Be the Change

An Interprofessional Team-Based Health Advocacy Summit

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In a complex health care environment, nursing and health care professional graduates should be able to understand and collaboratively advocate for health policy benefitting patients, families, and communities. This study explored the effectiveness of interprofessional team-based learning to improve political astuteness in undergraduate health profession students. This engaging method may prove to enhance health care professionals’ likelihood of understanding, involvement, and influencing health policy in the future.

Keywords: health policy advocacy; health professions education; interprofessional education; political astuteness; team-based learning

It is critical that nursing and health care professionals are prepared to collaboratively advocate for health policy. Known as political astuteness, Primomo defined this as an “awareness and understanding of legislative and policy processes and political skills.” To quantify graduate students’ policy prowess, she used an adapted Clark’s Political Astuteness Inventory (PAI) assessment tool in a health policy course, as well as among RNs and undergraduate nursing students attending a state legislative day. Both studies found significant improvement in political astuteness scores after events focused on health policy education and advocacy. Similar results were attained among 300 baccalaureate nursing students after a student-centered experiential health policy initiative.

Although traditional education models favor individual learning, a pedagogy that emphasizes engagement within small teams of students to solve conceptual course-related problems is team-based learning (TBL). Using the measure of political astuteness, this study explored the effectiveness of interprofessional TBL to address a cutting edge health policy crisis in Virginia, the Medicaid expansion gap.

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Background

Evidence suggests a disparity between health care providers’ attitudes and experiences regarding health policy advocacy. Physicians’ perceptions of the importance of their role in political advocacy indicate that although 91.6% specified that this was an important aspect of their profession only approximately 25% were politically active. Similarly shocking is a study of health educators’ policy activities, which found that most reported participating in an average of 4 to 5 different activities and/or initiatives per career. Among nutritionists, only 7% report being highly active in the policy-making process, whereas 44% admit no involvement. Surprisingly, 31% of health commissioners stated involvement in public policy advocacy, with only 15% indicating significant knowledge of how to make or change health policy. Barriers to participation were similar in all studies, including time constraints and frustration with the political process, whereas shared benefits included addressing health issues and improving population health.

Nurses also exhibit lackluster enthusiasm and poor understanding regarding the political health policy-making process. A study of 347 RNs indicated that although 73.5% had participated in up to 2 health policy–related activities 26.5% reported no participation at all. More importantly, 68.8% reported receiving no health policy education in the duration of their nursing studies; of those who did have prelicensure health policy education, 66.7% rated it as poor, highlighting a serious need for a clear emphasis on the health policy–making process.

From an ethical perspective, nurses and other health care professionals are positioned to advocate for social justice and equality-based health policy. In many cases, a discipline-specific code of ethics exists, requiring health policy advocacy with a professional orientation toward a socially responsible health policy system. For example, because socioeconomic factors adversely affect the health of people in poverty in particular, the National Association of Social

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Workers advocate for access to comprehensive health care and health services that include appropriate mental, physical, dental, and behavioral health across the life-span through the biopsychosocial approach that social workers use. With the growing prominence of social determinants as the major contributors to population health, an interprofessional understanding and approach to policy education are vital.

To ensure political astuteness and engagement, the American Association of Colleges of Nursing’s Essentials of Baccalaureate Education for Professional Nursing Practice and Masters Education in Nursing specifically name health policy education as an expected student outcome. Other drivers include the emphasis of the 2010 Patient Protection and Affordable Care Act (PPACA, or more commonly, ACA) on interprofessional patient-centered care, population-focused health, and the need to move health care activities into communities. Similarly, a broadening view of the socio-economic and structural contributions to health set the political context for interprofessional health policy education, using policy as a tool to improve population health. For nursing in particular, impetus for health policy education includes specific recommendations from the Institute of Medicine’s Future of Nursing report to change for better population health.

Nurses are teaming with other professions to improve population health, because an interprofessional approach to coalition building and community organizing leads to political influence affecting health policy change. Eaton’s example involved coalition building related to nursing education funding and emphasized the power of interprofessional stakeholder involvement in the policy-making process. In this case, Virginia nurses, along with the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, and Virginia’s Chapter of American Association of Retired Persons (AARP), collaborated to successfully influence the enactment of legislation increasing funding support for nursing faculty salaries and nursing education.

Little is known, however, about the most effective means to teach and learn health policy in an interprofessional environment. Traditional and distance learning health policy courses and curricula have been designed and implemented at both the graduate and undergraduate levels to address health policy, process, and advocacy alongside policy theory. However, although several IOM reports explicitly promote interprofessional health policy education, these courses are generally homogenous in nature.

To prepare all health care professionals for collaborative practice, health care quality improvement, and the betterment of population health in the United States, the need for practice-based interprofessional education is evident. Nursing researchers and faculty have commonly used a service-learning approach. For example, O’Brien-Larivée implemented a community participation project that is inherently, although not explicitly, interprofessional by incorporating community members and agencies in the baccalaureate nursing students’ education. Frequently, these students engaged in policy assessment and development projects that are integrated into community health nursing clinical practica by placing health policy content in the larger perspective of public health, creating a comprehensive approach to population health.

As an innovative interprofessional education pedagogy, TBL enhances student and group understanding while promoting team growth, requiring 3 key strategies. First, groups must be managed by the diversity of their individual backgrounds. Secondly, students must be accountable to themselves, the instructor, and their group. This is accomplished through individual and group readiness testing on preparatory material for the particular group assignment or problem. Lastly, students receive feedback throughout the TBL activity from both peers and their instructor(s). All individuals and groups should attempt the same problem, with the actual assignment design being case- or problem-based, requiring course concepts to resolve it, and should therefore elicit simultaneous reporting from all groups.

This study originated from 2 catalysts. The first was a concerned group of faculty at a large northwestern Virginia university. The second included a request to faculty from Virginia legislators after the enactment of the ACA led to a polarizing nationalized political controversy because lawmakers of The Commonwealth of Virginia declared the Medicaid expansion initiative as unconstitutional. With the state refusing to accept it, 400,000 Virginians became uninsured.

During a health policy summit (HPS), students registered in health policy courses developed innovative projects to address the gap in health insurance coverage for those individuals who do not qualify for Medicaid nor for the Health Insurance Marketplace.

Purpose
This study explored the effectiveness of a team-based policy advocacy exercise to improve political astuteness in undergraduate health professions students. The HPS brought together groups of students from nursing, social work, health administration/health sciences, and communication sciences and disorders (CSD) for 2 separate sessions to participate in this summit activity.

Methods
During the HPS, the same interprofessional TBL health policy advocacy exercise was used in a pilot study in 2014 (n = 82) and a larger study in 2015 (n = 263). Planning began by asking 2 questions: “At the end of this exercise, what do we want the students/participants to be able to do?” and “How will we know they are able to do it?” A policy exercise called “Mind the Gap” was developed using the 4 critical instructional design tenets of TBL outlined by Parmelee and Michaelson as significant problem, same problem, specific choice, and simultaneous reporting. The participants were required to work in small teams to develop an alternative plan to finance the gap. Assigned readings and short videos inclusive of core knowledge needed to address the problems presented in the summit were provided 1 month in advance to all student participants.

During the HPS, the participants initially completed a case study on Medicaid expansion, first individually and then in small groups. This was designed to assess their readiness for the policy advocacy exercise. Open discussion of the case study responses included lobbying and legislative insights, providing the participants with essential background information necessary for synthesis in the policy.
advocacy exercise that followed. The participants then engaged in the “Mind the Gap” small group exercise. After completion, student participant group proposals were displayed simultaneously for a gallery walk (a visual presentation of students’ proposal posters surrounding the space perimeter) and voted on by their peers. State legislators also attended the summit and reviewed student proposals during the gallery walk. The top 3 were rapidly developed into 10-minute presentations by the winning participant groups, followed by a question-and-answer period held with the legislators.

Both the 2014 pilot and 2015 larger studies used a descriptive comparative design to measure political astuteness. Informed consent was obtained before both studies via institutional review board approval, and there was no penalty for lack of study participation. The 2014 pilot study was a 4-hour session including undergraduate student participants (n = 82) registered in 4 courses containing health policy content from health administration/health sciences, nursing, and social work majors. The 2015 study mirrored the pilot design with the exception of extending the study length by 1 hour to allow for the management of more than 3 times the amount of students, with registration, evaluation, and the majority of time spent sorting participants in their groups to ensure group diversity. The 2015 study included undergraduate student participants (n = 263) from health administration/health sciences, nursing, social work, and CSD majors who were registered in 5 courses containing health policy content. There were more student registrants in the HPS than participated in the 2014 and 2015 studies (see Table 1 for HBS registrant breakdown). Political astuteness was measured using the PAI tool before and after the summit.

The data for both studies were analyzed using descriptive frequencies and t test comparison (2014, paired t test; 2015, independent t test) to measure HPS effectivens. The data were analyzed using SPSS (IBM, Armonk, New York).33

Instrument

The PAI is a 40-item inventory that assesses political understanding, participation, and general knowledge of the legislative process.2 34 Using a score of 1 for each item answered affirmatively or a score of 0 for each item answered negatively, a final score ranging from 0 to 40 was tallied and divided into 4 categories. These include completely politically unaware, 0 to 9; slight awareness of political activity, 10 to 19; a beginning political awareness, 20 to 29; and politically astute, 30 to 40. In summary, scores closer to 0 indicate political unawareness, whereas results closer to 40 indicate political astuteness. Moreover, those who score in the highest level are also considered to be an asset to their profession.2 34 Internal consistency reliability for the PAI using Cronbach’s α was .81 in Primomo’s study, and .84 in Byrd et al’s study of changes in political astuteness after experiential learning.

Results

Study results are encouraging. Both the 2014 and 2015 exercises demonstrated that political astuteness was significantly different after participants experienced the HPS with an interprofessional TBL policy advocacy activity, as measured using the PAI. Resulting means indicated scores increased significantly, from 9.09 (SD, 5.69) and 8.14 (SD, 4.9) before each activity to 12.0 (SD, 6.40) and 9.85 (SD, 5.85) after the summit exercises (2014 pilot: t = 2.78, P < .01; 2015 study: t = −3.59, P < .01). A Mann-Whitney test validated significance for the 2015 study regarding a smaller mean difference. Results indicated that the median political astuteness was greater post TBL activity, (U = 37.492 with n1 = 238 or the standardized test statistic of 3.838, P < .01). Moreover, both study results demonstrated a shift in political astuteness from level 1, or completely politically unaware, to level 2, slightly politically aware, after participating in the interprofessional TBL health policy advocacy activity (See Table 2 for participant levels of political astuteness).

In the 2014 pilot study, 48 participants scored in the range of level 1, totally politically unaware, before engaging in the interprofessional TBL policy advocacy activity, whereas 30 participants maintained a level 1 score after participating in the HPS. At the same time, the number of participants scoring at level 2, slightly aware, increased after the activity, from 30 to 42 participants. The results of the PAI category scores in the 2015 study also demonstrated a rise in political astuteness from level 1 to level 2 after participating in the health policy activity. For example, after engaging in the exercise, the number of those scoring at level 2, slightly aware, improved from 80 of 263 to 102 of 238. The large number of participants in both studies with an initial score in the lowest PAI category (48 students in the pilot and 176 in the 2015 study), completely unaware politically, validates previous studies of health professionals’ understanding and involvement with health policy advocacy.

Specific items in the PAI of interest include (32) I know of at least 2 issues related to my profession that are currently under discussion at the state or national level; (33) I know at least 2 health-related issues that are under discussion at the state or national level; and (37) I find myself more interested in public issues now than in the past.2 34 In both the pilot and the 2015 studies, there was an increase in awareness but not an increase in intention to participate in advocacy activities. For example, after engaging in the interprofessional TBL policy advocacy activity, there was a 15.8% increase in item 32 in the pilot study and a 9.4% increase in the 2015 study in this item. However, there was a slight decrease (of 1.2%) in the pilot and decrease of 1.18% in the 2015 study in item 37. This goes along with the political astuteness level.
2 “just slightly aware of political activity” that most participants self-reported.

### Table 2. Levels of Political Astuteness

<table>
<thead>
<tr>
<th>PAI Level</th>
<th>Pre</th>
<th>Post</th>
<th>Pre</th>
<th>Post</th>
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</thead>
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<td>1</td>
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<td>4</td>
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<tr>
<td>Totals (n)</td>
<td>82</td>
<td>82</td>
<td>263</td>
<td>238</td>
</tr>
</tbody>
</table>

**Abbreviation:** PAI, Political Astuteness Inventory.

Number of participants scoring at each level (1–4) on PAI tool. Levels: 1, completely politically unaware; 2, slightly political aware; 3, a beginning political awareness; and 4, politically astute.

**Discussion**

Both the 2014 pilot and the 2015 studies demonstrated that using a team-based approach to interprofessional policy advocacy activities were effective in improving undergraduate students’ political astuteness. Results of both studies support previous findings that revealed that participants were initially politically unaware.1,2,3 After participation, the mean PAI scores increased, particularly from level 1 to level 2, and further incremental improvements were noted across levels of political awareness. Study results demonstrated a statistically significant change in PAI scores, lending credence to enhancing undergraduate health professional student “awareness and understanding of legislative and policy processes, and political skills.”1,2,3,4 Furthermore, the increase in political astuteness scores after students have participated in an experiential health advocacy educational teaching strategy strengthens previous study findings.1,2,3,4

The smaller sample of 82 students in the pilot study (2014) had multiple benefits. These included an enhanced ability to control the HPS registration, the assignment of groups, and interacting with the gallery walk, presentations, and discussion with the legislators. The administration of the PAI both pre and post-TBL health policy advocacy exercises were also easier to control with a smaller sample.

Because of the success of the pilot study, the researchers decided to expand the reach and increase the number of participants. The resulting group of 263 participants strained the ability of facilitating and maintaining control over the activities of the HPS event and study. There was a mal-distribution of nursing students in comparison to other health majors who participated. In addition, TBL is known to be most effective when students are in teams that meet over time, building relationships and interpersonal accountability.3 In the HPS, teams did not have time to form these bonds, other than the large group of nursing students attending who were cohort-friendly. Furthermore, the use of TBL in large groups has had varying levels of success because of faculty-student ratios and faculty ability to facilitate student participation within teams.3,4,5 In both the pilot and the 2015 studies, participants made a connection with local legislators; top proposals were presented and discussed in a forum setting.

In fact, legislators requested proposal ideas to take back to the Virginia General Assembly to promote change in health care insurance coverage for Virginians.

Accrediting bodies and standards of educational practice mandate health policy education. A true deficit of research in the area of health policy advocacy education highlights a need for further studies to strengthen the generalizability of study findings; TBL is only one teaching strategy available, not representative of previous strategies. In addition, different health policy advocacy teaching strategies can be used to achieve the same effect.3,4 Study findings indicate that TBL has potential for success.

There were 2 noted study limitations. As with any self-reported tool, the risk of response bias exists. In this case, the participants could have reported a socially desirable response because of the interprofessional team-based activities and the potential for group expectations of improving political knowledge and engagement.3,4 In the 2015 study, the 263 participants completing the pre-PAI and 238 participants completing the post-PAI resulted in the use of independent t test statistic. This could have an effect on individual changes related to the group as a whole, as would normally be evaluated with a paired group test.3,5

### Conclusion

The need for health policy advocacy education is clear; educators are challenged to find effective teaching methodologies to improve health profession students’ knowledge, skills, and engagement in health policy advocacy. The HPS incorporated interprofessional student TBL health policy advocacy activities using a team-based learning model. This was effective in improving student knowledge and engagement in health policy advocacy and increasing political astuteness. Improving collaborative interprofessional health policy advocacy may prove to enhance health care professionals’ likelihood of understanding and involvement. This has the potential to influence health policy in the future. Further research on TBL pedagogy’s influence on political astuteness and health policy advocacy will add evidence to this instructional model, increasing student knowledge and involvement in political advocacy to affect health policy.

### References

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