Pioneering the Path for Public Protection

2010 NCSBN ANNUAL MEETING SESSION BOOK

AUG. 11 –13, 2010
Portland, Ore.

NCSBN Environmentally Conscious Meeting Commitment

As our members have requested, NCSBN is committed to holding environmentally friendly or green meetings. As part of our new policy, each hotel that is considered to host an NCSBN meeting will be given a green checklist to determine the property's environmental impact. As we move forward with our green meetings initiative, we will also ask you to contribute to the effort to decrease our carbon footprint and help preserve our world.

How You Can Help

- Recycle all paper in the provided bins in the meeting rooms.
- Reuse the towels in your guest room by hanging them up after use.
- Request that housekeeping does not replace the sheets for the entire length of stay.
- Turn off all the lights in your room each time you leave.
- Place your badge in the provided recycle bin at the end of the meeting.

How the Hilton Portland & Executive Tower is Helping By:

- Providing collection bins for the recycling of paper in meeting rooms.
- Providing condiments, beverages and other food items in bulk instead of individually packaged and assuring that the packaging of these items is recyclable and recycled, when possible.
- Providing reusable glass bottles in meeting rooms.
- Banning Styrofoam in any food/beverage functions or outlets.
- Providing all paper bathroom supplies with post-consumer recycled content paper.
- Using environmentally responsible cleaning products for carpets, floors, kitchens and bathrooms.
- Using china service or biodegradable disposable service.
- Avoiding the use of polystyrene #6 plastic.
- Using cloth napkins or post-consumer recycled paper napkins.
- Using sustainable food.
- Using compact fluorescent light bulbs in guest rooms.
- Replacing towels and sheets upon request.
- Using refillable shampoo dispensers.
- Guest rooms have "smart" AC/heat units—motion sensors that turn on and off as guest leaves room.

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SESSION BOOK | NCSBN 2010 ANNUAL MEETING

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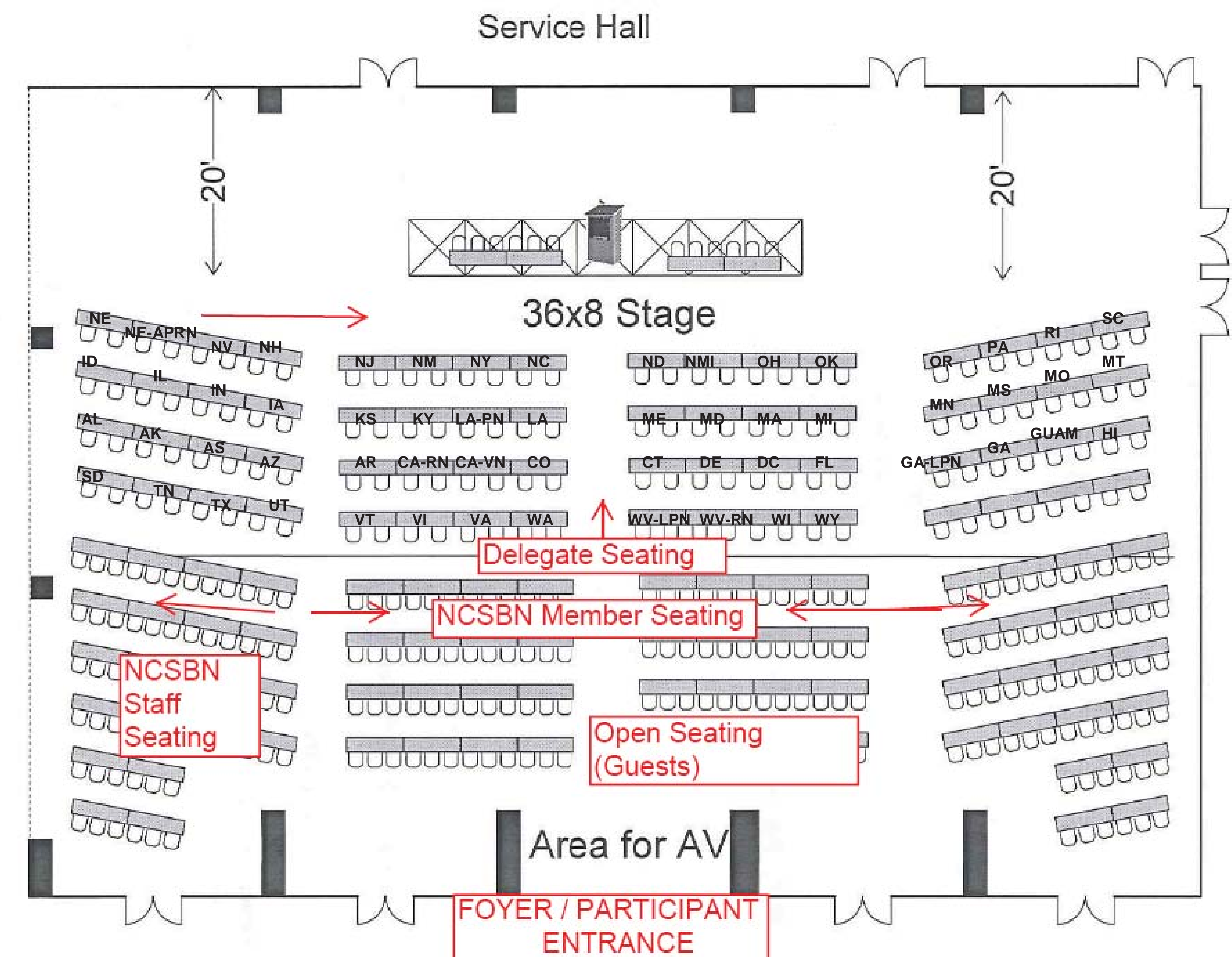

Service Hall
20'
20'
36x8 Stage
NE
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DC
FL
WV-LPN
WV-RN
WI
WY
OR
PA
RI
SC
MN
MS
MO
MT
GA-LPN
GA
GUAM
HI
Delegate Seating
NCSBN Member Seating
NCSBN Staff Seating
Open Seating (Guests)
Area for AV
FOYER / PARTICIPANT ENTRANCE

Directions for Obtaining Continuing Education (CE) Contact Hours for the 2010 Delegate Assembly

In an attempt to streamline the CE process, as well as to be environmentally responsible, we are awarding your CE certificates electronically:

Please follow these directions carefully if you'd like to receive CE contact hours:

1. Sign the CE roster at the registration desk. ***This is critical for obtaining CE contact hours.*** If you don't sign in, we won't be able to send you an electronic evaluation form.
2. Attendance at designated CE sessions is required to obtain contact hours, along with completion of the evaluation form pertaining to those presentations.
3. After the meeting concludes, NCSBN will e-mail the electronic evaluation form, which must be completed in order to obtain CE contact hours.
4. Once we receive your electronic evaluation, NCSBN will send you an electronic CEU certificate. ***The deadline to complete the electronic evaluation is Friday, Sept. 3, 2010.***
5. If you have any questions, e-mail Qiana Hampton, administrative assistant, Regulatory Innovations, NCSBN at qhampton@ncsbn.org.

Thank you

Finance Committee Forum

Presented by:

Randall Hudspeth, MS, APRN-CNS/NP, FRE, FAANP
Treasurer, NCSBN Board of Directors

Finance Committee Report

Presented by: Randall Hudspeth, Treasurer

Finance Committee Charge

- Financial Policies
- Budget
- Financial Statements
- Audit
- Investments
- Liability Insurance

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Finance Committee Members

Rula Harb, MS, RN, Massachusetts Area IV

Diane M. Sanders, RN, BC, MN, CNA, Washington, Area I

Mark Majek, MA, PHR, Texas, Area III

Cynthia Burroughs, BA, MA, PHD, Arkansas, Area III

Daniel Hudgins, North Carolina, Area III

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Finance Strategy

Initiatives	Outcomes
Financial Planning	•Financial stability •Internal source of funds •Financial resource allocation aligned with mission
Investment Management	•Optimum return on investments
Internal Control Risk Management	•Asset protection

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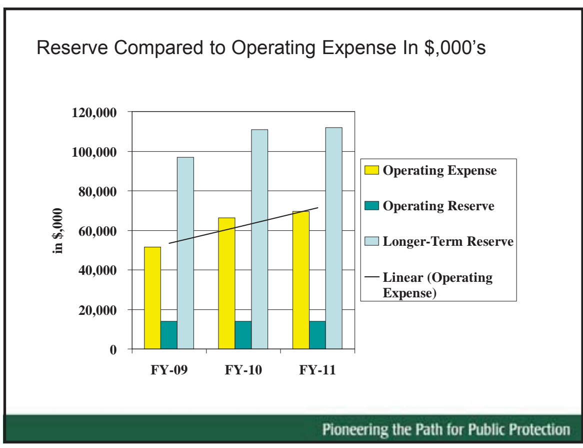

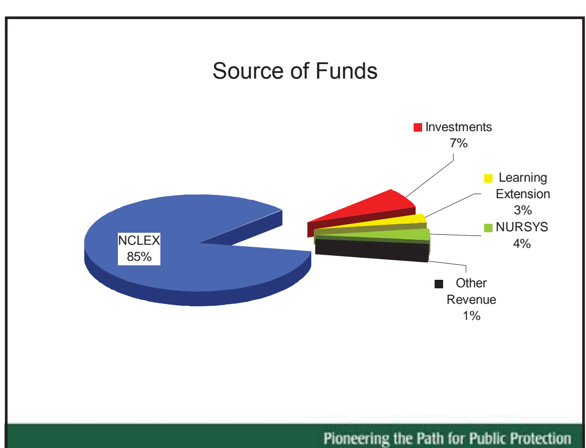

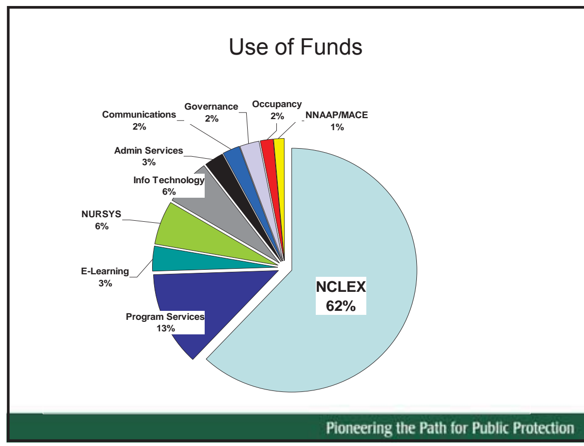

Use of Funds for Program Services to Support the Membership

- Annual Meeting ($ 529,000)
- Midyear Meeting ($353,000)
- Support 16 Committees ($716,000)
- Educational Conferences ($455,000)
- Resource Fund ($125,000)
- Data Integrity Project ($1.8 million) expended over multiple years

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Financial Planning Performance Summary

Internal Source of Funds	• $ 14 million short-term operating reserve. • $111 million combined long-term and intermediate reserves.
Financial Stability	• Budgeted revenues exceed operating expenses. Focus on operating expense budget that can be supported by primary revenue source over the longer term.
Resource Allocation	• Operating budget linked to mission with consideration for impact on financial reserves.

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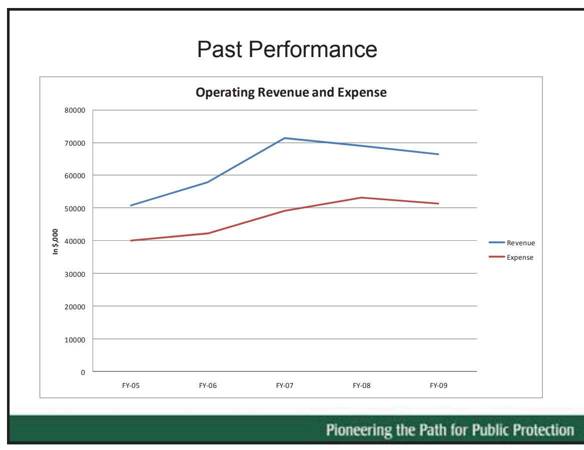

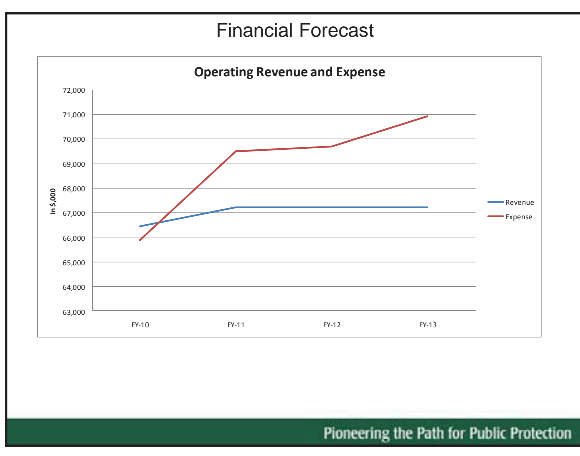

Protect Assets

- Unqualified opinion on financial statement audit
- Independent audit committee
- Internal Control Policy
- Favorable report from investment prudence review
- Adequate property and professional liability insurance coverage

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Financial Performance Summary

- Reserve position that provides an internal source of funds
- Balanced operating budgets
- Budgets linked to the mission and the strategic plan
- Investment returns equal benchmarks
- Comparatively minimal losses during severe economic downturn
- An unqualified audit opinion from the independent accountants
- Policies that guide good internal control practices
- Liability insurance that protects against loss

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Questions

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NCLEX® Examination Committee Forum

Presented by:

Patricia Spurr, EdD, MSN, RN
Chair, NCLEX® Examination Committee

2010 NCLEX® Examination Committee Report

Patricia Spurr, EdD, MSN, RN, Chair
NCLEX® Examination Committee

NCLEX® Examination Committee Members

Patricia Spurr, EdD, MSN, RN
- Kentucky, Area III

Margarita Bautista-Gay, MN, RN
- Guam, Area I

Usrah Claar-Rice, MS, MSN, RN
- Washington, Area I

Claire Glaviano, MN, RN
- Louisiana-PN, Area III

Doris Hill, PhD, RN, CNOR
- Minnesota, Area II

Janice Hooper, PhD, RN
- Texas, Area III

Lorinda Inman, MSN, RN
- Iowa, Area II

Patricia Lange-Otsuka, EdD, APRN
- Hawaii, Area I

Barbara Peterson, EdD, MSN, RN
- Delaware, Area IV

Barbara Zittel, PhD, RN
- New York, Area IV

Board Liaison: Pamela Autrey, PhD, MSB, MSN, RN – Alabama, Area III

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NCLEX® Item Review Subcommittee Members

Susan Baltrus, MSN, RN, CNE
- Maine, Area IV

Kristin Benton, MSN, RN
- Texas, Area III

Pamela Ambush-Burris, MSN, RN
- Maryland, Area IV

Amanda Campbell, BSN, RN
- Connecticut, Area IV

Patricia Johnson, LPN
- Arizona, Area I

Barbara Knopp, MSN, RN
- N. Carolina, Area III

Cecilia Mukai, PhD, APRN
- Hawaii, Area I

Nancy Murphy, MS, RN-BC
- S. Carolina, Area III

Christine Naas, LPN
- New Hampshire, Area IV

Judith Pelletier, MSN, RN
- Massachusetts, Area IV

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NCLEX® Item Review Subcommittee Members

Sharon Ridgeway, PhD, RN
- Minnesota, Area II

Cristiana Rosa, MSN, RN
- Rhode Island, Area IV

Catherine Rose, MSN, RN
- Rhode Island, Area IV

Kathleen Sullivan, MBA, RN
- Wisconsin, Area II

Rhonda Taylor, MSN, RN
- Washington, Area I

Linda Young, MS, RN-BC
- South Dakota, Area II

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Recommendation to the Delegate Assembly

- Adopt the proposed *2011 NCLEX-PN® Test Plan*

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Rationale for the *2011 NCLEX-PN® Test Plan* Recommendations

Recommendations are based on:

- *2009 PN Practice Analysis*
- Expert Judgment
- Feedback from Boards of Nursing
  - 75% of the Member Boards submitted feedback

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Proposed *2011 NCLEX-PN® Test Plan*

– Overall format is retained

– Minor edits for currency and clarification

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Proposed *2011 NCLEX-PN® Test Plan*

– "Client Needs" structure is retained

– "Integrated Processes" section is retained

– Majority of the items continue to be written at the application or higher level of cognitive complexity

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Item Allocation Percentages

2008 PN TEST PLAN CATEGORIES		2011 PN TEST PLAN CATEGORIES	
Client Needs Categories/ Subcategories	Percentage of Items	Client Needs Categories/ Subcategories	Percentage of Items
Safe and Effective Care Environment		**Safe and Effective Care Environment**	
• Coordinated Care	12-18%	• Coordinated Care	13-19%
• Safety and Infection Control	8-14%	• Safety and Infection Control	11-17%
Health Promotion and Maintenance	7-13%	**Health Promotion and Maintenance**	7-13%
Psychosocial Integrity	8-14%	**Psychosocial Integrity**	7-13%
Physiological Integrity		**Physiological Integrity**	
• Basic Care and Comfort	11-17%	• Basic Care and Comfort	9-15%
• Pharmacological Therapies	9-15%	• Pharmacological Therapies	11-17%
• Reduction of Risk Potential	10-16%	• Reduction of Risk Potential	9-15%
• Physiological Adaptation	11-17%	• Physiological Adaptation	9-15%

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Proposed Implementation Timeline
2011 NCLEX-PN® Test Plan

- **August 2010 -** Delegate Assembly action is provided on proposed test plan
- **September 2010 -** Panel of Judges Standard Setting Workshop is convened
- **December 2010 -** Board of Directors evaluates the passing standard for the NCLEX-PN examination
- **April 2011 -** Implementation of the *2011 NCLEX-PN® Test Plan* and the passing standard

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Questions

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Continued Competence Committee Forum

Presented by:

Katie Daugherty, MN, RN
Chair, Continued Competence Committee

Guiding Principles for Continued Competence

Katie Daugherty, RN, MN
Chair, Continued Competence Committee

Approve the Guiding Principles of Continued Competence

- Provide a common ground for discussion
- Guide future research and work in the area of continued competence

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Guiding Principle #1

The individual nurse in collaboration with the state board of nursing, nursing educators, employers and the nursing profession has the responsibility to demonstrate continued competence through:

- **Acquisition of new knowledge and skills**
- **Appropriate, safe application of knowledge and skills**

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Guiding Principle #2

A culture of continued competence is based on the premise that the competence of any nurse should be periodically evaluated.

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Guiding Principle #3

Requirements for continued competence should support nurse accountability for lifelong learning and foster improved nursing practice and patient safety.

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Guiding Principle #4

The state boards of nursing have the regulatory authority for establishing continued competence requirements.

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Thank you for your attention!

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Bylaws Committee Forum

Presented by:

Nathan Goldman, JD
Chair, Bylaws Committee

Bylaws Committee Forum

Nathan Goldman, JD
Chair, Bylaws Committee

2010 Bylaws Committee

Chair: Nathan Goldman, JD, Kentucky, Area III
Board Liaison: Laura Rhodes, MSN, RN, West Virginia-RN, Area II
Staff: Kathy Apple

Committee Members
Patti Clapp (Consumer Member), Texas, Area III
Cereese Lewis-Smith, MSN, BSN, RN, Virgin Islands, Area IV
Laura Poe, MSN, RN, Utah, Area I
Patricia A. Seabrooks, ARNP, BC, DNSc, Florida, Area III

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What are Bylaws?

- Significant written rules by which an organization is governed
- Subordinate to the Articles of Incorporation; if there is a conflict, the articles always prevail.

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What is included in the Bylaws?

- Statement of Purpose
- Members
- Member Requirements and Classes
- Board of Directors
- Method of Selection
- Terms and Limits
- Quorum, Voting, and Proxies
- Vacancies
- Conflicts of Interest
- Officers

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What else is included in the Bylaws?

- Meetings
- Committees
- Standards of Conduct and Codes of Ethics
- Financial Controls
- Indemnification, Immunity, and Insurance

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Amendment of Bylaws

- If a bylaws provision no longer fits the organization's current situation or preferred method of operation, the bylaws provision must be formally changed
- According to Article XIV, two-thirds vote is needed by the Delegate assembly at annual Meeting in order to approve proposed amendments to the bylaws.

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Proposed Bylaw Revision #1

Election of Officers
Pg. 4, Article V, Section 5, letter f

- **Notwithstanding any provision of this Section, in the event there is only one candidate for an officer or director position, election for that position shall be declared by acclamation. No ballot shall be necessary.**

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Proposed Bylaw Revision #2

Leadership Succession Committee
Page 5, Article VII, Section 1, letter c, second sentence

- The Committee shall be elected by plurality vote of the Delegate Assembly at the Annual Meeting. **In the event there is only one candidate for a committee position, election for that position shall be declared by acclamation. No ballot shall be necessary.** The Chair shall be selected by the Board of Directors.

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Proposed Bylaw Revision #3

Leadership Succession Committee
Page 5, Article VII, Section 1, letter f, last sentence

- Ensuring that nominees for election, who are nominated from the floor, are vetted for qualifications and geographic distribution in the same manner as all nominees.
- Will not affect nominations from the floor.

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Proposed Bylaw Revision #3 Continued

Leadership Succession Committee
Page 5, Article VII, Section 1, letter f, last sentence
Language reads:
• The Leadership Succession Committee shall recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning; present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee. The Committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee. The Leadership Succession Committee shall determine qualifications and geographic distribution of nominations from the floor for recommendations to the Delegate Assembly.

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Thank you

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Disciplinary Resources Committee Forum

Presented by:

Sandy Evans, MAEd, RN
Chair, Disciplinary Resources Committee

Disciplinary Resources Committee Forum:

Boundary Violation and Sexual Misconduct Model Act and Rules

Sandra Evans, MAEd, RN, Executive Director, Idaho BON, Chair of DRC

Delegate Assembly
August 11, 2010
2:10 - 2:25 pm

Committee Members:

Sandra Evans, ID- Chair
Myra Broadway, ME – BOD Liaison
Dennis Corrigan, OH
Linda Taft, MI
Lynn Lewis, SC
Margaret Sheaffer, PA
Mary Trentham, AR
Rene Cronquist, MN
Trent Kelly, WA
Nancy Spector- Staff

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DRC 2010 Charge

Develop model rules on sexual misconduct including boundaries

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Why the Charge is Relevant

Findings from 3 MB surveys:

- Current related model language is limited
- BONs are reporting increased complaints of boundary violations, particularly with use of the Internet
- BONs requested model language specific to sexual misconduct and boundary violations

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NCSBN's Model Act and Rules

- A living document regularly reviewed
- Reflects current practice, but also suggests new approaches
- Boards can adopt in total, in part, or adapt as necessary for their jurisdiction

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Process for Development of New Model Language:

- Surveys and communication with membership
- Review of current NCSBN Model language
- Literature Review
- Review of statute/rules of other health professions
- DRC review of numerous draft iterations

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Proposed Changes to the Models

- Additional definitions
- Additions to Model Act ‘Grounds for Discipline’
- Model Rules that serve to clarify provisions of the Model Act

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Definitions – Article III, Chapter 3:

Existing:

Professional boundaries- the space between the nurse’s power and the client’s vulnerability; the power of the nurse comes from the professional position and access to private knowledge about the patient; establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the patient’s needs.

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New Definitions

- Dual relationship
- Electronic media
- Key party
- Professional boundary crossing
- Professional boundary violation
- Sexualized body part
- Sexual misconduct

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Changes to Model Rules Chapter 11, Section 2

- Addition of rules of conduct for establishing/maintaining appropriate professional boundaries
- Addition of rules of conduct identifying what constitutes sexual misconduct
- Clarification that patient consent is not a defense
- Clarification of parameters for when the professional relationship ends
- Identification of factors that clarify relationships with former patients
- Clarification of what the rules do not prohibit

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Electronic Media

Boundaries:

Avoid statements or disclosures that create a risk of compromising a patient's privacy, confidentiality and dignity. This includes, but is not limited to, statements or disclosures via electronic media.

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Electronic Media

Sexual misconduct:

Transmitting information via electronic media that can be reasonably interpreted as sexual or sexually demeaning by the current or former patient or key parties.

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Some Discussion Points

- Definition for professional boundaries - kept current
- Why designate 2 years for psychiatric nurses having a relationship? American Psychological Association Ethical Principles of Psychologists and Code of Conduct: http://www.apa.org/ethics/code/index.aspx

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Questions?

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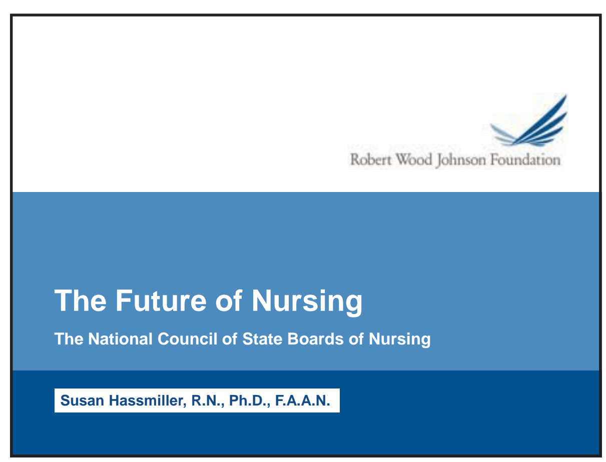
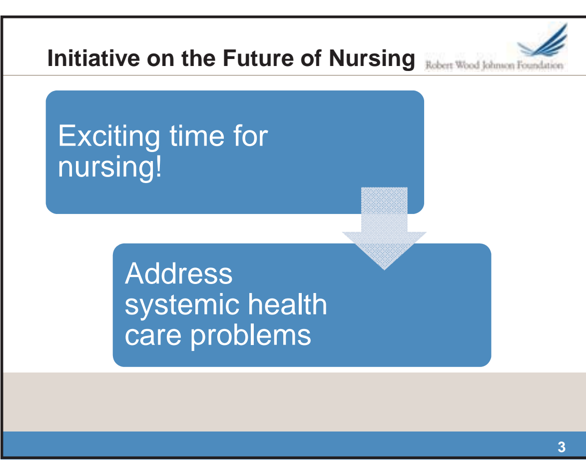
Keynote Speaker: Susan Hassmiller

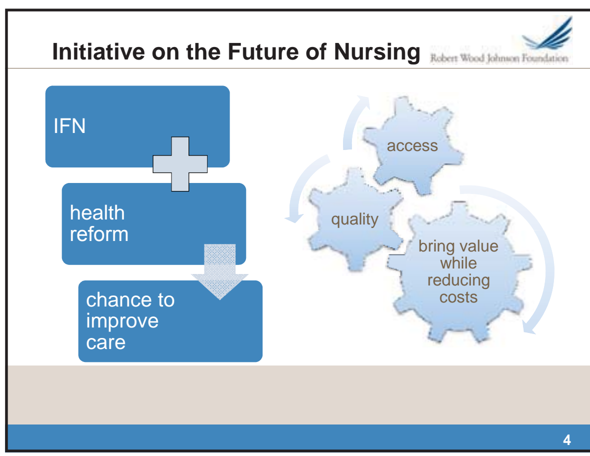
Presented by:

Susan Hassmiller, PhD, RN, FAAN, Senior Adviser for Nursing, Robert Wood Johnson Foundation, and Director of the Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine


Robert Wood Johnson Foundation
The Future of Nursing
The National Council of State Boards of Nursing
Susan Hassmiller, R.N., Ph.D., F.A.A.N.

Initiative on the Future of Nursing
Robert Wood Johnson Foundation
ROBERT WOOD JOHNSON FOUNDATION
INITIATIVE ON THE FUTURE OF NURSING
AT THE INSTITUTE OF MEDICINE
Showcases nurse contributions for a more effective and efficient health care system
2


Initiative on the Future of Nursing
Robert Wood Johnson Foundation
Exciting time for nursing!
Address systemic health care problems
3

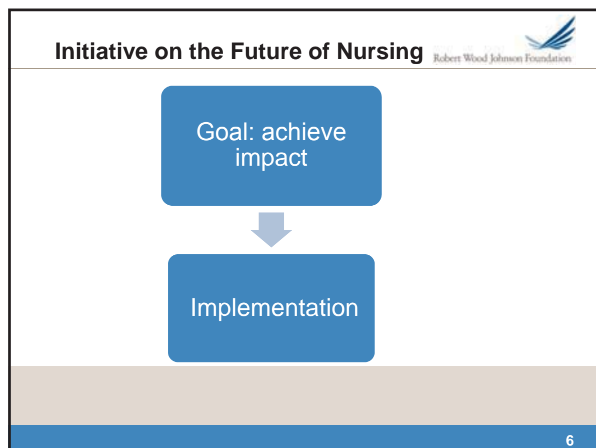


My Objectives

Robert Wood Johnson Foundation

1. IFN
2. Health reform law
3. My vision for 21st century nursing workforce
4. Your role in promoting public protection
5. Request your support

5



Initiative on the Future of Nursing

- Stellar leadership
- Diverse committee
- Open process
- Public engagement

Commission Chair
Donna Shalala

7

Initiative on the Future of Nursing

National forums:

- acute care
- community care
- nursing education

Media outreach

National forum in Houston

8

IFN Goal…

A blueprint for transforming the nursing field

9

IFN Implementation

Robert Wood Johnson Foundation

Plan:

- prioritize recommendations
- determine gaps; add other recs
- engage strategic partners
- select national advisory commission
- launch AARP advocacy effort

10

IFN Implementation

Oct. 5: Press conference to unveil recommendations

Nov. 30-Dec. 1: Implementation Launch Conference:

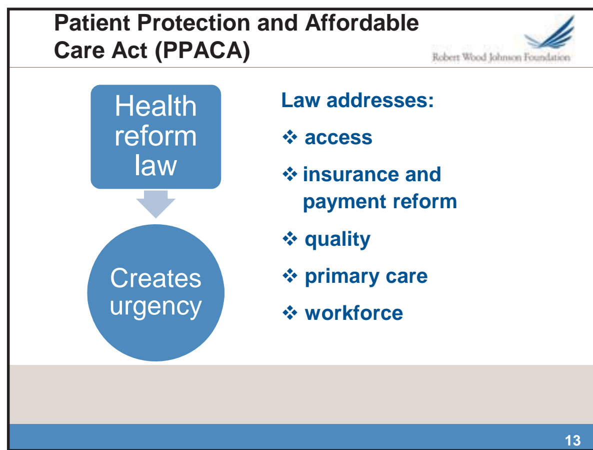
- invitation only
- action-oriented event
- diverse partners to attend
- VIPs to provide commitment
- break out groups to foster engagement/develop strategy

11

IFN Implementation

We'll devote at least two years to implementation

12


Patient Protection and Affordable Care Act (PPACA)
Robert Wood Johnson Foundation
Health reform law
Creates urgency
Law addresses:
❖ access
❖ insurance and payment reform
❖ quality
❖ primary care
❖ workforce
13

Patient Protection and Affordable Care Act (PPACA)
Robert Wood Johnson Foundation
32 million people to receive health insurance coverage
Fear: Long waits
Fear: High costs
Solution: Nurses can help fill voids in primary care and chronic care management
14

Example: Community and Retail Clinics
Robert Wood Johnson Foundation
Over 1,200 retail clinics use NPs
❖ ERs and urgent care clinics freed up for severe aliments
❖ Convenient
❖ More affordable
Retail clinic*
*Photo by Jim Amon, The Denver Post, September 30, 2009.
15

Patient Protection & Affordable Care Act

Nursing Provisions:

1. Increases funding for nursing education
2. Expands existing programs:
   - Nurse-Family Partnership home visiting program
   - School-based health clinics
   - Nurse-managed clinics
   - National Health Service Corps

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Patient Protection & Affordable Care Act (cont.)

3. New demo projects:
   - Independence at Home
   - Community Care Transitions
   - Medicare GNE
   - Family Nurse Practitioner Training
4. Health Care Workforce Commission
5. "Level B":
   - quality, trauma, wellness, disaster, ACOs

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My Vision: 9 Goals for the 21st Century

Our health system will need:

- prevention
- chronic care management
- care coordination
- end-of-life care

Nurses can fill these needs

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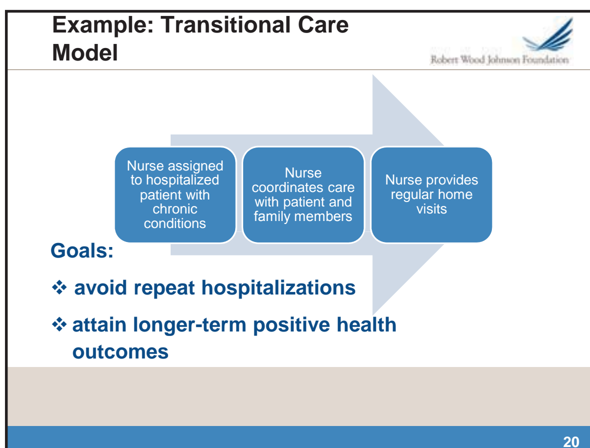
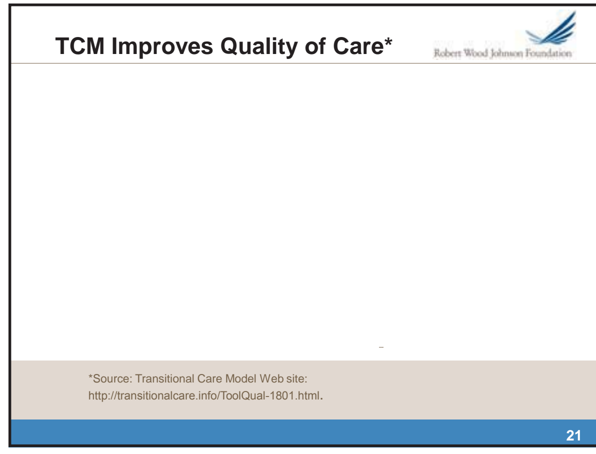
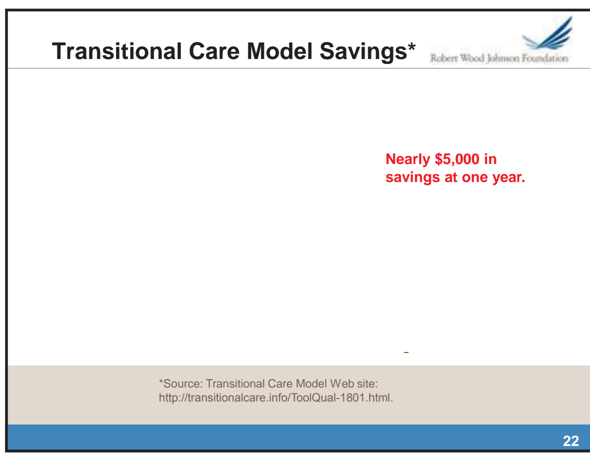
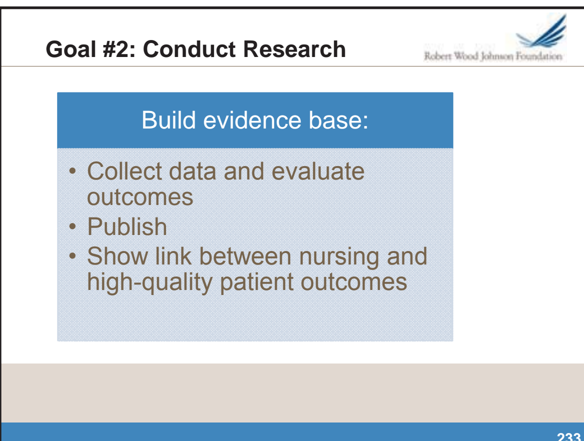
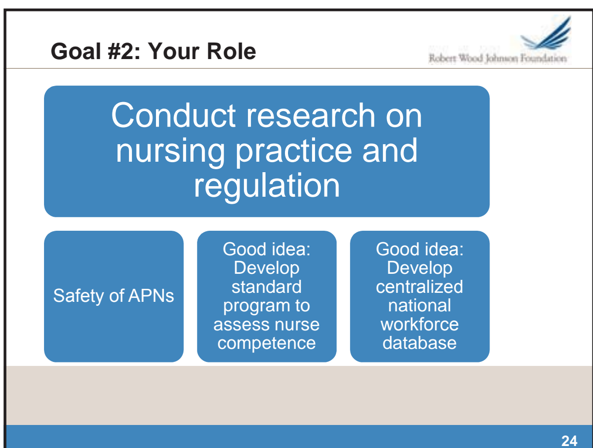
Goal #1: Develop Nurse-Led Innovations
Robert Wood Johnson Foundation
New models of care:
❖ expand access
❖ improve quality
❖ reduce costs
❖ enhance value
19

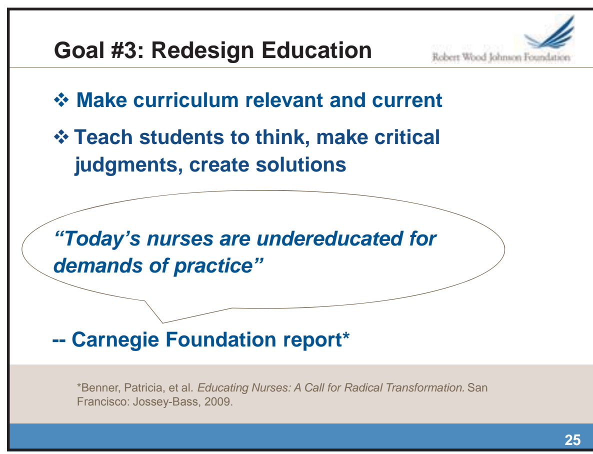

Example: Transitional Care Model
Robert Wood Johnson Foundation
Nurse assigned to hospitalized patient with chronic conditions
Nurse coordinates care with patient and family members
Nurse provides regular home visits
Goals:
❖ avoid repeat hospitalizations
❖ attain longer-term positive health outcomes
20

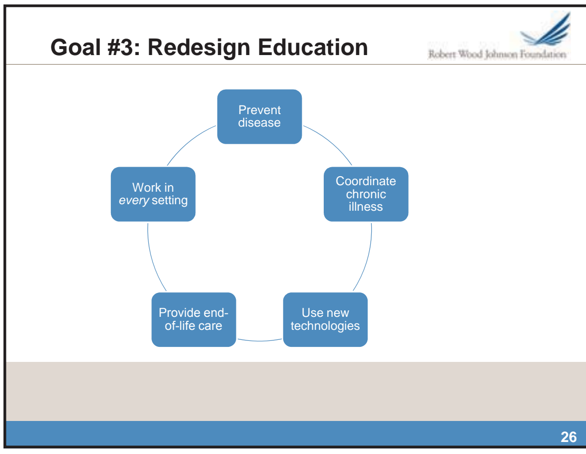

TCM Improves Quality of Care*
Robert Wood Johnson Foundation
*Source: Transitional Care Model Web site: http://transitionalcare.info/ToolQual-1801.html.
21

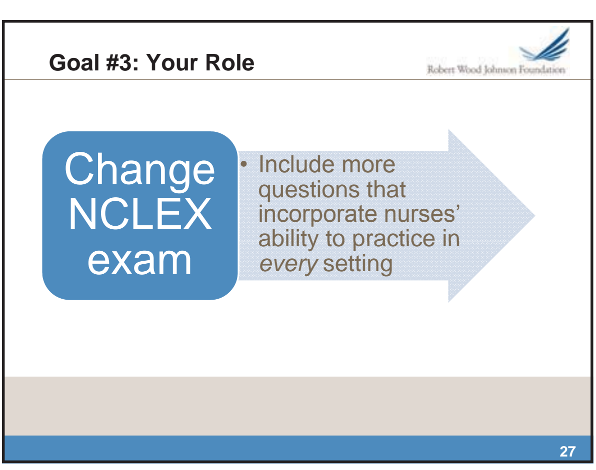

Transitional Care Model Savings*
Robert Wood Johnson Foundation
Nearly $5,000 in
savings at one year.
*Source: Transitional Care Model Web site:
http://transitionalcare.info/ToolQual-1801.html.
22

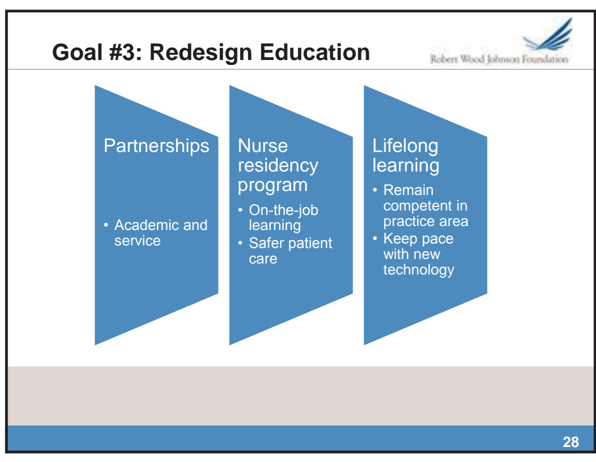

Goal #2: Conduct Research
Robert Wood Johnson Foundation
Build evidence base:
• Collect data and evaluate outcomes
• Publish
• Show link between nursing and high-quality patient outcomes
233

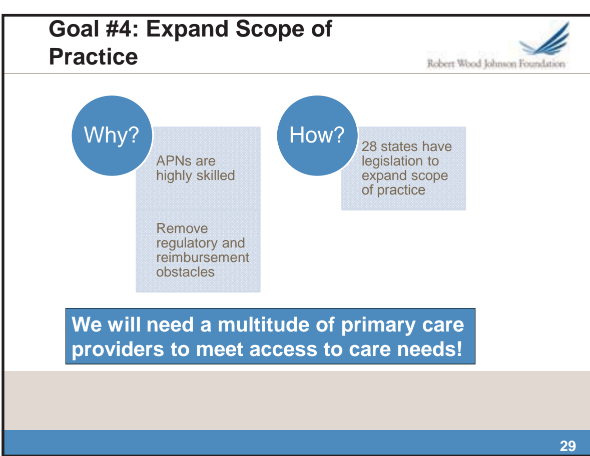

Goal #2: Your Role
Robert Wood Johnson Foundation
Conduct research on nursing practice and regulation
Safety of APNs
Good idea: Develop standard program to assess nurse competence
Good idea: Develop centralized national workforce database
24

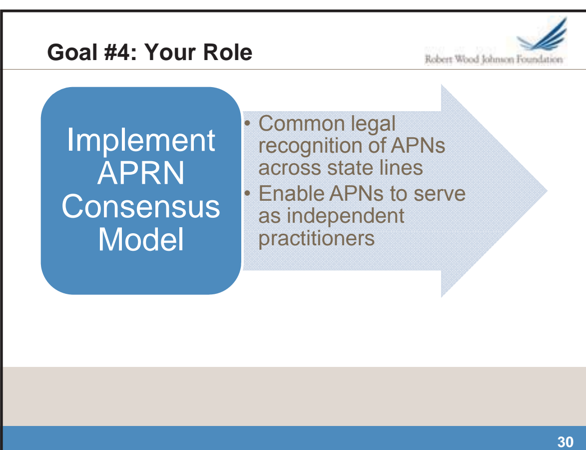

Goal #3: Redesign Education
Robert Wood Johnson Foundation
Make curriculum relevant and current
Teach students to think, make critical judgments, create solutions
"Today's nurses are undereducated for demands of practice"
-- Carnegie Foundation report*
*Benner, Patricia, et al. Educating Nurses: A Call for Radical Transformation. San Francisco: Jossey-Bass, 2009.
25

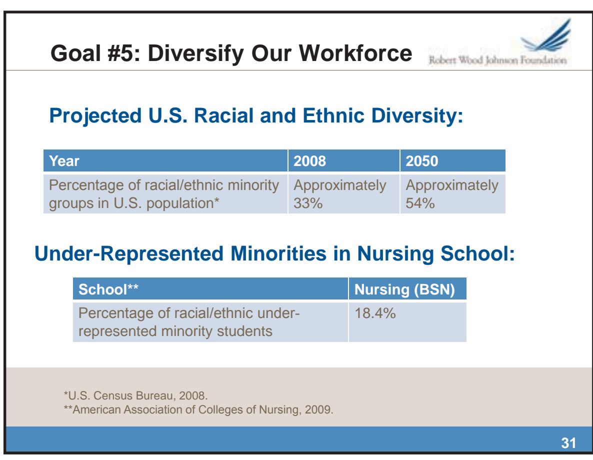

Goal #3: Redesign Education
Robert Wood Johnson Foundation
Prevent disease
Coordinate chronic illness
Use new technologies
Provide end-of-life care
Work in every setting
26


Goal #3: Your Role
Robert Wood Johnson Foundation
Change NCLEX exam
Include more questions that incorporate nurses' ability to practice in every setting
27


Goal #3: Redesign Education
Robert Wood Johnson Foundation
Partnerships
• Academic and service
Nurse residency program
• On-the-job learning
• Safer patient care
Lifelong learning
• Remain competent in practice area
• Keep pace with new technology
28


Goal #4: Expand Scope of Practice
Robert Wood Johnson Foundation
Why?
APNs are highly skilled
Remove regulatory and reimbursement obstacles
How?
28 states have legislation to expand scope of practice
We will need a multitude of primary care providers to meet access to care needs!
29


Goal #4: Your Role
Robert Wood Johnson Foundation
Implement APRN Consensus Model
• Common legal recognition of APNs across state lines
• Enable APNs to serve as independent practitioners
30


Goal #5: Diversify Our Workforce
Robert Wood Johnson Foundation
Projected U.S. Racial and Ethnic Diversity:
Year | 2008 | 2050
Percentage of racial/ethnic minority groups in U.S. population* | Approximately 33% | Approximately 54%
Under-Represented Minorities in Nursing School:
School** | Nursing (BSN)
Percentage of racial/ethnic under-represented minority students | 18.4%
*U.S. Census Bureau, 2008.
**American Association of Colleges of Nursing, 2009.
31

Goal #6: Embrace Technology
Robert Wood Johnson Foundation
❖ Medical devices
❖ E-records
❖ Virtual patient visits
❖ Simulation labs
❖ Online classes
❖ Social media
Nursing simulation lab
Nurses need more input into technology decisions!
32

Goal #7: Foster Inter-professional Collaboration
Robert Wood Johnson Foundation
❖ Develop collaboration skills in nursing and medical schools
❖ Care coordination crucial to high-quality care
A hospital care coordination team
33

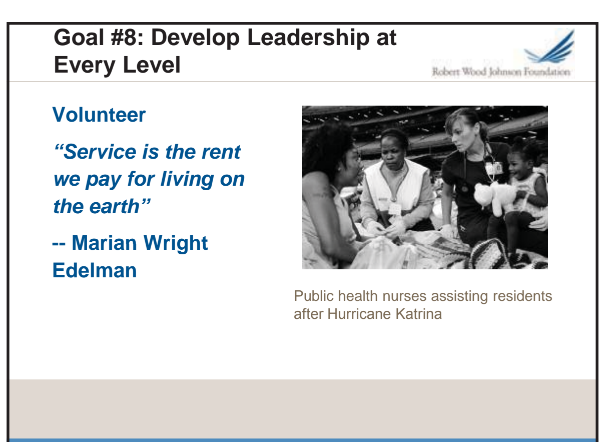
Goal #7: Your Role

Robert Wood Johnson Foundation

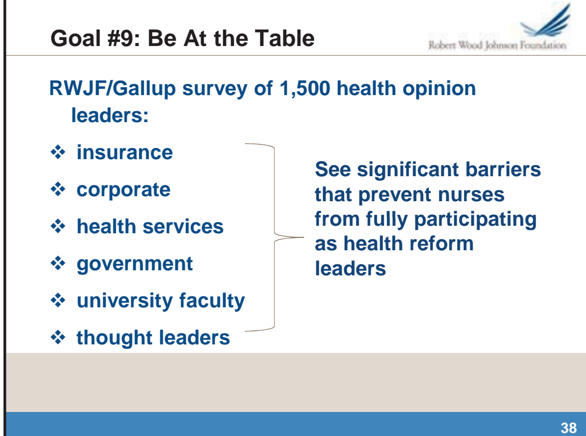
Work with medical licensing boards

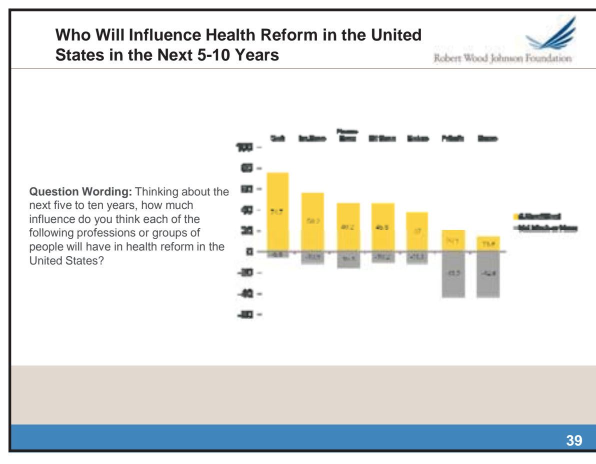
- Improve understanding of supply data
- Standardize data across profession

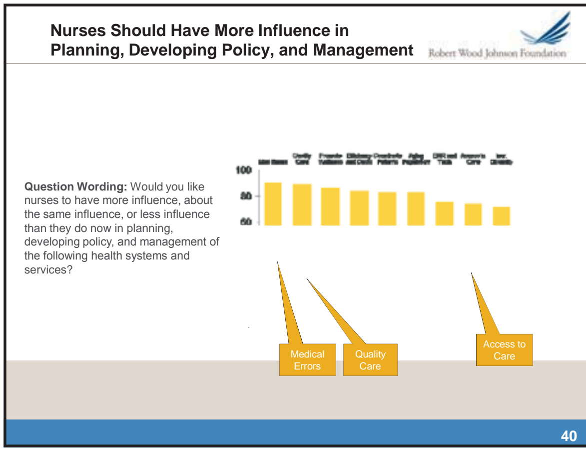
34

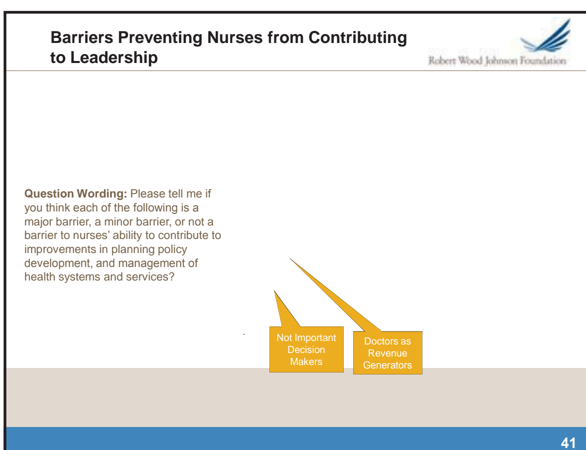


Goal #9: Be At the Table
Robert Wood Johnson Foundation
Join boards
Enter policy debates
Nurses hold about 2% of all board positions
WE LACK INFLUENCE
37


Goal #9: Be At the Table
Robert Wood Johnson Foundation
RWJF/Gallup survey of 1,500 health opinion leaders:
insurance
corporate
health services
government
university faculty
thought leaders
See significant barriers that prevent nurses from fully participating as health reform leaders
38


Who Will Influence Health Reform in the United States in the Next 5-10 Years
Robert Wood Johnson Foundation
Question Wording: Thinking about the next five to ten years, how much influence do you think each of the following professions or groups of people will have in health reform in the United States?
39





How Nurses Can Take on More Leadership

Robert Wood Johnson Foundation

Question Wording: What, if anything, do you think could be done to ensure that nurses take on more leadership in improving health status and delivering healthcare services in the United States today?
(Open-end question; Percent shown)

42

Call to Action

- Health reform law and IFN offer perfect opportunity
- Help implement IFN recommendations
- Let's make our voices heard!

43

Call to Action

- Implement recs: organizational, regional and state levels
- Advocate and educate stakeholders
- Spread word that nursing is societal issue
- Mentor young RNs
- You tell me

We need you!

44

Flo's Vision and My Vision Too!

"Were there none who were discontented with what they have, the world would never reach anything better"

-- Florence Nightingale

45

IFN Resources
Robert Wood Johnson Foundation
❖Visit us on the Web at:
www.thefutureofnursing.org
❖Follow us on twitter at:
www.twitter.com/futureofnursing
❖Leave a comment on the Initiative blog at:
www.blog.thefutureofnursing.org
❖Join us on Facebook at:
http://facebook.com/futureofnursing
46

Charting Nursing's Future

A Publication of the Robert Wood Johnson Foundation

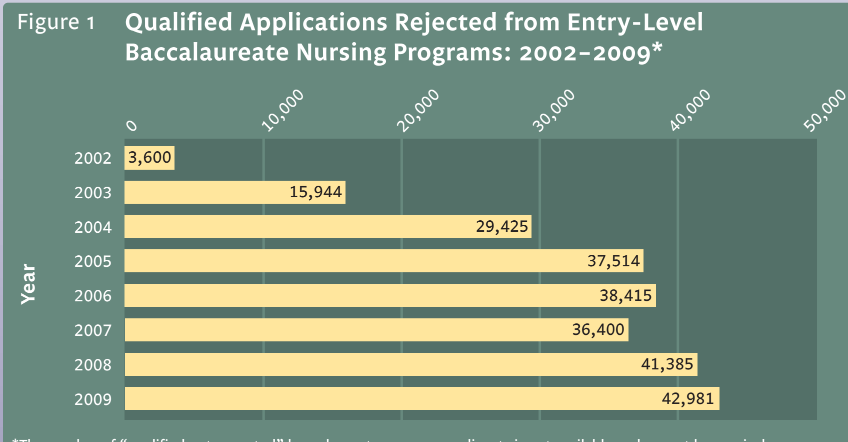
Reports on Policies That Can Transform Patient Care

MAY 2010

Expanding America's Capacity to Educate Nurses: **Diverse, State-Level Partnerships Are Creating Promising Models and Results**

Experts now predict that the United States will be short substantially more than 260,000 registered nurses by 2025 unless it expands nursing education capacity quickly and dramatically. Lack of faculty and clinical placements, as well as other capacity deficits, are causing prelicensure nursing programs nationwide to reject tens of thousands of qualified applications annually (see figure 1 for baccalaureate program data). Diverse, state-level partnerships are indispensable to solving capacity problems. This issue of the series describes the capacity innovations of 12 partnerships; all participated in extensive coalition-building and planning activities at two national Nursing Education Capacity Summits sponsored in 2008 and 2009 by the Robert Wood Johnson Foundation, in collaboration with the Center to Champion Nursing in America, the Department of Labor, and the Health Resources and Services Administration (HRSA).

Figure 1 **Qualified Applications Rejected from Entry-Level Baccalaureate Nursing Programs: 2002–2009***



*The number of "qualified not accepted" baccalaureate program applicants is not available and cannot be precisely derived from counting applications because some applicants apply to more than one school.

Source: Based on a data display provided by the American Association of Colleges of Nursing, Research and Data Center.

Issue Number 13

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The Value of Nursing Education

Clinical Placements

Two Florida International University nursing students check a young patient's heart sounds and provide respiratory therapy during a pediatric clinical placement at Miami Children's Hospital. Good clinical placements can offer students powerful skill-building opportunities with real patients and the health care team. The limited supply of clinical placements is a major obstacle to expanding prelicensure nursing programs (see figure 2, p. 2 for other obstacles).

To use scarce clinical resources more efficiently, the Nursing Consortium of South Florida employs a regional clinical placement system that is both centralized and electronic. To expand clinical education opportunities, experts recommend developing more clinical placements outside acute care settings, big cities, and traditional hours. Many schools are expanding the use of technology to build clinical skills through simulation, virtual health care facilities, robot technology, and more (see pp. 6–7).

Photo: Edgar Estrada, Miami Children's Hospital

A Call for New Partners, New Paradigms, and New Policy

The first wave of baby boomers will turn 65 in 2011, and between 2014 and 2019 the nation will complete the implementation of recently enacted health care overhaul legislation. These changes "are highly likely to increase demand for health care services and hence for nurses," says Peter I. Buerhaus, PhD, RN, FAAN, Valere Potter Professor of Nursing, Vanderbilt University School of Nursing. Buerhaus predicts that his next nursing shortage forecast will be well above his widely quoted "260,000 by 2025" projection.

To address a growing shortage, the nation will need to expand its educational capacity quickly, an effort that faces huge obstacles (see figure 2). This can only happen through a brave embrace of new partners in change, new educational paradigms, and new policy. So say leading experts and members of 49 state-level coalitions who participated in two national Nursing Education Capacity Summits (June 26–27, 2008, and February 4–5, 2009).

The Summits offered inspiration and opportunities to share best practices, imagine new approaches and coalition plans, and build skills in four critical dimensions of change:

- **Developing strategic, diverse partnerships and aligning resources** (e.g., through asset mapping, regionalization, and new alliances with business and others);
- **Creating more effective advocacy for policy and regulatory change** (e.g., regarding educational standards as well as faculty training and compensation);
- **Redesigning education** (e.g., with new technology, curricula, and clinical education models); and
- **Increasing faculty capacity and diversity** (e.g., by sharing resources and creating grow-your-own approaches).

Figure 2

Main Barriers to Expanding Admissions to BSN-RN Programs (2009)

Percentage of Schools Reporting Each Barrier	
Lack of Faculty	61.4%
Lack of Clinical Sites	60.8%
Lack of Classroom Space	47.5%
Budget Constraints	32.2%
Lack of Clinical Preceptors	31%
Other	34.5%

Source: Adapted from data provided by the American Association of Colleges of Nursing.

The Center to Champion Nursing in America is providing technical assistance to 30 states now implementing plans (see "Special Supplement," p. 6A).

The following pages profile the innovations of seven Summit states and preview the work of five more. Together they exemplify success in all the dimensions of change: Texas, Virginia, and Michigan in policy advocacy and diversifying partnerships (pp. 3-5) and New York, North Carolina, Florida, North Dakota, Oregon, California, Massachusetts, Hawaii, and Mississippi in redesigning education and increasing faculty capacity and diversity (pp. 6–8).

For More Information

- Benner, P., M. Sutphen, V. Leonard, and L. Day. 2009. *Educating nurses: A call for radical transformation.* San Francisco: Jossey-Bass.
- Visit http://championnursing.org and select Education Capacity and Resources for access to a Summit white paper and reports.
- Visit http://www.careeronestop.org/RED/Illuminate_regional_Aug2007.pdf for a tool kit on asset mapping.

Policy Recommendations

State-Level Policy

Appropriate state funds to

- make nursing faculty salaries, benefits, and work culture attractive;
- spread technologies such as simulation centers and electronic portals for clinical placement and faculty hiring and train faculty in their use (see pp. 1, 4, 6, and 7);
- support nursing workforce data centers (see pp. 3 and 7);
- spur innovation and partnerships by tying state nursing education funds to performance outcomes such as better graduation rates (see page 3);
- enlarge and sustain nursing programs reaching rural and minority populations (see p. 8).

Use earmarks on nurse licensure fees to raise additional funding for nursing education and support state chief nurse executives (see p. 4).

Provide incentives to hospitals that offer clinical placement sites and master's-prepared instructors.

Make BSN completion within 10 years of graduation a requirement for nurses with an ADN degree.

Fund statewide collaboration between nursing programs to

- share curricula and technology;
- create seamless educational pathways that increase graduation rates from BSN and graduate nursing programs (see pp. 6 and 7).

Revise state board regulations to

- permit MSN and PhD students to teach as nursing faculty interns—with mentoring by faculty (see p. 8);
- allow simulation to fulfill a portion of clinical hours (see p. 7);
- foster new curricula that emphasize geriatrics, treatment of chronic conditions, quality and safety, cultural competence, and the economics of care; create residency or internship requirements for nurses (see pp. 4, 5, 6A, and 6B).

Federal-Level Policy

Replicate the Troops-to-Teachers program for retired military nurses.

Consolidate federal funding for nursing education and workforce into block grants to states (like Maternal Child Health grants).

Institute a federal Nursing Faculty Corps with stipends and return-of-service agreements to accelerate MSN and PhD completion (see p. 4).

Support research to answer key education policy questions, such as What is the appropriate balance of clinical, virtual, and simulation education in building clinical skills?

Expand grants to fund the use of standardized patients in nursing education programs (see p. 5).

Policy Strategies: Pay-for-Performance Funding

Texas

In 2009, Texas was facing an immediate nursing shortage of 22,000 and a staggering projection: by 2019, the shortage would grow to 70,000. Though the legislature had been building nursing education capacity since 2002 (see table 1), graduation rates had not kept pace with demand.

Expanding the Shortage Coalition

Fresh from the Summits, leaders of the Texas Workforce Shortage Coalition determined that they would have to double the number of nursing graduates by 2013. This would require more than tripling state appropriations for capacity building in the 2010-11 biennium. To achieve such a victory from the state's conservative legislature, the coalition radically expanded its membership, attracting new representation from the powerful Texas Association of Business (TAB) and many chambers of commerce.

Business in fact played a key role in hammering out the expanded coalition's legislative proposal. "The coalition wasn't coming to business *after* a legislative position was taken," says Patti Clapp, vice president of the Dallas Regional Chamber. "We worked together to develop a position."

"The TAB's bottom line for support was that funding had to be pay-for-performance, and there had to be accountability," says Ron Luke, PhD, president of RPC Consulting and chair of the TAB's health policy committee. This view set new plan parameters.

A Pay-for-Performance Plan

With data from the Texas Nursing Workforce Center, the coalition zeroed in on the graduation rates of all state nursing programs, discovering a troubling range: 22 to 98 percent.

The resulting legislative proposal divided nursing programs into high grad producers (70 percent or more) and lower producers (below 70 percent) and asked the legislature for $60 million in new and continuing funding. Most of new money was to go to the high producers to *expand enrollment*; the lower producers would receive much less new money to *improve graduation rates.* Schools in both groups that failed to meet set target percentages would have to return state money on a *pro rata* basis. All schools would be held harmless for continuing funding.

Persuaded by the approach, and by a statewide publicity campaign and business-led lobbying effort, the legislature appropriated $49.7 million in new and continuing capacity-building funds. High-producing schools will receive approximately $20.5 million over two years in new money, while lower producers will receive approximately $9.5 million (see table 1 for details).†

Both groups of schools are free to expand capacity in innovative ways.

The Texas Nurses Association (TNA) is supportive of the legislative outcome: "Hearing that all schools aren't equally productive and deserving of money was hard but important," says Clair Jordan, TNA executive director and long-time coalition member.

"You should never underestimate the power of a broad coalition," says State Representative Lois W. Kolkhorst (R–District 13), who shepherded the bill to passage.

A strong ally of the health professions and results-based funding, Kolkhorst is monitoring the bill's outcomes closely. "I share concerns that schools with bigger appropriations could just steal faculty from poorer Texas schools." The emphasis on "bodies" rather than quality, and short-term (biennial) thinking worries others. Yet Kolkhorst is upbeat about the approach: "The legislature is trying to move pay-for-performance throughout higher education."

For More Information

- To learn about New Jersey's Business Alliance for Nursing, contact Dana Egreczky at dana@njchamber.com.
- For more on the Texas story, write to ed.buchanan@thecb.state.tx.us.

"Policy needs a metric to measure results. So we told nursing schools, 'We'll fund you based on the number of graduates you produce.' The coalition brought us this vision."

State Representative Lois W. Kolkhorst (R–District 13)

Table 1

New Heights in Legislative Funding to Build Nursing Education Capacity*

	Bienniums Appropriated			Bienniums Appropriated		Total
	2002–03	2004–05	2006–07	2008–09	2010–11	
Dramatic Enrollment Growth Funding (Capacity Building)	$10.9 mil	$5.8 mil				$16.7 mil
Professional Nursing Shortage Reduction Funding (Capacity Building)			$6.0 mil	$14.7 mil	$49.7 mil†	$70.4 mil
Total	**$10.9 mil**	**$5.8 mil**	**$6.0 mil**	**$14.7 mil**	**$49.7 mil**	**$87.1 mil**

*This table shows funding for education capacity building only; between 2001 and 2009, the legislature appropriated $20–25 million for other nursing purposes.

†High-producing schools will receive $20,517,888 in new funds over two years at the rate of $10,000 per additional enrollee per year, while lower producers will receive $9,482,112 over two years at the rate of $10,000 per graduate per year, based on each school's projected number of additional nursing graduates by the end of 2011. Another $14,606,959 for fiscal years 2010–2011 will be divided among nursing programs that have shown any increase in graduates between 2008 and 2009 (maximum possible award: $11,850 per additional graduate). The University of Texas at Arlington received a separate sum of $5,000,000 for its simulation learning lab.

Source: Chart data adapted from the Texas Nurses Association's "Five Session Initiative (2001–2009) to Address RN Shortage"; footnote data drawn from Professional Nursing Shortage Reduction Program announcements (2009), provided by the Texas Higher Education Coordinating Board.

Policy Strategies: A Home in the State Executive Branch

Michigan

While many state nursing coalitions must look outside government for funding and leadership, Gov. Jennifer M. Granholm has made nursing education a major priority: "Michigan is striving to lead the nation in investment, innovation, and tangible outcomes from our initiatives to address the nursing shortage and other workforce needs of our state."

One of Granholm's first investments was creating the Office of the Chief Nurse Executive (OCNE) and naming Jeanette Wrona Klemczak, RN, BSN, MSN, to the post in 2004.

Klemczak assumed her duties in what she calls "a perfect storm": a projected shortage of 18,000 nurses by 2015, just as the state was suffering massive job losses in manufacturing. With health care emerging as the largest economic growth sector, she has presided—in concert with the Labor and Economic Growth Department—over the investment of tens of millions of dollars to increase the nurse faculty and nursing workforce.

Michigan State Policy Wins

- Established the Michigan Center for Nursing to collect and report on nursing workforce data.
- Created the Office of the Chief Nurse Executive.
- Has produced 10,000 new nurses, 3,500 new clinical placements, 277 new clinical instructors, and 150 new faculty-in-training since 2005.
- Created Web-based systems to better manage clinical placements.
- Increased money for nursing education through a nurse licensure earmark.
- Assisted all 56 nursing schools in developing required diversity plans.
- Now advancing major changes in nursing education policy (see "Proposed Policy," column 3).

Priming the Pipeline

Second-Degree Programs

"When legislators think about capacity, they think 'seats' in nursing schools, but seats alone don't solve the problem," says Klemczak. "There have to be programs and supports in place to assist students with timely completion of degrees."

To remove barriers to completing degrees, the governor has invested $30 million in accelerated second-degree programs that have attracted a diverse demographic of displaced auto workers, engineers, lab technicians, and architects (14 percent African American and 15 percent male). The funds were granted to partnerships among schools, hospitals, and the Regional Skills Alliance (local and state workforce collaboratives).

> "When legislators think about capacity, they think 'seats' in nursing schools but seats alone don't solve the problem. There have to be programs and supports in place to assist students with timely completion of degrees."
>
> Jeanette Wrona Klemczak, RN, BSN, MSN
> Michigan's chief nurse executive

"Some programs decreased time-in-school by 50 percent, yet graduates had National Council Licensure Examination (NCLEX) pass rates that equaled or surpassed their traditional counterparts," says Klemczak. The partnership programs alone have produced 4,000 nurses, 3,000 new clinical placements, and 277 clinical instructors since 2005.

The Michigan Nursing Corps

Half of the nursing faculty in many state schools are now eligible to retire. Yet students preparing for faculty roles often have work obligations that prevent timely completion of graduate degrees. To counter these trends, the governor established the Michigan Nursing Corps, with $6.8 million in appropriations (2008–2010), to rapidly educate clinical and classroom faculty. Participants receive tuition and stipends in exchange for signed agreements to teach in Michigan nursing programs. At present, 150 have either graduated or are completing MSNs and PhDs.

Web-Based Management of Clinical Placements

Two Web-based systems developed by the Michigan Center for Nursing (MCN) are reducing inefficiencies in orienting and matching students to clinical sites in Southeastern Michigan. The ACE Placement system drove a 30 percent increase in sites for 2008–2009, says Carole Stacy, the MCN's executive director. "Two or three faculty and hospital staff used to do this manually."

The ACE Passport system offers students one-time, online orientation modules that fulfill various federal training requirements and are accepted by all six member hospitals. More than 4,700 students used the system in 2008–2009. The MCN and both ACE systems are programs of the Michigan Health Council.

Proposed Policy and Regulation

With Klemczak's guidance, a special task force has recommended far-reaching changes to modernize nursing policy and regulation. When implemented, these changes will require all nursing programs to achieve national accreditation, mandate nursing residency programs, embed quality and safety in nursing curricula, increase the numbers of advanced practice registered nurses, and reform nursing education financing.

The $2 earmark on the biannual nurse licensing fee that funds the OCNE has been quadrupled to $8 to support nursing strategic plan initiatives for education and practice.

For More Information

- For information on the OCNE or OCNE initiatives, visit www.michigan.gov/mdch/ocne or www.michigancenterfornursing.org.
- See *CNF 8* (p. 5).

Policy Strategies: A Kitchen Cabinet

Virginia

While Michigan's nursing policy nerve center is firmly established in the executive branch of state government, Virginia's is unofficial and largely outside government. In fact, the state's so-called kitchen cabinet began in 1995 as an informal network of nurses interested in policy and politics.

"Initially, there were no grand schemes; we were just getting together to have some fun," says Rebecca Bowers-Lanier, EdD, MSPH, MSN, a founding network member who had just finished a stint as deputy director of Colleagues in Caring, a Robert Wood Johnson Foundation grant program aimed at creating collaboratives to build the nursing workforce and establish nursing workforce centers (1996–2002).

Many other well-connected nursing leaders soon joined the network's inclusive and fluid membership. Then a number of state policy losses for nursing galvanized the group into becoming a clear, strong voice in the policy advocacy arena.

The evolving group's first initiative was to heal splits among nursing organizations and get them to agree to stop fighting publicly about policy. The cabinet also resolved to be wholly nonpartisan, recruiting members from all parties and sectors.

Today, its most important work is creating an easy-to-articulate nursing policy agenda well before elections, after consulting with its own members and a wide array of other stakeholders. It then assigns nurses to educate gubernatorial candidates, governors, and legislators on key health committees, by using disciplined messages and getting other groups to speak on behalf of the agenda.

For a summary of state policy achievements, see "Policy Wins" in column 3. For a Virginia nursing education innovation, see "Using Standardized Patients to Teach Cultural Competence," below.

Virginia Nursing Policy Wins

The kitchen cabinet has made major contributions to the following state policy wins:

- A 10 percent raise for all nursing faculty in public colleges and universities that has helped to create a 50 percent increase in nursing graduates since 2005
- Significant scholarship appropriations and prevention of cuts in scholarship funds for graduate education
- Creation of a nurse-directed workforce data center
- Appointment of nurses and kitchen cabinet members to key state positions (e.g., secretary of Health and Human Resources)
- A clear, credible nursing policy agenda and advocacy mechanism

Using Standardized Patients to Teach Cultural Competence

Graduating nurses able to care for the diverse patient populations of the 21st century is a major goal of new nursing education curricula.

Their aim is not to produce superficial political correctness but rather to create awareness and sensitivity to how the culture and ethnicity of patients may relate to disease development and treatment.

Old Dominion University (ODU), Norfolk, Virginia, is "at the forefront of nursing schools enhancing students' cultural competency," says Richardean Benjamin, PhD, associate dean of the College of Health Sciences.

With more than $2 million in HRSA grants, ODU has established a special training program that uses actors prepared to represent patients with frequently encountered conditions and cultural or ethnic identities (called standardized patients).

While the use of standardized patients is common in medical schools, ODU's application is pioneering.

In one typical teaching scenario, a poor African American woman enters a doctor's office complaining of dizzy spells. Students must tease out physical and psychological symptoms but also take into account her cultural characteristics, such as low-income status, living situation, stress, and food choices. Patients rate students on strengths and weaknesses, including nuances such as eye contact and body posture. Scenarios are often videotaped for later review by students and faculty.

"Students speak favorably of this approach," says Benjamin. "They enter these encounters with lots of apprehension, but they get a chance to make and correct their mistakes in a safe and supportive place."

The Value of Nursing Education

Photo: Old Dominion University School of Nursing

Standardized Patients
A nursing student at Old Dominion University (Norfolk, Virginia) begins an examination of a standardized patient portrayed by an actor trained to represent a particular cultural group and medical complaint. After the examination, standardized patients provide detailed feedback, with special attention to students' sensitivity and awareness of the impacts of cultural and ethnic identity on disease development and treatment.

New Curricula and Technology: Creating Seamless Pathways

The New York–North Carolina RIBN Alliance

Community colleges prepare roughly two-thirds of all nurses through associate degree programs (ADNs), while universities prepare only a third through the baccalaureate (BSNs). Tensions between the two—fueled by clashes over public funding and competing educational philosophies—have hampered needed cooperation for decades, depriving thousands of nursing students of a clear, efficient route to the BSN (only 15 percent of nurses with an ADN earn a BSN).

Creating a Seamless Pathway

This regrettable turf war is headed for the history books in North Carolina and New York, thanks to a demonstration project called RIBN (the acronym is pronounced "ribbon" and stands for Regionally Increasing Baccalaureate Nurses). Urban academic partners are Queensborough Community College and Hunter College, both part of the City University of New York system; rural partners are Asheville-Buncombe Technical Community College and Western Carolina University (WCU). RIBN is modeled on the Oregon Consortium for Nursing Education (see p. 6A and *CNF 4* for more).

Both RIBN pairs are embracing the traditional strengths of each degree program while redesigning their individual ADN and BSN curricula to form connected seamless pathways that expect and encourage students to earn the BSN.

The model marries the strengths of community colleges—large diverse classes, highly supportive learning environments, and a focus on practical skills—with the BSN's additional competencies and position as a gateway to graduate education as well as faculty and leadership roles.

"We are trying to build a graduate who gets the best of both worlds," says Vincent Hall, PhD, RN, CNE, director of WCU's School of Nursing.

RIBN organizers expect the new model to dramatically increase the number of students completing the BSN and to boost diversity. They also predict that RIBN will be widely replicated.

> "RIBN is a role model for bridging the communication and expectation gaps between ADN and BSN programs—a way of turning a negative into a positive for patient care, nurses, students, and faculty."
>
> Darlene Curley, executive director
> Jonas Center for Nursing Excellence (New York)

"RIBN is a role model for bridging the communication and expectation gaps between ADN and BSN programs—a way of turning a negative into a positive for patient care, nurses, students, and faculty," says Darlene Curley, executive director, Jonas Center for Nursing Excellence (New York).

The center is managing RIBN with a $250,000 matching grant from the Robert Wood Johnson Foundation (RWJF) through its Partners Investing in Nursing's Future initiative (PIN). A collaboration between RWJF and the Northwest Health Foundation, PIN addresses nursing issues at the local level through funding partnerships with community and regional foundations.

North Carolina's Foundation for Nursing Excellence provides administrative support, coordination, and evaluation for RIBN's rural partners.

RIBN Nuts and Bolts

RIBN cohorts will begin classes in 2010, dually enrolled in the ADN and BSN programs. Students will spend three years on their community college campus and a fourth year at their university, after passing the NCLEX. Both regions have hired success counselors to provide intensive mentoring. The North Carolina Nurse Scholar's Commission will award NC-RIBN students full scholarships; NY-RIBN students will pay community college tuition for all years.

The RIBN curriculum, though different in each locale, anticipates 21st-century patient needs by emphasizing gerontology, public and community health, leadership and management, informatics, quality improvement, and evidence-based practice.

"RIBN is system change in the educational environment," says Margaret McClure, EdD, RN, FAAN, RIBN project national coordinator. "And the urban-rural mix will show that it can succeed anywhere."

For More Information

- Visit www.jonascenter.org and www.partnersinnursing.org/grants.html.

The Value of Nursing Education

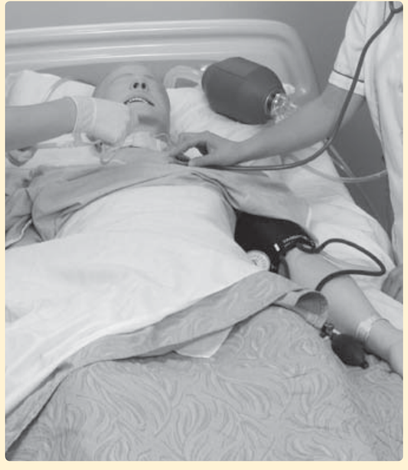

Photo: Old Dominion University School of Nursing

Simulation

Most nursing programs and many hospitals use electronic simulator mannequins to teach a variety of clinical skills. The two nursing students pictured above are practicing tracheotomy suctioning (left) and listening to breath sounds (right)—without the safety risks, limitations, and downtime often present in real clinical settings. Faculty develop simulation scenarios or purchase scenarios from vendors. They may also make or purchase videotaped simulations for classroom use and uploading to course Web sites, where students may view them anytime.

Charting Nursing's Future

A Special Supplement
To Issue 13, May 2010

Redesigning Nursing Education for a 21st-Century Workforce

The *American Journal of Nursing* Profiles Innovations in Five States

In a seven-part series, "Uniting States, Sharing Strategies," the *American Journal of Nursing* examines how strategic collaborations across the country are redesigning nursing education to increase capacity and build a nursing workforce with the skills necessary to meet Americans' changing health care needs. The series tells success stories and outlines challenges the Center to Champion Nursing in America is encountering and addressing as it provides technical assistance to 30 geographically diverse multi-stakeholder teams with variations in team structure, focus, and strategic direction. The series also presents several best practices and highlights five state exemplars to inform the efforts of others and to provide insights about the impact of technical assistance on expanding and redesigning nursing education at the state level.

The strategies discussed address systemic problems in nursing education and the shortage of nurses overall. According to the American Association of Colleges of Nursing, for the ninth straight year, enrollment in entry-level baccalaureate nursing programs increased, by 3.6 percent in 2009. Despite this trend, nearly 43,000 qualified applications to these programs were rejected, primarily because of insufficient faculty and clinical placement resources (see figures 1 and 2 on pp. 1 and 2 of this issue of *Charting Nursing's Future*).

Team Composition and Technical Assistance

Thirty state teams are working to increase nursing education capacity, and to educate, build, and deploy the nursing workforce of the future. Teams comprise representatives from nursing education, health care delivery systems, state workforce entities, consumers (often AARP state offices), local businesses, philanthropies, and others. They are redesigning nursing education in ways that both improve outcomes and accommodate more students and are advocating for private and public support.

Following two national collaborative summits to support this work, the Center to Champion Nursing in America, an initiative of AARP, the AARP Foundation, and the Robert Wood Johnson Foundation, is providing ongoing technical assistance to help teams accomplish critical tasks and is fostering collaborative learning experiences that link the teams and allow them to share best practices and lessons learned with their peers in the other states.

Featured States

Oregon
Common Admission Standards and Curriculum Link Community Colleges and University Programs

Massachusetts
New Nurse Competencies Guide Nursing Education

California
Confronting the Nursing Shortage through Simulation and Regional Collaborations

Hawaii
Technology and Collaborations Help Overcome Geographic Isolation, Reform Curriculum

Mississippi
Learning Why Students and Faculty Drop Out Was Key to Progress

To Read More About It

The *American Journal of Nursing* series, "Uniting States, Sharing Strategies," can be read free of charge online at http://journals.lww.com/ajnonline/pages/collectiondetails.aspx?TopicalCollectionId=9.

For more information about the Center to Champion Nursing in America and to find more nursing education capacity solutions, visit www.championnursing.org.

Oregon

Common Admission Standards and Curriculum Link Community Colleges and University Programs

The Oregon Consortium for Nursing Education (OCNE) has launched a groundbreaking program to increase the number of baccalaureate-prepared nurses. OCNE has created a partnership of eight community colleges and the five Oregon Health & Science University campuses, which now share common admission standards and other resources.

Associate degree and baccalaureate nursing partners have also collaborated on new nursing competencies that improve education outcomes and allow for a seamless curriculum. Oregon is already seeing a significant increase in the number of nurses pursuing bachelor's degrees.

Oregon is also working to increase nursing faculty numbers. Nurses who become faculty can now take advantage of a loan repayment program recently developed through the leadership and advocacy of the Oregon Center for Nursing.

Continues on reverse

Massachusetts

New Nurse Competencies Guide Nursing Education

To address the nursing shortage and its consequences for health care consumers, the Massachusetts team looked at how the state could graduate more nurses to care for its citizens and what kind of competencies nurses will need for their growing role in health care settings.

To that end, the state developed the Nurse of the Future Core Nursing Competencies©, a comprehensive framework for educating not only more, but better prepared, nurses. The competencies are a set of standards resulting from extensive research into the science and practice of contemporary nursing that provides a powerful framework that drives outcome-generated policies.

The goal is to standardize the outcomes of education through a focus—across a variety of nursing programs—on the competencies required of future nurses. Several nursing programs have been funded to develop curriculum models to more efficiently transition nurses between all levels of nursing education. Partnerships between education and practice collaboratives are at the heart of all programs and funded projects.

California

Confronting the Nursing Shortage through Simulation and Regional Collaborations

Through multi-stakeholder regional collaborations, California is increasing clinical placements, integrating simulation into nursing education, recruiting and developing new faculty, and increasing access for nursing students to higher education.

The Bay Area Simulation Collaborative, for example, comprises representatives of schools of nursing and hospitals in 10 San Francisco Bay Area counties. This collaborative is sharing its training approach and scenarios

California, continued

with other facilities statewide through the California Simulation Alliance.

The state has also funded three regional clinical simulation laboratories in rural areas: in Northern California, in the Sierra area, and in Sonora. Each is a joint project involving at least one medical center and one college. Finally, nursing graduation rates have been greatly increased through a decade of allocations from the governor.

Hawaii

Technology and Collaborations Help Overcome Geographic Isolation, Reform Curriculum

To decrease isolation and make educational opportunities available for all, regardless of their island of residence, Hawaii has for many years relied on such technology as distance learning and simulation to educate nursing students and practicing nurses.

Innovative educational approaches have made up for faculty shortages and lack of classroom space, which at least half of the eight nursing education programs in Hawaii cite as reasons for rejecting students. Distance learning and Web-based simulation allow educators to reach more students and thus enable more students to participate in nursing programs.

For example, in December 2009, four groups—the Hawaii Medical Service Association Foundation, Hawaii Pacific Health, Kaiser Permanente Hawaii, and Queen's Medical Center—contributed a total of $1.05 million to the Hawaii Nursing Simulation Center Fund. The University of Hawaii at Manoa is housing and facilitating the creation of the simulation center, which will link existing campus and hospital simulation laboratories statewide. Among features of the new center will be patient simulators, bedside computers, interactive instructional software, and realistic hospital and outpatient practice settings.

Mississippi

Learning Why Students and Faculty Drop Out Was Key to Progress

By the start of the last decade, Mississippi was one of many states experiencing a growing nursing shortage. Before the state began implementing solutions to expand education capacity, such as simulation and education redesign, it wanted to clearly understand the story behind the numbers.

To that end, the Mississippi Office of Nursing Workforce, a group with many collaborating partners (including the Mississippi Nurses Association, Mississippi Hospital Association, Mississippi Board of Nursing, Mississippi State Department of Health, Mississippi Council of Deans and Directors of Schools of Nursing, and others) conducted a series of surveys to determine why students dropped out. Initial survey results indicated that lack of financial support, family issues, inability to balance family and school, and inability to work and go to school simultaneously kept students from graduating.

In response, Mississippi, for example, developed the Mississippi Student Nursing Navigator (http://studentnavigator.org), which directs students to information on financial, tax, utilities, fuel, and transportation assistance; health insurance; legal services; child care; stress management; and academic preparation.

As a result of these and various other efforts, Mississippi has doubled the number of nursing graduates since the 2000–2001 academic year. Graduation rates from both the 16 associate degree and the seven baccalaureate degree programs have been increasing steadily in recent years. With the hiring and retention of more faculty, fewer students are being turned away from nursing education programs.

Credits

Supplement Funding: *American Journal of Nursing*
Supplement Text: Center to Champion Nursing in America

New Curricula and Technology: **Promoting Simulation**

Florida Center for Nursing

"You can't expect state legislators to give you money to expand nursing education capacity unless you can say, 'Here's what we know about the nursing workforce,'" says Mary Lou Brunell, executive director of the Florida Center for Nursing (FCN) and coleader of the state's Summit team.

Producing credible nursing workforce data is the mission of 34 state workforce centers and their national organization, the Forum of State Nursing Workforce Centers. Center data informs policy and has also guided Summit teams.

One of the most advanced centers, FCN routinely produces authoritative state and regional nursing workforce supply, demand, and education workforce data. FCN trend analyses have established that—absent rapid change—Florida faces by 2020 a shortage of 52,200 full-time employee RNs, 7,000 full-time employee LPNs, and faculty vacancy rates above 20 percent for all nursing degree programs.

Center surveys on the two top causes of these shortages mirror national studies: barriers to hiring faculty and limited clinical sites.

In addition to defining key problems, FCN is working to eliminate them. With $470,000 in matching PIN grants from RWJF and the Blue Foundation for a Healthy Florida, FCN has recently embarked on a two-year Gap Analysis "to discern Florida's current utilization of simulation and to maximize its use for both practicing and new nurses," says Brunell (see "Using Technology," below).

Brunell sees potential for simulation training to move medical-surgical nurses up the career ladder into specialties with the most severe shortages. This could help retain experienced nurses and make room for new nurses. More use of simulation in prelicensure nursing programs could reduce the need for clinical sites.

The Florida Board of Nursing allows 25 percent of clinical education to be conducted through simulation, but no one knows if this option is being used, says Brunell. Nor are simulation resource needs clear.

In year one, project leaders will gather data and recommendations from all stakeholders; in year two, they will develop state and regional approaches to promoting simulation, perhaps, Brunell says, through regional simulation centers and Web portals for sharing simulation scenarios and technology support.

For More Information

- Visit www.flcenterfornursing.org.
- See *CNF 2* on state workforce centers.

Using Technology to Expand Capacity

Smart Hospitals/Sim Centers

Some states have large interdisciplinary facilities that simulate the medical conditions of entire acute care units and have multidisciplinary skill-building scenarios for new employees or students pursuing different health professional degrees, including OT, PT, RN, and MD.

Interactive Audio/Visual Aids

IVNs—interactive video networks— allow for transmission of live lectures, procedures, and discussions in real time across great distances but require participants to travel to specially equipped rooms. Newer software products, such as **WIMBA and Adobe Presenter** (with webcams and mics) give computers the same capabilities. Using **computers, mp4 players, and smart phones,** students can view Web-streamed IVN presentations and instructional videos, as well as download reference material. Mobile devices increase collaborative learning and knowledge production.

Wright State University uses **Doctor Robots** for health career education. Students with notebook computer joysticks can follow an a/v-equipped robot that moves through a real hospital, viewing clinical activities and interacting with staff. Faculty can participate from home or school.

Online Classrooms and Schools

Web 2.0 Tools for Second Life allow schools to create virtual clinical facilities where, for example, students can practice doing in-home patient assessments and patient nutritional education, through voice-activated conversations with avatars or actors.

Faculty can offer complex **Webquest** problem-solving assignments to teams of students working on long-term projects requiring interdisciplinary study (visit http://www.questgarden.com/51/22/4/070608090111/index.htm for a sample assignment).

To reduce the workload of clinical instructors, some nursing educators are using or contemplating the use of **voice thread technologies such as wikis, blogs, and social networking sites** for case discussions among students, patients, and clinical experts and for disseminating program information. **Web-hosted patient support groups and chat rooms** conducted by retired nurse clinical experts are also being imagined as new ways to give students more contact with patients and extend scarce clinical resources.

Online learning management systems allow for posting assignments, class notes, grades, tests, and course documents and can grade exams instantly and accept clinical paperwork.

Web-based nursing degree programs are proliferating. Western Governors University, for example, is a nonprofit private school that offers a variety of majors, including several different undergraduate and graduate nursing degrees. Students do most of their coursework online but complete tests and assessments at special centers and arrange clinical placements locally (visit www.wgu.edu).

New Curricula and Technology: **Reaching Rural and Ethnic Communities**

North Dakota

North Dakota's four urban centers—Minot, Grand Forks, Bismarck, and Fargo—form the corners of a rectangle that outlines the state's midsection. Small, isolated rural communities predominate both inside and outside this rectangle. Providing enough nursing education and nurses for these areas remains a work in progress. Yet three programs are making inroads.

Dakota Nursing Program

The Dakota Nursing Program (DNP) is a unique consortium of five community colleges* that use a common curriculum to deliver a Certificate in Practical Nursing (PN) and the ADN to place-bound, certified nursing assistants living outside urban centers. The DNP's enrollment is typically 90 RN and 120 PN candidates.

DNP faculty encourage their ADN graduates to pursue BSNs at two cooperating universities; BSN graduates are urged to complete advanced degrees and teach for the consortium. This career ladder allows students to increase skills and job prospects while remaining in their communities.

The small, widely dispersed schools accomplish this mission by sharing administrative resources and faculty, and "using technology to the nth degree," says Julie Traynor, MSN, RN, the consortium's nursing director. "We have young faculty, and they are very savvy technologically. This really helps our students and program."

A faculty specialist in pediatrics, for example, develops course materials and lectures for the whole consortium that are disseminated by IVN or WIMBA and Web-streamed for students to download (instructional films are also Web-streamed). The DNP uses Pearson's eCollege for online learning management (e.g., for e-mail, assignment submission, grading, and document posting). DNP labs share mobile simulators.

The Nurse Faculty Intern Program

Since attracting out-of-state faculty is difficult for North Dakota, grow-your-own approaches are imperative. In 2004, the State Board of Nursing launched a pilot Nurse Faculty Intern (NFI) program, allowing BSN-RNs with at least two years of clinical experience to teach in nursing schools while pursuing graduate degrees—under the guidance of a faculty mentor and a consulting PhD-level educator. Of NFI's 81 participants, 15 are teaching for the DNP. The state board expects to complete a study of NFI outcomes soon and will pursue funding for a second phase of the popular program.

*Consortium partners: Bismarck State College, Fort Berthold Community College (tribal college), Lake Region State College, Dakota College at Bottineau, and Williston State College.

The Value of Nursing Education

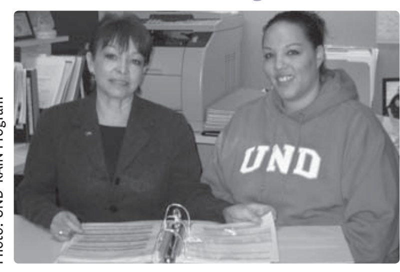

Photo: UND-RAIN Program

Mentoring
University of North Dakota BSN student Angel Dubois (right), a Turtle Mountain Chippewa, pauses during a mentoring session with RAIN assistant program coordinator Barb Anderson, also a Turtle Mountain Chippewa. RAIN provides mentors, financial assistance, and other supports. Many participants are single parents who come from poor rural areas and are the first in their families to pursue higher education (see "RAIN," column 3).

The RAIN Program: Recruitment and Retention of American Indians into Nursing

Though North Dakota has 34,112 Native American residents and is home to five reservations, only 19 Native Americans had earned BSN degrees from the University of North Dakota (UND) as recently as 1990. UND is the state's primary center for professional education and training.

"Prior to the start of the RAIN program in 1990, Native American nursing students felt no sense of belonging in UND's College of Nursing," says Deb Wilson (Mandan Hidatsa tribe), RAIN program coordinator. "Students often arrive on campus from rural areas having never seen a big city or known a college-educated family member."

To address these challenges, RAIN has created an atmosphere of "total support" in a "home away from home" in the middle of the College of Nursing, says Wilson.

RAIN offers scholarships, an eight-day immersion orientation, a prenursing program, academic mentors, help with child care, free taxi service to day care and classes, and cash assistance for emergencies.

Just as important are the emotional and cultural supports. "Sometimes RAIN students come with a vision of success, but sometimes you have to mentor that vision," says Julie Anderson, PhD, RN, CRCC, dean of UND's College of Nursing. "We tell students in many ways, 'We are here for you. You *can* accomplish your dream.'" The school also incorporates native traditions into its academic ceremonies.

As its 20th anniversary approaches, RAIN boasts 149 BSN and 39 MS graduates—the highest such numbers in the country. Anderson is seeking increased, sustainable funding for RAIN and sees it as a model for reaching other underserved populations.

Robert Wood Johnson Foundation

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Executive Editor: Maryjoan D. Ladden, PhD, RN, FAAN, *Senior Program Officer, Robert Wood Johnson Foundation*

Contributing Editor: Susan B. Hassmiller, RN, PhD, FAAN, *Senior Advisor for Nursing, Robert Wood Johnson Foundation and Director, RWJF Initiative on the Future of Nursing at the Institute of Medicine*

Researcher and Writer: Jeri Spann, MPA, MFA, *Senior Writer, Spann Communications, LLC, Pittsburgh, Pennsylvania*

Design: Rob Henning Design, *for Spann Communications, LLC*

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