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Predicting Levels of Policy Advocacy Engagement Among Acute-Care Health Professionals

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Abstract

This study aims to describe the factors that predict health professionals' engagement in policy advocacy. The researchers used a cross-sectional research design with a sample of 97 nurses, 94 social workers, and 104 medical residents from eight hospitals in Los Angeles. Bivariate correlations explored whether seven predictor scales were associated with health professionals' policy advocacy engagement and revealed that five of the eight factors were significantly associated with it ($p < .05$). The factors include patient advocacy engagement, eagerness, skills, tangible support, and organizational receptivity. Regression analysis examined whether the seven scales, when controlling for sociodemographic variables and hospital site, predicted levels of policy advocacy engagement. Results revealed that patient advocacy engagement ($p < .001$), eagerness ($p < .001$), skills ($p < .01$), tangible support ($p < .01$), perceived effectiveness ($p < .05$), and organizational receptivity ($p < .05$) all predicted health professional's policy advocacy engagement. Ethical commitment did not predict policy advocacy engagement. The model explained 36% of the variance in policy advocacy engagement. Limitations of the study and its implications for future research, practice, and policy are discussed.

Keywords

advocacy, ethics, political action, nursing workforce, patient-centered care, quality of care

This article reports findings from a research project that examined the predictors of nurses', medical residents', and social workers' engagement in policy advocacy in acute-care hospitals. Patient well-being is influenced by an array of policies that derive from federal, state, and local governments; courts; relevant communities; regulatory bodies; and government budgets (California Hospital Association, 2014; Jansson, 2011). Other factors that affect patient well-being include internal policies of hospitals related to services, budgets, personnel, missions, referrals, and discharge dispositions (Jansson, 2011). The California Consent Manual (California Hospital Association, 2014) consists of more than a thousand pages of fine print that summarizes key federal, state, legal, and regulatory policies that impact hospitals

and patients, including and not limited to regulations associated with Medicare, Medicaid, and the Affordable Care Act (ACA).

Members of vulnerable populations appear to be at heightened risk of experiencing adverse consequences of

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hospital policies (Barr, 2008; Beach et al., 2006; Brashler, 2006; Institute of Medicine, 2003; Jansson, 2011; Kawachi, Daniels, & Robinson, 2005; Patrick et al., 2003; Wartman, 2006). Many other patients are also at heightened risk from medical errors that lead to injuries and deaths, 98,000 to 440,000 annually of which are considered to be preventable (Gawande, 2009; Lawrence, 2003; "Survive Your Stay at the Hospital," 2014). In addition, patients' problems often stem from characteristics of health-care delivery systems, such as fragmentation of services and unwieldy bureaucracies. Many patients live in communities that place them at risk of violence, substance abuse, mental health problems, and other factors that adversely affect their health. Some patients cannot locate or access needed resources, such as mental health services, when they are discharged. Even with enactment of the ACA, the U.S. Centers for Disease Control and Prevention estimated from interviews conducted in the first 3 months of 2014 that 41 million individuals of all ages (13.1% of the population) were medically uninsured at the time they were interviewed; 55.5 million individuals had been uninsured for at least part of the year prior to their interviews (Cohen & Martinez, 2014). At least 16% of residents in politically conservative states remained uninsured in 2015 (Bui & Sanger-Katz, 2015). Frontline workers need to engage in policy advocacy to improve problems that existed before enactment of the ACA and that have remained or arisen in its wake.

Conceptualizing Policy Advocacy

The current study draws upon Jansson's (2011) definition of policy advocacy as "interventions to change dysfunctional policies in institutions, communities, and government that may create the need for patient advocacy in the first place including statutes, regulations, budgets, mission and organizational culture, eligibility requirements and organizational policies" (p. 3). Policy advocacy is contrasted with patient advocacy, which Jansson (2011) defines as an intervention "to help patients obtain services, rights, and benefits that would (likely) not otherwise be received by them and that would advance their well-being" (p. 3). The distinction between policy advocacy and patient advocacy is made clear by these two definitions: If patient advocates help specific patients, policy advocates seek to change policies within hospitals, communities, and legislatures that will improve the well-being of significant numbers of patients.

This study also draws upon Jansson's (2011) identification of seven categories of patient problems including (a) failure to honor patients' ethical rights, (b) lack of good quality care, (c) lack of culturally competent care, (d) lack of preventive care, (e) inadequate mental health

care, (f) lack of affordable and accessible care, and (f) care that is insufficiently linked to patients' homes and communities. Jansson (2011) identified these *seven core problems* from a search of 800 articles and books. They are consonant with biopsychosocial, person-in-environment, and patient-centered frameworks that consider the impact of social, cultural, and psychological factors on individuals' well-being (Bergeson & Dean, 2006; Brody, 1999; Coulton, 1981; Earp, French, & Gilkey, 2008; Epstein, 2000).

Policy Advocacy by Frontline Health Professionals

The research team gathered data from nurses, social workers, and medical residents because these professionals have close proximity to patients and see a broader range of patients than attending and consulting physicians who have smaller caseloads. Nurses, social workers, and medical residents are expected to engage in case finding where they identify unresolved patient problems—a task that is part of the training of medical residents. Nurses, medical residents, and social workers can make important contributions to policy deliberations in hospitals. They can identify policies related to the seven core problems that adversely impact hospitalized patients, discuss hospital policies with hospital administrators, help create multiprofessional education programs, and develop protocols and recommendations to improve patient services. They can also identify community problems, such as a lack of mental health agencies, that impact discharged patients. Nurses, social workers, and medical residents can also identify individuals' challenges in accessing Medicaid coverage and receiving services for other programs enacted under the ACA. These health professionals are obligated by their professional codes of ethics to engage in policy advocacy (American Medical Association, 2014; American Nurses Association, 2014; National Association of Social Workers, 2005).

Despite these ethical obligations and the potential for health professionals to make a marked difference in lives of their patients, little is known about why some health professionals seek to change policies that negatively impact their patients while others do not. Even less is known about why some health professionals engage in policy advocacy outside of their hospitals.

Predicting Engagement in Policy Advocacy

Research findings suggest a mixed picture regarding the extent to which nurses, physicians, and social workers engage in policy advocacy. In a national mail survey of U.S. physicians listed in the American Medical Association's master file, over 90% of more than 1,600

respondents reported that community participation, political involvement, and collective advocacy were important to them; yet, one third of all respondents had not participated in any such activities in the past 3 years (Gruen, Campbell, & Blumenthal, 2006). Moreover, despite physicians' apparent endorsement of policy advocacy as a professional responsibility, they were more likely to engage policy makers on issues affecting their own economic well-being than with respect to public health (Earnest, Wong, & Federico, 2010). In 1999–2000, Dodd, Jansson, Brown-Saltzman, Shirk, and Wunch (2004) surveyed 165 acute-care nurses in Los Angeles to ascertain the extent to which they engaged in ethical activism (another term for policy advocacy as it pertains to ethics). They discovered that about half of respondents had not engaged in ethical activism during the prior 6 months as measured by the extent they had "sought written protocols to promote social workers' or nurses' participation in ethical deliberations," "sought multidisciplinary training sessions in ethics that included social workers or nurses," or "educated physicians about social workers' or nurses' roles in ethics" (p. 20). Herbert and Leven (1996) found that social workers spent the least amount of time on advocacy compared with other traditional social work roles such as counseling and referrals. Yet some hospital administrators, such as those at Denver Children's Hospital, encourage their health professionals to engage in policy advocacy, such as speaking with legislators about policy issues affecting patients in their state (Jansson, 2011).

Without an understanding of factors that predict health professionals' level of engagement in policy advocacy, it is difficult to develop strategies to increase or promote it through organizational changes, personnel policies, education, incentives, or other approaches.

Study Aims

In this study, the researchers sought to develop and validate a policy advocacy engagement scale to measure policy advocacy engagement of frontline health professionals (Jansson, Nyamathi, Heidemann, Duan, & Kaplan, 2015). They tested the predictive power of seven multi-item scales that measured health professionals' engagement in patient advocacy ("patient advocacy engagement"), their possession of specific skills needed to engage in policy advocacy ("skills"), their eagerness to engage in higher levels of policy advocacy in the future ("eagerness"), their ethical commitment to engaging in policy advocacy ("ethical commitment"), on-the-job support they receive to engage in policy advocacy ("tangible support"), receptivity of their hospital organizational environments for policy advocacy ("organizational receptivity"), and their perception of the effectiveness of policy advocacy ("perceived effectiveness").

The following research questions guided the study: (a) To what extent are seven specific factors (patient advocacy engagement, skills, ethical commitment, eagerness, tangible support, organizational receptivity, and perceived effectiveness) associated with health professionals' levels of policy advocacy engagement? (b) Which of these factors are significantly associated with health professionals' levels of policy advocacy engagement when controlling for other factors including age, race, gender, site, and profession?

Methods

Design

Researchers used a cross-sectional research design with data collected from a sample of 97 nurses, 94 social workers, and 104 medical residents in eight acute-care hospitals in Los Angeles to determine which of the aforementioned factors are associated with health professionals' policy advocacy engagement. Researchers used bivariate analyses to explore the extent each factor was associated with policy advocacy engagement. Next, researchers used multiple regression analysis, controlling for age, race, gender, site, and profession, to examine the extent each factor predicted health professionals' level of engagement in policy advocacy.

Instrument Development

An expert stakeholder panel of nine persons was established at the outset of this research project. The panel consisted of a social worker who supervised a hospital case management program for 20 years, a nurse who is also a breast cancer survivor who successfully lobbied for state legislation to enhance the care of breast cancer patients with dense breast tissue, a physician who pioneered advocacy training for individuals with withdrawal symptoms from substance abuse, a nurse who headed a university-based center on bioethics with expertise in patient advocacy for individuals at end of life, a social worker who pioneered advocacy for discharged patients at a major public hospital for 30 years, the chief nursing officer of a major hospital who had been named the nurse of the year by a national nursing publication and who founded an annual award for nurses who excelled in patient advocacy in her hospital, an associate professor of social work with research expertise on advocacy with respect to ethical issues in acute-care hospitals, a clinical associate professor of social work with expertise in advocacy for senior citizens in acute-care hospitals, and a professor of nursing who has conducted research related to advocacy for persons with HIV/AIDS. Each of these professionals had extensive experience in hospitals and gave hours of time to this project.

After focused discussion, members of the stakeholder panel accepted Jansson's (2011) definition of policy advocacy and the seven core problems that he identified, including failure to honor patients' ethical rights, and failure to provide high-quality care, culturally competent care, preventive care, affordable and accessible care, mental health care, and care linked to patients' households and communities. The research team met in the summer of 2012 to consult the existing literature on advocacy in health-care settings and to discuss the development of a scale to measure engagement in policy advocacy, as well as several *predictor* scales.

Development and validation of the dependent variable scale used in this study (the policy advocacy engagement scale) is reported elsewhere (Jansson, Nyamathi, Heidemann, et al., 2015). The predictor scales developed to measure constructs hypothesized to predict patient advocacy are described later. All scales and demographic variables were compiled into a survey containing more than 400 items.

Site Selection and Recruitment of Participants

Hospital selection. A convenience sample of eight acute-care hospitals was selected in Los Angeles County based upon auspices and the extent stakeholders and members of the research team had contacts to allow expeditious obtainment of institutional review board (IRB) approvals from each of them. The research team selected hospitals of different auspices so that idiosyncratic characteristics of specific kinds of hospitals would not bias health professionals' responses to questions in the online survey. The eight participating hospitals included a community-based nonprofit hospital, university-affiliated nonprofit general hospital, public children's hospital, public general hospital, veterans' hospital, nonprofit university-affiliated cancer hospital, and two church-affiliated hospitals. Researchers initially planned to include a for-profit hospital but were unable to obtain requisite permission despite repeated efforts.

Participant eligibility and recruitment. Approximately 300 respondents were needed to ensure sufficient effect size for statistical analyses, including roughly 100 respondents from each of the three professional groups, to enable comparisons among them on the many variables and constructs being measured. Researchers wanted nurses, social workers, and medical residents who had served at least 6 months in their hospitals as study participants to enhance the likelihood they would be familiar with its personnel and policies. The research team selected these health professionals for its sample because they are positioned to serve large numbers of patients in their hospitals and often act as *case finders* as they make rounds

within their respective units. Medical residents are taught to identify patients with unresolved problems as part of their medical training. No restrictions were placed on medical residents' area of specialty. The expert stakeholders of this project agreed with these sampling choices.

Inclusion criteria for the sample of frontline health professionals included the following: (a) being a nurse, social worker, or medical resident in an acute-care hospital; and (b) having worked full-time, part-time, or per diem in this hospital setting for at least 6 months. Nurses were required minimally to have an RN with either an associate or baccalaureate degree, and social workers were required to have a Master of Social Work degree. Temporary and student workers were excluded.

Researchers obtained staff rosters and work e-mail addresses of all nurses, social workers, and medical residents, at each participating hospital from lead nurses, social workers, and persons who administered the work of medical residents. The study team contacted all social workers in each participating hospital because only one social work department had 14 or more members. They oversampled this large social work department to obtain participation of roughly 100 social workers. A random number generator was used to generate a pool of nurses and medical residents from staff rosters of the eight hospitals. The Project Coordinator e-mailed letters to these individuals inviting them to participate in the study and provided a link to the online survey. Participants were given 1 month to complete and return the survey, which they could leave and resume at any point during the month. Participation was voluntary. Responses were confidential but not anonymous because the research team received names of respondents from lead administrators at participating hospitals. Response rates varied by site and among the three professions. Of the 732 total professionals invited to participate, 40% consented to participate and completed the online survey. For a full report of the number of social workers, nurses, and medical residents invited to participate in each of the eight hospitals, the number who completed the survey, and the response rate for each profession, see Jansson, Nyamathi, Duan, Kaplan, Heidemann, and Ananias (2015).

Data collection occurred between September 2013 and May 2014. The final sample of 295 participants ensured adequate statistical power for estimating reliability and validity (Streiner & Norman, 2008). The researchers mailed \$100 checks to all participants who completed the survey, which contained more than 400 total items and took 35 minutes on average to complete. IRBs of all participating hospitals and the University of Southern California approved this incentive.

Measures

Items within the policy advocacy engagement scale and all independent variable scales described later were operationalized with response sets ranging from 1 (*never*) to 5 (*almost always*) or from 1 (*not at all*) to 5 (*a great deal*), depending on the question. Items contained within each of the scales are presented in Table 1 except for 26 items in the patient advocacy engagement scale, which we validated and presented elsewhere (Jansson, Nyamathi, Duan, et al., 2015).

Dependent variable. The policy advocacy engagement scale is a seven-item instrument designed by Jansson, Nyamathi, Heidemann, et al. (2015) to measure the frequency with which health-care professionals engage in policy advocacy related to specific patient problems in seven categories: (a) patients' rights, (b) quality care, (c) culturally competent care, (d) preventive care, (e) affordable care, (f) mental health care, and (g) community-based care. Jansson, Nyamathi, Heidemann, et al. (2015) report data that support both the validity and reliability of the policy advocacy engagement scale for measuring the frequency of policy advocacy engagement by nurses, social workers, and medical residents in acute-care settings. Construct validity was supported through confirmatory factor analysis, with items loading onto a single component. A Pearson correlation coefficient of .36 for the scale in two administrations supported its test-retest stability. Cronbach's α for the scale was .93, indicating strong internal consistency.

Independent Variables

Age. Participants were asked to indicate their age in years. These data created a continuous variable.

Race. Participants were asked to self-identify as Caucasian/White, Hispanic/Latino, Asian/Pacific Islander, African American, Middle Eastern/Arab, American Indian/Alaskan Native, or Other. These data were subsequently reduced to a nominal variable with three categories—White, Asian, and Other—because very few respondents self-identified as being other than White or Asian.

Gender. Researchers asked participants to self-identify as male or female. These data created a dichotomous variable.

Site. Participants were asked to indicate in which of the eight participating hospitals they were employed. These data created a nominal variable with eight categories. This variable was included in the regression analysis to test whether the specific type of hospital, such as

veterans', children's, or cancer hospitals, influences the clinicians' patient advocacy engagement. Because our IRB protocol requires that we keep the names of the hospitals confidential, they are labeled as Site 1, Site 2, and so forth.

Profession. Participants were asked to indicate their profession—nurse, social worker, or medical resident. These data created a nominal variable with three categories.

Patient advocacy engagement scale. The research team hypothesized that respondents' levels of patient advocacy engagement would predict their levels of policy advocacy engagement. We reasoned that health professionals who want to help *individual patients with unresolved problems in the seven core areas* would be more likely to want to change *dysfunctional policies* that cause patients to have these kinds of unresolved problems in these same seven core areas. The patient advocacy engagement scale is a 26-item instrument designed by Jansson, Nyamathi, Duan, et al. (2015) to measure the frequency with which health-care professionals engage in patient advocacy related to specific patient problems in the seven core areas. Jansson, Nyamathi, Duan, et al. (2015) report data that support both the validity and reliability of the scale for measuring the frequency of patient advocacy engagement by nurses, social workers, and medical residents in acute-care settings. Cronbach's α for the scale was .95.

Policy advocacy eagerness. Azjen's (1985) *theory of planned behavior* asserts that people intend to and do engage in an activity when they feel driven or eager to do so. We developed a seven-item scale ("eagerness") that measures respondents' eagerness to engage in higher levels of policy advocacy in the future by asking them to estimate to what extent they had wished to engage in more advocacy with respect to each of the seven core problems during the prior 6 months. Cronbach's alpha for the scale was .91.

Policy advocacy ethical commitment. Many theorists have linked advocacy to the ethical beliefs of health-care professionals (Dodd et al., 2004; Earnest et al., 2010; Grady et al., 2008; Hanks, 2008, 2010; Jansson, 2011). We developed a five-item scale ("ethical commitment") to measure the extent respondents are ethically committed to engage in policy advocacy. Cronbach's alpha for the scale was .82.

Patient advocacy skills. Literature suggests that health professionals are more likely to engage in policy advocacy if they possess specific skills related to it (Dodd et al., 2004; Hanks, 2010; Itzhaky, Gerber, & Dekel, 2004; Jansson, 2011; Stafford, Sedlak, Fok, & Wong, 2010). We developed a 13-item scale ("skills") designed to measure respondents' perceptions of having skills necessary to

Table 1. Items in Dependent and Independent Variable Scales.

Scales and Items

Dependent variable

Policy advocacy engagement scale

“During the last 6 months, how often have you engaged in patient advocacy related to each of the numbered issues below?”

1. Patients’ ethical rights may be at risk.
2. Patients’ quality of care may be at risk.
3. Patients’ cultural content of care may be lacking.
4. Patients’ preventive care may be lacking.
5. Patients’ affordable or accessible care may be problematic.
6. Patients’ care for mental health conditions may be lacking.
7. Patients’ community-based healthcare may be lacking.

Independent variables

Policy advocacy ethical commitment scale (“ethical commitment”)

“To what extent do you believe that members of your profession:”

1. Have an ethical duty to engage in policy advocacy?
2. Are mandated by your profession’s Code of Ethics to engage in policy advocacy?
3. Should change organizational policies, including their budgets and procedures, to make patient advocacy less necessary?
4. Should develop multidisciplinary training programs to enhance policy advocacy skills?
5. Should work to correct flaws in current public policies?

Policy advocacy eagerness scale (“eagerness”)

“During the last 6 months, how often did you wish you had been able to engage in more policy advocacy related to each of the numbered issues below?”

1. Patients’ ethical rights may be at risk.
2. Patients’ quality of care may be at risk.
3. Patients’ cultural content of care may be lacking.
4. Patients’ preventive care may be lacking.
5. Patients’ affordable or accessible care may be problematic.
6. Patients’ care for mental health conditions may be lacking.
7. Patients’ community-based healthcare may be lacking.

Policy advocacy skills scale (“skills”)

“Please rate the extent you have the following policy advocacy skills. I have the skill to:”

1. Influence other people to work with me to change specific policies.
2. Initiate policy changing interventions.
3. Negotiate or bargain to achieve my policy goals.
4. Mediate conflicts.
5. Talk with community leaders.
6. Communicate with public officials.
7. Help patients become policy advocates.
8. Discuss specific kinds of unresolved patient issues with hospital administrators.
9. Change policies in my hospital.
10. Establish multidisciplinary training sessions in my hospital.
11. Develop better coordination between different units or departments of my hospital.
12. Make budget suggestions in my hospital.
13. Change protocols or operating procedures in my hospital.

Organizational receptivity scale (“organizational receptivity”)

“To what extent:”

1. Have you been excluded from discussions about unresolved patient problems?(reverse coded)
2. Are you invited to participate in case conferences about patients with specific unresolved problems?
3. Is there an atmosphere that invites you to question the resolution of unresolved problems with specific patients?
4. Do you experience hostile behaviors from other professionals? (reverse coded)
5. Is sufficient discussion devoted to patients’ unresolved problems in your setting by health-care professionals, supervisors, and administrators?
6. Do patients’ attending or consulting physicians ask you to gather information from patients relevant to specific unresolved problems?
7. Do patients’ attending or consulting physicians ask you to gather information from family members, friends, or significant others that is connected to patients’ unresolved problems?

(continued)

Table 1. Continued.

Scales and Items
8. Do patients' attending or consulting physicians confidentially discuss with you patients' unresolved problems when several courses of action exist in a specific case?
9. Do patients' attending or consulting physicians encourage you to inform them when you see patients' unresolved problems?
10. Are you encouraged by attending or consulting physicians to become involved in a range of patients' unresolved problems?
11. Are members of your profession encouraged to make referrals to ethics committees related to one of the unresolved problems?
12. Are views of members of your profession solicited by ethics committees with regard to unresolved problems?
13. Are specific kinds of patients' unresolved problems addressed by multidisciplinary teams (e.g., physicians, social workers, and nurses)?
14. Are you an integral member of discussions about patients' unresolved problems?
15. When nurses, social workers, and medical residents participate in discussion about patients' unresolved problems, do they participate as co-equals?
Policy advocacy tangible support scale ("tangible support")
"Please rate the extent you agree with the following statements:"
1. Policy advocacy is part of my job description.
2. My supervisor encourages me to engage in policy advocacy.
3. My supervisor supports me when I experience negative repercussions resulting from my policy advocacy.
4. I believe my supervisor will come to my defense if I am criticized for doing policy advocacy.
5. I believe administrators are aware of unresolved problems.
Perceived effectiveness of policy advocacy scale ("perceived effectiveness")
"Please rate the extent you believe that policy advocacy is effective in improving health-care policies in:"
1. Organizational settings?
2. Community settings?
3. Governmental settings?

engage in policy advocacy. Cronbach's alpha for the scale was .92.

Organizational receptivity. Many researchers have identified work environment and working conditions that encourage or discourage patient advocacy (Brown & Leigh, 1996; Chafey, Rhea, Shannon, & Spencer, 1998; Jansson, 2011; Josse-Eklund, Petzäll, Sandin-Bojö, & Wilde-Larsson, 2013; Makary, 2012; Sundin-Huard & Fahy, 1999). We developed a 15-item scale ("organizational receptivity") to measure the extent hospitals' organizational climate supports health professionals' engagement in advocacy. The scale includes four subscales: (a) Extent health professionals feel invited to engage in patient advocacy (5 items), (b) Extent health professionals report that attending and consulting physicians encourage them to assist with patients' unresolved problems (5 items), (c) Extent respondents' views are solicited by ethics committees (2 items), and (d) Extent respondents report that they are viewed as co-equals in multiprofessional teams (3 items). Cronbach's alpha for the scale was .91.

Policy advocacy tangible support. Evidence suggests that employees engage in activities perceived to have few obstacles and that are associated with resources and opportunities to support their engagement (Armitage & Conner, 2001; Sellin, 1995). We developed a five-item scale ("tangible support") to measure respondents'

perception of receiving tangible support for policy advocacy. Cronbach's alpha for the scale was .82.

Perceived effectiveness of policy advocacy. Ajzen (2002) based the theory of planned behavior on the assumption that human behavior is partly guided by behavioral beliefs about the consequences or attributes of a specific behavior, such as engaging in policy advocacy. Thus, the research team hypothesized that health professionals are most likely to engage in policy advocacy when they perceive it to be effective. We developed a three-item scale ("perceived effectiveness") to measure the extent respondents believe that policy advocacy is effective in improving health-care policies in organizational, community, and government settings. Cronbach's alpha for the scale was .88.

Analyses

Descriptive statistics, such as means and frequencies on demographic variables, were obtained for the overall sample. Cronbach's alpha was calculated for each of the scales used in the study. Correlations among patient advocacy factors were examined separately. Further, a multiple regression model was used to assess the relationship between the outcome scale and its predictors when adjusting for each other. Unstandardized betas for each factor, and overall R^2 values, are reported later. All analyses were performed in SAS (v 9.4).

Results

Participant Demographics

Ninety-four social workers, 97 nurses, and 104 medical residents completed the online survey, for a total sample of 295 of which 70.2% identified as female and the remainder as male. Nearly half (45.8%) identified as White/Caucasian, 26.8% as Asian, 13.2% as Latino/Hispanic, 5.1% as African American, 3.1% as Middle Eastern or Arab, and 6.1% as other or multiracial. The median age of the sample was 33 years ($M=37.5$, $SD=11.15$), with a range of 24 to 73.

Correlations

Researchers conducted bivariate analyses to ascertain the extent of association between each of the scales described earlier and the policy advocacy engagement scale. Results of the bivariate analyses are presented in Table 2. Correlations between the policy advocacy engagement scale and other factors indicated two small, nonsignificant associations, with a Pearson correlation r of .09 for perceived effectiveness and .11 for ethical commitment. Analyses further revealed several small to medium associations ranging from .23 to .39. Specifically, five scales were significantly associated with the policy advocacy engagement scale at the $p < .001$ level, including the patient advocacy engagement scale, eagerness, skills, tangible support, and organizational receptivity (see Table 2). Thus, of the seven scales we hypothesized to be associated with the policy advocacy engagement scale in univariate analyses, five were found to be significantly associated with it.

Univariate analyses further revealed that many of the factors were significantly associated with one another. For example, the patient advocacy engagement scale was significantly correlated with all the other scales minimally at the $p < .05$ level, a finding that supports the research team's hypothesis that patient advocacy engagement will predict policy advocacy engagement because the two types of advocacy are each predicted by many of the same scales. Eagerness, skills, tangible support, ethical commitment, and perceived effectiveness were all significantly correlated with one another ($r = .16-.39$, $p < .01$). Organizational receptivity was significantly correlated with skills, tangible support, and perceived effectiveness ($r = .18-.44$, $p < .01$).

Regression

Researchers performed a multiple regression analysis to explore which scales were associated with the policy advocacy engagement scale when controlling for socio-demographic variables and hospital site. The model explained 36% of the variance in the policy advocacy

Table 2. Correlations Among Factors.

	Number of items	Cronbach's alpha	Mean (SD)	Policy advocacy engagement scale	Patient advocacy engagement scale	Eagerness	Skills	Tangible support	Ethical commitment	Perceived effectiveness	Organizational receptivity
Policy advocacy engagement scale	7	.93	17.0 (7.0)	1							
Patient advocacy engagement scale	26	.95	75.3 (20.6)	0.33***	1						
Eagerness	7	.91	21.6 (6.4)	0.39***	0.36***	1					
Skills	10	.92	28.0 (8.2)	0.30***	0.19**	0.24***	1				
Tangible support	5	.82	16.5 (4.4)	0.32***	0.14*	0.18**	0.27***	1			
Ethical commitment	5	.82	19.2 (3.8)	0.11	0.22**	0.31***	0.33***	0.2***	1		
Perceived effectiveness	3	.88	11.4 (2.5)	0.09	0.24***	0.25***	0.23***	0.16**	0.39***	1	
Organizational receptivity	15	.91	50.4 (10.2)	0.23***	0.25***	0.03	0.18**	0.44***	0.09	0.19**	1

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 3. Multiple Regression of Policy Advocacy.

Variable or Scale	Unstandardized beta
Age	0.04
Gender	
Female	-0.06
Male	reference
Race	
White	-1.32
Asian	0.79
Other	reference -
Profession	
Medical resident	1.22
RN	1.62
Social worker	- reference -
Study site	
Site 1	-3.57
Site 2	-1.66
Site 3	1
Site 4	-1.56
Site 5	-1.61
Site 6	-3.85
Site 7	-0.03
Site 8	- reference -
Patient advocacy engagement scale	0.07***
Eagerness	0.34***
Skills	0.14**
Tangible support	0.27**
Ethical commitment	-0.19
Perceived effectiveness	-0.32*
Organizational receptivity	0.09*
R ²	0.36

* $p < .05$. ** $p < .01$. *** $p < .001$.

engagement scale (see Table 3). None of the sociodemographic variables, nor hospital sites, were significantly associated with the policy advocacy engagement scale. Six of the seven predictor scales were significant predictors of policy advocacy engagement. Engagement in patient advocacy was associated with higher engagement in policy advocacy (unstandardized $\beta = 0.07$, $p < .001$). Eagerness to engage in greater levels of policy advocacy in the future was associated with higher engagement in policy advocacy (unstandardized $\beta = 0.35$, $p < .001$). Possessing requisite policy advocacy skills was associated with higher engagement in policy advocacy (unstandardized $\beta = 0.14$, $p < .01$). Receiving higher levels of tangible support to engage in policy advocacy was associated with higher engagement in policy advocacy (unstandardized $\beta = 0.27$, $p < .01$).

Believing that policy advocacy is effective was associated with higher engagement in policy advocacy (unstandardized $\beta = 0.32$, $p < .05$). Lastly, perceiving the organizational climate as receptive to policy advocacy was associated with higher engagement in policy advocacy (unstandardized $\beta = 0.09$, $p < .05$). Results are displayed in Table 3.

Although five of the predictor scales were significantly related to the policy advocacy engagement scale in bivariate analyses, the regression analysis demonstrated that six scales (patient advocacy engagement, eagerness, skills, tangible support, perceived effectiveness, and organizational receptivity) were independent predictors of patient advocacy engagement in the regression analysis, which controlled for all other scales and a range of sociodemographic variables and hospital site. Specifically, although the perceived effectiveness scale was not significantly associated with the policy advocacy engagement scale in bivariate correlations, it did emerge as significantly associated with it in the regression analysis in a *negative direction*; that is, respondents who were *less* likely to report they believe policy advocacy is effective were more likely to engage in policy advocacy than others, an unexpected finding. Ethical commitment was not significantly associated with the policy advocacy engagement in either the bivariate correlation analysis or the multiple regression analysis.

Discussion

In this study, researchers aimed to understand the factors associated with health professionals' levels of engagement in policy advocacy in acute-care hospitals. Bivariate analyses demonstrated that five of the seven factors examined were significantly correlated with policy advocacy engagement: health professionals' levels of patient advocacy engagement, eagerness, policy advocacy skills, tangible job supports, and the organizational climate. Ethical commitment and perceived effectiveness were not associated with policy advocacy engagement in bivariate correlations.

Multiple regression analysis revealed that six of the seven predictor scales (patient advocacy engagement, eagerness, skills, tangible support, perceived effectiveness, and organizational receptivity) were associated with high levels of policy advocacy when controlling for age, gender, race, profession, and hospital site. Multiple regression analysis also showed that ethical commitment was not significantly associated with policy advocacy engagement.

The study's findings demonstrate that health professionals who reported engaging in high levels of patient advocacy were also more likely to engage in policy advocacy than respondents who reported low levels of patient advocacy engagement. We speculate that these

professionals are more likely to see the need for policy advocacy with regard to the unresolved problems in care that their patients face. Educating health professionals about patient advocacy may thus increase their engagement in policy advocacy and vice versa. This education may usefully discuss how patient advocates and policy advocates share some skills in common, such as use of influence, negotiating, and bargaining.

A strong relationship between health professional's eagerness to engage in policy advocacy and their actual levels of engagement in policy advocacy emerged from our findings. Eagerness may help health professionals surmount the time commitments and steep obstacles they may face in changing specific policies in their setting, as well as barriers they may encounter from superiors and high-level decision makers who may feel antagonized or exposed by their policy advocacy engagement efforts. We suspect that eagerness may be increased through advocacy education that provides respondents with specific cases where advocacy led to improvements that ultimately benefited patients and health professionals, and where the absence of advocacy had negative consequences for patients and professionals.

The study's findings reveal that health professionals who reported they possessed requisite policy advocacy skills were more likely to engage in policy advocacy than those who did not. This may be true because many of these advocacy skills are different than skills used in the clinical and personal encounters with patients. Advocacy skills could be taught through simulations, demonstrations by expert advocates, and discussion of case studies.

Our findings also demonstrate that health professionals who perceive the organizational climate as being receptive to policy advocacy engagement, as well as those who reported receiving high levels of tangible supports to engage in policy advocacy were more likely to engage in policy advocacy. Supervisors, department heads, and administrators may assume an important role in alerting their staff to specific policy issues in their hospitals, communities, and relevant government settings. Supervisors can discuss policy advocacy with nurses, social workers, and medical residents, as well as publicize policy advocacy endeavors undertaken by health professionals in their settings, thereby creating or promoting an organizational culture that supports such work.

Perceived effectiveness of policy advocacy was negatively associated with policy advocacy engagement in the regression analysis, suggesting that health professionals were more likely to engage in policy advocacy if they do not believe it is effective. Further research is needed to explore this puzzling finding. Perhaps some health professionals realize that policies are often difficult to change because of entrenched interests and power realities—hence, policy advocacy is ineffective—but are

nonetheless motivated to improve healthcare even when they experience setbacks. Frontline health professionals may need to learn that persistence is an important attribute for policy advocates by examining instances when policy successes were achieved only after sustained effort over a long time span.

Ethical commitment did not predict policy advocacy engagement. This finding may partly be due to the small amount of variation among frontline health professionals' responses on the scale that tested ethical commitment. Specifically, more than 95% of respondents in this study reported strong ethical commitments as manifested in awareness that their professional codes mandate policy advocacy. This lack of variation in levels of ethical commitment may explain why the ethical commitment scale fails to predict engagement in policy advocacy.

Directions for Future Research

Additional research is needed to ascertain whether frontline professionals in acute-care hospitals, substantially burdened by their regular work responsibilities, could feasibly expand their policy advocacy beyond their hospitals to communities and government settings. It might require, for example, trips into the community or to a legislature with extended discussions and follow-up if policy advocates are to be successful. They may have to form or join coalitions, see an array of officials, and use the mass media. Hospital administrators might consider establishing policy-focused units within their hospitals to whom frontline health professionals can communicate their observations about how specific policies negatively impact patients. Policy specialists in these units could engage in advocacy in community and government settings, as well as in liaison with state and national chapters of their professional associations.

Further research is also needed to develop education strategies for increasing the provision of policy advocacy by frontline health professionals. No strategies have yet been subjected to rigorous evaluation, although models do exist (Chamberlain et al, 2013; Klein & Vaughn, 2010). The policy advocacy engagement scale provides a measurement tool that may prove useful as a pretest and posttest measure for evaluating the effectiveness of specific reforms and strategies to increase health professionals' levels of engagement in policy advocacy (Jansson, Nyamathi, Heidemann, et al., 2015).

Implications for Practice

Health managers and supervisors, as well as frontline health professionals, have many possible avenues for increasing and sustaining levels of policy advocacy engagement. The multiple associations between the various scales discussed in this article with the policy

advocacy engagement scale suggest that single strategies may be less successful in supporting policy advocacy in hospitals than multiple ones that include components that attend to health professionals' eagerness, skills, tangible job supports, and the organizational climate. Associations between patient and policy advocacy engagement suggest the need to identify how patients' problems sometimes stem from dysfunctional organizational and public policies (Jansson, 2011). Health managers and supervisors might consider developing interdisciplinary planning groups that address specific policy issues and their negative impacts on patients, such as failure of insurance companies to finance certain kinds of medications, lack of mental health resources for discharged patients in surrounding communities, and caring for populations of uninsured patients.

Policy advocacy engagement of nurses and social workers is likely enhanced as they are accorded larger roles in the health-care system. As the scope of practice of nurses is expanded to allow them "to lead and manage collaborative efforts with physicians and other members of the health-care team" they are more likely to make policy recommendations to hospital personnel (Institute of Medicine, 2010, p. 11). As the Joint Commission expands its requirements for social work personnel in hospitals beyond merely parttime consultants, social workers may have more time to engage in policy advocacy.

Study Limitations

The study had several limitations. The cross-sectional design precludes researchers' ability to draw causal inferences. Significant associations between the independent and dependent variables should be understood as correlational but not causal in nature. The eight participating acute-care hospitals were all based in Los Angeles County and may not be representative of hospitals in other regions, thus limiting the study's generalizability. Our participant recruitment strategy yielded a low response rate overall, and differential response rates by hospital and profession. We surmise this is related to acute-care health professionals' heavy workload.

The low response rate (40%) has implications for the study's generalizability to members of these health professions. Moreover, the study relied on respondents' self-reports rather than other sources of data, such as medical records and patients' reports. Participants' confidentiality was protected by this project's recruitment strategy but not their anonymity because they were recruited by name from hospital rosters. The research team de-identified that data so that individuals' responses could not be linked with specific data.

Conclusion

This study has advanced the science of policy advocacy in acute-care hospitals by identifying factors that predict health professionals' level of engagement in policy advocacy.

Findings from this study are timely because of changes in health services in the wake of the ACA (Brill, 2015). These changes include mergers, establishment of medical homes and accountable care organizations, greater coordination of services between providers and community agencies, and strategies to avert readmissions to hospitals within 30 days of discharges. The insurance industry is also in flux as companies seek to compete in insurance exchanges while complying with standards established by the ACA. While these and other changes may improve patient outcomes, they may also breed confusion for patients as well as flawed services. Many consumers still lack health insurance (Bui & Sanger-Katz, 2015) or discover that they have to pay more of the bill because they received care from a hospital or physician not in their insurer's network (Pear, 2015). Many rural counties and towns lack a single psychologist, social worker, or psychiatrist even when these areas have high rates of mental illness and suicide (Beil, 2015). Frontline health professionals are well positioned to view patients' unresolved problems that emerge during this period of marked changes in health policies and programs. They need to move beyond observations, however, to policy advocacy in order to ensure their patients' well-being. Their codes of ethics, after all, oblige them to do so. Further research is needed to explore how frontline health professionals can be enabled and encouraged to increase levels of policy advocacy within their hospitals and in surrounding communities and governmental arenas.

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