Increasing access to maternity care in rural Georgia through public health advocacy

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Increasing Access to Maternity Care in Rural Georgia through Public Health Advocacy

By

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Submitted to the Graduate School of the

University of Massachusetts Amherst in partial fulfillment

of the requirements of the degree of

Doctor of Nursing Practice

May, 2015

College of Nursing

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Acknowledgments

The author would like to acknowledge the support of Dr. Raeann G. LeBlanc & Dr. Pamela Aselton for critiquing this manuscript and providing support and guidance throughout this project and process.
Abstract

Georgia has the second highest maternal mortality rate and eighth highest infant mortality rate in the country. Regardless of location, race, socioeconomic class or education level, access to quality maternity care will significantly improve the outcomes for both mother and baby. In 2012, the maternal mortality rate in rural Georgia was 24.3% compared to 16.5% in non-rural Georgia. Increasing the use of well-trained Certified Nurse Midwives (CNMs) is essential to the provision of high-quality rural maternity care throughout pregnancy, birth and the postpartum period. Including CNMs as preceptors in the Georgia Preceptor Tax Incentive Program (GA-PTIP) policy can increase the quantity of midwives who will practice in the rural areas. Nurses need education in the role of advocate in order to change policies and systems that effect the population they are caring for. The purpose of this project was to implement a public health education intervention with nurses and nursing students on how to address increasing access to quality maternity care in rural Georgia through public health advocacy as an initial phase in addressing this problem of healthcare access.

Keywords: health policy, nursing practice, Nursing education, Health care policy, legislative arena, legislative process, nurse advocacy, policy advocates, politics, policy process, health policy
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Increasing Access to Maternity Care in Rural Georgia through Public Health Advocacy

Introduction

Maternal death and complications are a problem both in the United States and around the world. Globally, the rate of women dying due to childbirth has decreased by 2.6% per year since 1990; however, as of 2013 approximately 800 women continue to die each day from preventable causes related to pregnancy and childbirth (World Health Organization [WHO], 2014a). The United States (U.S.) places 47th in the world for maternal mortality, which is higher than almost all European countries, as well as several countries in Asia and the Middle East. (Coeytaux, Bingham, & Strauss, 2011).

The problems of maternal mortality can be prevented by using an upstream approach of increasing quality access to maternity care from the beginning of pregnancy. The United States Department of Health and Human Services (DHHS), Healthy People 2020 (2011) states the risk of maternal and infant mortality in addition to pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. These issues are significantly plaguing rural areas of the U.S. due to a lack of qualified maternal care providers including certified midwives and obstetricians.

Nurses can address this issue through advocacy. Advocacy is defined as “Pleading someone’s cause or act on someone’s behalf, with a focus on developing the community, system, individual or family’s capacity (Minnesota Department of Health [MDH], 2001). Nurses can speak knowledgeably about what patients and communities need because they experience it first-hand (Mason, Leavitt & Chaffee, 2007, p. 35). They also possess skills which can be used in the political arena that are learned though their education and further refined in clinical practice such as communication, persuasion, education, critical thinking, analysis, collaboration and advocacy
(Mason et al., 2007). Nurses are able to contribute significant information and wisdom on a variety of issues, initiatives, policies, etc. They can make an impact and encourage systemic change by incorporating public health advocacy into their practice through the various levels of activity in the roles of nurse citizen, nurse activist and nurse politician.

**Problem Statement**

There is a lack of accessible care for pregnant women in rural Georgia outside of metropolitan Atlanta. It has been estimated that there is currently a 52% deficiency of maternal care providers for women of childbearing age in rural Georgia and by 2020 it is projected to increase to 75% if successful interventions are not implemented (Zetuche & Spelke, 2013) (See Appendix A for map of projection). This is caused by the inadequate recruitment and retention of rural obstetric providers and increasing maternity unit closures in rural hospitals (Zetuche & Spelke, 2013). According to Zetuche & Spelke, Georgia OB/GYNs providers discontinue obstetrical care due to a variety of issues including:

1) Demanding call schedules related to departure of other local obstetricians

2) Unfavorable legal environment related to quash of the malpractice compensation cap as well as a restrictive political climate

3) Low reimbursement rates since 50-60% of Georgia births are Medicaid-funded and pays approximately $1,300 for pre- and perinatal care which is 50-60% the private reimbursement rate (2012). Low Medicaid reimbursement, hospital closures, inadequate inter-professional collaboration & state laws are also part of the problem.

Nurses are not generally prepared to engage in any level of activity in policy work, and tend to focus on individual patient advocacy rather than population based initiatives. It has been
suggested that the reason some nurses are indifferent about policy issues may be due to a lack of knowledge and preparation to assume these roles as well as understanding that their influence can produce results (O’Brien-Larivee, 2011).

Evidence of Problem

**Background.** Women who reside in Georgia have difficulty accessing health care mainly due to deficient access to obstetric providers. There are 1,164,302 women living in rural Georgia out of the 9,992,167 people who live in the entire state (Online Analytical Statistical Information System [OASIS], 2014; United States Department of Agriculture Economic Research Service [USDA ERS], 2014). See Appendix F for the population distribution of Georgia. There are 375,429 women between the childbearing ages of 15-49 who reside in rural areas (OASIS, 2014).

Women who reside in Georgia have difficulty accessing health care mainly due to deficient access to obstetric providers. There are currently 148 hospitals in Georgia, 67 of which are located in rural counties (Rural Assistance Center [RAC], 2014). Hospitals and many of the maternity units in the rural areas are closing at a fast rate due to insufficient funding and staffing. There is only one OB/GYN per 7,125 women in the state (Chu & Posner, 2013). Those women residing in rural areas are more likely to be poor, travel longer distances to receive care, and inadequate medical insurance. (American College of Obstetricians and Gynecologists [ACOG], 2014). For those women who can access the providers, 35% of them do not have insurance and the rest either have inadequate health insurance or rely substantially on Medicaid and Medicare (ACOG, 2014; National Women’s Law Center [NWLC], 2010).
According to the Economic Research Service, the average per-capita income for Georgia residents in 2012 was $37,449 much higher than the rural per-capita income which was $29,828, however this figure is highly influenced by the majority of residents who live in the metropolitan Atlanta area (RAC, 2014). The unemployment rate in rural Georgia is 9.5%, while in urban Georgia it is 7.9% (USDA-ERS, 2013). As a result the poverty rate is an estimated 24.9% in rural Georgia, compared to 18.0% in urban areas of the state (RAC, 2014). Despite the high poverty and unemployment rate, the governor opposed expanding Medicaid eligibility to assists those who do not earn enough to get subsidized private coverage under the Affordable Care Act. This makes it even more difficult for these individuals to fund their medical needs without insurance.

Georgia has the second highest maternal mortality rate and eighth highest infant mortality rate in the country (Chu & Posner, 2013). In Georgia, over one million women who reside in rural areas are at greater risk for experiencing these deaths due to the lack of maternity care available (NWLC, 2010; WHO, 2014b). In 2012, the maternal mortality rate in rural Georgia was 24.3% compared to 16.5% in non-rural Georgia (OASIS, 2014). Infants of mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care (United States Department of Health and Human Services [HHS], Office of Women’s Health, 2012).

For infant mortality rates the differences are not as great as the maternal rates with an infant mortality rate of 7.7% in rural areas compared to 6.6% in non-rural Georgia (OASIS, 2014). Women who receive no prenatal care are three to four times more likely to die of pregnancy-related complications than women who do (Coeytaux, Bingham, & Strauss, 2011). Those with high-risk pregnancies are 5.3 times more likely to die if they do not receive
prenatal care (Coeytaux, Bingham, & Strauss, 2011). These rates demonstrate apparent health disparities rural women in Georgia are facing compared to their non-rural counterparts (see Appendix B for comparisons). Increasing the practice of midwives in rural areas may assist in decreasing these maternal mortality rates.

**Key to Access**

The key to addressing this issue of accessibility to care in rural areas is to focus on increasing access to quality maternity providers since it is the major factor that contributes to these women not receiving obstetric care. Certified Nurse Midwifes (CNMs) are a qualified to address this public health issue (MANA, 2014). There are approximately 15,000 practicing midwives in the United States and they attend approximately 10% of births in the U.S. in multiple setting such as hospitals, birth centers, and private homes (MANA, 2014).

Midwives attended 18.1% of births in Georgia compared to the national average of 8% (NWLC, 2014). In every setting, midwife-led maternity care results in reduced infant and maternal mortality and morbidity, fewer medical interventions, decreased costs, increased savings, and improved client satisfaction (MANA, 2014). As of August 2014, Georgia has 458 CNMs, which is the fourth highest number per state in the U.S. (American Midwifery Certification Board, [AMCB], 2014). However, these CNM’s are significantly concentrated in the Atlanta metro area (BLS, 2014), and not dispersed into the rural areas (See Appendix C).

**Barriers to CNM Practice**

Midwives face many barriers to practice in rural areas such as insufficient practicum sites and preceptors, inadequate Medicaid reimbursement, regulatory issues, unsatisfactory inter-collaboration with physicians and other healthcare professionals, low pay and continuing education opportunities. In the state of Georgia, 50-60% of births are paid by Medicaid which is
a 37% decline in rates from 2001 to 2011 (Zertuche & Spelke, 2013). Although third-party reimbursement is not mandated in Georgia, CNMs are reimbursed by Medicaid at 100% of the physician rate (American College of Nurse Midwives [ANCM], 2014).

The Georgia Maternal and Infant Health Research Group (GMIHRG) conducted a qualitative study to outline the challenges facing Georgia’s obstetric system. They surveyed OB/GYNs residents and CNM students in their last year to determine potential influences on career choice and job location of these future obstetric providers (Zertuche & Spelke, 2013). They found that financial incentives may be the most effective strategy in recruiting OB providers in shortage areas. They also found that CNMs are more likely than OB/GYN residents to seek employment in a shortage area.

**Financial Incentives to Encourage CNM in Rural Areas**

The Health Resources and Services Administration (HRSA) NURSE Corps Loan Repayment Program will pay 60% of registered nurses (including advanced practice registered nurses) unpaid nursing student loans in just two years, and an additional 25% of the original balance for an optional third year if they agree to work in a critical shortage area or facility which are usually located in poor urban and rural areas (HRSA, 2014). It is difficult to fulfill this obligation in rural areas since many of the facilities that are in a critical shortage area or are a critical shortage facility have either closed or shut down the only labor and deliver unit in the county. As these institutions close, the providers move away. CNMs need a hospital, or at least a birthing center to practice from in order to improve access to obstetrical care in rural Georgia.

The state of Georgia mandates these sites as the only place they are allowed to deliver babies. Inadequate inter-professional collaboration is a barrier as well. There is a resistance to
collaboration within the obstetric provider’s field, and it is significantly more apparent in areas where there is not currently a strong midwifery presence. An example of this is in Augusta, the second largest city in Georgia, where there are only two CNMs in this area. Both CNMs only work out of the prenatal clinic, but do not deliver babies. Currently the only physical midwifery school in the state is in Atlanta, while medical schools are only located in four cities; therefore, continuing education is limited in the rural areas. With this shortage, alliance and partnership is necessary for easy access for guidance, collaboration and even educational opportunities.

Solution

By 2030, Georgia’s female population is expected to increase by 25% (ACOG, 2014). Recruiting and retaining an adequate amount of experienced obstetrics providers to care for this influx in rural Georgia is significant in delivering effective services and improving health outcomes (WHO, 2012). Increasing the use of well-trained CNMs is essential to the provision of high-quality rural maternity care throughout pregnancy, birth and the postpartum period (Miller et al., 2012). With the lack of providers in the rural areas, inter-professional collaboration and the use of knowledgeable providers can assist in increasing access promoting good maternal health in addition to reducing morbidity and mortality rates. In order to do this we need to increase quality CNM student placements in rural areas and support CNM preceptors.

Supporting Preceptors to Increase the Accessibility of Care in Rural Areas

Training rural health workers in the rural setting is likely to result in greatly improved recruitment and retention of skilled health-care providers in rural underserved areas with consequent improvement in access to health care for the local communities (Strasser & Neusy, 2012). In order to get more healthcare providers into underserved areas, the Georgia Preceptor
Tax Incentive Program (GA-PTIP) was created in 2014. It is a $10,000 income tax credit for primary care community based faculty physicians precepting third and fourth year Georgia medical students, Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA). In this policy the definition of a preceptor is “A licensed Georgia Physician (either MD or DO) providing uncompensated community based training for medical, nurse practitioner, or physician assistant students matriculating at a Georgia program” (Preceptor tax incentive program, n.d).

Midwifery students are unable to find CNM preceptors in the rural and underserved areas where many are interested in practicing upon graduation. The GA-PTIP should be modified to include APRNS as preceptors in the upcoming 2016 legislative session. Although they both deliver babies, CNMs and OB/GYNs operate under different models and scope, therefore, it would be best for them to be precepted by another CNM. This concept extends to other APRNs. If more APRNs are able to get this credit, then this will lead to providers in the rural area precepting students, having assistance in administering care and retention of students after they complete their studies. Increasingly, clinicians and faculty members are motivated to provide students quality preceptorship placements in rural areas, particularly in light of the potential for recruitment of new graduates to underserved areas (Yonge, Myrick, & Ferguson, 2012). This solution will assist in increasing access to both maternal care and general care providers in rural Georgia.

Evidence

The terms that were included in the literature search for this review were: “midwives and maternity and rural”, “midwives and rural”, “incentives and rural maternity care”, “incentives and rural healthcare”, “incentives and midwifery and rural maternity care”, “Preceptorship & Rural Health Nursing”, “Preceptorship & Rural Health”, “Preceptorship & Rural Health &
recruit*”, “nurse and health policy”, “public health nursing education and policy”. A total of eight databases were used to retrieve evidence on CNM’s providing quality maternity care and how nurses are being educated to incorporate policy and advocacy into their practice: CINHAL, Cochrane Database, PubMed Central, Academic Search Premier, Google Scholar, Health Reference Center Academic, Up-To-Date & Sage.

**Review of Evidence**

Hatem, Sandall, Devane, Soltani & Gates (2008) conducted a systematic review of eleven trials (with a total of 12,276 women) to compare midwife-led models of care with other models of care for childbearing women and their infants. Substantial benefits for women at low risk of pregnancy complications who received continuity of midwifery care were noted such as: decreased risk of antenatal hospitalization, use of regional analgesia, episiotomy, instrumental delivery, experiencing fetal loss before 24 weeks' gestation and shorter length of stay at hospital (Hatem, 2008).

It was also noted that CNM assisted births resulted in an increase in spontaneous vaginal delivery versus induced vaginal deliveries, breastfeeding initiation and women feeling in control during labor and childbirth. The systematic review did not find any differences between groups for caesarean births (Hatem, 2008). Sandall, Soltani, Gates, Shennan & Devane (2013) had similar results as Hatam et al., after systematically reviewing 13 trials involving 16,242 to compare midwife-led continuity models of care with other models of care for childbearing women and their infants.

They also reported a trend towards a cost-saving effect for midwife-led continuity care compared to other care models (Sandall et al., 2013). Wilson et al., conducted a systematic review with a meta-analysis on six cluster randomized controlled trials (n=138 549) and seven
non-randomized controlled studies (n=72,225) to assess the effectiveness of strategies incorporating training and support of traditional birth attendants on the outcomes of perinatal, neonatal, and maternal death in developing countries. They reported perinatal and neonatal deaths are significantly reduced with strategies incorporating training and support of traditional birth attendants.

McLachlan et al. (2012) conducted a randomized controlled trial on a total of 2,314 low-risk pregnant in a tertiary care women’s hospital in Melbourne Australia. Despite finding comparable outcomes in every area as Hatam, et al. (2008) & Sandall et al. (2013), McLachlan et al. found in settings with a relatively high baseline caesarean section rate, caseload midwifery for women at low obstetric risk in early pregnancy shows promise for reducing caesarean births (2012).

Crampton, McLachlan & Illing systematically reviewed 54 articles to infer the strengths and weaknesses for medical students and supervisors of community placements in underserved areas (2013). Although financial incentives have been the focus area when considering policy development for recruiting and retaining healthcare providers in rural and underserved areas, studies have indicated they are not very effective for long term retentions (Crampton et al., 2013). They found that mentoring, clinical supervision and preceptoring are all valuable in meeting the particular challenge of recruitment and retention of rural nurses. Implementing these strategies seems to be essential when considering policies aiming at nursing recruitment and retention of rural nurses in the futures.

McMillian & Barrie surveyed 304 dental students and found that despite financial and academic challenges, students who were from rural areas had a significantly stronger commitment to rural employment than students from cities and towns (2012). Young, Kent &
Walters evaluated 1,450 medical students from 2005–2009 who completed Australia’s John Flynn Placement Program (JFPP), which aims for medical students to experience both rural medicine and rural life as a way of increasing rural career intentions (Young et al., 2010). They used longitudinal tracking data to provide an indication of the success of the program in terms of recruitment into the rural workforce (Young et al, 2010). It was concluded that the JFPP program has an immediate and positive impact on students' perceptions of rural practice and intentions regarding working in rural practice as a career option for 85% of students (Halaas et al., 2008).

Similarly, the outcomes of the Rural Physician Associate Program (RPAP), a state funded program to increase the number of primary care physicians practicing in rural Minnesota, was examined in recruiting and retaining rural primary care physicians (Halaas, Zink, Finstad, Bolin, & Center, 2008). More than 40% of all RPAP students continue to practice in rural settings for the duration of their careers (Halaas et al., 2008). Haalas and colleagues found that RPAP graduates become rural clinicians and often become RPAP preceptors (Halaas et al., 2008).

Summary of Literature review

Based on the results of the studies reviewed, since there are no significant difference between groups for caesarean births, midwives should ensure they have access to a hospital and a provider that is capable to handling a caesarean sections in case of an emergency. These findings also support that the longer the duration of community-based learning experience in a rural area, the more likely providers are to actually practice there upon graduation (Halaas et al., 2008; Young et al., 2010). Therefore, including CNMs as preceptors in the GA-PTIP policy can increase the quantity of midwives who will practice in the rural areas.

Theoretical Framework
The framework to be used to address this population’s problem is the Public Health Intervention Wheel (See Appendix E). This model defines the scope of public health nursing practice by the type of intervention and level of practice (systems, community, and individual/family) (MDH, 2001). It integrates 3 distinct and equally important components:

1) The population basis of all public health interventions

2) The 3 levels of public health practice

3) The 17 public health interventions

Population-based systems-focused practices are the optimal strategy for this problem since it seeks to change organizations, policy laws and power structures (MDH, 2001). The approach to change systems is usually a more effective and long lasting method to impact population health and the effects will eventually percolate to the community, family and individual level.

The system-focused interventions to address this problem to achieve transformation in policies and laws include Health Teaching, Collaboration, Community Organizing, Advocacy and Policy Development (See Table 1 for definitions).

Table 1. Public Health Interventions Wheel Definitions (MDH, 2001)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Health Teaching</td>
<td>Communicates facts, ideas and skills that change knowledge, attitudes, values, beliefs, behaviors, and practices of individuals, families, systems, and/or communities.</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Commits two or more persons or organizations to achieve a common goal through enhancing the capacity of one or more of the members to promote and protect health</td>
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Community Organizing

Helps community groups to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they collectively have set.

Advocacy

Pleads someone’s cause or act on someone’s behalf, with a focus on developing the community, system, individual or family’s capacity

Policy Development

Places health issues on decision-makers’ agendas, acquires a plan of resolution, and determines needed resources. Policy development results in laws, rules and regulation, ordinances, and policies.

The interventions in this framework are broad, thus, can be used for inter-professional collaboration across several disciplines to successfully increase access to maternity care (MDH, 2001). Health teaching can lead to collaboration within the nursing profession and with other healthcare providers, community leaders, policy makers, etc. on various areas. They lead to community organizing and increase the success of advocacy and policy development because they are operating together. With nurses being the largest profession in healthcare, they have the ability to be the catalyst and change agents in any area they choose to focus on. The way to address and promote this is through their nursing education.

Hypothesis

Gebbie, Wakefield and Kerfoot interviewed 27 American nurse involved in health policy as the national, state and local levels to determine why nurse activists became involved (2000). Their results found nursing education provided role modeling and mentoring by faculty, deans and alumni as well as the opportunity to increase political awareness through courses in policy,
political science and economics (Gebbie, Wakefield & Kerfoot, 2000). Nurse educators can modify their curriculum to include a strong foundation where students can learn how to operate as nurse citizens throughout the course of their program. The approach that will be used to increase access to maternity care in rural Georgia is educating nursing student on how to incorporate public health advocacy into their practice. Nursing students are socialized into the profession during their initial educational experience (O’Brien-Larivee, 2011, p. 333). The focus of their nursing program is what will remain and be incorporated into their practice for years to come. Reutter and Williamson (2000) proposed that health policy should be introduced at the baccalaureate level to promote an understanding of policy and advocacy, to move beyond an individual focus of health care, and to begin the process of “thinking policy” (as cited in O’Brien-Larivee, 2011, p. 333). This evidence was used to determine where and what audience would be selected to participate in this intervention.

Method

Project Description

**Population & Organizational Analysis.** The intervention was conducted at Georgia Regents University (GRU) College of Nursing, located in Augusta, Georgia, the second largest city in Georgia (Georgia Regents University [GRU], 2014). GRU was chosen due to the contribution of the school and teaching hospital has on the surrounding areas as well as the dependency the community has on them. GRU is one of four comprehensive research universities within the University System of Georgia, and includes the state's sole public academic health center, representing a statewide vision for health care education, biotechnological development, public health, disease prevention and advanced clinical care (GRU, 2014). GRU encompasses nine colleges with an enrollment of nearly 10,000 students and
over 100 academic programs (GRU, 2014). Additionally, hundreds of residents, fellows and postdoctoral fellows complete advanced training on the GRU Health Sciences Campus (GRU, 2014). The Georgia Regents Health System (GRHS) includes the 478-bed Georgia Regents Medical Center (GRMC) – one of four level one trauma centers in the state, the 154-bed Children’s Hospital of Georgia (CHOG) and Georgia Regents Medical Associates (GRMA), a 400-physician practice group with more than 80 specialty clinics and centers. GRU also operates the Georgia War Veterans Nursing Home (GWVNH) and Georgia Correctional Healthcare (GCHC), (GRU, 2014).

The city of Augusta, where GRU is located, is on border of Georgia and South Carolina. The closest major hospitals in Georgia are in Atlanta and Savannah which are both approximately two and half hours away and Columbia, South Carolina is about an hour and a half away. There are only four community hospitals with limited resources, open in the surrounding 11 counties which are located in rural areas and only one of them has a maternity unit. Residents who live in rural areas receiving any major care usually go to GRHS (which is attached to GRU) or the other hospitals in the Augusta area due to their expertise, resources and providers. GRUs CON is the only one in this part of Georgia area with a Bachelor of Science in Nursing (BSN) program and residential graduate programs for APRNs. Despite being surrounded by rural counties in both states, GRU has limited clinical sites and preceptors to operate in these areas.

**Implementation.** Organizing this community of nursing students to be taught through health teaching about the problem, solutions supported by the literature review and collaborate as they engage in addition to advocate in the role of a Nurse Citizen, will ensure that every aspect of the Public Health Intervention Wheel framework will be initiated during this intervention. The goal
of this project was to conduct a public health education intervention program to nursing students of Georgia Regents University on the problems rural women in Georgia are facing with accessing maternity care, educate them on the policy issues impacting preceptorships with APRNs, how they can use their role as a nurse citizen to advocate on this issue while also supplicating them to contact their congressman. They also learned how to use the evidence from the literature review to support their proposed solution. In this case, they will use a criteria which is discussed later to support Modifying the GA-PTIP to include APRNS as preceptors will increase the amount of CNMs who practice in these rural communities by having more students there during there and who may stay after completing their studies.

This project specifically focused on nursing students (senior BSN students and Masters of Science in Nursing [MSN]). Both program are pre-licensure nursing programs, however, the BSN is for traditional students and the MSN is for second-degree nursing students who will graduate with an MSN in Clinical Nurse Leadership. IRB approval was not necessary since this project did not entail research to be conducted, but was an education intervention where research was translated. The nurses and students personal information was not collected, and therefore protected. Students were recruited to attend the presentation that was not done during class hours with the incentive that the three hours would be added to their practicum hours. The participants consisted of 17 BSN and four MSN senior students (n=21) matriculating GRU ranging between the ages of 21 to 46. Despite the small cohort, it allowed the presentation to be more interactive and engaging. The sample included 18 women and three men.

The post-presentation objectives for students included the ability to:

1) Explain the significance of increasing access to maternity care in rural Georgia
2) Indicate how the GA-PTIP policy can be modified to address this public health issue

3) Apply what they have learned about incorporating the legislative process into their practice to seek to modify the GA-PTIP policy to include APRNs for the next legislative session in 2016

Although similar projects are usually implemented throughout the duration of an entire program or a semester, this project was instituted during the length of time of one regular 3 credit hour course (3 hours) and sectioned into 3 phases. The purpose of creating it in this manner was to offer educators an opportunity to have at least one class in the course dedicated to teaching students how to advocate and be a catalyst to empower them to continue to engage in it after graduation. The three phases of the presentation were as follows:

- **Phase 1: Present the issue (45 minutes)**-
  - Discussed the issue on the lack of access to maternity care in rural Georgia, how this problem has affected the population, the causes and effects of this issue, the solution of using CNMs and the evidence to support it

- **Phase 2: Present information on Advocacy as a Nurse (45 minutes)**
  - Explained what advocacy is and how it relates to nurses
  - Discussed how nurses are minimally involved in policy work and advocacy beyond an individual patient
  - Provided examples of how nurses have made a difference through being involved in advocacy and policy in the past and in the present
  - Discussed how incorporating advocacy, policy, legislative process into their practice can affect them by providing examples on how it can be used in their unit, their organization and community and government
Educated them on how they can become involved by engaging in the various levels of activity presented in Figure 1.

Figure 1. Levels of Activity for Nurse Advocacy (Mason et al., 2007, p. 43)

- Phase 3: Engage in an interactive activity (85 minutes)
  - Integrate the issue with the levels of advocacy through 8 steps
    - Step 1- Find an Issue (Use presented issue discussed earlier as example) they are passionate about, research it and know the opposing views
    - Step 2- Find a policy relating to the Issue (ex. GA-PTIP) whether it is old, new, in process of being created or if one does exist
    - Step 3- Get support by collaborating with others (ex. nurses, other disciplines, organizations, etc.) who are interested in the same issue (collaboration occurred with students to advocate on this issue)
    - Step 4- Find out who the policy makers are
This can be the chain of command at their place of employment or a legislator

Showed them how to find their local, state and federal legislators

Once they found out who it was they were divided into groups based on who their federal and state legislator is

- Big groups broken down into smaller ones

- Step 5- Contact the policy maker by mail or in person.

  Showed them step by step how to set up an appointment while they followed either on their laptops or smartphones.

  Demonstrated what to include in a letter or say to policymaker using the RIATA Asking Criteria in Figure 2, created by author, to have a guide on format to follow when speaking to policymaker:

Figure 2
Provided students with a sample letter based on issues discuss earlier so they can have an idea of what one looked like (See Appendix G)

There was an electronic copy ready of the same copy for those who wanted to email their congressman and a hard copy with a stamped envelope for those who wanted to send it through the post office

Dedicated 15 minutes so students can modify the letter by adding their contact and legislator’s information in addition to something personal to personalize the letter.

Submitting the letter was optional but highly encouraged

- **Step 6- Meet with them**
  - Be on time
  - Look professional
  - Know what you are going to say (30)
    - The next activity will be to role play what they would say to the staffer or congressman with the group they were assigned to previously

- **Step 7- Follow up**
  - Send them a thank you note to follow up and reiterate what you are asking
  - Request to be their resource
- Step 8- On to the next
  - Find another topic of interest and address it by engaging in the different levels of advocacy
  - Encourage students that the more they do it the easier it becomes

- Phase 4- Administer Post-Test evaluation form (See Appendix H)

After the presentation was completed, Georgia residents were encouraged to continue to petition changing the GA-PTIP and tell others about it. For those who are residents of other states, they can use the tools acquired during the intervention to determine if there is a similar policy in place. If there isn’t then they can advocate to their legislators to formulate a similar law to address this issue but include APRNs. Collaborating with other stakeholders to advocate as a unified entity to seek change would be effective since all rural areas of every state are negatively impacted by not receiving quality care in rural areas.

Results

The evaluation process consisted of a nine question post-test evaluation form administered at the end of the presentation. It was created to determine if there was a change in their knowledge base, in addition to if they would be willing to incorporate this in their practice and on what level. Appendix I include the evaluation form that was used. They were also asked if they contacted their legislature to petition changing the GA-PTIP law to include APRNs in the 2016 legislative session when they were given the option to submit the letter they created in class.
All 21 students attended the education intervention and filled out the post-test evaluation form. The results indicated 100% of them thought the presentation was informative. In addition, 9.52% knew how to contact their legislator prior to the presentation and 80.95% stated they knew how to find their legislator’s after the presentation. Seventy six percent stated they did submit the policy letter to their legislator during the exercise, and 57.14% of the students stated they would likely or very likely continue to contact their legislature to petition changing the GA-PTIP law to include APRNs in the 2016 legislative session.

Sixty two percent said they would likely or very likely contact their legislator to advocate for the population they care for, and 71.3% would likely or very likely incorporate what they have learned in this presentation in their practice. Prior to the presentation, 90.48% of the students did not engage in any level of advocacy, however, upon competition of the presentation, 52.38% decided to operate as a nurse citizen, 38.1% nurse activist and 9.52% has decided to engage as an nurse advocate (See Table 2).

Table 2.

![Post-test Evaluation Form Results](image-url)
Although the sample size was small (n=21), it can be concluded that conducting the public health education intervention to educate nursing students has encouraged them to incorporate advocacy on another level into their practice. This intervention was a catalyst needed to ignite the sense of empowerment and knowledge needed to make a difference in the nursing profession and populations. Engaging the students through several interactive activities assists them in putting the theory into practice while purposefully advocating on increasing access to maternity care in rural Georgia.

**Recommendations**

The American Association of Colleges of Nursing’s (AACN) Essentials of Baccalaureate Education for Professional Nursing Practice framework states a BSN program should prepare their students to participate as a nursing professional in political processes and grassroots legislative efforts to influence healthcare policy as well as advocate for consumers and the nursing profession (2008). The author recommends a revision in BSN curriculums to reflect the integration of clinical and classroom learning consistent with the language found in the Baccalaureate Essentials relating to policy and advocacy, standards of the institutions' accrediting bodies, and the state boards of nursing (Mailloux, 2011).

Fostering such values and practices should be embedded into students early in the process of their professional socialization to ensure they continue to apply after graduation (O’Brien-Larivee, 2011). According to (Zauderer, Ballestas, Cardoza, Hood, & Neville (2009), incorporating political education into the general nursing curriculum, educators can show students that they can be instrumental in influencing the political process. Nurse educators can facilitate this process by being role models and presenting opportunities to teach nursing students
how to get involved, advocate and use their credentials to make an impact wherever they choose to practice. They can also modify the nursing curriculum.

Modifying the BSN program to create a solid foundation on being involved as a nurse citizen can be initiated in three ways depending on time, resources and the program. The first option would be to integrate health policy throughout the entire BSN program. Every semester students will learn about a certain area in nursing, find a policy that relates to it (it can be one or multiple ones based on the issue) and advocate to their legislator using the RIATA Asking Criteria. This can be done as a small group project or depending on the class size they can do it collectively and vote on what policy they would like to do together.

Another option would be to dedicate a semester to teach health policy and community advocacy to undergraduates. The Public/Community Health Nursing course is the optimal point in the curriculum to present advocacy since a big part of this area is centered on seeking advocacy beyond the individual level and acute care. Students can be assigned to find an issue where they will research a policy or proposed policy. Educators can coordinate a trip to the state capitol and encourage students to schedule appointment to speak to their legislators for extra points.

The actual experience of speaking to legislators will bridge the gap between theory, memorizing facts and active learning (Zaunder et al., 2001). Including a lobbyist or someone similar to speak during the course can prepare them for their visits by assisting with creating simple speaking points, providing them with advice on what they can do to be effective, etc. The final option is the public health advocacy intervention implemented in this project. It is simple, and can be conducted as a pilot program prior to expanding it in other areas of the curriculum. It
would require minimal resources and time commitment without sacrificing the essence of the message and yielding lasting behavioral change on the students.

Nurses need to take a stand in advocating for change with maternity care in rural Georgia. Nurses must be the force and the agents of change by advocating for their patients, community as well as profession. Since nurses are the largest professional group within healthcare and have been voted the most trusted profession by the public for 14 consecutive years, they need to capitalize on this and seek change when opportunities present themselves (Tomajan, 2012).

Advocacy should be given the same amount of importance as other subjects and skill sets in nursing education as well as practice. Nurse educators can take the lead in this area by preparing nursing students to take on their leadership roles in public health advocacy or other area of practice. Once engaged, nurses seldom turned their backs on the world of policy-making (Gebbie, Wakefield & Kerfoot, 2000). The 76.3% of students who participated in the intervention were able to make a difference the lives of rural women in Georgia in 15 minutes. The level of activity that a nurses chooses to participate will vary based on the individual’s goals, time, comfort level, focus knowledge, etc. The goal is to provide them with the knowledge and tools they need to at least operate as a nurse citizen.

Although the three roles of nursing advocacy operate differently, they synergistically operate together. Nurses who do incorporate advocacy into their practice, are more likely to function in the role of nurse citizen since it is the least labor intensive and time consuming. As a citizen, they can influence what the government is trying to do through vocalization of support or opposition. The Nurse activist can influence the introduction of legislation as constituents and as members of professional associations that lobby, providing testimony at bill hearings, write to
members of committees voting on pieces of legislation and block or submit amendments to bills both federally and at the state level (Campbell, 2004). If the nurse citizen doesn't speak-up, vote, write or discuss a policy, the activist has no sense of direction or purpose and the politicians will not be aware of important issues such as excessively high maternal mortality rates in rural Georgia (Campbell, 2004).

Conclusion

Maternal mortality is neglected problems in rural Georgia due to a lack of providers, frequent hospital and maternity unit closures and an insufficient amount of OB providers in these areas. This has resulted in increased complications and mortality for both mother and infant. Recruiting and retaining quality, experienced midwives in rural Georgia can address this dire situation. Midwives would be an appropriate solution when recruiting quality maternity providers to rural Georgia. The evidence has established that midwives are safe and provide quality care, which can result in substantial benefits to the women and babies.

The literature also demonstrates that precepting students in rural areas will help attract and retain providers in these under-served areas. A system-focused intervention is the right solution to achieve transformation in policies and laws. The public health intervention educated nursing students about the lack of access to maternity care in rural areas, the GA-PTIP policy and how to utilize this information to support this population at risk. This will hopefully lead to more nurses uniting to seek systemic changes through public health advocacy on various levels in their practice. This project presentation resulted in approximately three quarters of the students actively engaging in contacting their legislators on the revision of GA-PTIP, and all of them stating they will engage in some type of level of advocacy activity.
As our rapidly changing healthcare environment continues to create new policies, it is imperative nurses are included in the process providing their expertise, insight, and recommendations. Politically cognizant nurses assist in expanding and modifying the healthcare system by consciously connecting political awareness with what is occurring in practice (Zauderer et al., 2009). Advocating on an issue on behalf of a population at risk is no different than what is done when advocating for a patient. Every nurse in every setting has the opportunity to make a positive impact on the profession through advocating daily for nurses and the nursing profession (Tomajan, 2012). The essential skills required for advocacy are the core traits nurses need to provide safe and effective care which include: problem solving, communication, influence and collaboration. Equipped with the knowledge to translate these skills into advocacy, nurses can become engaged in the varying levels of activity in advocacy through the roles of a nurse citizen, nurse activist and nurse politician to make a change in rural Georgia, the nursing profession and community.
References


Citizens for Midwifery [CFM], (2014). Retrieved from cfmidwifery.org


In 2011, there were 29 counties that were adequately staffed, however, by 2020 only 9 will have a sufficient amount of providers.

(Zertuche & Spelke, 2013)
Appendix B

Georgia Mortality Rates

(OASIS, 2014)
Appendix C

Employment of nurse midwives, by area, May 2013

Blank areas indicate data not available.

(BLS, 2014)
## Evidence Matrix

<table>
<thead>
<tr>
<th>Study</th>
<th>Objective &amp; Subjects</th>
<th>Study Design/Method</th>
<th>Findings and Conclusions</th>
<th>Study Strengths and Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hatem, M., Sandall, J., Devane, D., Soltani, H., Gates, S. (2008). Midwife-led versus other models of care for childbearing women. Cochrane Database System Review, 8;(4):CD004667. doi: 10.1002/14651858.CD004667.pub2</td>
<td>The study included 11 trials (12,276 women) to compare midwife-led models of care with other models of care for childbearing women and their infants</td>
<td>Cochrane Review</td>
<td>Women who had midwife-led models of care were less likely to experience antenatal hospitalization, use of regional analgesia, get an episiotomy, have an instrumental delivery and were more likely to experience no intrapartum analgesia/anesthesia, feel in control during labor and childbirth, attendance at birth by a known midwife, and initiate breastfeeding. Patients of midwife-led care were less likely to experience fetal loss before 24 weeks' gestation. - All women should be offered midwife-led models of care and women should be encouraged to ask for this option</td>
<td>A strength of this study is it was a Cochrane review and the limitations is in regard to the best way to organize midwifery-led care (caseload and team care) due to insufficient events to do an analysis.</td>
</tr>
<tr>
<td>Sandall, J., Soltani, H., Gates, S., Shennan, A., &amp; Devane, D. (2013). Midwife-led continuity models versus other models of care for childbearing women.</td>
<td>To compare midwife-led continuity models of care with other models of care for childbearing women and</td>
<td>Cochrane Review; 13 trials involving 16,242 women</td>
<td>- Most women should be offered midwife-led continuity models of care and women should be encouraged to ask for this option although caution should be exercised in applying this advice to women with substantial medical or obstetric complications.</td>
<td>Given the heterogeneity in the choice of outcome measures routinely collected and reported in randomized evaluations of models of maternity care, a core (minimum) dataset and a validated measure of maternal quality of life and wellbeing would be useful not only within multi-center trials and for comparisons between trials, but might</td>
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<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Summary</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>McLachlan, J.L., Forster, D.A., Davey, A., Farrell, T., Gold, L., Biro, M.A., …. Waldenström, U. (2012). Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomized controlled trial. BJOG, 119(12):1483-92. doi: 10.1111/j.1471-0528.2012.03446.x.</td>
<td>Randomized controlled trial</td>
<td>- To determine whether primary midwife care (caseload midwifery) decreases the caesarean section rate compared with standard maternity care on a total of 2314 low-risk pregnant women.</td>
<td>- In settings with a relatively high baseline caesarean section rate, caseload midwifery for women at low obstetric risk in early pregnancy shows promise for reducing caesarean births; more likely to have a spontaneous vaginal birth, less likely to have epidural analgesia and have an episiotomy. - Infants of women allocated to caseload were less likely to be admitted to special or neonatal intensive care. - The study may not be generalizable in other settings. There may have been unique and unmeasured factors that make it different from other settings such as the single site study had strong management and organizational support whereas other settings may not have that. - There is a reduced risk of bias since it was an RCT.</td>
</tr>
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| Wilson, A., Gallos, I.D., Plana, N., Lissauer, D., Khan, K.S., Zamora, J., MacArthur, C. & Coomarasamy, A. | Systematic review with meta-analysis | To assess the effectiveness of strategies incorporating training and support of | - Perinatal and neonatal deaths are significantly reduced with strategies incorporating training and support of traditional birth attendants. - All six randomized controlled trials found |

Strength: the consistency in the results contributes to the generalizability of the findings, which will be important for policy making. Since only one cluster randomized
### PUBLIC HEALTH ADVOCACY

| (2011). Effectiveness of strategies incorporating training and support of traditional birth attendants on perinatal and maternal mortality: meta-analysis. *BMJ*, 343. doi: [http://dx.doi.org/10.1136/bmj.d7102](http://dx.doi.org/10.1136/bmj.d7102) | traditional birth attendants on the outcomes of perinatal, neonatal, and maternal death in developing countries.
- six cluster randomised controlled trials (n=138,549) and seven non-randomised controlled studies (n=72,225) | a reduction in adverse perinatal outcomes
- The meta-analysis showed significant reductions in perinatal death and neonatal death
- Meta-analysis of the non-randomized studies also showed a significant reduction in perinatal mortality and neonatal mortality
- Six studies reported on maternal mortality and our meta-analysis showed a non-significant reduction | controlled trial existed at the time of the review, they could not draw firm conclusions from the statement that “traditional birth attendant training had promising potential to reduce perinatal and neonatal mortality when combined with health services; however the limited number of studies included did not provide the evidence needed.” Our meta-analysis, consisting of six cluster randomized controlled trials and seven non-randomized controlled studies, allows firm inferences to be drawn. |

| McMillan, W. J., Barrie, R. B. (January 01, 2012). Recruiting and retaining rural students: Evidence from a faculty of dentistry in South Africa. *Rural and Remote Health*, doi: 10.1016/j.healthpol.2007.12.006 | A self-administered questionnaire was completed by 304 (70%) of the total number of 435 undergraduate dental students to investigate the factors affecting rural Descriptive Study | Only 7% (n=22) of the cohort (n=304) were from rural areas, and despite financial and academic challenges, rural students had a significantly stronger commitment to rural employment than students from cities and towns
Rural students were three times more likely than other students to want to work in rural areas. | Given that 59% of South Africans live in rural areas, to only have only 7% represented in this study is clearly inadequate. |

This paper reports on an evaluation of the John Flynn Placement Program (JFPP) for medical students. JFPP aims for medical students to experience both rural medicine and rural life as a way of increasing rural career intentions. Evaluation data from 1450 placements from 2005–

Medical students experience two weeks a year over four years with a rural doctor. Students are evaluated at the end of each placement for clinical and social experiences and career intent. They are followed up annually to monitor career intent. Mentors are evaluated - Overall mean for clinical and rural experiences is extremely positive for both students and mentors. After four JFPP placements 65% of students intend to work in rural areas. After one JFPP experience 9% indicate intent to practice as a rural general practitioner while after their fourth JFPP nearly 20% are indicating intent to practice as a rural general practitioner.

- Longitudinal experiences, such as the JFPP, are positively influencing intention to enter the rural workforce but the impact of urban centric vocational training might be negating this impact.

Data collection regarding JFPP alumni career outcomes will be strengthened in the future as JFPP links with the Medical School Outcome Database.
| 2009 are reported annually on clinical and rural experiences during a placement. | To examine RPAP outcomes in recruiting and retaining rural primary care physicians. | Descriptive statistics were used to examine data on RPAP graduates' demographics, community of origin, community where raised, specialty choice, and practice sites. | -RPAP data suggest that the 9-month longitudinal experience in a rural community increases the number of students choosing primary care practice, especially family medicine, in a rural setting. | Some graduates have been lost to follow-up. The AAMC's graduation questionnaire may not be a perfect reflection of match figures since it is completed by students in their fourth year before residency match results. |

Appendix E

MDH, 2001
Appendix F

Map of Georgia Population Distribution
The 5 counties in the darkest blue areas make up the Atlanta Metro area

Augusta, the second largest city in Georgia, is located Richmond County which is the second largest county

Columbus, Georgia is located in Muscogee County which is the 3rd largest county

Macon, Georgia is located in Bibb County which is the 4th largest county

Savannah, Georgia is located in Chatham County which is the 5th largest county
Dear State Senator Some Body,

My name is Fabiola Romain-Lapeine and I am a Registered Nurse. I am a faculty member at Georgia Regents University where we get many patients who come to receive maternity care at Georgia Regents Medical Center from rural areas as far away as 2 hours due to a lack of access to providers. Many do not make it or come at all due to the complex nature of trying to get here.

Studies show that there is a 52% deficiency or complete absence of maternal care providers in rural Georgia and it is projected to increase to 75% by 2020 if something doesn’t change. Studies have shown Certified Nurse Midwives (CNMS) to have great outcomes as OB/GYNs with less problems and are willing to work in rural areas which can alleviate this problem.

I would like to request that you consider modifying the Georgia Preceptor Tax Incentive Program (GA-PTIP) policy to include Advance Practice Registered Nurses APRNs as preceptors in the 2016 legislative session. Although they both birth babies, CNMs and OB/GYNs operate under different models and scope, therefore, it would be best for them to be presented by another CNM. This concept extends to other APRNS and Physician Assistants. This solution will assist in decreasing the rate of insufficient maternity care providers in these areas in the future.

I would like to meet you in person to discuss this further (OPTIONAL). If you have any questions or would like to use me as a resource please contact me at FLapeineRN@gmail.com or 347-555-5555. Thank you.

Date, 10, 2015

Fabiola Romain-Lapeine, BSN, RN, MHS
Appendix I

Increasing Access to Maternity Care in Rural GA through Advocacy

Post-Test Nurse Advocacy

* Required

1. **Was this presentation informative?** *
   - Yes
   - No

2. **Do you know how to find out who your legislators are after this presentation?** *
   - Yes
   - No

3. **Do you know how to contact your legislator?** *
   - Yes
   - No

4. **Did you submit the policy letter to your legislator during the exercise?** *
   - Yes
   - No

5. **After this presentation, how likely are you to contact your legislator to advocate for the population you care for?** *

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<tbody>
<tr>
<td>Not Likely</td>
<td>Very Likely</td>
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6. **How likely are you to incorporate what you have learned in this presentation in your practice?**

   | 1 | 2 | 3 | 4 | 5 |
7. **How likely are you to contact their legislature to petition changing the GA-PTIP law to include APRNs in the 2016 legislative session?**

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<tbody>
<tr>
<td>Not Likely</td>
<td>Very Likely</td>
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8. **Before this presentation, what level of advocacy did you engage in?** *
   - **None**
   - **Nurse Citizen**: Registers to vote, votes in election, Keeps informed about health care issues, Speaks out when services or working conditions are inadequate, Participates in public forums, Interacts regularly with local, state and federal elected officials, Joins politically active nursing organization
   - **Nurse-Activist**: Contact public officials through meetings, letters, email or telephone; Lobbies decision-makers by providing pertinent statistical and anecdotal information; Lobbies decision-makers by providing pertinent statistical and anecdotal information; Forms or joins coalitions that support an issue of concern; Writes letters to the editors of local papers;; Invites legislators to visit the workplace;; Holds a media event to publicize an issue; Provides testimony
   - **Nurse Politician**: Runs for elected office; Seeks appointment to a regulatory agency; Seeks appointment to governing boards in the public or private sector; Uses nursing expertise as a policymaker in public or private sector

9. **After this presentation, what level of advocacy do you plan on engaging in?** *
   - **None**
   - **Nurse Citizen**: Registers to vote, votes in election, Keeps informed about health care issues, Speaks out when services or working conditions are inadequate, Participates in public forums, Interacts regularly with local, state and federal elected officials, Joins politically active nursing organization
   - **Nurse-Activist**: Contact public officials through meetings, letters, email or telephone; Lobbies decision-makers by providing pertinent statistical and anecdotal information; Lobbies decision-makers by providing pertinent statistical and anecdotal information; Forms or joins coalitions that support an issue of concern; Writes letters to the editors of local papers;; Invites legislators to visit the workplace;; Holds a media event to publicize an issue; Provides testimony
- **Nurse Politician**: Runs for elected office; Seeks appointment to a regulatory agency; Seeks appointment to governing boards in the public or private sector; Uses nursing expertise as a policymaker in public or private sector