, feelings, and actions. The three goal-directed process components of transformation include: human flourishing, achieving equity, and transforming social relationships. Human flourishing is best described as a state of health and wellness. Equity refers to the ability of everyone within a social system to achieve positive and equitable outcomes. Finally, transforming social relationships is the process of productively reshaping the way individuals interact with one another, leading to improved collaboration and community-building.

Two conditional contexts underlie the transformative learning process of Emancipatory Nursing Praxis: relational and reflexive. The relational context refers to the external realms in which social justice engagement can occur, either singularly or in combination. Realms include: individual, group, organizational/institutional, community, national, and international. The reflexive context describes the internal process of self-reflection used to evaluate one's own role in creating or maintaining various practices or structures. As a person moves through the process of ENP, their reflexive context is dynamic, shifting between the following reflective practices: descriptive, self-aware, critical, and emancipatory.

ENACT Program Synthesis

The ENACT program was designed to incorporate the curricular design themes, pedagogical goals, and experiential learning activities best-supported by the review of literature.

These features were organized into a cohesive, 2-day experiential learning program, utilizing the theory of Emancipatory Nursing Praxis (Walter, 2017) as a framework to guide the learning process and program delivery. The result was an opportunity for participants to examine health policy and advocacy through the lens of social justice, and empower themselves by learning the technical knowledge and practical skills needed for emancipatory praxis. To create an impetus for sustained engagement and action, overall program design and student activities addressed perceived barriers to political involvement among nurses, and curriculum content explored the historical context of nurse advocacy and activism, the ethical tenets of the nursing profession, and the moral imperative for collective nursing action to promote social justice (Falk-Rafael, 2005). The practical and conceptual relationships between elements of the ENP framework, learning activities, design themes, and pedagogical goals, are provided in detail in Table 2.

Based on the ENP framework (Walter, 2017), the Virginia General Assembly (GA) served as the primary relational context for the ENACT program, which was designed for implementation during the 2021 legislative session. Due to the COVID-19 pandemic, the Virginia capitol complex was closed to the public, and therefore constituents were unable to visit the legislative chambers of the GA or schedule office meetings with legislators. Fortunately, for the first time in Virginia history, all legislative sessions were streamed online for public viewing and participation. The use of technology to facilitate experiential learning was well-supported in the literature (Nokes et al., 2005; Garritano & Stec, 2019), and thus legislative experiential learning activities during the ENACT program were adapted to incorporate the creative use of technology to immerse participants in the legislative process.

Experiential activities related to the 2021 legislative session of the Virginia General Assembly included: live-streaming committee meetings and floor sessions for both the Senate

and House of Delegates, watching public testimony on bills relevant to nursing and public health, learning to navigate the Legislative Information System (LIS) website, and discussing policy positions with various Virginia legislators, government-appointees, and keynote speakers who were directly involved in 2021 legislative efforts, both virtually and in-person.

Health policy and advocacy work requires a web of interdisciplinary collaboration in order to be successful. As such, keynote speakers were highly-experienced in policy and advocacy, and represented a variety of backgrounds and disciplines, which provided an opportunity for participants to make connections for future collaboration. Biographical sketches and detailed contact information for keynote speakers were collected as a resource for students.

All keynote speakers belonged to a historically marginalized group in terms of race, gender, sexuality, citizenship status, or religion, and in some cases, multiple aspects of their inherent identity. This included the first African American Lieutenant Governor of Virginia, the first Muslim elected to the Senate of Virginia, several members of the LGBTQIA+ community, and a Latino immigrant to the United States. Just over 80% of program speakers identified as female. The ENACT program schedule can be found in Appendix E.

Various legislators and government appointees from the Commonwealth of Virginia agreed to speak during the ENACT program, including: the Lieutenant Governor, Assistant Attorney General, Chief Deputy Commissioner for the Department of Behavioral Health and Developmental Services, a Senator from the 10th Senate District, and a Delegate from the 68th House District, who holds a doctorate in nursing practice and is a licensed Nurse Practitioner. An additional Virginia Delegate, who is also a Licensed Nurse Practitioner, planned to drop-in and interact with students, but she was ultimately unable to attend.

Keynote speakers from the non-profit and private sectors included: the Executive Director of the National Black Nurses Association, the Commissioner on Government Relations for the Virginia Nurses Association, the Chair of Government Affairs and Education Director for the International Council of Forensic Nurses, a highly experienced nurse lobbyist and policy expert with a doctorate in education, a health-policy fiscal analyst, and an attorney from the Virginia Poverty Law Center, who specializes in healthcare policy and was heavily involved in Medicaid expansion in Virginia.

Several notable individuals recorded video clips to be played at the ENACT program, including: a United States Congresswoman from Virginia, the Dean of the University of Virginia School of Nursing, the Executive Director of the Virginia Nurses Association, and the President of the Virginia Council of Nurse Practitioners. These speakers welcomed participants to the program, shared words of solidarity and encouragement, and reinforced the importance of nursing involvement in policy and advocacy work.

Most speakers attended the event in-person, though some delivered content and interacted with students via Zoom, using the large projection screen and an iPad that was available for students to personally ask questions. The primary investigator delivered lecture content, engaged the group in discussion and reflection, managed audiovisual conferencing, introduced keynote speakers, and helped to facilitate speaker-student interactions throughout the program. A retired physician served as the event assistant, and was present throughout the program to help with trouble-shooting when required.

The ENACT program was centered primarily on the experiential learning process, but a variety of pedagogical approaches were used to compliment participants' experiences, including: interactive lectures, inquiry-based learning activities, inter-professional collaboration, group

discussions, hands-on activities, and case-studies. These approaches were facilitated by participants themselves, the primary investigator, Virginia legislators, and keynote speakers with significant expertise in health policy across disciplines.

To promote emancipatory knowing, the primary investigator facilitated interactive lectures that explored patterns of injustice and inequity related to the social determinants of health (SDOH) on the local, state, and national levels. The specific issues and populations featured during interactive lectures corresponded to the expertise of keynote speakers, which helped to fully develop program themes. Speakers were generally asked to discuss specific policy issues related to their area of expertise, provide tips for successful policy involvement, describe how they became involved in policy and advocacy work, and talk about why their work was meaningful to them. This approach helped to thematically connect 11 total keynote speaker sessions that were staggered throughout the 2-day program, as well as highlight the wide variety of opportunities for involvement in policy and advocacy work. The interactive lecture topics facilitated by the primary investigator, and corresponding keynote speaker sessions, are provided in Table 3.

Table 3

Themes, Interactive Lectures, and Corresponding Keynote Speaker Sessions

Theme	Interactive Lecture Topics by Primary Investigator	Keynote Speaker Session
Collaboration & Coalition-Building	Defining Social Justice Poverty; Social Determinants of Health Richmond Public Housing Projects: History Repeats Itself	**Helen Hardiman, MSW, Esq.** Fair Housing in Virginia; Building Healthy Communities
Collaboration & Coalition-Building	Poverty; Access to Healthcare Health Disparities in Virginia Defining Heath Equity	**Jill Hanken, Esq.** Expanding Access to Care ENROLL Virginia, Medicaid Expansion
Promoting Equity	Racial Disparities and Systemic Injustice Racial Bias in Healthcare Nursing History of Advocacy and Activism: The National Black Nurses Association	**Millicent Gorham, PhD (Hon), MBA, FAAN** Policy Priorities of the NBNA; Strategies for Effective Policy Work; Barriers to Policy/Advocacy for Nurses of Color
Promoting Equity	The Politics of Gender and Sexuality Women in Government: Representation Matters Syndemic Theory and Health Disparities Discrimination, Bias, and Violence Victimization: The Virginia Transgender Health Initiative Study (2007)	**Sarah Jennings, DNP, RN, SANE-A, SANE-P, AFN-BC** Human Trafficking and Violence Victimization: Policy and Advocacy Work at the Local, State, National, and International levels
Leveraging Power	Individual and Collective Advocacy The History of Nursing Advocacy and Activism Nursing Ethics and the Moral Imperative	**Becky Bowers-Lanier, EdD, MSN, MPH** Harnessing Political Power for Policy Work; Establishing Relationships; Nurse-Action outside of PNOs **Mary Kay Goldschmidt, DNP, RN, PHNA-BC** Policy and Advocacy: The Role of PNOs VNA Policy Priorities and Legislative Successes: 2021
Advocating for Vulnerable Populations	Case Study: Deinstitutionalization of Mentally Ill and Disabled Americans The Marcus David Peters Act	**Mira Signer, MSW** Virginia Department of Behavioral Health and Disability Services (DBHDS) Update The Marcus David Peters Act: Collaboration Between Law Enforcement Agencies and Mental Health Services
Policy Analysis	EBP: Evidenced Based Policy Critically Reflective Questions for Policy Analysis	**Freddy Mejia, MSW** "What Makes a Good Policy?" Fiscal Analysis Strategies
Legislative Praxis	2021 Legislative Session, Commentary and Context How a Bill Becomes Law (Video: New Virginia Majority) with Commentary and Context	**Justin Fairfax, Esq.** *Lt. Governor and Presiding Officer of the Senate* The Importance of Nurse-Involvement in Policy and Advocacy Legislative Priorities Related to COVID-19

Theme	Interactive Lecture Topics by Primary Investigator	Keynote Speaker Session
Legislative Praxis	Utilizing Technology to Engage in Policy and Advocacy Hands-On Exercise: Legislative Information System (LIS) Talking with Legislators Hands-On Exercise: Who's My Legislator? Virginia General Assembly Website	**Delegate Dawn Adams, DNP** *Committee: Health, Welfare and Institutions* *Chief Patron:* HB 1736 : School Nurses HB 1737: Nurse Practitioners HB 1817: Certified Nurse Midwives *Reflections:* Representation Matters: Becoming a Nurse-Legislator **Senator Ghazala Hashmi, PhD** *Committee: Education and Health* *Chief Patron:* SB 1319: Department of Environmental Quality Task Force *Reflections:* Representation Matters: Becoming the First Muslim in the Virginia Senate

Emancipatory thinking was facilitated via group discussions, and engaging in critical analysis of existing social and political structures that influence health and wellness. Participants practically applied the concept of emancipatory thinking by using Chinn's critically reflective questions for policy analysis (2011) to evaluate a case-study on the deinstitutionalization of mentally ill and developmentally disabled Americans during the late twentieth century. The synergistic effects of state and federal policy decisions related to deinstitutionalization were discussed in the context of increased homelessness, lack of access to care, and social stigma among mentally ill and developmentally disabled individuals. This case-study exemplified the negative impact public policies can have on vulnerable populations, and underscored the value of engaging in critical and reflective analysis during the planning and implementation phases of policy work, as a means to prevent unintended consequences.

The primary investigator facilitated hands-on learning activities to promote technical skills for legislative involvement. Participants learned to navigate the Legislative Information System (LIS) website for the Virginia General Assembly, which included the following

exercises: accessing the legislative schedule, performing the query process to access bills of interest, discussing the "Lobbyist in a Box" feature to follow self-selected legislative content, accessing information about legislators and their committee assignments, exploring the process for submitting written comments and providing virtual testimony to committee members, and accessing live-stream links to virtual committee meetings and floor sessions for both the Virginia Senate and House of Delegates. Students also utilized the "Find my Legislator" feature of the Virginia General Assembly website to identify their elected officials and view relevant district maps at the state and federal levels. After identifying their legislators, they utilized the site to quickly obtain contact information for each legislator, and were encouraged to use the "one-click" feature to send constituent emails.

Setting

The ENACT program was scheduled on two consecutive days in January, during the 2021 legislative session of the Virginia General Assembly. The event was held in a large conference room at the SunTrust building, immediately adjacent to legislative offices and Capitol Grounds, at 919 East Main St., Richmond, Virginia 23219. The meeting site is routinely utilized by organizations such as the Virginia Nurses Association for nurse-lobbying days and other legislative programs, and is accessible to those with physical disabilities. The site included several useful amenities, such as a speaker podium, a projector with a very large backlit screen, a sound system with integrated microphones and audiovisual conferencing capabilities, a large lobby area with additional seating, nearby restrooms and vending machines, a dedicated security team, and on-site parking.

Tools and Measures

The ENACT program featured two main pedagogical goals: to build the technical knowledge and practical skills necessary for effective involvement in health policy and advocacy, and to cultivate an impetus for sustained engagement and action. Both quantitative and qualitative data were collected during the program in order to assess the degree to which pedagogical goals were achieved, analyze the integration of existing evidence into program design, and evaluate participants' perceptions about the program and their learning experience. The ENACT program utilized the tools and measures most commonly found in the literature, and comparison of data can be used to inform future program design and improvement, which is an integral component of the Iowa Model for Evidence Based Practice (The Iowa Model Revised, 2016).

Demographics Survey

ENACT participants were asked to complete a brief demographics survey at the start of the program, which requested the following information: age, race/ethnicity, gender, number of years as a registered nurse, and highest educational degree earned. To best capture aspects of personal identity that were important to participants, the survey utilized open-ended prompts and participant-generated responses. The survey can be found in Appendix F.

Political Astuteness Inventory

Knowledge of the legislative and policy processes, as well as civic skills, significantly predict political involvement (Byrd et al., 2012; Vanderhouten, 2011). These collective attributes describe an individual's "political astuteness," an integral component of effective involvement in health policy (Primomo, 2007). The political astuteness of nurses was evaluated in several

studies included in the literature review, all of which used the Political Astuteness Inventory to measure this attribute (Primomo, 2007; Byrd et al., 2012; Primomo & Bjorling, 2013).

The Political Astuteness Inventory (PAI) was developed in 1981 by Philip Clark, and has since been used to assess the political astuteness of both nursing students and practicing registered nurses in various settings. In the review of literature, the Cronbach Alpha inter-item reliability of the PAI ranged from (α = .81) to (α = .989), which generally supports the internal consistency and reliability of the tool (Byrd et al., 2012; Primomo, 2007; Primomo & Bjorling, 2013). The PAI was validated in 2007 by Janet Primomo, and it is the only validated tool found in the literature that is specific to nurses.

The PAI evaluates a nurse's knowledge of health policy-related issues, the legislative process, federal and state elected officials, positions taken by professional nursing organizations, the structure and function of nurse regulatory boards, and more. It also evaluates specific behaviors among nurses, such as voting in recent elections, communicating with legislators and policy experts, participating in professional nursing organizations, supporting political candidates or causes, and disseminating knowledge about health policy issues, among others. The 40-item tool elicits "yes" or "no" responses, and assigns either one point or zero points for each item, respectively. Total scores range from 0 – 40, and correspond with one of four ascending categories of political astuteness: *totally politically unaware*, *slightly aware of the implications of political activity for nursing*, *shows a beginning political awareness*, and *politically astute and an asset to the profession.*

The PAI can be utilized to establish an individual's baseline political astuteness, and subsequent assessments help to quantify changes in political astuteness over time. The timing between baseline and subsequent assessments impacts the likelihood of score changes for some

items. For example, if a respondent indicates that they did not vote in the last election, a score change would not be expected for that item at follow-up assessment, unless another election occurred in the interim. The exact number of time-invariant items on the PAI is dependent on the timing of follow-up assessments in relation to the political cycle, as well as the length of time that elapses between baseline and follow-up assessments. This does not appear to limit the overall usefulness of the tool for evaluating changes to political astuteness. In the literature, the PAI was used to assess changes in political astuteness after engaging in experiential learning activities over the course of one-semester (Primomo, 2007; Byrd et al., 2012), as well as changes in astuteness after attending just one nurse legislative day (Primomo & Bjorling, 2013).

Formal permission to utilize the PAI was sought via email from Mary Jo Clark, the wife of Philip Clark, who is widely cited as granting permission for its use. Dr. Clark is retired, and no contact information was publicly available. Dr. Janet Primomo, who validated the PAI in 2007, and has worked with Dr. Clark extensively in the past, was able to provide one email address for Dr. Clark. Permission was sought from Dr. Clark to use the PAI, however no response was received. Dr. Primomo graciously provided the PAI, and granted permission to use it for this project. Written correspondence with Dr. Primomo and Dr. Clark can be found in Appendix A and B, respectively. The PAI can be found in Appendix C.

Post-Program Survey

Several studies in the review of literature primarily utilized qualitative data to assess various aspects of political and civic engagement, as well as students' perceptions about their experience (McGuire et al., 2016; DiCenso et al., 2012; Garner et al., 2008). A brief open-ended qualitative survey was designed to elicit ENACT participants' perceptions about curriculum content and their own learning process. The survey aimed to explore the perceived value of the

ENACT program, including its strengths and opportunities, as a means to assess program efficacy and inform future program design. By asking participants about their experience, they were also given an additional opportunity for personal reflection, which is an integral component of emancipatory nursing praxis.

The survey included four open-ended questions, each representing one of the four conceptual categories of the ENP framework: becoming, awakening, engaging, and transforming. These questions aimed to explore participants' perceptions about their own learning process. The first question asked participants to identify their baseline perceptions about social justice prior to the program, and the second question offered an opportunity to reflect on how their previously held beliefs regarding social justice may have changed. These questions represent becoming and awakening, respectively. The third question, centered on the concept of engaging, explored participants' perceptions of nurse-involvement in health policy, and how they might have changed during the program. Finally, the fourth question asked participants to identify a policy issue or goal they would like to address in the future, and suggest actions that could be taken to influence the policy process. This question was centered on the concept of transformation, which is the culmination of the ENP process, and was designed to stimulate responses that promote sustained engagement and action in the future.

Three additional open-ended questions sought to obtain practical information for future program planning. Participants were asked to identify the program activity that they most valued, and describe why it was important to them. They were also asked to suggest improvements for future programs, in an effort to innovate content and delivery. Finally, participants were asked how they might describe their experience to a colleague that did not attend the program. This

question sought to provide additional insight on perceived program value that was not revealed in prior responses. The survey is included in Appendix D.

Procedures

Protection of Human Subjects

In the interest of protecting human subjects, both the overall project design, and specific components of the ENACT program, were reviewed by the Institutional Review Board (IRB) at the University of Virginia. The IRB determined that this evidence-based practice project did not constitute human subjects research, and therefore IRB oversight was not required. The IRB tracking ID is # 22918. Irrespective of this determination, the protection of participants remained a high priority throughout project implementation.

The ENACT program occurred during the COVID-19 pandemic, and great care was used to ensure that social distancing guidelines were adequately observed, as directed by the Governor of Virginia and local public health officials at the time of implementation. Safety measures included: mandatory face masks, physical distancing, the use of a high-powered air filtration unit in the meeting area, and distribution of personal hand sanitizers and extra disposable masks to all participants. Most of the participants voluntarily reported having been either fully or partially vaccinated against SARS-CoV-2 at the time of the event, though this information was not expressly asked by the primary investigator.

Project Funding

The primary investigator was selected as a Virginia Nurse Advocate Health Policy Fellow for 2020 and 2021. The fellowship provided a $1000 grant to be spent at the discretion of the fellow, and that grant was used to pay for the conference room rental and other program supplies. Additional expenses were paid for out-of-pocket by the primary investigator, including:

printing, lunch for participants, and paid on-site parking as a means to reduce safety concerns related to armed protests in Richmond in the days leading up to the event. Total event cost was roughly $1,500 U.S. dollars. Approval for grant-funding of this project was obtained from the Office of Student Programs at the University of Virginia, and the PTAO account number is: 165681.101.GI15661.40100.

Invitations

Participation in the ENACT program was first offered to all graduate nursing students at the University of Virginia (UVA), including PhD nursing students who are technically enrolled through the College of Arts and Sciences, approximately six weeks prior to the event. When seats remained available three weeks prior to the event, participation eligibility was expanded to include all students at UVA School of Nursing. A total of 909 students were emailed a recruitment flyer and invitation featuring general information about program content, activities, and expected time commitments.

In an effort to reduce barriers to participation, the invitation offered students financial assistance to offset the cost of hotel accommodations, if they were traveling greater than thirty miles each-way to participate in the program, and if they would not be able to attend the event without financial assistance. Students were advised that the exact amount of financial assistance available to them would depend on the number of individuals in need, as available funds were limited. Students were also informed that single-day participation was possible, though priority would be given to those who could attend both days of the program. Social-distancing guidelines were communicated to students to assuage concerns about attending an event during the COVID-19 pandemic.

Students interested in attending the event were asked to complete a "participant interest form," which collected the following basic information: name, title of academic program, phone number, address of primary residence, nursing credentials, and whether or not they anticipated the need for financial assistance. Seats were reserved on a first-come, first-served basis.

Because recruitment occurred primarily over the winter break, when students may have been less likely to read school-related email, the invitation was sent to all graduate nursing students a total of three times, and when participation eligibility was expanded, it was sent to undergraduate students twice in the weeks leading up to the ENACT program. The event flyer was also featured in a digital newsletter published by the UVA School of Nursing, and distributed to all nursing students via email, which prompted two pre-licensure undergraduate nursing students to register for the program. No undergraduate students responded to the emailed invitation.

A total of 11 participants initially registered to attend the ENACT program; however, one student cancelled just a few days prior to the event, and another student failed to show up, bringing total attendance to nine participants on day one. One additional doctoral student contacted the primary investigator during the first day of ENACT, and subsequently attended day two of the program. One student who attended day one of the program was unable to return for day two. A total of 10 students participated in the ENACT program, but only eight students attended both days.

Although a few students initially indicated the need for financial assistance with hotel accommodations, none ultimately utilized the offer. Two students expressed safety concerns about staying overnight in Richmond. The ENACT program occurred just two weeks after the insurrection at the United States Capitol, and armed protests were planned in downtown

Richmond to coincide with President Biden's inauguration, which occurred the day before the ENACT program began. One student reported that the planned protests influenced her decision to commute each day rather than staying in Richmond overnight.

Registered participants were contacted via email prior to the event, and a map of the event location was provided, with specific instructions regarding on-site parking and the security check-in process, as well as recommendations for attire. Students were also invited to identify any special learning, dietary, or accessibility accommodations they might need during the program, and were encouraged to ask questions and seek clarifications about the event, if needed.

Program Materials

Upon arrival to the ENACT program, students were asked to choose a welcome packet from a table near the entrance, which included a program schedule, biographical sketches and contact information for all scheduled speakers, a blank name card, two disposable masks, a brief demographics survey, two copies of the PAI, and one post-program survey. At each seat, students were provided with an ENACT program lapel pin and personal hand sanitizer. Students were asked to write their preferred name on the blank name card, and place it where it was visible to others in the group. Students were seated 6 feet apart in a horseshoe configuration, so that they could observe physical-distancing guidelines while still promoting interaction throughout the program.

Data Collection and Analysis

Participants were asked to provide hand-written responses for all administered tools, and no students required special accommodations to complete this process. Each student had a unique identification number within the welcome packet they self-selected, in order to correlate

pre and post-program PAI scores and post-program survey responses. The only demographic information connected to each unique identification number was the participants' level of education, as measured by highest earned degree.

Demographics

To best capture the aspects of identity that were important to participants, the demographics survey utilized open-ended prompts and participant-generated responses. These responses were transcribed verbatim into Microsoft Excel, where frequencies and percentages were calculated for each response within the group. Results were narratively described and summarized in table-format.

PAI Score Analysis

All PAI scores were transcribed into Microsoft Excel, and then checked for accurate transcription. Basic descriptive statistical analysis was then performed on PAI scores. PAI scores were calculated at both baseline and follow-up for each participant, and then mean scores were calculated for the entire group at baseline and follow-up. Score changes between baseline and follow-up were assessed for each participant, and mean score change was calculated for the entire group. This process was repeated a second time with participants grouped by highest earned degree. Mean baseline PAI score calculations included all participants for whom baseline data was available (n = 10). Mean follow-up score calculations included all participants for whom follow-up data was available (n = 9). Mean PAI score-change calculations included all participants for whom both baseline and follow-up data were available (n = 9). Numerical values were rounded to the nearest tenth, when applicable.

The PAI designates four score-ranges which convey an ascending level of political astuteness for each level. Each participant's PAI score was used to identify their corresponding

level of political astuteness at baseline, and upon completion of the program, and the distribution of astuteness categories among the entire group were assessed for each time point. Changes were reported using descriptive statistics. The distribution of participants' baseline levels of political astuteness, and changes observed after program participation, were compared between participants based on highest earned degree.

The frequency of pre- and post-program score changes were calculated for each individual item on the PAI, and the items demonstrating the highest and lowest frequency of change were identified. Characteristics of interest were described in terms of the number and percent of participants who answered affirmatively on baseline and follow-up PAI assessments. Items with a higher frequency of score changes naturally reflect lower baseline scores for that item within the group, but a high frequency of change also suggests particular aspects of political astuteness that were impacted by program attendance; therefore, itemized score analysis was used to assess the adequacy of program content and the degree to which pedagogical goals were achieved.

Because this pilot project utilized an evidence-based practice implementation framework, and the efficacy of experiential learning has been well-established in the literature, assessing the statistical significance of ENACT pilot data was not necessary. Total PAI scores, categories of astuteness, and itemized PAI scores were generally compared to existing data as a means to assess the integration of evidence into ENACT program content and design, and evaluate various aspects of program effectiveness.

Post-Program Survey

A written survey consisting of seven open-ended questions was completed by ENACT program participants at the end of day two, along with the follow-up PAI. The survey can be found in Appendix D.

Questions on the survey were fairly straight-forward, as were the responses they generated. Analysis of survey data was conducted using a much-simplified version of Braun and Clark's thematic analysis process (2006), and interpretation of participant responses utilized an inductive approach. A table produced by Braun and Clarke (2006) describes each phase and associated processes in detail, and it can be found in Appendix G.

Survey responses were transcribed verbatim into Microsoft Word, and the document was saved and stored for reference. Responses were then copied verbatim to a separate Microsoft Word document for evaluation. Responses were read multiple times, and notes were taken about initial impressions. Due to the very small data set, codes were not needed in order to identify aspects of interest within survey responses. Components of survey responses were collated into a list of potential themes, primarily related to the type of answer provided, and the best supported themes were "mapped" for each survey question using tables generated in Microsoft Word. Supportive excerpts from participant responses were listed for each theme in the table. Themes were analyzed and refined, and supportive excerpts were cross-referenced back to participants' full original responses to assess for fidelity. A simple narrative analysis was generated for each individual question, using supportive excerpts, as well as the frequency and percent of common responses or themes, to illustrate findings.

After evaluating each question individually, identified themes were compared between questions, and notes were taken on commonalities. Impressions were then cross-checked with

original survey responses, and supportive excerpts within original survey responses were color-coded and analyzed in terms of frequency and percent, as they related to each general theme. A reflective analysis of participants' overall experience was narratively described.

When the exact meaning of a survey response was less clear, context was sought by evaluating the individual's responses to other survey questions. Connecting responses in this way allowed for a more robust understanding of each participants' program experience, and provided additional insight into the intended meaning of responses that were brief or somewhat vague. The analysis of survey data was assessed for fidelity by Dr. Terri Yost, PhD, RN, FNP-BC.

Results

Demographics

Demographic characteristics of participants were assessed via participant-generated responses, which are presented in Table 3. Nine participants identified as female, and one identified as a cisgender woman. Participants had a mean age of 34.1 years (*SD = 11.4*) with a range of 37 years. Some participants reported only race, and did not report ethnicity.

Table 3

Demographic Characteristics of ENACT Participants

Characteristic	*n*	%	Mean (*SD*)	Range
Age	10		34.1 (11.4)	20.0 – 57.0
Gender				
Female	9	90		
Cisgender Woman	1	10		
Race/Ethnicity				
Asian/Non-Hispanic	1	10		
Black	1	10		
Black, Biracial	1	10		
White/Hispanic	2	20		
White/Native American	1	10		
White or Caucasian	4	40		

[a]Some participants did not report ethnicity. Values rounded to the nearest tenth, when applicable.

Nursing experience and academic history among ENACT participants are demonstrated in Table 4. At the time of the ENACT program, all participants were enrolled at the University of Virginia School of Nursing, of which 80% (n = 8) were registered nurses and 20% (n = 2) were pre-licensure nursing students. Four registered nurse participants also held an advanced practice nursing license, including three family nurse practitioners, one adult geriatric acute care nurse practitioner, and one neonatal nurse practitioner. Although participants were not expressly asked about their number of years in advanced practice, one participant self-reported a 21-year career in her role. Participants were enrolled in a variety of academic nursing programs at the University of Virginia, at the bachelor's, master's, and doctoral levels. Doctor of nursing practice (DNP) students were best-represented at ENACT, making up 60% of all participants (n = 6).

Table 4

Nursing Experience and Academic History of ENACT Participants

Characteristic	*n*	%	Mean (*SD*)	Range
Years as a registered nurse	8		13.3 (9.4)	3.5 – 35.0
Highest nursing license				
Pre-licensure students	2	20		
Registered Nurse	4	40		
Nurse Practitioner	4	40		
Highest earned degree				
High school diploma	2	20		
BSN	2	20		
MBA	1	10		
MSN	5	50		
Academic Nursing Program				
BSN	2	20		
CNS	1	10		
DNP	6	60		
PhD	1	10		

Note. BSN = Bachelor of Science in Nursing. MBA = Master of Business Administration. MSN = Master of Science in Nursing. CNS = Clinical Nurse Specialist. DNP = Doctor of Nursing Practice. PhD = Doctor of Philosophy.
[a]Years as a registered nurse do not include pre-licensure nursing students. Values rounded to the nearest tenth, when applicable.

PAI Scores

Baseline levels of political astuteness were assessed for all participants (n = 10). Out of 40 possible points, total baseline PAI scores ranged from 7 to 26 (M = 14, SD = 6). Based on these scores, 20% of participants (n = 2) were characterized as "totally unaware politically," 60% (n = 6) as "slightly aware of the implications of politics for nursing," and 20% (n = 2) as "shows a beginning political astuteness" at baseline.

Levels of political astuteness among participants were assessed a second time upon completion of the ENACT program. One participant was unable to attend day two of the program and thus did not complete the follow-up PAI. The nine remaining participants completed the follow-up PAI as planned. Out of 40 possible points, the mean total follow-up PAI score was 24.8 (SD = 4.6). Based on follow-up PAI scores, one participant (11.1%) was characterized as "slightly aware of the implications of politics for nursing," and the remaining eight participants (88.8%) as "showing a beginning political astuteness." Total scores increased for all participants who completed both PAI assessments (n = 9). Score changes between baseline and follow-up PAI assessments were normally distributed, with a mean increase of 11.7 points (SD = 5.1) and a range of 3 to 20. Baseline and follow-up PAI scores, as well as categories of astuteness, can be found in Table 5.

Table 5

Levels of Political Astuteness Before and After ENACT

Student	Baseline PAI		Follow-up PAI		Change
	Score	Category	Score	Category	Score
1	7	Totally Unaware	14	Slightly Aware	7
2	11	Slightly Aware	25	Beginning Astuteness	14
3	11	Slightly Aware	28	Beginning Astuteness	17
4	13	Slightly Aware	26	Beginning Astuteness	13
5	15	Slightly Aware	24	Beginning Astuteness	9
6	11	Slightly Aware	22	Beginning Astuteness	11
7	8	Totally Unaware	28	Beginning Astuteness	20
8	16	Slightly Aware	27	Beginning Astuteness	11
9	26	Beginning Astuteness	29	Beginning Astuteness	3
10	22	Beginning Astuteness	-	-	-
M (SD)	14 (6.0)		24.8 (4.6)		11.7 (5.1)

[a]Participant 10 did not complete a post-program PAI; Mean score-change was calculated using only paired pre- and post-program PAI scores; Categories and scores generated from the Political Astuteness Inventory (Clark, 1984).

When grouped according to the highest earned degree, mean baseline PAI scores differed slightly between groups, and scores are demonstrated in Table 6. For participants with a high school diploma ($n = 2$), the mean baseline PAI score was 13 ($SD = 2.8$), for those with a bachelor's degree ($n = 2$), it was 13.5 ($SD = 3.5$), and for students with a master's degree ($n = 6$),

it was 14.5 (*SD* = 7.8). The mean follow-up PAI score was 23 (*SD* = 1.4) for participants with a high school diploma (*n* = 2), 26 (*SD* = 1.4) for those with a bachelor's degree (*n* = 2), and 28.5 (*SD* = 6.2) for those with a master's degree (*n* = 6). The mean score-change on the post-program PAI assessment was 10 (*SD* = 1.4) for those with a high school diploma (*n* = 2), 12.5 (*SD* = 2.1) for those with a bachelor's degree (*n* = 2), and 15.5 (*SD* = 7) for those with a master's degree (*n* = 5). One participant with a master's degree did not complete a follow-up PAI assessment, and thus was excluded from mean score change calculations. The participants with the highest and lowest PAI scores at baseline and follow-up all held a master's as their highest earned degree, as did the participants with the highest and lowest PAI score-changes.

Table 6

Comparison of PAI Scores by Highest Earned Degree

		Baseline			Follow-up		Change	
Degree	*n*	*M*	*SD*	*n*	*M*	*SD*	*M*	*SD*
High School Diploma	2	13.0	2.8	2	23.0	1.4	10.0	1.4
Bachelor's Degree	2	13.5	3.5	2	26.0	1.4	12.5	2.1
Master's Degree	6	14.5	7.8	5	28.5	6.2	15.5	7.0

[a]One participant with a master's degree did not complete the follow-up PAI; Scores generated from the Political Astuteness Inventory (Clark, 1981).

Score changes were analyzed for each of the 40 items included on the PAI, and results are reported in Table 7. Score increases were observed for 26 items at follow-up, with 13 items increasing for more than half of participants, and four items increasing for more than 75% of participants. One participant did not complete the follow-up PAI, so percentages reflected for follow-up scores are based on the nine remaining participants.

Table 7

Comparison of PAI Scores by Item

Item	Baseline n = 10 %	Follow-up n = 9 %
1. I am registered to vote.	100	100
2. I know how to obtain an absentee or mailed ballot.	100	100
3. I voted in the last general election (at the polls or by mailed ballot).	100	100
4. I voted in the last two elections.	100	100
5. I recognized the names of the majority of candidates on the ballot and was acquainted with the majority of issues at the last election.	50	56
6. I stay abreast of current health issues.	80	89
7. I belong to my state professional (or student nurse) organization, or a specialty organization.	90	89
8. I participate (committee member, officer, local union representative, etc.) in that organization.	20	11
9. I attended the most recent meeting of my district association or local chapter of my specialty nurses' association.	30	22
10. I attended the last state or national convention or conference held by my organization.	10	11
11. I am aware of at least two issues discussed at that convention and the stands taken.	20	44
12. I read literature (print or electronic) by my local, state or national nurses' association, a professional journal, or other literature on a regular basis to stay abreast of current health issues.	50	56
13. I know the names of my senators in Washington, DC.	60	100
14. I know the names of my representatives in Washington, DC.	50	89
15. I know the name of the state senator from my district.	30	100
16. I know the names of the state representatives from my district.	30	100
17. I am acquainted with the voting record of at least one of the above in relation to a specific health issue.	10	78
18. I am aware of the stand taken by at least one of the above on one current health issue.	20	89
19. I know whom to contact for information about health-related issues at the state or federal level.	20	78
20. I know whether or not my professional organization employs lobbyists at the state or federal level.	30	67
21. I know how to contact these lobbyists.	10	67
22. I contribute financially to my state or national professional organization's political action committee (PAC).	20	22
23. I actively supported a senator, representative or other elected official (campaign contribution, campaigning service, wore a button, or other) during the last election.	20	33
24. I have written, telephoned, emailed or communicated via a website with one of my local, state or national representatives regarding a health issue in the last year.	10	11
25. I am personally acquainted with a senator or representative or a member of his or her staff.	20	22
26. I serve as a resource person for one of my elected officials or his or her staff.	0	0
27. I know the process by which a bill is introduced in my state legislature.	20	89
28. I know which elected officials are supportive of nursing.	10	78

Item	Baseline n = 10 %	Follow-up n = 9 %
29. I know which legislative committees usually deal with health-related issues.	20	89
30. I know the committees on which my elected representatives hold membership.	10	67
31. I know of at least two issues related to my profession that are currently under discussion at the state or national level.	50	100
32. I know of at least two health-related issues that are currently under discussion at the local, state or national level.	40	100
33. I am aware of the composition of the state board that regulates the practice of my profession.	30	34
34. I know the process whereby one becomes a member of the state board that regulates my profession.	10	34
35. I know what the letters DHHS mean.	60	78
36. I have at least a vague notion of the purposes of DHHS.	40	78
37. I am a member of a local, state or national committee or advisory board to a health organization or agency that addresses health-related issues.	0	11
38. I attend public hearings related to health issues	10	11
39. I have used a governmental, professional nursing or health organization website to obtain information about my elected officials, health-related issues, or to advocate for a health issue.	20	78
40. I have written a letter to the editor of a newspaper on a health-related or nursing issue.	0	0

[a]One participant did not complete the follow-up PAI; Follow-up scores are rounded to the nearest whole number; Items are from the Political Astuteness Inventory (Clark, 1984).

Post-Program Survey

A total of eight participants completed the post-program qualitative survey at the end of the ENACT program. In question one (Q1), participants were first asked to describe their baseline feelings or perceptions about social justice (SJ). In response, 87.5% of participants (*n* = 7) reflected on their baseline conceptual understanding of social justice. Among them, six described limited knowledge related to SJ, including four participants who specifically used the word "vague" to characterize their understanding of the concept. Only one student described feeling knowledgeable about SJ, and it was in the general context of "issues" and "movements." Three participants directly described their feelings related to SJ, which they characterized as

strong, positive, or empathetic. Among those who positively described their feelings about SJ, two participants focused on SJ in terms of action. One lamented that, despite feeling strongly about the issue, she had yet to act due to time constraints and a lack of knowledge on how to help. The other student reported that she "had a lot of listening to do" on the subject, and said she was unsure of which SJ issues impact her.

Survey Q2 asked participants if their perceptions related to social justice changed after participating in the ENACT program, and if so, how they had changed. In response, 100% of participants (n = 8) reported a positive change after program participation, and the changes that were described can be found in Table 7. Four students directly affirmed a change using terms such as "yes," "definitely," and "absolutely," and three students implied a "yes" within their response. One participant stated that it was "not really" her perceptions about SJ that had changed, and instead, described a change in outlook on her ability to plan and act in the future.

Table 7

Changes in Perceptions Related to Social Justice after ENACT (n =8)

Themes	Student Perceptions
Conceptual	Importance of representation
	Scope of social justice and population impact
	Importance of equity
	Connection between social justice and direct nursing action
	"Real life" impacts of social injustice
Practical	Local government is "the way to change"
	How nurses can become involved in social justice-related policy work
	Ability to make changes for social justice through participation in the legislative process
Emotional	Feeling hopeful about future planning and action
	The value of unique perspectives and experiences; everyone deserves a voice

[a]Themes were generated by the primary investigator during inductive analysis of survey responses.

In Q3, students were asked if their understanding of the nurse's role in policy and advocacy had changed after attending the ENACT program, and if so, how it had changed. In response, 100% of participants (n = 8) indicated a positive change in understanding, either expressly or implied within their answer. Two students described changing "an immense amount," and, "tremendously," and one student used all capital letters and underlined her response. The changes described by students after participation in the ENACT program regarding the nurse's role in health policy and advocacy are summarized in Table 8.

Table 8

Changes in Understanding of the Nurse's Role in Policy and Advocacy after ENACT

Themes	Students' Understanding
Conceptual	Enhanced knowledge from prior graduate health policy course
	Value of nurse subject-matter experts for influencing policy
	Nurses contribute a population health perspective
	The power nurses have to influence policy
	Nurses are uniquely positioned for "a seat at the table"
	How nurse-voices are "heard" in the policy world
	How advocating for professional practice issues can also benefit patients
Practical	How nurses can become lobbyists or legislators
	How nurses become involved in policy work
	Actionable steps to take in order to influence policy
	How nurse story-telling can influence the legislative process
	Broadened understanding of the Virginia legislature
Emotional	Renewed sense of power

[a]Themes were generated by the primary investigator during inductive analysis of survey responses.

In Q4, ENACT participants were asked to identify an issue they would like to address in the future, and list actions they could take to influence the policy process. Issues and proposed actions are illustrated in Table 9.

Table 9

ENACT Participants' Issues of Interest and Proposed Actions to Address Them (n = 8)

Issue of Interest	*n*	Proposed Actions
Social Determinants of Health	1	Staying abreast of policies proposed by legislators
*Autonomous Practice/Full Practice Authority for Nurse Practitioners	2	Provide Expert Testimony Write and call Delegate or Senator
Nursing Scope of Practice	2	"Jump in Deeper" Look to other countries as models for U.S. healthcare reform Push to transform the U.S. approach to healthcare
*Having an RN in every public school	1	Advocate for incentives to help LPNs become RNs Increase pay for school nurses
Housing Reform	1	Join a PNO Join a committee on housing
Access to Primary Care, Affordable Care	1	Join a PNO and attend meetings Become involved in the legislative process at different levels

Note: LPN = Licensed Practical Nurse. RN = Registered Nurse. PNO = Professional Nursing Organization.
[a]An asterisk denotes issues of interest that were associated with bills introduced during the concurrent legislative session

In Q5, participants were asked to identify their most valued activity or topic during the ENACT program. In response, 50% of participants ($n = 4$) identified more than one activity or topic, and one student identified a total of three. All of the students included an experiential component of the program as being most valuable, including one student who remarked about the value of the "open and trusting environment." Fifty percent of participants ($n = 4$) named the keynote speakers as valuable, either in general terms, by naming a specific speaker, or both, and one student remarked on the passion speakers brought to the program. One student cited Becky Bowers-Lanier, the nurse lobbyist, and referenced how she valued her talk on the importance of establishing relationships in policy work. Another student named Millicent Gorham, the executive director of the National Black Nurses Association, calling her "charismatic" and

characterizing her talk as "very impactful." That student went on to speculate that she could see herself becoming more involved in the NBNA as a result.

Although legislators were technically also keynote speakers, three additional students identified speaking with legislators as a most valued activity, either in general terms or by naming a specific legislator. One student described Delegate Dawn Adams' talk as "instant knowledge," and another student remarked about how "cool" it was to talk with the Lieutenant Governor of Virginia, Justin Fairfax.

Two students (25%) named hands-on activities as being most valuable, specifically, learning to navigate the Legislative Information System (LIS) and utilize the "Who's my Legislator" feature of the GA website to follow bills and contact legislators. One student named the presentations given by the primary investigator as particularly valuable, and other responses included group discussions and "understanding the ways we can get involved."

In Q6, students were asked to recommend improvements for future ENACT programs. Of the eight survey participants, 75% (n = 6) provided recommendations in their response. Two students (25%) declined to provide a recommendation, with one describing the program as "awesome," and the other stating, "I just feel bad for the people who did not take advantage."

Of students who provided recommendations, all but one echoed the theme of increasing participation (n = 5), either expressly, or by listing strategies that would help to facilitate program expansion, and in some cases, both. Importantly, one student buffered her recommendation by stating that she "loved the intimate seminar feel to facilitate conversation." One student suggested that the program be offered in UVA School of Nursing policy classrooms, though she clarified that she didn't consider this to be an improvement, but rather a suggestion. Strategies proposed by students to facilitate program expansion are demonstrated in Table 10.

Table 10

Student-Generated Strategies for Program Expansion (n = 5)

Strategic Domain	*n*	Student Recommendation (n)
Program Setting	1	Offer program in UVA School of Nursing policy classrooms
Target Audience	1	Offer attendance to more nursing organizations and programs
Publicity	1	Increase advertising for enrollment
Recruitment	2	Offer Continuing Education Credits
	1	Ask teachers to advocate for enrollment

[a]Strategic domains were generated by the primary investigator during inductive analysis of survey responses.

In Q7, students were asked how they might describe the ENACT program to a nursing colleague. Four major themes were observed in responses: description of the participants' own experience, description of program content, description of why it would be beneficial to attend, or an overall value judgement of the program. To describe their own experience in the program, students used words like "empowering," "inspiring," "eye opening," "meaningful," and one student said, "I learned so much." When describing program content, one student remarked that it was "jam-packed with speakers from all platforms in policy and advocacy." Another student reported, "We learned about the nursing profession and how that directly relates to social justice legislation and advocacy." Regarding the benefits of program attendance, one student described speakers as being nurse-advocates, which she said "is great for identifying policy allies." Another student said, "It will light a fire under you and make you feel more knowledgeable about state government." Overall value-judgements about the ENACT program included phrases

such as “most excellent,” “well done,” “wonderful program,” and, “it was awesome.” One response to Q7 incorporated all four identified themes, when a student described the ENACT program as, “An absolutely inspiring and empowering experience about the limitless influence and power nurses possess for good.”

Discussion

This project utilized an evidence-based practice framework to assess the feasibility of adopting an experiential learning program into practice within health policy education, through implementation of a pilot program at the University of Virginia School of Nursing. Within the EBP framework, pilot project data can provide insight into how effectively existing evidence was integrated into the design and implementation of the practice change, assess the benefit of the practice change in a particular setting, and generate a roadmap with which to make improvements moving forward; therefore, data collected during this pilot project will be discussed, and when appropriate, compared to existing evidence and analyzed in terms of design, benefit, and opportunities for improvement, should the program be adopted into practice. Because Emancipatory Nursing Praxis (ENP) was used as a framework to guide both the learning process and program delivery, it will also be incorporated in discussion about the degree to which pedagogical goals of the program were met, based on an analysis of program data.

Participation

A total of 909 students at the University of Virginia School of Nursing were invited to attend the ENACT program via multiple emails, and an announcement in a nursing school-wide electronic newsletter, which generated 11 registrations prior to the event. One student cancelled in advance, and one did not show up for the program. A total of nine students participated on day one, but one of the students was unable to return for day two. An additional student registered on

day one to attend day two, making a total of nine participants on day two. In total, 10 people attended the ENACT program, but only eight attended both days.

Some possible barriers to participation include: hesitancy to attend an in-person event during the COVID-19 pandemic, concern regarding protests planned in Richmond before the event, the timing of the event during winter break, and the distance of the program site from the University of Virginia, which is approximately 79 miles. Efforts to overcome these potential barriers, included: physical distancing between students, mandatory mask-wearing, a high-powered air filtration unit in the room, and complimentary parking under the building, so no participants would need to walk outside near Capitol grounds. To overcome financial barriers to participation, financial assistance was offered to anyone traveling greater than 30 miles each-way who required assistance in order to attend, but no participants utilized the offer. This information was communicated to students via the event flyer and invitation emails. Despite the significant efforts undertaken to reduce barriers to participation, only 1.1% of invited students attended the ENACT program.

In the literature, participation rates were much higher, though no study used the precise approach to participation that was utilized for the ENACT program. Recruitment in the literature was most often conducted among a captive audience, for example: inviting nurses to participate who were already attending a nurse legislative day (Primomo & Bjorling, 2013), collecting data from students in one or more classes that expressly integrated experiential learning activities throughout the semester, (Byrd et al., 2012; Primomo, 2007; Garner et al., 2008; McGuire et al., 2016; Garritano and Stec, 2019), collecting data from graduate students and post-doctoral fellows who had already completed a health policy practicum as part of a fellowship (DiCenso

et al., 2012), and in one study, mandating participation in an experiential activity as part of curriculum requirements (DeBonis, 2015).

Only one study in the review of literature was similar to the ENACT program, both in terms of event duration, and methods used to invite participants. Nokes et al. (2005) utilized emails to invite students to participate in one of two 15-hour pilot service-learning programs, with 17% (n = 6) and 10% (n = 9) of invited students ultimately participating. The participation rates achieved by Nokes et al. were much higher than the overall participation rate for the ENACT program, which was approximately 1.1% (n = 10). It's important to note that Nokes et al. recruited participants from a theory class that required clinical practicum hours that could be partially satisfied by attending the 15-hour program, though participation remained totally voluntary. In comparison, all 72 DNP students at the University of Virginia were offered practicum hours as an incentive to participate in the ENACT program, and 8.3% of those students ultimately attended (n = 6). This is still lower than the rates achieved by Nokes et al. (2005), but considerably higher than the participation rate among UVA nursing students who were not offered practicum hours for program participation (0.04%); furthermore, DNP students accounted for 60% (n = 6) of all ENACT participants, a finding which suggests that offering practicum hours may be a particularly effective way to incentivize participation in future programs at UVA.

ENACT participants directly addressed the issue of participation in their post-program survey responses. Students were asked to recommend improvements for future ENACT programs, and among those who provided a recommendation (n = 5), 80% spoke about increasing participation (n = 4), either expressly, or by listing strategies to facilitate program expansion, and in some cases, both. Strategies suggested by students included: offering

continuing education credits, increasing advertisement for enrollment, asking teachers to advocate for enrollment, offering attendance to more nursing organizations and programs, and offering the ENACT program in UVA School of Nursing policy classrooms, though that student noted her suggestion was not an "improvement," but rather, a suggestion. It is notable that ENACT participants wanted to increase participation, because it suggests a high level of perceived value and benefit of program attendance.

Establishing the baseline level of policy engagement among UVA nursing students was not within the scope of this evidence-based practice pilot project; however, the comparatively low level of participation in the ENACT program suggests baseline policy engagement as an important area for future exploration and analysis, in addition to better-incentivizing program participation and expanding program capacity.

Representation

ENACT participants all identified as female (including one self-identified cisgender woman), which is reflective of the female-dominated nursing profession, and consistent with the disproportionate number of females represented in the literature. Females comprised greater than 90% of participants in all studies for which that data was reported, and one study reported a 100% female group (Primomo & Bjorling, 2013). It's important to note that one male-identifying student initially registered for the ENACT program, though he was ultimately unable to attend. These data points suggest the need for strategies to overcome the gap in representation among male students in future programs.

ENACT participants were asked to self-identify their race and ethnicity. Responses indicated that the group was 10% Asian (n = 1), 20% Black (n = 2), including one student who identified as "black/biracial," and 60% White (n = 6), which included one student who identified

her ethnicity as Hispanic, and one who identified her ethnicity as Native American. It was difficult to compare the racial and ethnic makeup of ENACT participants to samples in the literature, because, out of the nine included articles, only one reported on race. Nokes et al. (2005) reported racial demographics that were similar to those of the ENACT program, indicating that 13% of the group was Asian, 31% was African American, and 56% was Caucasian, out of 14 total participants. Unfortunately, the lack of data on racial and ethnic diversity in the literature leaves much unanswered about representation in policy-related experiential learning activities; furthermore, the lack of data prevents insight on how these activities are experienced by racial or ethnic minorities.

The theme of representation was woven throughout ENACT program content, and demonstrated to students through the selection of keynote speakers who represent a historically marginalized group in terms of race, gender, sexuality, citizenship status, or religion, and in some cases, multiple aspects of their inherent identity. Students echoed the impact of this program theme in post-program survey responses, with “the importance of representation,” and, “the value of unique perspectives and experiences,” listed as perceptions that positively changed after program participation, with one student adding, “everyone deserves a voice.”

Policy programs, like ENACT, that promote emancipatory nursing praxis among participants, are well-served to model emancipatory nursing praxis within program design and implementation. In order to overcome barriers to involvement in the legislative process, it is vital to know how policy engagement is experienced by groups with more or less perceived political power. Baseline racial and ethnic data collected during the ENACT pilot can be used as a benchmark for comparison, and future data collection efforts should seek to identify gaps in representation, so that they can be addressed through improved recruitment strategies.

Becoming

Age, Experience, and Level of Education. The age, nursing experience, and education level of ENACT participants provides important context for the analysis of PAI scores, both within the group itself, and in comparison to existing evidence. The dynamic relationship between these demographic features and levels of political astuteness among nurses was demonstrated throughout the literature. Age and level of education were each positively associated with PAI scores at baseline and follow-up (Primomo & Bjorling, 2013), significant differences were found in both baseline and follow-up PAI scores based on level of education, with higher educational ranks having higher PAI scores (Byrd et al. 2012), the number of years as a nurse was positively related to PAI scores in one study group reported by Primomo and Bjorling (2013), and in the other study group, Primomo and Bjorling found a significant effect of educational rank on the change in PAI score between baseline and follow-up testing, with higher educational ranks achieving higher score increases. Primomo (2007) did not detect an association between age, educational rank, or nursing experience and PAI scores at baseline or follow-up, though this may have been due to the fairly small sample size ($n = 40$) or other aspects of study design.

ENACT participants had a mean age of 34 years ($SD = 11.4$) with a range of 37 years. 20% ($n = 2$) were pre-licensure nursing students and 80% ($n = 8$) were registered nurses. RNs reported a mean of 13.3 years in practice ($SD = 9.4$) with a range of 31.5 years, and 62.5% reported being a nurse for greater than 10 years ($n = 5$). Half of registered nurses ($n = 4$) were also licensed nurse practitioners.

Stratifying levels of education among nurses can be somewhat complex, as two different data sets reflect on this measure. Both highest earned degree and current academic program are

routinely reported in the literature, and both measures convey important aspects of each group. Highest earned degree was most commonly used in comparison to political astuteness in the literature. When asked to identify their highest earned degree, 20% (n = 2) of ENACT participants reported a high school diploma, 20% (n = 2) reported a bachelor's degree, and 60% (n = 6) reported a master's degree.

When stratified according to highest earned degree, mean PAI scores increased as level of education increased. Among students with a high school diploma, bachelor's degree, and master's degree, mean baseline PAI scores were 13, 13.5, and 14.5, mean follow-up PAI scores were 23, 26, and 28.5, and mean PAI score-changes were 10, 12.5, and 15.5, respectively. This pattern is consistent with the literature, and supports a connection between level of education and political astuteness; however, it is important to note that, among all ENACT participants, both the highest and lowest PAI scores at baseline and follow-up were achieved by students with a master's degree, and both the highest and lowest score-changes were achieved by students with a master's degree, an important reminder that program benefit for an individual student, in terms of political astuteness, is not determined by their level of education.

Three studies in the review of literature utilized the PAI for data collection, and these three were also the most similar to ENACT in terms of program design and experiential activities. Of these, only two reported age or years in practice. Primomo (2007) reported that 86% of the group was older than age 40, and Primomo and Bjorling (2013) reported mean ages of 39.6 (SD = 11.7) and 40 (SD = 12.7) for each of the study groups. ENACT participants had a mean age of 34 years (SD = 11.4), making the group younger, on average, than those reported in the literature.

Primomo (2007) sampled exclusively registered nurses, of whom 83% reported being a nurse for 10 years or more, and 44% for 20 years or more. Primomo & Bjorling (2013) sampled both pre-licensure nursing students and registered nurses in both groups who participated in the study, with 13.5 and 18 mean years as a nurse reported for each group. Among ENACT participants, 80% (n = 8) were registered nurses, and they reported 13.3 mean years as a nurse (SD = 9.4), with 62.5% (n = 5) having been a nurse for greater than 10 years. Overall, ENACT participants reported fewer mean years as a nurse, as compared to the literature.

Regarding level of education, Primomo (2007) sampled MSN students, whose highest earned degree was a BSN. Primomo and Bjorling (2013) sampled a wide variety of education levels, including several MSN students, though 42% of group one, and 35% of group two, were pre-licensure nursing students with less than a bachelor's degree as their highest level of education. Byrd et al. (2012) sampled traditional BSN students, as well as RN-to-BSN students, though most participants were not yet registered nurses. Comparatively, ENACT participants had a much higher level of education, on average, than studies in the review of literature who utilized the PAI. Among participants, 80% (n = 8) were registered nurses, 60% had a master's degree (n = 6), and 70% were enrolled in a doctoral program (n = 7).

The comparatively younger age, shorter duration of nursing experience, and higher level of education found among ENACT participants, is important context when comparing mean PAI scores to samples found in the literature. This comparison is important, because it provides insight on degree of program benefit for nursing students at UVA, and how adequately the existing evidence was integrated into program design. Similarities in PAI score-increases would suggest similarities in effectiveness between the ENACT program and the studies from which it was designed and implemented.

Baseline Positioning. The baseline characteristics of ENACT participants, particularly as related to political astuteness, level of engagement, and perceptions of social justice, are incredibly important in order to tailor future program content to meet the specific needs of students at the UVA School of Nursing. While these students are hardly representative of all UVA nursing students, they are presumably somewhat representative of students who might be likely to attend ENACT programs in the future. The ENACT program was designed based on evidence found in the literature, but baseline data from this specific setting can help to identify which aspects of the program should be prioritized in the future, in terms of time and focus.

Baseline political astuteness was measured for all participants in the ENACT program (n = 10) and results demonstrated a mean score of 14 (SD = 6). This was much lower than the mean baseline scores reported by Primomo and Bjorling (2013) which were 16.6 (SD = 9.8) and 19.3 (SD = 10.5) for each study group. Primomo and Bjorling (2013) reported an overall lower level of education than was present among ENACT participants, but they were generally older and had more nursing experience than ENACT participants, and the study was conducted among individuals who were already in attendance at a state legislative day, factors that may have contributed to the notably higher baseline PAI scores in that study.

The mean baseline PAI score for ENACT participants (M =14, SD = 6) was very similar to the mean baseline score reported by Primomo (M = 13.6, SD = 5.2) in 2007. This similarity is interesting given that Primomo (2007) reported comparatively older participants with more years of nursing experience than were found among ENACT participants. It's important to note, however, that Primomo (2007) sampled only MSN students whose highest earned degree was a BSN, whereas 60% of ENACT participants (n = 6) already possessed a master's degree, and 70% (n = 70) were enrolled in a doctoral program. The higher level of education found among

ENACT participants may explain why these two groups were still comparatively similar in mean baseline PAI scores, despite differences in age and nursing experience.

Baseline PAI scores for ENACT participants (M =14, SD = 6) were much higher than the scores reported by Byrd et al. (2012) (M = 10.5, SD = 5.5), but the sample utilized in that study consisted entirely of baccalaureate students, most of whom were not yet registered nurses. Among the RN-to-BSN students included by Byrd et al., baseline PAI scores (M = *13.6*, SD = 5.3) were much more similar to those of ENACT participants (M =14, SD = 6). This similarity is interesting given the much higher level of education among ENACT participants, of whom 80% (n = 8) were registered nurses enrolled in a masters or doctoral program. Unfortunately, no data was reported by Byrd et al. (2012) regarding the age or years of nursing experience among registered nurse participants, so comparison to ENACT participants was not possible for those features.

There were four items on the PAI for which 100% of ENACT participants (n = 10) answered affirmatively at baseline. All participants reported being registered to vote, knowing how to obtain an absentee or mail-in ballot, voting in the last election, and voting in the last two elections. Primomo (2007) reported that all participants were registered to vote at baseline, but only 95% had voted in the last election, and Byrd et al. (2012) reported that 83% (n = 249) were registered to vote, and 73% (n = 219) voted in the last election. No data was provided for these items by Primomo and Bjorling (2013). While these PAI items are generally useful indicators of prior action and engagement among nurses, they are of somewhat limited utility for comparison between groups. At the time of the ENACT program, the most recent election was perhaps one of the most divisive in modern history, produced the highest percentage of voter-turnout since at least 1980 (DeSilver, 2021) and utilized an extremely high rate of mail-in and absentee ballots as

compared to prior elections due to the COVID-19 pandemic. This unique sociopolitical climate may have contributed to the comparatively high scores on these items among ENACT participants.

Despite 100% (n = 10) participation in the last election, only 50% of ENACT participants (n = 5) reported recognizing the majority of candidates on the ballot and feeling familiar with the majority of issues during that election; furthermore, only 60% (n = 6) could name their U.S. Senators, 50% (n = 5) could name their U.S. Representatives, and just 30% (n = 3) could name the state senator or representative from their district. Out of 10 total participants, only two reported being aware of the stand taken by one of their legislators on a current health issue, and just one person reported being acquainted with the voting record of any of their legislators in relation to a health issue. Byrd et al. (2012) reported a higher percentage of participants who could name a state senator (38.7%) or state representative (33%), but that study included only baccalaureate nursing students, of whom 86.6% were not yet registered nurses. The comparatively lower scores among ENACT participants, of whom 70% were doctoral students, is concerning.

The mismatch between political participation and political knowledge demonstrated by these scores is stark. The fact that 100% of participants voted in the last election, yet only 50% recognized the majority of candidates and felt familiar with the issues, suggests a fairly superficial level of baseline political knowledge among ENACT participants. Based on this data, it's quite possible that participants' political participation occurred in the form of down-ballot partisan voting, or described differently, voting for candidates simply based on political party, rather than having any substantive knowledge or meaningful understanding of the candidates or issues. An apparent lack of baseline civic and political awareness among ENACT participants is

suggested by the fact that 70% of participants could not name a state legislator from their own district. This is problematic because the state legislature is where some of the most consequential health policies are enacted.

The second highest scoring item among ENACT participants at baseline addressed membership in a state professional or specialty nursing organization, and 90% (n = 9) of students reported they were indeed a member. While this may seem to suggest a high level of professional engagement, the items that assessed participants' actions within those organizations suggest otherwise. Among students, 20% (n = 2) reported participating in the state organization as a committee member, officer, representative, etc., 30% (n = 3) reported attending the most recent meeting of their district or local chapter professional organization, 10% (n = 1) reported attending the most recent state or national convention of their organization, and 20% (n = 2) reported being aware of at least two issues discussed at the state or national convention. Out of the nine participants who reported membership in a professional organization, 44.4% (n = 4) did not engage in any of these actions. On items specifically related to political involvement within professional nursing organizations (PNOs), 30% (n = 3) of participants reported knowing whether or not their organization employed lobbyists at the state or federal level, but only one knew how to go about contacting them. Interestingly, the only two students who reported making a financial contribution to their organization's political action committee (PAC), were also among the 44.4% (n = 4) who did not engage in any action within their organization. The mismatch between membership and action within PNOs suggests a somewhat superficial level of baseline professional engagement among ENACT participants.

Because the ENACT program featured experiential learning activities predominantly related to the legislative process, it's important to mention the baseline characteristics of

participants in this area. Out of 10 total participants, only two (20%) reported knowing how a bill is introduced in the state legislature, two (20%) reported knowing which legislative committees deal with health-related issues, one student (10%) knew the committee on which their legislator served, one student (10%) reported knowing which elected officials are supportive of nursing, and one student (10%) reported communicating with a representative at any level regarding a health issue in the past year. No students reported serving as a resource person for their elected official or a member of their staff.

Scores for items related to the legislative process suggest a very low baseline level of knowledge and participation among ENACT participants, though it's important to note that they were generally higher than scores reported by Byrd et al. (2012), with one notable exception. Byrd et al. (2012) reported that 19% of students knew the process by which a bill was introduced in the state legislature, which is consistent with the 20% (n = 2) of ENACT participants who reported having this knowledge, but that study sample consisted entirely of baccalaureate nursing students, of whom 86.6% were not yet registered nurses. Given that 70% (n = 7) of ENACT program participants were doctoral students, 80% (n = 8) were registered nurses, and 40% (n = 4) also held an advanced practice nursing license, having a similarly low level of knowledge about the legislative process as pre-licensure nursing students is troubling. Byrd et al. (2012) was the only study that reported baseline PAI scores for all items.

There were three questions for which no ENACT participants answered affirmatively at baseline, including: serving as a resource person for one of their elected officials or a member of their staff, being a member of a local, state, or national committee or advisory board to a health organization or agency that addresses health-related issues, and writing a letter to the editor of a newspaper on a health-related or nursing issue. There were no items reported by Byrd et al.

(2012) for which no participants answered affirmatively at baseline. Neither Primomo (2007) nor Primomo and Bjorling (2013) reported this data.

Among ENACT participants, 20% (*n* = 2) were deemed "totally unaware politically," 60% (*n* = 6) as "slightly aware of the implications of politics for nursing," and 20% (*n* = 2) as "shows a beginning political astuteness" according to baseline PAI scores and corresponding categories of astuteness, as established by Clarke (1984). While the baseline astuteness of ENACT participants was fairly similar to data found in the literature, they had a much higher level of education, on average, than the study samples. Among ENACT participants, 70% (n = 7) were doctoral students, and as such, they might be expected to have a generally moderate to high level of baseline political astuteness, but that did not seem to be the case. Similarly, doctoral nursing students might be expected to have a generally moderate to high understanding of the concept of social justice, due to the advanced academic preparation they receive in nursing ethics, health policy, and population health, but that also did not appear to be the case.

Although the specific relationship between political astuteness and knowledge about social justice was not expressly discussed in the literature, social justice concepts were incorporated, in some way, into all studies that utilized the PAI, and they were widely incorporated in several studies that did not utilize the PAI. A comparison between perceptions of social justice and political astuteness, at baseline and follow-up, provides interesting context with which to evaluate the experience of participants in the ENACT program.

On the post-program survey, participants were asked to describe their baseline feelings or perceptions about social justice prior to attending ENACT. Among all participants who returned the survey (*n* = 8), 87.5% (*n* = 7) reflected on their conceptual understanding of social justice within their response, and six of those students described having limited knowledge on the

subject. Four participants specifically used the word "vague" to characterize their understanding, and interestingly, all four were graduate students, including three doctoral students. Only one student reported feeling knowledgeable about social justice, describing herself as "educated and involved." Of note, this participant was a pre-licensure nursing student, and she had a higher baseline PAI score than 60% (n = 6) of all ENACT participants (n = 10).

No definitive conclusions can be drawn about the baseline political astuteness of ENACT participants as compared to the three studies that utilized the PAI in the review of literature; however, comparison suggests that baseline astuteness was fairly similar between groups, and in most cases, differences could be reasonably explained by the distribution of demographic characteristics such as age, years in nursing, and level of education, within each group. Baseline comparison of mean PAI scores and itemized PAI scores between ENACT participants and samples in the literature provides useful context when considering the benefits of ENACT program adoption at the University of Virginia. The comparison did not reveal any evidence to suggest that ENACT participants had a higher level of baseline political astuteness than other groups, and thus there is no reason to think that students would receive any less benefit from participation in an evidence-based experiential learning program like ENACT.

Awakening

Changes to Political Astuteness. Scores were higher for all ENACT participants who completed the follow-up PAI. Among the items with the greatest change, four items increased for 77.7% (n = 7), of participants, which included: knowing the name of their state senator, knowing the name of their state representative, being acquainted with the voting record of at least one of those legislators, and being aware of a stand taken by one of those legislators on a current health issue. Of these four items, one was reported as being among the items with the

greatest change in the literature, which was knowing the name of their state senator (Primomo, 2007), though the percent of positive change for that item was not provided.

A total of four items increased for 66.7% (n = 6) of participants, including: knowing the process by which a bill is introduced in the state legislature, knowing which elected officials are supportive of nursing, knowing which legislative committees usually deal with health-related issues, and knowing of at least two health related issues that are currently under discussion at the local, state, or national level. Interestingly, all of these items were reported as being among those with the highest score change by Primomo (2007), and Primomo and Bjorling (2013). Byrd et al. (2012) conceptually categorized items, and reported greatest change in terms of category rather than item. In that study, the two categories with the greatest score change at follow-up were knowledge of the legislative and policy process, and knowledge of legislators, both of which are consistent with the changes observed among ENACT participants, as well as the other two relevant studies (Primomo, 2007; Primomo & Bjorling, 2013).

The high degree of similarity in items with the greatest score change between the literature and ENACT program data are unsurprising, given that the ENACT program incorporated the design themes, experiential activities, and pedagogical goals described in the literature. This similarity does suggest that existing evidence was well-integrated into the design and implementation of the ENACT pilot program, and provides a useful benchmark for future program planning and design.

The mean post-program total PAI score among ENACT participants was 24.8 (SD = 4.6), with a mean score increase of 11.7 points (SD = 5.1) and a range of 3 to 20. Primomo and Bjorling (2013) reported a mean post-program total PAI score of 26.7 (SD = 6.7) and 26.7 (SD = 8.1) for each study group, with a mean score increase of 10.1 and 7.4, respectively. The mean

total PAI score increase was larger among ENACT participants, though it's important to note that Primomo and Bjorling (2013) reported higher baseline PAI scores, which provides less opportunity for score increases at follow-up.

Despite having mean baseline PAI scores that differed by just 0.4 points, the mean follow-up PAI score reported by Primomo (2007) was 23.1 (*SD* = 5.8) with a mean score increase of 9.5 points, and the mean follow-up PAI score among ENACT participants was 24.8 (*SD* = 4.6), with a mean score increase of 11.6 points. The comparatively higher follow-up PAI scores and larger mean score-increase among ENACT participants could be related to the higher level of education in the group, as a positive association between level of education and PAI score increases was demonstrated in the literature (Byrd et al., 2012; Primomo & Bjorling, 2013), but it is also possible that the ENACT program was slightly more effective in raising PAI scores. Interestingly, Primomo (2007) included experiential learning activities over the course of an entire semester during a graduate-level health policy course, though the ENACT program was conducted over a short, two-day intensive program. This suggests not only that existing evidence was well-integrated into the ENACT program, but that the shorter duration of the program did not appear to decrease the benefit for participants, as measured by the PAI.

Recall that Byrd et al. (2012) reported lower baseline scores among all participants (*M* = 10.5, *SD* = 5.5) as compared to ENACT participants (*M* =14, *SD* = 6); however, for the registered nurse participants (*n* = 41), Byrd et al. reported baseline PAI scores that were very similar (*M* = 13.6, *SD* = 5.3) when compared to ENACT participants. At follow-up, Byrd et al. reported a mean total PAI score of 25.7 (*SD* = 5.4) for registered nurse participants, with a mean score increase of 12.1 points. ENACT participants' follow-up mean total PAI score was 24.8 (*SD* = 4.6), with a mean score increase of 11.7 points, demonstrating very similar results as Byrd et

al., with the mean total PAI score being just one point lower, and mean score change being just 0.4 points lower among ENACT participants. Interestingly, ENACT participants had a much higher level of education than did the registered nurses in Byrd et al., but ENACT was a short, two-day intensive program, compared to a semester-long public policy and community health class which featured many of the same experiential learning activities included at ENACT. Again, the similarity in mean follow-up PAI scores and mean score changes, suggests that existing evidence was fairly well-integrated into the ENACT program, and that the shorter program duration did not appear to have a negative impact on benefit.

Changes in Perception. Three studies in the review of literature performed qualitative data analysis to evaluate policy-related experiential learning activities or programs (Garner et al., 2008; DiCenso et al., 2012; McGuire et al., 2016). These studies provided rich descriptions of participants' feelings, and experiences related to the learning activity or program, many of which were similar to feelings expressed by ENACT participants in the post-program survey; however, neither Garner et al. (2008) or DiCenso et al. (2012) were similar enough to ENACT in terms of program type or duration to make a useful comparison with the program-specific survey responses collected from ENACT participants. Stated differently, a comparison between ENACT and these two studies would not provide significant insight on the efficacy or benefit of program implementation, nor assist with improvements to future ENACT programs.

McGuire et al. (2016) incorporated activities such as interviewing public policy-makers, attending policy meetings, and spending a day at the State Capitol, all of which were incorporated to some degree in the ENACT program. ENACT participants did not perform a formal interview of policy-makers, but they actively engaged in Q&A sessions with every keynote speaker and legislator that participated in the program. They virtually attended

committee meetings specific to health policy, and spent a virtual "day at the State Capitol" by watching live legislative sessions and tracking bills of interest. Activities utilized in the ENACT program were similar enough to those used by McGuire et al. (2016) to warrant comparison of student feedback.

The largest benefit reported by McGuire et al. (2016) was related to attitudinal changes about the legislative process and students' own role within that process, with students reporting a clearer understanding after attending a live legislative session at the State Capitol. Improved understanding of the law-making process was observed among ENACT participants as well, with 66.7% (n = 6) of participants who completed the follow-up PAI (n = 9) indicating they had learned the process by which a bill is introduced in the state legislature during the course of the ENACT program. In fact, knowledge of the legislative process was among the items with the highest PAI score change after ENACT program attendance.

ENACT participants were not expressly asked how watching a live legislative session impacted their knowledge of the legislative process, but after attending the ENACT program, students echoed the theme of having a clearer understanding of the issue in their responses to the post-program survey. When asked how they might describe the program to a nurse colleague, one student reported that it would "make you feel more knowledgeable about state government." When asked about changes in perception after program attendance, one student referred to the nurse's role within the Virginia Legislature, and two students indicated an improved understanding about their ability to impact the legislative process.

Engaging

Analyzing Power and Collective Strategizing. McGuire et al. (2016) reported that participants aptly illustrated how they could bring a concern to their elected official after

program participation, and ENACT participants did the same. When asked what actions they could take to influence the policy process, ENACT participants suggested: collective advocacy via PNOs, providing expert testimony, communicating with lawmakers, attending legislative meetings, and tracking policy proposals. These responses demonstrate a fairly robust understanding of how power is leveraged during the legislative process, and more specifically, the nurse's role within that process. In fact, when asked if their perceptions about the nurse's role in health policy and advocacy had changed, 100% (n = 8) indicated a positive change in perception, either expressly, or implied within their answer, and several students emphasized the degree of change using descriptors like "tremendously" and "an immense amount." Almost all of the changes described were related to students' conceptual or practical understanding of the nurse's role. Notably, the power nurses have, and their ability to make an impact, were themes present in several responses, with power being referred to in the context of conceptual understanding, as well as the emotional context of personal empowerment.

Praxis. Nokes et al. (2005) and DeBonis (2015) utilized a service-learning approach to experiential education among registered nurses, and improvements were seen in civic engagement, cultural competence, and attitudes about social justice and health disparities. In contrast to most policy-related experiential learning programs found in the literature, these studies did not include any legislative activities, and instead, explored public health policy through clinical immersion within vulnerable communities.

The ENACT program did not incorporate service-learning in the clinical environment; however, by featuring public health data, pictures, and stories from local vulnerable communities during interactive lectures, and further integrating these themes into keynote speaker content, participation in the legislative process was framed for participants as a form of community

service. This methodology qualifies the ENACT program as a service-learning activity, as defined by Bailey et al. (2002), and it's notable that post-program survey responses reflected themes that are consistent with DeBonis (2015), who reported an increase in students' intent to engage in advocacy, and belief that their efforts could have a positive impact.

Persisting. ENACT participants were asked to suggest a policy issue they would like to address in the future, but were not expressly asked about their intent to act. In response to this question, and others on the survey, students used language that was suggestive of intent, such as "I could really see myself advocating for housing reform," "I'd like to join a PNO," and "I could see myself involved in [the National Black Nurses Association]," and one student described a positive change in outlook about her ability to make plans and act in the future. Two ENACT participants described an improved understanding of their ability to "make a difference," and "have a huge impact," on social justice issues and the legislative process. Four students described a change in perceptions about the power they have as nurses to affect positive change. The way these feelings will shape future engagement and action remains unknown.

Transforming

Evaluation of Pedagogical Goals. The ENACT program featured two main pedagogical goals: to build the technical knowledge and practical skills necessary for effective involvement in health policy and advocacy, and to cultivate an impetus for sustained engagement and action. One of the primary goals of data collection was to determine whether or not pedagogical goals were met, as a means to reflect on program benefit and inform future program design. Based on a thorough evaluation of pilot program data, it appears that pedagogical goals were sufficiently met.

Political Astuteness scores increased for all ENACT participants, with a mean score increase of 11.7 (*SD* = 5.1). Compared to the three studies in the literature review that utilized the PAI, the mean score-increase among ENACT participants was higher than two (Primomo, 2007; Primomo & Bjorling, 2013), and only 0.4 points lower than the third (Byrd et al., 2012). As compared to the same three studies, mean PAI scores after participating in the ENACT program were consistent with the literature, with one study reporting lower follow-up scores (Primomo, 2007), and two reporting higher follow-up scores (Primomo & Bjorling, 2013; Byrd et al., 2012). Regarding the PAI, areas of highest program impact were extremely similar to those found in the literature, and included: knowledge of the legislative process, knowledge of elected officials and legislators who are supportive of nursing, and knowledge specifically pertaining to health-related legislative issues. These areas of impact represent the technical knowledge that is vital for effective engagement in policy and advocacy work, and it appears that sufficient learning occurred during the pilot program.

The ENACT program sought to provide practical skills to participants by engaging them in hands-on activities such as learning to navigate the Legislative Information System (LIS), tracking bills of interest, locating information about elected officials, virtually attending committee meetings and floor sessions of the House and Senate, submitting written comments on legislation of interest, and registering to provide public testimony. On the post-program survey, two students named these hands-on exercises as their most valued activity, and two students suggested providing more of this content in future programs. These recommendations might suggest that some students found the time spent on these activities to be inadequate; however, when asked what strategies they could take to address a policy issue of concern to them, students stated they could become directly involved in the legislative process, provide expert testimony,

contact their legislators, and stay abreast of the policies proposed by their elected officials, all of which are actions that integrate practical skills taught in the hands-on exercises. Based on survey responses, it appears likely that sufficient learning occurred in relation to practical skills, although increasing the number and duration of hands-on activities may help to improve program content in the future.

The third, and perhaps most complex pedagogical goal of the ENACT program was to create an impetus for sustained engagement in policy and advocacy work. Knowledge of the legislative process is a significant predictor of political involvement (Byrd et al., 2012), and ENACT participants certainly improved their knowledge of the legislative process; however, there was a paucity in data regarding long-term engagement as a result of new legislative knowledge, and thus additional evidence-based strategies were incorporated in ENACT program design, namely service-learning, which has been shown to increase civic engagement as well as the intent to act in the future (Nokes et al., 2005; DeBonis, 2015). Similar to these service-learning programs, the concept of social justice was woven throughout program content and activities, and social inequities were revealed through examination of the social determinants of health, health disparities, representation in government, voter disenfranchisement, discrimination, bias, and more. By incorporating these themes throughout the program, policy and advocacy work was presented to students in the context of community service, and the duty to act was reinforced through exploration of nursing's long history of advocacy and activism, and the ethical tenets of the nursing profession.

Chinn and Kramer (2011) described emancipatory knowing as the ability to recognize the problem of injustice, and realize that it can be corrected by taking part in social or political efforts to improve the lives of others. Of the 8 students who submitted the post-program survey,

75% (*n* = 6) described having limited knowledge about social justice prior to the ENACT program, and 50% (*n* = 4) specifically used the word "vague" to describe their understanding; however, 100% (*n* = 8) described a change in perceptions or outlook on social justice after attending the program. Survey responses acknowledged the size and scope of social justice, the practical impacts injustice has on "real life," and the importance of equity, which suggests an expanded or improved recognition of social injustice as a significant problem.

Among survey respondents, 100% (*n* = 8) indicated a positive change in perceptions about the role of the nurse in health policy and advocacy, citing powerful examples such as: the value of nurse subject-matter experts, how one can become a nurse-lobbyist or nurse-legislator, and the unique population-health perspective nurses bring to the policy table. When asked to name an issue they would like to address, and list actions they could take to influence the policy process, students named a wide variety of important issues, from professional nursing practice to the social determinants of health, and cited astute strategies for action, including: examples of both individual and collective advocacy, becoming a committee member, providing expert testimony, and taking multi-level legislative action. These responses demonstrated an improved understanding of students' own capacity to create change, by taking part in social or political efforts to improve the lives of others.

Scholars such as Chinn & Kramer (2011), and Snyder (2004), have described emancipatory knowing as the impetus for emancipatory nursing praxis. In other words, emancipatory knowing compels nurses into reflective action to promote justice. Based on survey responses, it appears that at least some level of emancipatory knowing was cultivated for many ENACT participants; however, measuring their long-term policy engagement was not within the scope of this pilot project, so no conclusions can be drawn about the usefulness of facilitating

emancipatory knowing as an impetus for sustained engagement and action in this setting. Future programs would be well-served to conduct follow-up assessments among students over time, as a means to evaluate the efficacy of this pedagogical approach in producing sustained engagement.

Strengths and Limitations

The ENACT program used a mixed-methods approach to data collection and analysis. By utilizing the PAI, a validated tool that is specific to nursing, in conjunction with open-ended post-program surveys, a fairly robust analysis of program impact and student-experiences was possible. Additionally, extensive documentation of the design and implementation process provides valuable insight into the feasibility of incorporating this type of experiential learning program into health policy education. Should the program be formally adopted as standard practice, the data generated from this pilot can be used to inform future program design, provide a roadmap for implementation, and serve as a benchmark with which to compare results.

The primary investigator had some prior experience in policy and advocacy, including knowledge about the legislative process in the Commonwealth, and prior legislative involvement at the Virginia General Assembly, which helped to streamline project planning and tailor program content to the 2021 legislative session; additionally, as a Virginia Nurse Advocate Health Policy Fellow at the time of implementation, the primary investigator had expanded access to information, including unpublished legislative schedules and an invitation-only webinar conducted by the Clerk for the House of Delegates prior to the legislative session, both of which were incredibly helpful during a time of great uncertainty due to COVID-19. Additionally, the fellowship grant enabled the primary investigator to secure a conference room with expanded space for adequate physical-distancing and high-tech audiovisual capabilities to facilitate some of the program content, which was adapted due to COVID-19. These amenities

would have likely been cost-prohibitive without grant-funding. All of these factors significantly contributed to the success of the pilot program during an unprecedented situation in the United States and around the world.

Finally, this pilot project demonstrated an evidence-based practice approach to experiential learning, and did so with very little overhead costs. This suggests the feasibility of piloting other evidence-based experiential learning activities at the UVA School of Nursing, with little financial burden.

There were a few notable limitations in this pilot project. Successful experiential learning activities used to convey technical knowledge and practical skills were clearly described in the literature; however, specific activities that motivate students into sustained engagement and action were less clear. Service-learning activities that incorporated sociopolitical issues such as health disparities and inequity were associated with an increased sense of civic and social responsibility, as well as intent to act (Nokes et al., 2005; DeBonis, 2016), and the ENACT program incorporated these strategies into design and implementation in an effort to promote sustained engagement. Unfortunately, data collection on long-term policy engagement among ENACT participants was outside the scope and time-constraints of this pilot project, and thus it was difficult to assess the efficacy of this specific pedagogical approach within the program, which also limited the ability to fully assess program benefit.

The success of this pilot program was dependent on its ability to provide meaningful experiential learning activities to participants. Unfortunately, the COVID-19 pandemic prevented some of the high-impact experiential activities initially planned for the ENACT program, such as attending a live legislative session in the historic and ornate chambers of the Virginia General Assembly, assisting participants to schedule office-meetings with their legislators and lobby for

bills of interest, and exploring Capitol grounds during program breaks. Because of the adaptations that were required due to COVID-19, it's likely that some of the experiential benefit was reduced for participants, thus limiting the ability to fully explore the impact of those evidence-based activities within the ENACT program.

While there were significant program planning benefits associated with the primary investigator's role as a Virginia Nurse Advocate Health Policy Fellow, orchestrating a two-day event featuring prominent policy experts and legislators was difficult and time-consuming, particularly given the uncertainty surrounding the legislative schedule, and the unprecedented format of legislative sessions, which occurred totally remotely for the House of Delegates, and in-person but closed to the public for the Senate, at the Science Museum of Virginia. The difficulty presented by COVID-19 during pilot program planning and implementation may not be a problem for future programs; however, the significant time and effort required to schedule high-profile speakers during a legislative session is likely to remain an issue. While this pilot project certainly demonstrates feasibility, and provides a roadmap to streamline future program content and event planning, future programs will continue to require significant time and energy from the coordinator, which could impact the feasibility of using the exact same program design as was utilized for ENACT.

Integrate and Sustain the Practice Change

The feasibility of integrating an evidence-based experiential learning program into nursing health policy education at the University of Virginia (UVA) was adequately demonstrated through analysis of data collected during the planning, implementation, and evaluation phases of the ENACT program. The benefits of using experiential learning as a complement to didactic coursework in nursing health policy education are well-supported in the

literature. Now, the benefits of a policy-focused experiential learning program have been demonstrated for nursing students at UVA, through the successful implementation of the ENACT program, and a thorough analysis of the data generated during that process; therefore, the adoption of a policy-focused experiential learning program at the University of Virginia is well-supported.

Implications for Practice

This project successfully utilized an evidence-based practice implementation framework to pilot an experiential learning program in health policy and advocacy for nursing students at the University of Virginia (UVA), which was centered on the concept of social justice, and aimed to promote emancipatory nursing praxis among participants. The success of this pilot program could have a significant impact on nursing health policy education at UVA and beyond, while also adding practical context to existing evidence related to experiential learning and emancipatory pedagogy.

Existing evidence was successfully integrated into the content, design, and implementation process utilized for the ENACT program, as demonstrated through a comparison of program results with those found in the literature. Two of the three studies that were most similar to the ENACT program, in terms of both experiential activities and outcomes of interest, were implemented over an entire semester as part of a policy class. This project was implemented over a two-day period, and provided extremely similar results in terms of PAI score-increases, suggesting that the shorter duration of the program did not appear to decrease benefit for participants; furthermore, several of the experiential learning activities utilized an interactive virtual format due to the impact of COVID-19, and that approach did not appear to reduce the overall benefit as compared to existing evidence. It is unknown if this partially-virtual

approach might have produced less benefit than if ENACT participants had been able to attend legislative sessions in-person and meet with legislators in their offices, but the overall success of the program in comparison to the literature supports the feasibility and effectiveness of utilizing a partially virtual approach. While in-person attendance is the standard among existing evidence, and should be utilized when possible, the successful implementation of a partially-virtual program has significant implications for program delivery when in-person attendance is not possible for students or program contributors.

By conducting the ENACT program concurrently with the legislative session of the Virginia General Assembly, students were given an opportunity to be involved in the legislative process, make professional connections, and expand their understanding of the policy work through collaboration with legislators, lobbyists, policy analysts, leaders from professional nursing organizations, attorneys, and other state government officials. Not only does this format directly engage students in policy and advocacy work, but it also exposes those in positions of power to more nurses, which can help to reinforce the value and utility of nursing expertise in the policy arena. Most importantly, incorporating this experiential learning program into nursing education will likely help to increase both the quantity and quality of nurse-involvement in health policy and advocacy, while also promoting equitable public policies and serving our most vulnerable patients in the Commonwealth of Virginia, and beyond.

Sustainability Plan

The sustainability of the ENACT program is dependent on several factors, the most significant being the ability to secure a long-term funding mechanism. The pilot program, which cost about $1500, was fairly inexpensive to conduct; however, as the program expands to include a larger number of students, program costs will certainly increase. By far the largest associated

cost with program implementation was the conference room rental, which was $987 in total after negotiating on the price of several ancillary fees. This particular site is extremely well-suited for the event, because it is just steps away from Capitol grounds, as well as the Pocahontas Building, where legislative offices are located. When the Capitol is reopened to the public, future participants would have an opportunity to walk to the General Assembly building for a live legislative session in each chamber, and walk to meet with legislators in their offices. The close proximity of this site to the Capitol complex also provides easy access for legislator drop-ins throughout the program, which is vital in order for them to participate in-person during the busy legislative session.

The exact cost per person for future program implementation would depend on the number of participants, as well as any remaining physical distancing requirements in place at the time of implementation, as the need for distancing reduces overall room capacity. Without physical distancing requirements in place, the conference room utilized for the ENACT program could comfortably accommodate 30 students, while still allowing for desks to be optimally configured to promote student interactions. In that scenario, the total cost for program attendance would be about $65 per student.

Excluding room rental fees, remaining expenses are less costly, with parking, lunch, and printing being the next three largest expenses, respectively. On-site parking was provided for students in an effort to reduce safety concerns related to protests in the area. Lunch was provided for students due to the lack of open restaurants and cafeterias near Capitol grounds as a result of COVID-19, as well as the timing of virtual Senate floor sessions, which occurred during the lunch hour, and were virtually streamed into the meeting room. Future programs are less likely to face these issues, and thus could reasonably forego providing lunch and on-site parking, as a

means to reduce overall program costs, without placing a significant financial burden on participants. In a scenario with 30 program participants, elimination of lunch and on-site parking could reduce the total cost per student to as low as $35 U.S. dollars. Because financial barriers already exist for policy involvement among nurses, and students may have even fewer financial resources, students should not be relied upon to pay for program attendance. Funding should be acquired from the academic institution, public grants, or community sponsorships.

The keynote speakers and legislators were reported by students to be one of the most valued aspects of the ENACT program. Though students did not specifically refer to the high-profile status of keynote speakers within their survey responses, they communicated excitement about the caliber of speakers throughout the event. After speaking with the Lieutenant Governor of Virginia, who is also the presiding officer of the Virginia Senate, he personally greeted the group and specifically mentioned UVA nurses from the floor of the Senate during the live legislative session, which was being virtually streamed into the conference room. The students erupted in cheers when this occurred, and the group was clearly excited about having had that experience. This type of excitement is much-needed in the experiential setting. Providing students with access to speakers in positions of power not only helps to establish connections for future collaboration, but it likely also promotes increased program engagement, and demonstrates the accessibility of lawmakers to their constituents.

All of the keynote speakers reported having a positive experience during the program, and thus it is likely that many would be willing to speak at future events, schedule permitting. Each program should incorporate several new speakers, but maintaining relationships with high-profile speakers and legislators, and inviting them to be regularly involved in the program, is an

excellent strategy to reduce the workload on the event coordinator in terms of recruiting new speakers, and also promote program engagement.

Perhaps the most important aspect of sustainability is student participation. Despite significant efforts to overcome barriers to participation, only 1.1% of invited students participated in the ENACT program. This finding may suggest a particularly low baseline level of policy engagement among students. In order to sustain the ENACT program, baseline engagement must be high enough to recruit program participants. Utilizing the strategies outlined by students themselves to boost future program participation will likely help to sustain the program moving forward, and as word spreads about the positive experiences of former participants, increased interest is likely. Regardless, fostering engagement in policy and advocacy among nursing students is essential if we are to fulfill our ethical obligations as nurses, and manifest social justice on behalf of our most vulnerable patients.

> "Speaking truth to power, that is, influencing public policies that impact health, advocating for those whose voices have been silenced, and challenging ideologies that contribute to the exclusion of some groups for the benefit of others, is to practice empowered caring" (Falk-Rafael, 2005).

Dissemination of Results

The final project will be submitted to the University of Virginia in partial fulfillment of the requirements for the Doctor of Nursing Practice degree, and it will be submitted for publication in Libra. An abstract and poster will be created based on the products of this scholarly work, which will be submitted to Sigma Theta Tau for possible presentation at a future conference.

This project appeals to a broad range of topics, including the nursing profession, nursing education, health policy and advocacy, interprofessional collaboration, and even public health. For this reason, a variety of peer-reviewed academic journals will be considered for potential publication of the project manuscript. Journals of particular interest are: *The Journal of Professional Nursing*, which is associated with the American Association of Colleges of Nursing; *Nurse Education Today*, which has a particular interest in interprofessional healthcare education; *The Online Journal of Issues in Nursing*, which is the academic journal associated with the American Nurses Association; *Policy, Politics, and Nursing Practice*, which is distributed quarterly and focuses on health policy; *Public Health Nursing*, which has a focus on vulnerable populations and accepts articles related to public health policy and education; and *The American Journal of Nursing*, which welcomes evidence-based practice and quality improvement articles.

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Table 1

Summary of Literature Review

Study Citation (Author; Year)	Study Purpose	Study Design	Sample	*n*	Variables (Independent; Dependent)	Findings	JHNEBP Rating
Byrd, M. E., Costello, J., Gremel, K., Schwager, J., Blanchette, L., & Malloy, T. E. (2012)	To describe changes in political astuteness after participation in public policy learning activities.	Quasi-experimental with one-group pre/post-test design; no random assignment	Senior nursing students enrolled in a community health nursing course; 260 pre-licensure; 40 RN-to-BSN students	300	Series of health policy learning activities; Political Astuteness Inventory score after participation in activities.	Students' political astuteness mean scores significantly increased ($p = .000$); Participation in professional organizations and knowledge of the legislative and policy processes significantly predicted posttest political involvement ($p = .000$).	2; A
DeBonis, R. (2016).	Evaluate impact of service-learning on cultural competence, civic engagement, knowledge and understanding of the effects of poverty on health care.	Non-Experimental; pre/ post-test design; no random assignment	Convenience Sample; Graduate Nursing Students	152	16 to 20 hours of service in a nurse-run clinic for the impoverished/ medically underserved community; Centers for Healthy Communities survey results	Increases were noted in graduate students' civic engagement ($p = .0001$ to .0495), knowledge and understanding of health care issues ($p = .0001$), and in three of six statements related to cultural competence ($p = .0001$ to 9.662).	III; B

Study Citation (Author; Year)	Study Purpose	Study Design	Sample	*n*	Variables (Independent; Dependent)	Findings	JHNEBP Rating
DiCenso, A., Housden, L., Heale, R., Carter, N., Canitz, B., MacDonald-Rencz, S., & Buckley, C. R. (2012)	This article focuses on the integration of the policy practicum into graduate nursing education for advanced practice nurses.	Qualitative; Reflective phenomenology	Graduate students and postdoctoral fellows. All were nurses, including 6 nurse practitioners and 1 clinical nurse specialist.	16	90 to 120-hour health policy practicum; Meeting objectives, projects, student learning, and reported benefits and challenges of the practicum.	Participants reported a positive response to the role modeling provided by preceptors both in leadership and mentorship roles, a solidified interest in research and policy, and lasting connections created between the participants and the policy setting.	III; B
Garner, B. L., Metcalfe, S. E., & Hallyburton, A. (2009)	To pilot a collaboration between students in the US and UK, focusing on leadership, advocacy, activism, and professional accountability	Qualitative Pilot Study; Reflective phenomenology	RN-to-BSN students in the US; Pre-licensure and advanced practice nurses in the UK.	15	Experiential learning via web-based interaction, a service learning project, and international travel; Reflective journals, discussions, post-travel survey, essay.	Written and oral response themes: cultural awareness, the impact of politics on healthcare provision, and similarities between the US and UK nursing. Leadership competencies improved, including communication skills and self-confidence. Participants' professional growth evidenced by induction to Sigma Theta Tau.	III; B

Study Citation (Author; Year)	Study Purpose	Study Design	Sample	*n*	Variables (Independent; Dependent)	Findings	JHNEBP Rating
Garritano, N., & Stec, M. (2019)	To evaluate a DNP health policy course that leveraged technology to provide an active and experiential learning environment.	Quasi-Experimental; Pre/post-test design	DNP Students over 5 semesters	102	iPad-based immersive health policy program, meeting with lawmakers and video presentation; Changes in attitudes toward health policy, including level of interest and readiness to participate.	All students reported being likely to advocate for a health policy or professional issue. There was a 50% increase in students' assessment of their global health policy knowledge. Students who wanted to meet with their representative increased from 10% to 98%. 8 DNP students became professionally involved in health policy, 5 became board members, and 1 was named to a committee by the Governor of Ohio.	II; B
McGuire, M., Goldstein, C., Claywell, L., & Patton, R. (2017)	To examine students' thoughts and feelings after completion of the experiential learning assignments in a health policy class.	Qualitative retrospective study	134 Master's level nursing students, 59 Doctoral students	187	Policy-maker interview, public policy meeting, legislative session at the State Capitol; Experience, attitude, educational value, and intent to act.	62% of students who went to the Capitol, and 35% who interviewed an elected official, indicated an intention to be more involved in the legislative process. Doctoral students indicated they would offer expertise; master's students were more likely to offer their opinion on a piece of legislation.	III; A

Study Citation (Author; Year)	Study Purpose	Study Design	Sample	*n*	Variables (Independent; Dependent)	Findings	JHNEBP Rating
Nokes K. M., Nickitas, D. M., Keida, R, & Neville S. (2005)	To develop and refine a 15-hour service-learning intervention and explore whether participation made a difference in the critical thinking, cultural competence, and civic engagement of participants.	Quasi-experimental with pretest/ post-test design	RN-to-BSN Students	14	Seminars, Blackboard 5.0 interactive program, service learning completed in practicum; Civic engagement, attitudes about community involvement, Influence of service-learning on major/ profession	Statistically significant increase was seen in civic engagement scores ($t = -3.54$, $p = .004$).	II; B
Primomo, J., & Björling, E. A. (2013).	To determine if political astuteness changed after participants attended a state nurse legislative day.	Qausi-Experimental design; Study 1: single time-point retrospective survey; Study 2: pre/ post-test design	Student nurses and RNs with varying levels of education, ranging from Associates Degree to Master's degree.	80 & 34	Participation in WNSA legislative day; Political Astuteness score after legislation day.	Following legislative day, political astuteness scores were higher for participants in both studies. A positive relationship was found between age and educational rank, and age and years as an RN.	II; B

Study Citation (Author; Year)	Study Purpose	Study Design	Sample	*n*	Variables (Independent; Dependent)	Findings	JHNEBP Rating
Primomo, J. (2007)	Describe levels of political astuteness in graduate students, determine if political astuteness changed after a course in health systems and policy, and identify the specific changes that occurred.	Quazi-experimental with pre/ post-test design;	Graduate nursing students (average participant was 40 years or older with 10 or more years of nursing experience)	40	10-week graduate course in health systems and policy with either a guest lecture by a nurse legislator, or a trip to the state Capitol to meet with legislators during the legislative session; Political Astuteness Inventory (PAI) score, as a measure of political astuteness.	There was a statistically significant increase in political astuteness at the end of the course as compared with the first class. Age group, years as an RN, and type of basic nursing education (associate degree in nursing or bachelor of science in nursing) were not related to political astuteness levels at either baseline or follow-up. After the course, graduate students moved from a level of being only slightly aware to a beginning level of political astuteness.	II; A

Table 2

ENP Process	Experiential Learning Activities	Design Themes	Major Pedagogical Goals
Becoming			
Baseline Perceptions of Injustice	Brief Reflective Exercise: "What is Social Justice?"	Use of personal reflection to connect concepts and experiences; Focus on sociopolitical issues (social justice)	Emancipatory Knowing; cultivate interest and motivation for sustained engagement and action.
Awakening			
Positioning: introspective evaluation of formerly held beliefs in comparison to a different or new way of thinking, so that a deeper understanding of one's position in the world is gained. *Confirming*: the ongoing process by which a person's new world view is challenged or reinforced *Dialoguing:* process of self-education via discussion and interaction with people whose lived experience is different than one's own. *Dismantling:* breaking down attitudes and perceptions that function as barriers to authenticity.	Jill Hanken, Esq. (Virginia Poverty Law Center; Director, Center for Healthy Communities and ENROLL Virginia) "Poverty and Access to Healthcare in Virginia" Millicent Gorham, PhD (Hon), MBA, FAAN Policy Priorities of the NBNA; Strategies for Effective Policy Work; Barriers to Policy/Advocacy for Nurses of Color Helen Hardiman, MSW, Esq. Assistant Attorney General of Virginia "Fair Housing in Virginia; Building Healthy Communities" Sarah Jennings, DNP, RN, SANE-A, SANE-P, AFN-BC; Human Trafficking and Violence Victimization: Policy and Advocacy Work at the Local, State, National, and International levels	Focus on sociopolitical issues (social determinants of health, vulnerable populations, health disparities, and social justice); Use of personal reflection to connect concepts and experiences	Emancipatory Knowing; cultivate interest and motivation for sustained engagement and action.

Engaging

Analyzing Power: identifying various stakeholders and comparing the benefits and injustices imposed upon them by the status quo.

Collective strategizing: personal and professional collaboration to perform an assessment, gather support, and plan interventions that seek to accomplish common goals.

Praxis: simultaneous engagement in self-reflection and action, in order to enhance collective efforts to bring about change.

Persisting: sustaining praxis long-term, and mitigating risk.

Freddy Mejia, MSW (Policy Analyst, Commonwealth Institute) "What makes a Good Policy?"

Becky Bowers-Lanier, PhD, RN (B2L Consulting) Harnessing Political Power for Policy Work; Establishing Relationships; Nurse-Action outside of PNOs

Mary Kay Goldschmidt, DNP, RN, PHNA-BC (Commissioner on Government Relations, Virginia Nurses Association) "Policy and Advocacy: The Role of Professional Nursing Organizations"

Mira Signer, MSW (Virginia Department of Behavioral Health and Disability Services) DBHDS Update; The Marcus David Peters Act: Collaboration Between Law Enforcement Agencies and Mental Health Services

Review of Virginia government and the legislative process; Discussion of the current "bills of interest," Virtually attend committee meetings and legislative sessions; Navigation of LIS website

Remarks from Delegate Dawn Adams, DNP, RN, ACNP-BC (68th District) and Senator Ghazala Hashmi, PhD (7th District)

Justin Fairfax, Esq.
Lt. Governor and Presiding Officer of the Senate
The Importance of Nurse-Involvement in Policy and Advocacy; Legislative Priorities Related to COVID-19

Immersion in the legislative process; Interdisciplinary communication and collaboration; Service learning; Use of personal reflection to connect concepts and experiences

Development of technical knowledge and practical skills

Transforming			
Human Flourishing: Health and Wellness *Health Equity:* Social Justice *Transforming Social Relationships:* Collaboration and community-building	"Transformation: Wellness, Equity, and Community-building" Ashley Apple, MSN, RN, FNP-BC, CEN (Primary Investigator) Group Discussion: Plans for Action	Use of personal reflection to connect concepts and experiences; Focus on sociopolitical issues (social justice)	Emancipatory Knowing; cultivate interest and motivation for sustained engagement and action

Appendix A

Correspondence with Dr. Primomo

Ashley Apple <aka5nd@virginia.edu> Tue, Aug 4, 11:19 AM (4 days ago)
to jprimomo

Dr. Primomo,

My name is Ashley Apple, and I am a DNP student at the University of Virginia. I am preparing to defend my Capstone proposal, which aims to recruit nurses into health policy and advocacy. I have tremendous respect for your work in this area, and have cited several of your articles in my proposal. I would like to use the Political Astuteness Inventory in my project. I know it was originally created by Philip Clark- but Dr. Mary Jo Clark has been widely cited as granting permission to use the tool. I'm desperately trying to locate her, to no avail. I'm closing in on a deadline, and was hoping you might be able to help me. Do you by chance have any contact information for Dr. Clark?

I know your time is incredibly valuable, and would sincerely appreciate any insight or advice you have to offer.

With respect and gratitude,

Ashley Apple, MSN, RN, CEN
Pronouns: she/ her/ hers
Family Nurse Practitioner / Doctor of Nursing Practice Student (2021)
University of Virginia, School of Nursing
Cell: (804) 687-3733

Janet Primomo Aug 4, 2020, 11:32 AM (4 days ago)
to me

Greetings Ashley! Congratulations on nearing completion of your DNP program. I will forward a message I sent to another student who was interested in using the PAI that provide what I hope is useful information.

As you will read in the message I forward, if you don't hear back from Dr. Clark, feel free to go ahead and use the tool.

All the best and let me know how your study turns out. All the best and let me know how your study turns out.

Janet Primomo, RN, PhD
Associate Professor Emeritus
University of Washington Tacoma
School of Nursing & Healthcare Leadership
jprimomo@uw.edu 206-228-8093

Janet Primomo Tue, Aug 4, 11:36 AM (4 days ago)
to me

As promised, here is the message. Janet

> **From:** Janet Primomo <jprimomo@uw.edu>
> **Date:** February 10, 2020
> **Subject: Re: PAI Inventory**
>
> I am so pleased to learn that you interested in promoting political advocacy skills in your MN students.
>
> I attached the Political Astuteness Inventory [PAI] that I used in my studies. It was in an old Community Health Nursing text by Mary Jo Clark. I received her permission to adapt and use the tool.
>
> The address I have for Dr. Clark is mjoclark@cox.net If you don't hear back, I think you would be fine using the tool for your class project. She has approved its use for others.
>
> If you are interested in revising and using the tool for research purposes, let me know and I can link you with others I know of who used the PAI.
>
> All the best! Janet
>
> Janet Primomo, RN, PhD
> Associate Professor Emeritus
> University of Washington Tacoma School of Nursing & Healthcare Leadership
> Email: jprimomo@uw.edu
> Cell phone: 206.228.8093

Appendix B

Correspondence with Dr. Clark

Ashley Apple <aka5nd@virginia.edu> Tue, Aug 4, 12:01 PM (4 days ago)
to mjoclark

Dr. Clark,

My name is Ashley Apple, and I am a DNP student at the University of Virginia. I am currently designing my capstone project, which aims to recruit nurses into health policy and advocacy. I have read several articles you've written, and I admire your contributions to the nursing profession, particularly as related to policy and public health.

Dr. Janet Primomo gave me your contact information, and I'm hoping you might be able to help me. I would like to use the Political Astuteness Inventory in my project, and the only adaptation I foresee would be to administer the tool in an electronic format due to the COVID-19 crisis. I know the tool was created by Philip Clark, but you are widely cited as having granted permission for use in scholarly work. May I have permission to utilize the PAI in my capstone project? I'm happy to provide a more detailed description of my project proposal if needed.

Thank you for your time and consideration, and I look forward to hearing from you.

Respectfully,

Ashley Apple, MSN, RN, CEN
Pronouns: she/ her/ hers
Family Nurse Practitioner / Doctor of Nursing Practice Student (2021)
University of Virginia, School of Nursing
Cell: (804) 687-3733

Appendix C

Political Astuteness Inventory

_____

Political Astuteness Inventory*

Place a check mark next to those items for which the answer is "yes." Then give yourself one point for each check. After completing the inventory, compare your total score with the scoring criteria at the end of the inventory.

___ 1. I am registered to vote.
___ 2. I know how to obtain an absentee or mailed ballot.
___ 3. I voted in the last general election (at the polls or by mailed ballot).
___ 4. I voted in the last two elections.
___ 5. I recognized the names of the majority of candidates on the ballot and was acquainted with the majority of issues at the last election.
___ 6. I stay abreast of current health issues.
___ 7. I belong to my state professional (or student nurse) organization, or a specialty organization.
___ 8. I participate (committee member, officer, local union representative, etc.) in that organization.
___ 9. I attended the most recent meeting of my district association or local chapter of my specialty nurses' association.
___ 10. I attended the last state or national convention or conference held by my organization.
___ 11. I am aware of at least two issues discussed at that convention and the stands taken.
___ 12. I read literature (print or electronic) by my local, state or national nurses' association, a professional journal, or other literature on a regular basis to stay abreast of current health issues.
___ 13. I know the names of my senators in Washington, DC.
___ 14. I know the names of my representatives in Washington, DC.
___ 15. I know the name of the state senator from my district.
___ 16. I know the names of the state representatives from my district.
___ 17. I am acquainted with the voting record of at least one of the above in relation to a specific health issue.
___ 18. I am aware of the stand taken by at least one of the above on one current health issue.
___ 19. I know whom to contact for information about health-related issues at the state or federal level.
___ 20. I know whether or not my professional organization employs lobbyists at the state or federal level.
___ 21. I know how to contact these lobbyists.
___ 22. I contribute financially to my state or national professional organization's political action committee (PAC).
___ 23. I actively supported a senator, representative or other elected official (campaign contribution, campaigning service, wore a button, or other) during the last election.
___ 24. I have written, telephoned, emailed or communicated via a website with one of my local, state or national representatives regarding a health issue in the last year.
___ 25. I am personally acquainted with a senator or representative or a member of his or her staff.
___ 26. I serve as a resource person for one of my elected officials or his or her staff.
___ 27. I know the process by which a bill is introduced in my state legislature.
___ 28. I know which elected officials are supportive of nursing.
___ 29. I know which legislative committees usually deal with health-related issues.
___ 30. I know the committees on which my elected representatives hold membership.
___ 31. I know of at least two issues related to my profession that are currently under discussion at the state or national level.
___ 32. I know of at least two health-related issues that are currently under discussion at the local, state or national level.
___ 33. I am aware of the composition of the state board that regulates the practice of my profession.
___ 34. I know the process whereby one becomes a member of the state board that regulates my profession.
___ 35. I know what the letters DHHS mean.
___ 36. I have at least a vague notion of the purposes of DHHS.
___ 37. I am a member of a local, state or national committee or advisory board to a health organization or agency that addresses health-related issues.
___ 38. I attend public hearings related to health issues.
___ 39. I have used a governmental, professional nursing or health organization website to obtain information about my elected officials, health-related issues, or to advocate for a health issue.
___ 40. I have written a letter to the editor of a newspaper on a health-related or nursing issue.

___ Total Points Scoring: 0 to 9 points: totally unaware politically.
10 to 19 points: slightly aware of the implications of politics for nursing.
20 to 29 points: shows a beginning political astuteness.
30 to 40 points: politically astute and an asset to the profession of nursing.

*Developed by Philip E. Clark, R.N., 1981. Adapted with permission. From Clark, Mary Jo Dummer (1984). *Community Nursing: Health Care for Today and Tomorrow*. Virginia: Reston Publishing Company.

C:527/political astuteness inventory 1

Appendix D

Post-program Survey

Please record your responses in the space provided.

1. Please briefly describe your feelings or perceptions about social justice prior to participating in the ENACT program.

2. Have your perceptions related to social justice changed after participating in the ENACT program? If so, how?

3. Has your understanding of the nurse's role in health policy and advocacy changed after attending the ENACT program? If so, how?

4. What policy issue or goal would you address in the future? What actions could you take to influence the process?

5. Which activity or topic did you value most during the ENACT program? Why?

6. What improvements would you recommend for future ENACT programs?

7. How might you describe your program experience to a nursing colleague?

Appendix E

ENACT: Thursday January 21, 2021

0800 – 0830: Meet and Greet (Optional)

0830 - 0845: Welcome to ENACT; Introductions

0845 - 0900: Demographics Survey and PAI

0900 - 0945: Ashley Apple, MSN, RN, FNP-BC, CEN: Defining Social Justice; The History of Nursing Activism and Advocacy; Poverty and the Social Determinants of Health

09:45 – 10:15: Helen Hardiman, MSW, Esq. (Assistant Attorney General of Virginia; Policy Advisor for the Office of Civil Rights) Fair Housing in Virginia

10:15- 10:30: Break

10:30 – 11:00: *Jill Hanken, Esq. (Virginia Poverty Law Center; Director of the Center for Healthy Communities) Expanding Access to Care, ENROLL Virginia

11:00 – 11:30: Ashley Apple, MSN, RN, FNP-BC, CEN: Racial Disparities and Systemic Injustice

11:30 – 12:00: *Millicent Gorham, PhD (Hon), MBA, FAAN (Executive Director, National Black Nurses Association) Policy Priorities for the NBNA, Strategies for Effective Policy Work, Barriers to Policy/Advocacy for Nurses of Color

12:00 – 1:00: Lunch (provided) – Health, Welfare, & Institutions Sub-committee Meeting: Live-streaming in the Piedmont room (Optional)

1:00 – 1:30pm: Ashley Apple, MSN, RN, FNP-BC, CEN: The Politics of Gender and Sexuality

1:30 – 2:00pm: *Sarah Jennings, DNP, RN, SANE-A, SANE-P, AFN-BC (Chair of Government Affairs & Education Director, International Association of Forensic Nurses; VHHA Human Trafficking Task Force) Human trafficking and Violence Victimization: Policy and Advocacy Work

2:00 – 2:15: Focus Group Discussion: Gender and Power

2:15 – 3:00: Overview of Virginia Government and the 2021 Virtual Legislative Session (Courtesy of Anna Scholl and Progress Virginia)

3:00 – 3:15: Break

3:15 – 3:30: Ashley Apple, MSN, RN, FNP-BC, CEN: Individual vs. Collective Advocacy

3:30 – 4:00pm: Becky Bowers-Lanier, MSN, MPH, EdD (Principal, B2L Consulting) Harnessing Political Power for Policy Work; Advocacy and Activism: Nurse-Action Outside of PNOs

4:00 – 4:30: Live Stream: Virginia House of Delegates; Virtual Floor Session

4:30 – 5:00: Networking, Floor Session and Adjournment (Optional)

Appendix E

ENACT: Friday January 22, 2021

8:00 – 0830: Meet and Greet (Optional)

8:30 – 8:45: Lieutenant Governor Justin Fairfax, Esq. (Virginia)

09:30 – 10:00: Mary Kay Goldschmidt, DNP, RN, PHNA-BC (Commissioner on Government Relations, Virginia Nurses Association) Health Policy and Advocacy: The Role of Professional Nursing Organizations; Policy Priorities for 2021; Legislative Successes

10:00 – 10:15 Break

Navigating the LIS Website – Legislative Data at Your Fingertips

Current Bills of Interest and Legislative Action in 2021; Social Justice on the Agenda

Ashley Apple, MSN, RN, FNP-BC, CEN: Critically Reflective Questions for Policy Analysis; Evidence-Based Policy

Live Stream: House privileges and elections sub-committee on Voting Rights

12:00 – 1:00: Lunch – Live Stream: Virginia Senate; Virtual Floor Session (Optional)

1:00 – 1:30pm – Delegate Dawn Adams, DNP, ANP-BC, CHC (68th District, Virginia House of Delegates)

1:30 – 2:00 – *Mira Signer, MSW (Chief Deputy Commissioner, Community Behavioral Health - Virginia Department of Behavioral Health and Developmental Services) DBHDS Update

COVID-19 Policy Update; Analysis

2:30 – 3:00pm: Freddy Mejia, MSW (Health Policy Analyst, The Commonwealth Institute) What makes a good policy? Practical Tips for Policy and Fiscal Impact Analysis

3:00 – 3:15: Break

3:15 – 3:30: Senator Hashmi, PhD (10th District, Virginia Senate)

Ashley Apple, MSN, RN, CEN "Transformation: Wellness, Equity, and Community-building" Post- program PAI; Survey

Virginia House of Delegates; Virtual Floor Session (optional)

4:30 – 5:00pm: Networking, Cheers, and Sine Die

(ADDITIONAL LEGISLATOR DROP-INS ANTICIPATED AT VARIOUS TIMES THROUGHOUT THE DAY)

Appendix F

Demographic Survey

Please provide the following information:

Age:

Race/Ethnicity:

Gender:

Number of years as a Registered Nurse:

Highest educational degree earned:

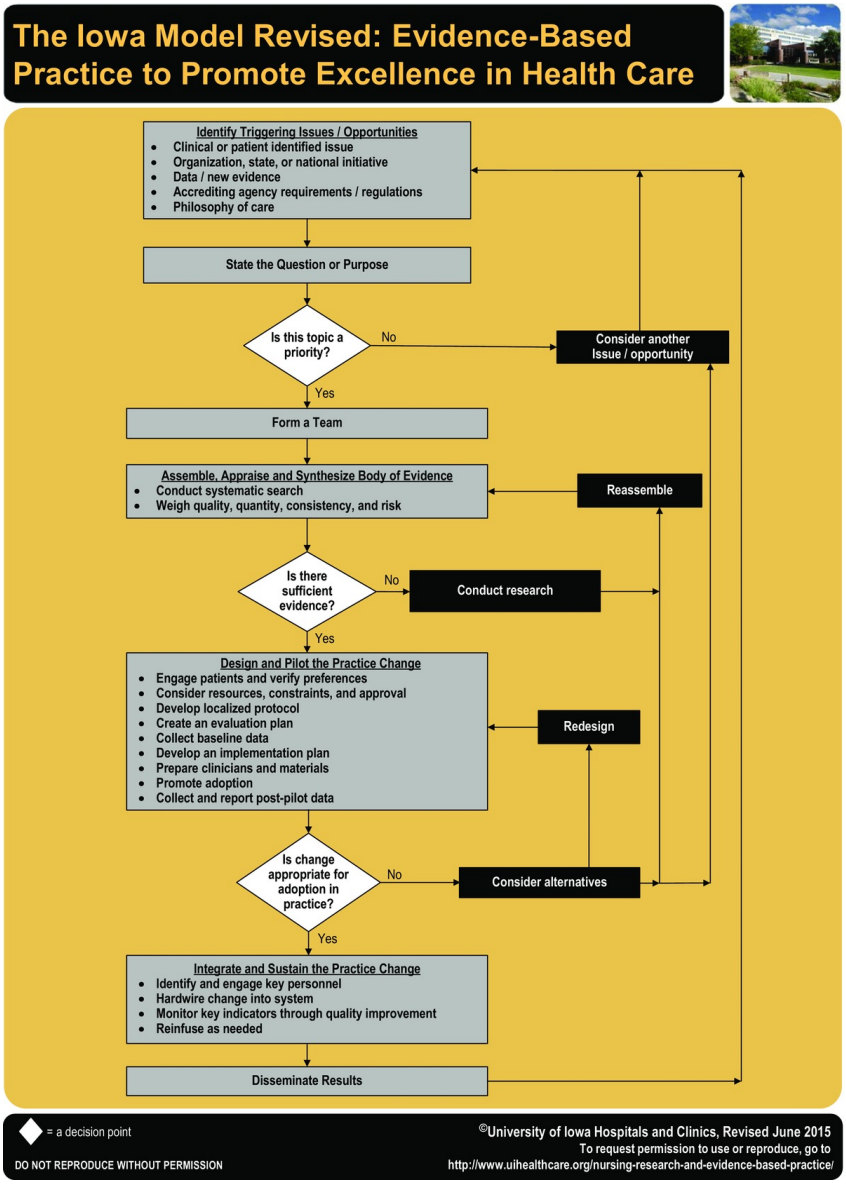
Appendix G

Braun and Clarke (2006) Thematic Analysis Process

Phase	Description of the process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

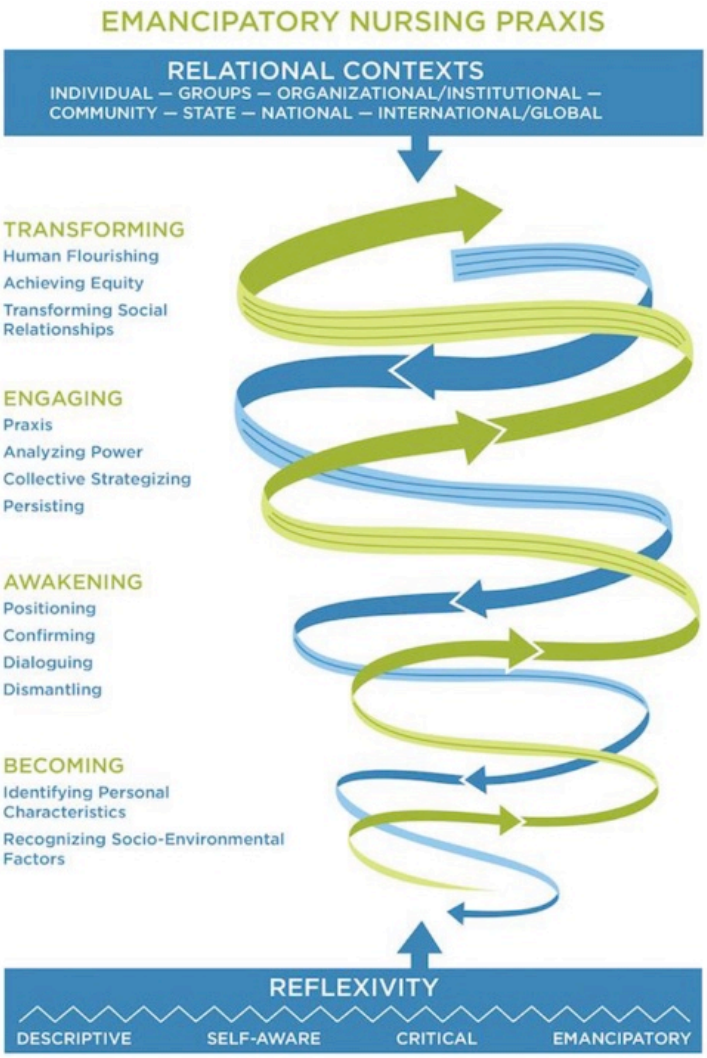
Appendix H

Iowa Model



Appendix I

ENP Framework



(Walter, 2017)