# CNO Advisory Committee Meeting

## Meeting Book

February 5, 2019 3:15 - 4:30 pm

Pasadena Conference Center

300 E. Green Street, Room 212 & 214

Pasadena, CA

Conference Call Option:

800-882-3610 passcode: 7795222#

# Meeting Book - CNO Advisory Committee Meeting

CNO Advisory Committee Meeting Agenda - February 5, 2019

# CNO ADVISORY COMMITTEE
# 2019 ROSTER

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CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

**GUIDELINES FOR THE**
**CALIFORNIA HOSPITAL ASSOCIATION**
**CNO ADVISORY COMMITTEE**

## I. NAME

The name of this committee shall be the CNO Advisory Committee

## II. MISSION

The mission of the CNO Advisory Committee is to advise CHA on key policy and advocacy issues specific to hospital and health system nurse executive practice.

## III. PURPOSE

The purpose of the CNO Advisory Committee is to provide support for member hospitals and to solicit input for CHA advocacy on key issues.

The committee will provide a forum to:

1. Provide advice and expert analysis on issues of importance.
2. Cooperate with CHA on programs and activities and to support the positions and services of CHA.
3. Make recommendations related to state and federal legislation and regulations related to hospital and health system nursing and clinical services.
4. Conduct other activities approved by the CHA Board of Trustees.

## IV. COMMITTEE

The Committee (the "Committee") shall consist of no more than 25 voting members representative of the types, location, and size of CHA institutional members.

A. MEMBERSHIP

1. Membership on the Committee shall be based upon institutional membership in CHA.
2. Committee members shall consist of various representatives from large hospital systems, public institutions, private facilities, free-standing facilities, small and rural facilities, university/teaching facilities and specialty facilities.
3. Non-hospital members will be considered ex-officio members including faculty, consumers and other members of the health professions who are beneficiaries of nursing practice and can only be appointed to the committee at the discretion of the CHA staff.
4. Committee members are appointed by CHA staff.
5. Committee members shall serve three-year terms staggered in a fair and equitable manner as determined by the nominating committee and accepted by the Committee.

Members are limited to two consecutive terms. There must be at least a one-year interval before being eligible for another term.

B. MEMBER RESPONSIBILITIES

1. Accept their appointment with an interest and willingness to serve.
2. Mark their calendars with the advance notice of meetings for the year and make every reasonable effort to keep those dates and times open for the meeting.
3. Attend every meeting possible.
4. Be prepared by reviewing any discussion material provided in advance of the meeting.
5. Contribute to the discussion and consider the subject matter for the benefit of the association as a whole, not just an individual member.
6. Respond to requests for input and feedback on business and issues before the Committee.
7. Disseminate information to committees and to member organizations as appropriate.

C. COMMITTEE MEETINGS

1. Meetings of the Committee shall be held quarterly in person. Additional conference call or web-based meetings may be scheduled as indicated.
2. To maintain continuity substitution of members is not normally allowed.
3. Three consecutive unexcused absences by a Committee member will initiate a review by the Chair and CHA staff for determination of the Committee member's continued service on the Committee.
4. Special meetings may be scheduled by the Chair, majority vote or CHA staff.

D. VOTING

1. Voting rights shall be limited to members of the Committee, and each member present shall have one vote. Voting by proxy is not acceptable.
2. All matters requiring a vote of the Committee must be passed by a majority of a quorum of the Committee members present at a duly called meeting or telephone conference call.

E. QUORUM

Except as set forth herein, a quorum shall consist of a majority of members present/participating or not less than eight.

F. MINUTES

Minutes of the Committee shall be recorded at each meeting, disseminated to the membership, and approved as disseminated or as corrected at the next meeting of the Committee.

## V. OFFICERS

The officers of the Committee shall be the Committee Chair, Vice Chair, Immediate Past Chair and CHA staff.

The Chair shall be appointed by CHA staff for a two-year term. Should a Chair vacate his/her position prior to the end of the term, CHA staff will appoint a replacement to complete the remainder of the term.

The responsibilities of the Committee Chair are to:

1. Monitor staff in the execution of their responsibilities to the Committee.
2. Conduct meetings which assure an orderly flow of the discussion and a constructive use of the group's time.
3. Interpret the action of the Committee and speak for the Committee when necessary to report to the CHA Board of Trustees.

The responsibilities of the Committee Vice Chair are to:

1. Assist the Chair in the execution of his/her responsibilities to the Committee.
2. In the absence of the Chair, assume the role and responsibilities of the Chair.

## VI. GENERAL PROVISIONS

A. COMMITTEE ACTIVITIES
Committee activities, including goals and objectives, shall be developed by the Committee with approval by CHA staff. Quarterly updates and progress reports shall be completed by the Committee and CHA staff. Committee staff should communicate regularly with the Committee on the activities and priorities of the Committee. The Committee may request that staff develop a general work plan which defines the goals and objectives of the Committee for the coming year.

B. SUB-COMMITTEES
Task forces or subcommittees of the Committee may be formed at the discretion of the Committee Chair and member and CHA staff for the purpose of con ducting activities specific to a special topic or goal.

C. STAFF SUPPORT
Staff leadership shall be provided by CHA with Regional Association staff leadership provided by Hospital Council, the Hospital Association of Southern California, and the Hospital Association of San Diego and Imperial Counties. The primary office and public policy development and advocacy staff of the Committee shall be located within the CHA office.

## VII. AMENDMENTS

These Guidelines may be amended by a majority vote of the members of the Committee at any regular meeting of the Committee and with approval by CHA.

## VIII. LEGAL LIMITATIONS

Any portion of these Guidelines which may be in conflict with any state or federal statutes or regulations shall be declared null and void as of the date of such determination.

Any portion of these Guidelines which are in conflict with the Bylaws and policies of CHA shall be considered null and void as of the date of the determination.

Information provided in meetings is not to be sold or misused.

## IX. CONFIDENTIALITY FOR MEMBERS

Many items discussed are confidential in nature, and confidentiality must be maintained. All Committee communications are considered privileged and confidential, except as noted.

## X. CONFLICT OF INTEREST

Any member of the Committee who shall address the Committee in other than a volunteer relationship excluding CHA staff and who shall engage with the Committee in a business activity of any nature, as a result of which such party shall profit either directly or indirectly, shall fully disclose any such financial benefit expected to CHA staff for approval prior to contracting with the Committee and shall further refrain, if a member of the Committee, from any vote in which such issue is involved.

**CNO ADVISORY COMMITTEE**
**MEETING MINUTES**
*October 3, 2018 / 10:00 a.m. – 2:00 p.m.*

**Members Present:** **Connie Clemmons Brown, Jerome Dayao, Anita Girard, Karen Grimley, Beverly Hayden-Pugh, Marketa Houskova, Anna Kiger, Linda Knodel, Joseph Morris, Terry Pena, Katie Skelton, Lauren Spilsbury, Pam Wells**

**On Phone:** **Margarita Baggett, Judee Berg, Tim Clark, Teri Hollingsworth**

**Guests:** **Tae Youn Kim**

**Staff:** **BJ Bartleson, Jenna Fischer, Barb Roth, Judith Yates**

## I. CALL TO ORDER/INTRODUCTIONS

Chair Anna Kiger called the committee meeting to order at 10:00 a.m.

**2019 Meeting Discussion**
Upcoming 2019 meeting changes, dates and formats were discussed. Updated technology will be needed to conduct productive virtual meetings, as conference calls are not conducive to good dialogue. It was suggested that the committee meetings could be tied to annual meetings for ACNL or the Hospital Council. The committee agreed to drop the January 30, 2019 date and perhaps tie first meeting to the ACNL Annual Meeting in February, conduct a virtual meeting in May, a face to face meeting in August 7 and leave November 6 open for a possible call.

- *ACTION: Ms. Bartleson to work with ACNL on possible February meeting date.*

## II. REVIEW OF PREVIOUS MEETING MINUTES

The minutes of the July 25, 2018, CHO Advisory Committee conference call were reviewed.

***IT WAS MOVED, SECONDED AND CARRIED:***

- *ACTION: minutes approved.*

## III. OLD BUSINESS

### A. Nursing Community (Miyamoto)

Suzanne Miyamota discussed the Nursing Coalition's focused work around workforce programs. The Coalition has 61 nursing organizations supporting their reform efforts. Their success has spurred on more collaboration. Their steering committee meets 1x week and they convene a full membership meeting 1x month. They do not take on every issue, but try to focus on areas where they can get the most consensus and gain success.

Their current work includes:

1. Gun Violence - their goal is to come to consensus, i.e. funding for gun violence research.
2. Separation of children from families at the border – seeking a balanced tone where they can gain consensus from all coalition members regarding reunification and mental health of children addressed.

Membership criteria – must be a national nursing association to be a member, no small grass roots operations or individuals. Each new member must meet the criteria: be a national organization, write letter on how they support the core principles, Tri council vs. membership of the tri council.

ANA-C and ACNL boards have meet and are working on some core principles.

- *ACTION: Ms. Bartleson to convene a subcommittee.*
- *ACTION: Committee members to advise CHA of interest in participating on this subcommittee.*
- *ACTION: Draft some core principles – working with ANA-C and ACNL.*

**B. Nursing Span of Control (Clemmons Brown)**

Changing the role of Charge Nurse to a Nurse Shift Manager. Nurse Shift Manager position is tied to business outcomes and clinical outcomes. Most positions are exempt, however a few are hourly.

- *ACTION: Ms. Bartleson to suggest for ACNL.*

**C. Clinical Training Capacity (Bartleson/Morris)**

By the end of the summits, there will be enough information to make recommendations, spur conversations and determine next steps for all students to have meaningful clinical experiences. Variability, streamlining and standardization are consistent themes from the summit meetings.

It is evident that the current practice environment has changed dramatically, but academia has not changed accordingly. Communication between the clinical placement environment and academia needs to improve. Each group needs to invite the other into their areas for collaboration. Also, regions within California have different challenges and opportunities. Some areas are experiencing nursing shortages and other areas have an oversupply. Therefore, how do we take advantage of the excess in certain areas to support shortage areas?

The committee discussed the use of consortiums or clinical placement systems. Currently, there are transparency and trust issues amongst the stakeholders. One consistent solution is the possibility of increasing simulation training availability. Of the 25% that is allowed, only 17-18% is being used collectively. There is no standardization in simulation training and its usage is varied

Dr. Morris expressed an interest in continuing the summits on an annual basis; perhaps a statewide 2-3 day conference to bring academia and organizations together. Perhaps CEUs could be offered to encourage participation.

- *ACTION: Ms. Bartleson will distribute the BRN Regional Summit Information when it is available.*

**D. Nursing Diagnoses (Kim)**

Dr. Tae Youn Kim, faculty at the University of California Davis, Betty Irene More School of Nursing, was introduced and she described her work that encompasses measuring nursing's contribution to improved patient outcomes. She has a history of working with health information systems technologies and exploring how nursing data and care is documented. Her research has focused on decision support system design, development of standardized

nursing terminology and evaluation of patient care using advanced data processing and analytic methods.

Dr. Kim has suggestions for our continued work on nursing diagnoses. She informed us that even though most hospitals use their own EHR and specific language or nomenclature for the nursing process there are avenues, through the IT links on the back end of IT systems, where commonalities can be collected to measure impact. This is work she has performed in a previous role and state. The study could be replicated across California if we put together an advisory group with academia and practice partners, and, the ability to do retrospective chart review.

- *ACTION: Ms. Kim to provide information to CHA.*
- *ACTION: Ms. Bartleson to convene a call with committee participants to review for next meeting.*

## V. Legislative

### A. Federal Regulatory Update (Bartleson)

Ms. Bartleson reviewed the federal regulatory issues and actions described in the memo from Alyssa Keefe, CHA, VP, Federal Regulatory Affairs. Two areas highlighted in the memo are: Regulatory provisions to promote program efficiency, transparency and burden reduction, and, Durable Medical Equipment challenges.

- *ACTION: Information only.*

### B. SB 1288 (Bartleson)

Ms. Bartleson discussed the Governor's veto on SB 1288 and his reasoning. He states, "Nurse to Patient ratios are a vital part of the state's regulatory scheme. Hospitals, however, are best evaluated in a comprehensive manner and I am reluctant to start singling out specific violations for a separate penalty". This was a positive win for CHA and our member hospitals.

- *ACTION: Information only.*

### C. Legislation (Bartleson)

General discussion of legislation signed and defeated for 2018. The CHA legislative wrap-up was shared and discussed. Although legislation on alternate destination and other types of community paramedicine did not pass this year, CHA continues to support community paramedicine and will pursue opportunities next year. Ms. Bartleson also discussed AB 2798 the CHA sponsored bill to require the California Department of Public Health to process all hospital applications within 100 days. Members are encouraged to contact CHA if they are experiencing CDPH issues, particularly relative to the CAU process.

- *ACTION: Information only.*

### D. Prop 8 (Bartleson)

Ms. Bartleson and Ms. Kiger discussed Proposition 8, the dialysis initiative with the committee. Members expressed concerns that if Proposition 8 passes, the two major private dialysis providers have advised that they will leave California. If that happens, dialysis patients would turn to the hospital EDs for their treatment. Currently, hospitals are not equipped with physicians, nurses or equipment to handle this sudden influx of dialysis patients. The public needs to know that if the providers leave the state, patients will die due to lack of care availability.

Ms. Bartleson shared that CHA is part of the large coalition opposing this ballot measure.

- *ACTION: Information only.*

**VII. NEW BUSINESS**

**A. Nursing Peer Review Policies (Dayao)**

Mr. Dayao is seeking a best practice for peer review. Ms. Kiger and Ms. Hayden-Pugh have information they can share with Mr. Dayao.

- *ACTION: Information only.*

**B. Prohibition on Universally-Connectable Tubing Connectors (Bartleson)**

Ms. Bartleson reviewed the memo from Debby Rogers regarding member complaints regarding leakage from some of the reengineered tubing connectors. Hospitals are encouraged to develop a careful transition to the new connectors as well as review the patient safety plans to ensure they adequately address the prevention of misconnecting intravenous, enteral and epidural lines.

- *ACTION: Information only.*

**C. Title 22 AFLs (Bartleson)**

CDPH recently issued AFLs regarding updating Title 22. The suggested regulatory updates from this group were included in the packet.

- *ACTION: Information only.*

**VII. INFORMATION**

**A. Patient Outcomes After the Introduction of Statewide ICU Nurse Staffing Regulations**

**VIII. NEXT MEETING**

TBD (perhaps in February, tied to the ACNL Annual Conference).

**IX. ADJOURNMENT**

Having no further business, the committee adjourned at 1:51 PM

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

February 5, 2019

TO: CNO Advisory Committee Members

FROM: Garrett Chan, PhD, RN, APRN, FAEN, FPCN, FNAP, FAAN
Chief Executive Officer, Health Impact
BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing and Clinical Services, CHA
Joseph Morris, PhD, MSN, RN
Executive Officer, California Board of Registered Nursing

SUBJECT: Regional Nursing Summits- Bridging the Gaps in Pre-Licensure RN Clinical Education Capacity – FINAL REPORT

**SUMMARY**

The final report of the California Regional Summits was released on 1/30/2018. The report is the culmination of surveys and collaboration between statewide academic and clinical partners to examine issues around pre-licensure clinical capacity and develop practical solutions to effectively address them. The initiative was funded by the California Community Colleges, CACN and CSU. Health Impact and a summit planning group of partners from across multiple academic and clinical sites, including Dr. Morris, EO of the BRN collected. The summit planning team facilitated all aspects of the summit initiative. Region specific nurse supply and demand information performed by Dr. Spetz along with survey results done by Dr. Morris on California pre-licensure nursing education programs and a second to clinical agencies.

The compiled results of all seven summits are reported in the document and summarized into three categories; 1) priorities identified as most important from all seven summits, 2) priorities identified in two or more summits and, 3) priorities identified in a single summit. It is important to note that there was a geographical mix of participants inside and outside the various regions who attended the summits and some participants attended one or more of the sessions.

The collaborative effort lead to a plan for key stakeholders to collaborate and cooperate to achieve the following: 1) Sustain the momentum to make needed changes for a salient process that produces sufficient clinical capacity and a well-educated, sufficient RN workforce. 2) Decide a process to move the work forward related to the summit's priorities, 3) work collaboratively to strengthen cooperative efforts for RN education and workforce transformation, and 4) build and refine existing data collection and reporting systems so a robust central repository of reliable data is used to guide clinical capacity, clinical placement and RN nursing workforce decision making and strategic planning.

**DISCUSSION**

1) What are your thoughts after reviewing the summit summary?

2) How do you envision these solutions being implemented?
3) How are the consortiums working in your region?
4) Is your consortium able to implement these solutions? What barriers do you perceive?
5) Do you envision this strategy as a means to pursue other RN workforce modernization activity?
6) Could this type of activity be spearheaded by the proposed nursing community of academic and clinical partners?

**ACTION REQUESTED**

- *Discussion and determination of next steps.*

Attachment: Regional Nursing Summits, Summary Report

BJB:br

HealthImpact
Optimizing health through nursing

# Regional Nursing Summits

## BRIDGING THE GAPS IN PRE-LICENSURE RN CLINICAL EDUCATION CAPACITY

**SUMMARY REPORT |** JANUARY 2, 2019

Submitted by Judith G. Berg, MS, RN, FACHE
CEO, HEALTHIMPACT

## SUMMIT INTRODUCTION/BACKGROUND

California demand for pre-licensure Registered Nurse (RN) clinical education capacity/clinical placements is outpacing current acute care capacity for pre-licensure Associate Degree Nursing (ADN), Baccalaureate Science Nursing (BSN), and Entry Level Masters (ELM) nursing programs and students.

This has resulted in some organizational flow disruptions in some regions of California due to increasing numbers of clinical requirements for clinical placement onboarding and orientation to clinical sites, increases in education program enrollments in some regions of California, coupled with decreases in acute care training capacity. These are just a few of the major organizational factors causing flow disruptions and concern among academia and healthcare organizations. For more details, please refer to the Summit Background/Issues document (Attachment B), which was provided to participants in advance of each Summit.

The growing degree of operational disruption has been slowing but steadily building over the past several years as both academia and healthcare settings strive to meet the needs of a dynamic, transforming health care system while achieving effective organizational efficiencies and targeted quality outcomes and improvements.

To examine clinical capacity in more detail, seven Regional Nursing Summits were held in September and October 2018 across California with the intent and purpose to address the clinical capacity issues and associated factors with key stakeholders in a collaborative, transparent manner. Summits were held in Riverside (78 participants), Irvine (62), Fresno (50), Sacramento (81), Los Angeles (67), San Diego (61), and Oakland (53).

All Summit discussions focused on pinpointing key clinical capacity issues and factors and practical solutions that would effectively address the pre-licensure nursing clinical capacity and clinical education placement dilemma California is experiencing in a manner that improves upon the strategies in place now.

The Summit Planning Team was comprised of representatives from the California Board of Registered Nursing, California Hospital Association, California Community Colleges Chancellor's Office, California State University Office of the Chancellor, California Organization of Associate Degree Nursing Program Directors, California Association of Colleges of Nursing, Association of California Nurse Leaders, American Nurses Association of California, and HealthImpact. The Summit planning team met frequently from spring through fall of 2018 to

design Summit discussions that would facilitate thoughtful dialogue among participants and successfully capture key **"Priorities for Action"** and some possible practical solutions to address the identified priorities.

Prior to each Summit session, participants were emailed three documents; a Summit agenda (Attachment A), a Summit Background/Issues document (Attachment B), and a copy of a letter sent to the California Board of Registered Nursing's (BRN) Executive Officer by the California Quad Council leadership (Attachment C).

At each Summit, region specific RN supply and demand forecast data was presented by Dr. Joanne Spetz, Associate Director for Research, Healthforce Center at the University of California, San Francisco (Attachment D). The regional nursing supply and demand workforce reports are included in this report and are also available on HealthImpact's website, www.healthimpact.org.

Dr. Spetz' reports used the same modeling framework as that used to report the statewide RN supply and demand forecasts available on the BRN's website, https://www.rn.ca.gov/. In the aggregate, i.e., statewide, the workforce supply and demand data is projected to be balanced between supply and demand for RNs. Nonetheless, the regional reports presented by Dr. Spetz clearly indicated there are regional variations, with some areas of California in balance while areas/regions are projecting shortages or an oversupply of RNs.

Each Summit also included a presentation by the California Board of Registered Nursing (BRN) Executive Officer Dr. Joseph Morris. Dr. Morris presented results from two recent surveys: one of California pre-licensure nursing education programs, and a second of California health care agencies. Both surveys related to the current status of clinical capacity/clinical displacement from each party's perspective. The surveys were conducted by the BRN to learn more detail about nursing programs' and hospitals' experiences related to pre-licensure nursing clinical capacity/clinical placements/clinical displacement (Attachment E). Results from the surveys showed clear variations in perspectives and experiences in relation to clinical capacity and the availability of clinical education placements among schools and hospitals.

Additionally, the results of the surveys demonstrated a high degree of **variation** among pre-licensure nursing education programs and clinical agencies statewide in relation to nursing education program curriculum, total program units, course credit load, nursing theory and nursing clinical practice hours, and participation in and use of regionally based academic-practice clinical capacity/clinical placement planning consortiums. Survey results also indicated variability in the organization and operation of consortium groups within regions and across

California as well as the clinical placement systems and tools used to identify clinical placement availability and manage clinical placement scheduling and associated clinical placement onboarding processes etc. by nursing education programs and their respective clinical practice/clinical agency partners.

## SUMMIT FORMAT

At each Summit, attendees representing executives and decision-makers from academia, practice in acute and community settings, public health, corrections/prisons, labor groups, policy experts from the California legislature, the Board of Registered Nursing, and other interested key stakeholders were pre-assigned to Summit session small group for discussion following the formal presentations of pertinent clinical capacity information.

Summit participants in each of the session's small groups were charged with responding to the same four questions:

1. Identify unique issues, challenges, and best practices for the region
2. Identify strategies for innovative, collaborative solutions, including the role of placement systems/consortiums
3. How can simulation/virtual learning be effectively leveraged for clinical experience?
4. How can education and service/practice (including nontraditional practice partners), communication, and joint planning be strengthened?

Following small group discussions, each group summarized and reported their discussion outcomes with the entire group of Summit participants. Each small group's answers to the four questions above listed key issues and suggested solutions related to clinical capacity. Each small group's answers were posted around the meeting room and briefly reported out to all Summit participants. Finally, each Summit session concluded with all individual participants being invited to identify their own personal top five priorities/issues/strategies for action using a "dot voting" system. HealthImpact staff then prepared this written summary report reflecting Summit participants identified **"Priorities for Action".**

## SUMMIT RESULTS

The compiled results of all seven Summits are reported in this document as **"Priorities for Action".** The results are divided into three categories:

- Priorities identified as most important in all seven summits. Priorities identified in two or more summits (Refer to Table items w/ a total of 2 or more XX's);
- Priorities identified in a single summit (Refer to Table items w/at least 1 X entry).

When reviewing Summit report results, it is important to note that there was a geographical mix of participants from inside and outside the various regions that participated in each Summit. Some participants attended one or more Summit sessions. Participants registered for Summit sessions on a first-come first served basis. Participants seemingly used date availability, convenience, and other factors besides geographical location when deciding their Summit session attendance. Summit participants may or may not have attended a Summit session in the particular region where the participant resides or works.

## SUMMARY TABLE OF "PRIORITIES FOR ACTION"

Table 1 below summarizes the **"Priorities for Action"** across the regions and identified importance. Following Table 1, there is a more detailed description of the identified priorities.

### Table 1. "Priorities for Action" Across Regions: Listed in this order below:

- Priorities identified as **most important in all seven summit regions** (Refer to Table items listing (7) **XXXXXXXs**);
- Priorities identified as important **in two or more summit regions** (Refer to Table items listing (2) or more **XX-XXXs**);
- Priorities identified as important **in one summit region** (Refer to Table items listing (1) **Xs**)

| **"Priorities for Action" identified as most important <u>in all seven Summits</u> *(Note items are not listed in any particular order/ranking)*** | **Riverside** | **Irvine** | **Sacramento** | **Oakland** | **Fresno** | **San Diego** | **Los Angeles** |
|---|---|---|---|---|---|---|---|
| Pursue greater standardization of nursing education curricula, credit load & clinical hours | **X** | **X** | **X** | **X** | **X** | **X** | **X** |
| All nursing programs and clinical partners need to regularly participate in clinical placement groups/consortiums/ systems tool use | **X** | **X** | **X** | **X** | **X** | **X** | **X** |
| Pursue greater standardization of clinical site requirements associated with regulatory, licensing and accreditation compliance including student and faculty on-boarding and orientation requirements for acute and non-acute settings | **X** | **X** | **X** | **X** | **X** | **X** | **X** |
| Facilitate increased use non-acute, community-based, and ambulatory clinical sites statewide | **X** | **X** | **X** | **X** | **X** | **X** | **X** |
| Pursue an increase in the amount of simulation allowed for clinical practice up to 50% via necessary regulatory changes | **X** | **X** | **X** | **X** | **X** | **X** | **X** |
| Institutionalize consistent senior level academic & practice partners communication, collaboration structures/contacts, decision making, cooperation | **X** | **X** | **X** | **X** | **X** | **X** | **X** |

| **"Priorities for Action" identified as important in <u>Two or More</u> Summits (Note items are listed in no particular order/ranking)** | **Riverside** | **Irvine** | **Sacramento** | **Oakland** | **Fresno** | **San Diego** | **Los Angeles** |
|---|---|---|---|---|---|---|---|
| Eliminate faculty approval variations and need for NP faculty remediation | **X** | | **X** | | | | **X** |
| Eliminate faculty and clinical site approvals for nursing programs w/ national nursing accreditation i.e., ACEN, CCNE etc. | **X** | | **X** | | | | |
| Streamline pre-licensure education program approval processes (initial, continuing approval, major curriculum changes) | | **X** | **X** | | | | |
| Support development of new models of academic progression; provide adequate type and number of co-enrollment pathways and sufficient spaces for AD to BSN & AD to MSN program completions | | | **X** | | | **X** | |
| Standardize RN post-licensure residency experiences | **X** | | | | | **X** | |
| Develop shared simulation space for use by schools and clinical agency partners | **X** | **X** | | | | **X** | |
| Standardize ratio of simulation hours to direct care hours | | **X** | **X** | | | | |
| Increase funding support & faculty preparation in the planning, implementation, evaluation of simulation | **X** | **X** | | | | | **X** |
| Develop regional approaches to achieve increased and consistent advisory committee(s) participation | | | | **X** | | | **X** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Adopt "BSN in Ten" strategy in California | | **X** | | | **X** | | |
| Discontinue the use of letters of impact as evidence justification for program approvals and or expansion requests | | | **X** | **X** | | | |

| **"Priorities for Action" identified as important in <u>One</u> Summit (Note items are listed in no particular order/ranking)** | **Riverside** | **Irvine** | **Sacramento** | **Oakland** | **Fresno** | **San Diego** | **Los Angeles** |
|---|---|---|---|---|---|---|---|
| Limit program growth in impacted areas as needed based on available impact evidence | | | | | | | **X** |
| Address faculty recruitment and retention needs; pursue joint faculty appointment opportunities | | | | | **X** | | |
| Consider replacing existing pre-licensure nursing education curricula with new more standardized statewide/shared curriculum | | | | **X** | | | |
| Eliminate pre-licensure nursing program preceptorships | **X** | | | | | | |
| Develop refined regional and statewide algorithms to better predict clinical capacity and RN workforce needs in future | | | | **X** | | | |
| Combine BRN and BVNPT boards | **X** | | | | | | |
| Establish more detailed guidelines for clinical placements in non-acute care settings | | | **X** | | | | |
| Facilitate/allow clinical placements w/o faculty or RN presence by using technology to provide needed oversight | | | | | | **X** | |

## "Priorities for Action" Identified as most important in all seven Summit regions (in no particular order)

- ✓ Pursue greater standardization of pre-licensure nursing education curricula, including credit load and clinical hour across programs and by type of program – ADN, BSN, ELM. Summit participants expressed the need to reduce the noted degree of variation existing within regions and across regions throughout the state. Discussion actions ranged from voluntary school reduction/alignment of credit loads and clinical hours, to mandates from the BRN or other sources. The California State University nursing programs were recognized by some Summit participants for the standardization accomplished in recent years.

- ✓ Pursue regular consistent participation by all nursing education programs and clinical partners in the use of clinical placement systems/tools/consortiums within regions and statewide. There was acknowledgement that multiple consortium systems/tools exist – sometimes multiple types even in the same region. It was also noted there has been a lack of consistent participation by both clinical partners and programs in any given system and or region/area with a region. There was also support for the value of a standardized, statewide approach to clinical placements. Cost, confidentiality, favoritism, and general lack of interest were all stated as reasons for not participating in a consortium or utilizing a scheduling system/tool. It was also noted existing consortiums and clinical placement systems are mainly used by nursing programs and acute care clinical agency partners rather than all clinical agencies providing placements in a region. Participation by all nursing education programs and clinical partners across all levels of care needs to occur to do a better job in successfully managing clinical capacity. Implementation of the suggested actions above is viewed as a better way to improve standardization and promote consistent and increased communication and cooperation.

- ✓ Standardize clinical site requirements for education program placements arising from regulatory, licensing, and accreditation requirements for orienting/onboarding students and faculty. Some regions have attempted to do this, but there remains much variability in clinical site requirements within a region and across the seven regions. Summit participants identified the lack of standardization and variation as creating administrative burdens for programs, students, and health care organizations.

- ✓ Increase and facilitate use of non-acute clinical practice settings statewide. This might include use of clinical practice settings such as correction facilities, telehealth, clinics, K-12 schools, etc., as well as expanded utilization of other non-acute care settings with capacity to provide a range of learning experiences along the continuum of care. Summit participants acknowledged RNs work in multiple settings and re-affirmed the significant value of developing and maintaining clinical learning experiences and placements across all levels of care. Participants emphasized that the focus moving forward should be on providing adequate student learning opportunities to develop safe competent clinical reasoning across different practice settings and levels of patient care delivery as opposed to skill building only for acute care practice settings.

- ✓ Pursue ways for schools to have flexibility in the use simulation/virtual reality experiences for up to 50% of pre-licensure clinical time to meet program learning outcomes when a program can demonstrate sufficient evidence to prepare a safe competent RN that meets regulatory requirements. Summit participants acknowledged this proposal would require regulatory changes and establishing and adopting a uniform set of simulation standards across California. There was also a clear recognition by participants that faculty should be prepared and certified to teach in simulation-based learning environments using national standards for teaching in simulation-based learning environments.

- ✓ Pursue more effective communication and collaboration regarding clinical capacity and clinical placement planning structures to institutionalize consistent participation by senior-level decision makers in both academic and practice settings. Implementation of new and different strategies is this area will result in regular, consistent contact with one another and better promote shared decision-making that is appropriate and timely in addressing nursing education and workforce needs. This could/should include appointments to regularly reoccurring committees, i.e., advisory meetings, in both settings, as well as working on joint projects and initiatives. The focus should be on clarifying shared goals, developing mutual approaches, sharing resources, and agreement on outcome metrics.

## "Priorities for Action" Identified as most important in Two or More Summit Regions *(in no particular order)*:

- ✓ Review and consider revision of some of the BRN's faculty and clinical site approval processes. Summit discussions identified aspects of the faculty and clinical site approval processes that are burdensome for some programs in some instances. Two specific suggested modifications were put forth: 1) Allow RNs with Nurse Practitioner certification/preparation to serve as faculty without additional remediation in acute direct care; and 2) Eliminate the need for BRN approval of faculty and clinical sites for nationally-accredited nursing programs.

- ✓ Eliminate inconsistencies in interpretation/application of standards, regulations, and approval processes within regions and across regions. For example, variation in clinical site approvals was frequently cited.

- ✓ Create a group of key stakeholders to work with the BRN and legislative bodies for regulatory reform related to the nursing education program approval processes. The goal would be to simplify and streamline the approval processes. Summit participants recognize this will most likely involve opening the Nursing Practice Act and will need to be carefully considered and analyzed before pursuing this option as a viable action moving forward.

- ✓ Increase and sustain the opportunities/enrollment options for ADN students to be co-enrolled in AD to BSN or AD to MSN programs to promote increased academic progression faster. The goal should be to encourage all ADN students to be co-enrolled in a university program, and to facilitate enrollment and completion processes with forgivable loans, employer scheduling flexibility, and reasonable credit loads when students are co-enrolled in courses.

- ✓ Standardize and streamline RN post-licensure residency experiences to onboard newly licensed RNs in all initial practice settings. Consider adopting statewide standards and processes that would be foundational to all residency programs in California.

- ✓ Support school and clinical practice setting partnerships for the creation and sustained use of simulation spaces that can be used by all parties. A suggested variation on this recommendation was to develop mobile simulation spaces that can be brought to nursing programs or practice settings within a region/area. Participants suggested mobile simulation labs might be developed together by several school partners, employers, and/or the Chancellor's Office, for example.

- ✓ Achieve greater standardization of the ratio of non-direct care/simulation/virtual labs/skills labs practice hours to direct care practice hours in the future. There is some evidence to support the theory that well

planned, organized, implemented, and evaluated simulation-based learning activities can be an effective instructional method to augment direct patient care clinical learning experiences.

- ✓ Increased funding and provision of more opportunities for faculty to obtain the requisite formal preparation to teach in simulation-based learning environments.

- ✓ Develop a regional approach to nursing program advisory committees. In urban areas, practice leaders find it challenging to attend multiple nursing program advisory committees if they host students from multiple nursing programs. Summit participants suggested regular participation/attendance at advisory meetings could more than likely be improved if individuals could attend one meeting that involved all the programs and clinical partners across all practice settings in the region. Moreover, participants suggested action in this area would have the added benefit of programs and practice settings sharing best practices with each other and provide continuing opportunities to standardize and further align curriculum and clinical practice needs and processes.

- ✓ Adopt a "BSN in Ten" strategy in California. This would require all future graduates of ADN nursing programs to obtain a BSN degree within ten years of graduation to qualify for continued RN licensure.

- ✓ Identify valid and reliable processes/practices that provide sufficient evidence of clinical capacity/clinical placement impact that will enable the BRN to replace the existing approval processes now requiring clinical sites and neighboring nursing programs to write letters of impact as part of the BRN's approval processes for nursing education program expansion or new program approvals should be discontinued.

- ✓ Develop processes that support joint faculty appointments.

## "Priorities for Action" Identified as most important in at least One Summit Region *(in no particular order)*:

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- ✓ Support BRN action to limit program growth in impacted areas of the state (LA region). Discussion encompassed both new programs coming into the region as well as existing programs expanding their pre-licensure enrollment capacity.

- ✓ Address faculty recruitment and retention. This is a major issue for nursing education (Fresno region) not just for the one region mentioned in the one Summit session listed here. Summit participants suggested several ideas such as increasing compensation, developing joint academic/practice appointments, creating faculty pipelines, and building different structures to recognize faculty expertise and tenure as solutions that could favorable impact faculty recruitment and retention.

- ✓ Eliminate pre-licensure nursing student preceptorships. This was a priority in one region (Riverside region). This action would free up preceptors to work with newly licensed nurses, and also allow them to be more available to higher numbers of pre-licensure students.

- ✓ Develop necessary algorithms to determine/predict the numbers and skill mix of nurses required year to year in a specific region (Bay Area region) and across all regions. The developed algorithms would also take clinical practice setting (across the continuum of care) capacity into consideration in setting future targets. These

targets could be used by nursing programs in the region to scale up, down, or maintain their student populations.

- ✓ Consider eliminating all nursing program curricula in the state and start over with a goal of building a statewide (or regional) shared curriculum (Bay Area region).

- ✓ Combine the BRN and Board of Vocational Nursing and Psychiatric Technician (BVNPT) into one board (Riverside region) was suggested. Having one board was suggested as a way to further streamline program approval processes and leverage regulatory learning and oversite responsibilities. California, West Virginia, and Louisiana are currently the only states in which these boards function as separate entities.

- ✓ Establish more refined/detailed BRN guidelines for clinical placements in non-acute care clinical settings (Sacramento). This would further support standardization of clinical placements in non-acute care, ambulatory care and other community-based clinical settings.

- ✓ Allow and facilitate use of clinical placements in non-acute care settings across all levels of care without faculty or RN presence when an RN role focus can be demonstrated to meet program/course objectives (San Diego region) and regulatory requirements. Provide necessary level of supervision/oversight via greater use of technology and or through an RN manager or provider role.

## CONCLUSION

It was clear throughout the Summit planning and implementation processes that statewide consensus is building for changing the way California addresses clinical placements for pre-licensure nursing students.

Summit participants' interest is clearly high to move the three categories of "**Priorities for Action"** forward and improve and modernize clinical placements for pre-licensure nursing students in California.

Moreover, Summit discussions validated there is broad based consensus to pursue greater standardization in many different aspects of the existing pre-licensure nursing education. Actions moving forward include more effective and efficient clinical capacity and clinical placement planning, as well as implementation of workable solutions and evaluations processes.

Collectively, Summit participants also expressed a continued commitment to work collaboratively and cooperatively to address the identified **"Priorities for Action"** included in this report in order to proactively sustain a highly educated California RN workforce in the future.

Summit participants clearly recognize a number of the identified "**Priorities for Action"** will require legislative or regulatory solutions/actions while others may be addressed more quickly. For example, priorities such as changing

the pre-licensure nursing education program approval processes or increasing the amount of simulation that can be used to augment a nursing education program's number of direct care hours will more than likely necessitate a number of regulatory changes.

A few "Priorities for Action" that could be acted on more quickly include nursing education programs working immediately with a variety of community-based clinical practice partners to pursue use of greater variety of non-acute care clinical settings to meet program objectives and achieve learning outcomes. Summit participants indicated action in this area within regions and statewide would have a very favorable and immediate impact on addressing some of the current clinical capacity/clinical displacement issues in acute care settings currently being identified. Additionally, there is interest in Identifying valid and reliable processes/practices that provide sufficient evidence of clinical capacity/clinical placement impact that will enable the BRN to replace The existing approval processes now requiring clinical sites and neighboring nursing programs to write letters of impact as part of the BRN's approval processes for nursing education program expansion or new program approvals

Still other **"Priorities for Action"** may require a combination of voluntary/mandatory initiatives/approaches. Examples include voluntary consistent participation and use of clinical placement systems/consortiums and voluntary curriculum revisions that reduce program credit load/clinical hour requirements.

Furthermore, other **"Priorities for Action"** might be addressed via pilot projects with small tests of change before broad implementation and acceptance in the field.

Finally, Summit participants collectively expressed a strong preference to address the identified **"Priorities for Action"** through a collaborative process that consistently engages a wide range of key stakeholder groups.

## SUGGESTED NEXT STEPS

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**Nursing leaders and other key stakeholders collaborate and cooperate to achieve the following:**

**I. Sustain the Summit momentum to make needed changes that ensure sufficient clinical capacity and a well-educated, sufficient RN workforce now and in the future.**

- Summit participants clearly acknowledged that the degree of variability in clinical capacity/clinical placements processes within regions and across the state needs careful and continued examination so workable/practical solutions can be more fully developed, implemented and evaluated. An example is to

identify valid and reliable processes/practices that provide sufficient evidence of clinical capacity/clinical placement impact that will enable the BRN to replace the existing approval processes now requiring clinical sites and neighboring nursing programs to write letters of impact as part of the BRN's approval processes for nursing education program expansion or new program approvals.

**II. Decide on the most effective mechanisms/processes to be used moving forward to lead the necessary ongoing work related to the Summit's "Priorities for Action" and solutions implementation and evaluation.**

- Summit participants suggested that a group of key stakeholders be convened following the Summits. It is anticipated the workgroup will convene, coordinate, and facilitate statewide efforts to address the Summit-identified **"Priorities for Action",** and implementation and evaluation of solutions related to this initiative. Possible workgroup membership is yet to be determined, but when established, the group will be charged with review of the Summit **"Priorities for Action",** additional environmental scans as needed, as well as determining more detailed solutions, next steps, implementation timelines, evaluation metrics etc. and the methods used to track/trend and report results of implemented solutions.

**III. Work collaboratively to continue strengthening relationships, partnerships (nursing practice/industry, academia, government/regulatory, business etc.), and statewide consensus building opportunities and engagement. Most importantly sustain partnerships that effectively promote sufficient clinical capacity/clinical placements, academic progression to the BSN level or higher, and a sufficient RN workforce**

- Summit participants also suggested that consensus building opportunities like the inaugural 2018 Summit sessions be done periodically in the years to come so all California key stakeholders have the opportunity to participate in statewide efforts to achieve a safe competent RN workforce, and clinical capacity and clinical placements that ensure excellent preparation of RNs in California.
- Consider development of other communication and messaging opportunities and mechanisms that promote continued interconnectivity among interested parties.

**IV. Build and refine existing data collection and reporting systems/resources so a robust central repository of reliable data is used to guide future clinical capacity, clinical placement, and RN nursing workforce decision-making and action planning.**

## REFERENCES AND RESOURCES

**Board of Registered Nursing**
Nursing Practice Act https://www.rn.ca.gov/practice/npa.shtml
Business & Professions Codes Article 4. Nursing Schools - 2785-2789
California Code of Regulations Article 3. Prelicensure Nursing Programs
Board of Registered Nursing approved programs **Pre-Licensure RN Programs (ADN, BSN, and ELM Programs)**
National Council Licensure Examination for Registered Nurses (**NCLEX**-RN ®) Pass Rates for California graduates
https://www.rn.ca.gov/education/passrates.shtml

**HealthImpact** https://healthimpact.org/
Regional Nursing Summits: Bridging the Gaps in Clinical Capacity CA BRN Regional Summit Report
https://healthimpact.org/publication/regional-nursing-summits-bridging-the-gaps-in-clinical-capacity/
https://healthimpact.org/publication/ca-brn-regional-summit-report/
Supply & Demand of RNs – Central Valley & Sierra region https://healthimpact.org/publication/supply-demand-of-rns-central-valley-sierra-region/
Supply & Demand of RNs – Inland Empire https://healthimpact.org/publication/supply-demand-of-rns-inland-empire/
Supply & Demand of RNs – LA/Orange/Ventura region https://healthimpact.org/publication/supply-demand-of-rns-la-orange-ventura-region/
Supply & Demand of RNs – Sacramento & Northern regions https://healthimpact.org/publication/supply-demand-of-rns-sacramento-northern-regions/
Supply & Demand of RNs – San Diego region https://healthimpact.org/publication/supply-demand-of-rns-san-diego-region/
Supply & Demand of RNs – SF Bay Area region https://healthimpact.org/publication/supply-demand-of-rns-sf-bay-area-region/

**National Council of State Boards of Nursing (NCSBN)** https://www.ncsbn.org/index.htm
National Simulation Guidelines for Prelicensure Nursing Programs https://www.ncsbn.org/9535.htm

Major funding for the summits was provided by the California Community Colleges Chancellor's Office, with additional funding provided by the California State University Office of the Chancellor and the California Association of Colleges of Nursing.

## BRN REGIONAL NURSING SUMMITS PLANNING GROUP

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# Attachment A

## Regional Nursing Summits Agenda

In collaboration with American Nurses Association\California, Association of California Nurse Leaders, California Association of Colleges of Nursing, California Hospital Association, California Organization of Associate Degree Nursing Program Directors, and Health***Impact*** (convener)**,** the **California Board of Registered Nursing presents Regional Nursing Summits:**

# Regional Nursing Summits

## Bridging the Gaps in Clinical Capacity

# AGENDA

**10:00 AM – 2:30 PM**

| | |
|---|---|
| 9:30-10:00 am | **Registration** |
| 10:00-10:30 am | **Welcome** *(Judee Berg)* |
| | **History – "What Got Us Here?"** *(Judee Berg)*<br>• Quad Council letter *(Quad Council Representative)* |
| | **Summit Purpose: Identify Priorities for Action** *(Dr. Joseph Morris)*<br>• Immediately actionable<br>• Long term |
| 10:30-11:00 am | **Regional Supply & Demand Forecast Reports** *(Dr. Joanne Spetz)* |
| 11:00-11:30 am | **BRN Nursing Program & Hospital Capacity Survey Results** *(Dr. Joseph Morris)* |
| 11:30 am-12:00 pm | **Box Lunch & Small Group Instructions** *(Judee Berg)* |
| 12:00-1:00 pm | **Small Group Discussion – Educating Nurses for the Future** *(All)*<br>1. Identify unique issues, challenges, and best practices for region ***(15 minutes)***<br>2. Identify strategies for innovative, collaborative solutions, including the role of placement systems/consortiums ***(20 minutes)***<br>3. How can simulation/virtual learning be effectively leveraged for clinical experience? ***(10 minutes)*** |

4. How can education and service/practice (including non-traditional practice partners) communication and joint planning be strengthened?
   ***(15 minutes)***

1:00-2:00 pm **Large Group De-brief/Innovative Ideas Discussion** *(All)*

2:00-2:15 pm **Innovative Ideas Ranking** *(All)*

2:15-2:30 pm **Next Steps** *(Dr. Joseph Morris)*

Major funding provided by the California Community College Chancellor's Office

California Community Colleges

Additional Funding provided by the California Association of Colleges of Nursing and the California State University Office of the Chancellor

CACN California Association of Colleges of Nursing

CSU The California State University

# Attachment B

## Bridging the Gaps in Pre-Licensure RN Clinical Capacity Issue Document

# Regional Nursing Summits

## Bridging the Gaps in Pre-licensure RN Clinical Education Capacity

**September 2018**

**Issue**

The demand for pre-licensure Registered Nurse (RN) clinical education capacity/clinical placements is outpacing current acute care capacity for pre-licensure Associate Degree Nursing (ADN)Baccalaureate Science Nursing (BSN), and Entry Level Masters (ELM) nursing programs and students. Increasing numbers of clinical training slot requirements, resulting from both increased enrollments is existing pre-licensure RN programs in some areas of the state coupled with simultaneous decreases in acute care training capacity due to a number of factors is causing flow disruption and concern among academia and healthcare organizations.

The degree of operational disruption has been slowly surfacing over the past several years as both academia and healthcare settings strive to meet the needs of a dynamic transforming health care system while achieving effective organizational efficiencies and targeted quality outcomes and improvements.

This year several issues and concerns arose that highlighted the need for re-examination of all aspects of academic and industry educational clinical placement coordination and programming. Left unresolved these issues can impact and potentially comprise effective RN student learning and strain organizational efficiencies. Most importantly, if not addressed, these issues/concerns may threaten the significant progress California has made in maintaining a viable professional workforce in the future.

The complex systemic challenges in academia, healthcare and the regulatory environment today all influence the depth and breadth of pre-licensure RN education. It is crucial that all stakeholders continue to work together so these complex multilayered issues, concerns and challenges are discussed and solutions identified. As many stakeholder groups and Summit participants already recognize, the clinical capacity/clinical displacement issues are part of a much larger complex set of nursing education and nursing practice issues partners deal with

regularly. These encompasses, but is not limited to, how best to prepare new RNs for the ever-changing practice environments, how to achieve the best patient care outcomes, how to maximize use of available resources while achieving operational efficiencies and effectiveness, how to manage changes in clinical capacity and availability of clinical placements in inpatient, outpatient/ambulatory and community based settings, how to maintain continued support for implementation of nursing education redesign initiatives, how to ensure seamless academic progression, how to effectively select and implement a variety of direct and indirect instructional methods that will most effectively prepare the RN graduate for clinical practice (direct patient care, indirect care skills/simulation labs), how to best to accomplish review and revision of nursing curriculum and how to effect regulatory changes to keep pace with the changing health care environment, how to address preceptor requirements, labor requirements, sufficiency of resources, and how to move forward so all pre-licensure RN nursing education programs in California have the necessary resources to support program implementation, compliance with Board of Registered Nursing Regulations and attainment of voluntary national nursing accreditation.

Addressing these very complex issues is a daunting challenge that demands academia, practice, labor and regulatory partners collectively and effectively work together to identify and implement new and different solutions and actions while sustaining those practices/processes that are working well and do not need to be modified.

Irrespective of the challenges and issues, it is crucial moving forward, that stakeholders remain committed to resolving the current and future issues. This will ensure California maintains effective clinical partnerships, placements and clinical learning experiences that continue to prepare pre-licensure RN program graduates that provide safe, competent, quality care for California residents/consumers, families and communities.

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**Summit Goals**

The goals of the Summits are to discuss clinical capacity and identify better ways to sustain adequate clinical capacity and clinical placements for all three types of pre-licensure nursing education programs. It is believed addressing these complex multilayered issues ensures there will continue to be a sufficient supply of well-educated, safe and competent nursing professionals in California's RN work force now and in the future.

**Summit Outcomes**

Moving forward, the information gathered from the Summit discussions will be used to develop a comprehensive plan for student clinical experiences across the state, taking into consideration regional and local differences.

**Summit Planning Group Beliefs/Assumptions**

The collective beliefs and assumptions held by the Summit Planning Group set the backdrop to facilitate Summit discussions. This document is designed to provide a brief overview and basic information about the various factors/issues that may be impacting clinical capacity in some way.

First, the group supports the need for changes in the ways nurses are educated for the future. This was a specific recommendation in the *Nursing Education Plan White Paper and Recommendations for California. (*HealthImpact, August 2016).

Also relevant to Summit discussions is California's White Paper Recommendation II: "Promote academic progression for all registered nurses to obtain a BSN or higher degree by 2030."

California recognizes the crucial importance of providing education opportunities to California's very diverse population. Stakeholders recognize and support the educational opportunities and inclusive teaching and learning environments all three types of degree programs (AD, BSN, ELM) provide to meet the diverse educational, cultural, and economic needs of the communities the programs serve. All three types of programs support the value of lifelong learning and afford all Californians, irrespective of economic means, the opportunity to achieve their educational goals.

These programs consistently provide rigorous, high quality nursing degree preparation. Collectively these programs provide graduates with excellent RN educational preparation for safe competent entry in to registered nursing practice. All Board approved pre-licensure nursing programs provide clinical learning experiences in a variety of clinical practice settings that ensure graduates are prepared to function safely and competently in the current and emerging practice environments.

RN licensure examination (NCLEX-RN) first-time tester pass rates for the majority of California's nursing programs are at or exceed the annual national pass rates for each type of degree program.

California's Education White Paper recommendations are consistent with the Future of Nursing Report (IOM, 2010) recommendation that established a goal of 80% of nurses in the workforce having a BSN or higher degree by 2020. Recommendation V in California's Education Plan White Paper states, "Provide transformative learning opportunities that prepare nurses for evolving roles in rapidly changing interprofessional practice environments." The Summit Planning Group also believes and supports attainment of voluntary national nursing accreditation by all pre-licensure RN nursing education programs in California. Presently, all BSN and ELM nursing programs are accredited by a national nursing accreditation body (CCNE or ACEN). About 30% of Associate Degree nursing programs hold national nursing accreditation. In California, Board of Nursing approval is required and national nursing accreditation decisions are made by each nursing program. State Board of Nursing approval and national nursing accreditation processes have the same goals to provide society with a safe competent RN workforce. Both bodies review and evaluation processes use appropriate evidenced based outcome metrics to determine program success in meeting compliance and established standards of quality and improvement.

In 2012 the National Council of State Boards of Nursing (NCSBN) published "Model Rules" for State Boards of Nursing (SBON) to consider adopting related to national nursing accreditation. This Model Rule if adopted by the SBON called for all pre-licensure nursing programs to achieve voluntary national nursing accreditation by January 1, 2020. NCSBN also noted that the determination to require national nursing accreditation is made by individual SBON based on needs.

To date, the BRN has not adopted regulations requiring national nursing accreditation for initial BRN program approval or continuing approval. Although the Board supports nursing program decisions to obtain voluntary national nursing accreditation, the Board has not identified the need to adopt new regulations that require Board approved also obtain national nursing accreditation. In the past, some nursing education programs in California indicated funding resources for initial and ongoing nursing accreditation were cost prohibitive. *The Summit Planning group supports external review for accreditation as valuable and recommends that nursing programs be nationally accredited.*

Lastly, the Summit Planning group supports program curriculum change initiatives to achieve less variability in the total degree units and required clinical units/hours beyond the BRN minimum requirements (18 semester units or 27 quarter units). It is believed that curriculum changes would help to even out the need for clinical space. While the BRN regulations set the overall minimum clinical unit and hours requirements for nursing education programs, it is each college/nursing program that determines the total number of units required to earn the nursing degree. If all nursing education programs adopted the BRN clinical minimums required, this action alone may "open up" a number of additional clinical slots and hours for other nursing programs needing placements.

For example, in the California State University system nursing education programs consistently require 120 units for the bachelor's degree, but that may not be the case for all other California BSN degree programs. For the Associate Degree Nursing programs, total degree units across this degree type programs may vary and range from 70 units to 90 or more units. The Summit Group suggests now is an opportune time for nursing programs and faculty to make the curriculum revisions necessary. The recommendation is … *To create efficient educational pathways that minimize student burden (including debt), maximum credit units should be 70 units for ADN and 120 units for BSN programs to avoid programmatic variability and even out need for clinical space.*

In summary, the academic and healthcare agencies/service partners and the BRN have agreed to host regional summits to collectively identify practical solutions to the pre-licensure nursing clinical placement capacity dilemma. The regional summit planning group has identified the aforementioned beliefs and assumptions as guiding principles for Summit discussions. Moreover, the Summit Planning group recognizes value, nature and importance of the present regional planning consortium infrastructure where it exists and the invaluable role regional clinical planning groups play managing the complex clinical placement scheduling, programming, and coordination activities associated with securing needed clinical placements in the various regions throughout California. These groups have been pivotal to the many successes achieved in matching regional clinical placement requests by large numbers of nursing education programs with available clinical sites in an efficient and effective manner. Action steps specific to each region will specifically address local needs, using the identified assumptions to guide conversation and solutions.

**Stakeholder Information**

**The Board of Registered Nursing (BRN)**

Pre-licensure nursing education program approval is an integral part of the BRN's mission of public protection in California. The laws and regulations governing program approval and inspections are found in Business and Professions Code (BPC) Sections 2786-2788 and California Code of Regulations (CCR) 1420-1432. The educational regulations, standards, and policies established by the BRN are designed to produce safe competent RN graduates. These laws and regulations describe the standards, formal mechanisms and requirements for Board actions related to initial program approval, clinical facilities, continuing approval visits, curriculum/enrollment changes, skills and simulation lab hour regulations, as well as, a number of other areas.

Each approved program is assigned a Board nursing education consultant to facilitate and enforce compliance with Board regulations. This includes compliance with clinical facilities regulations and approval processes.

The Board regulations pertaining to clinical learning experiences mirror the National Council of State Boards published work related to Clinical learning experiences (Spector et al. 2018). Board regulations reflect the national standards that student clinical experiences require faculty planned and supervised "hands on" clinical learning experiences with patients in a variety of settings in order for students to be able to apply the knowledge and skills in accordance with Board regulations. The Board requires the clinical learning experiences be designed by faculty to meet progressive clinical learning objectives/outcomes across the curriculum. The clinical experiences should be consistent with program and clinical learning outcomes and enable students to gain clinical judgment, decision making and clinical management skills necessary of safe competent entry in to RN practice.

In California, it is each clinical agency that decides which nursing education programs will be provided placements in their agency clinical sites. Nursing education programs provide the Board staff with evidence of compliance that the program has secured and maintained the necessary clinical learning experience to implement the approved curriculum inclusive of an adequate type and number of clinical sites to meet program objectives and achieve student learning outcomes.

BRN regulations require pre-licensure nursing education programs obtain BRN approval of all clinical sites prior to use. The program submits required forms/paperwork and sufficient evidence showing compliance with the regulations.

For decades, the Board has supported and approved clinical placements in a wide variety of clinical settings across all levels of care including inpatient, outpatient/ambulatory care, and community-based healthcare agencies. There is no Board regulation that requires all of an approved program's clinical learning experiences be completed in an acute care clinical agency. In the past, some programs may have depended on available acute care agencies to achieve a significant portion of program objectives and student learning outcomes.

Board approved nursing program faculty select, plan, implement, and evaluate the appropriateness and suitability of the clinical placements to meet clinical objectives and student learning outcomes. The selected and approved clinical placements are expected to provide a sufficient number and type of learning experiences and an adequate patient census to support the number of students placed in the clinical rotation. Selected approved clinical sites/placements need to provide the appropriate level of complexity to meet learning objectives, and enable student mastery of the knowledge, skills, abilities and clinical judgment that facilitates student progression in providing safe competent care at the level of required complexity in each nursing course.

The Board has been asked by nursing education programs to increase the percent of allowable hours for skills and simulation labs beyond the 25% stated in current regulations (CCR 1420(e) and CCR 1426 (g)(2)) due program challenges in securing needed clinical learning experiences in each of the five required clinical areas (Geriatrics, Medical Surgical, Obstetrics, Pediatrics, and Psych/Mental Health), particularly the latter three clinical areas, in the past several years. Nursing education regulation changes are needed for the Board to approve more than the allotted 25%. BRN annual school survey data shows many nursing programs currently use a small percentage of the allowable clinical course hours for skills and simulation lab clinical learning.

The BRN is working closely with the BRN Nursing Education and Workforce Advisory Committee (NEWAC) and its simulation workgroup to facilitate quality driven simulation to the allowable amount. Currently the NEWAC

simulation workgroup has developed a set of uniform simulation standards and is working on nursing program adoption of a uniform set of simulation moving forward. Adoption of a uniform set of simulation use standards is an important next step in relation to simulation and ensuring the delivery of quality simulation learning experiences across all nursing programs. Simulation is also a regular agenda item for the NEWAC BRN advisory committee.

The BRN annual school surveys provide a significant amount of data regarding pre-licensure nursing education programs. Annually, the NEWAC committee reviews the annual school survey tool and makes needed revisions. The NEWAC group has done a fine job of revising the surveys year to year. Recently the BRN received a comment suggesting it may be valuable to capture more information via the annual school survey processes in relation to Associate Degree to BSN Degree Program affiliations that support academic progression and information regarding co-enrolled students (AD-BSN). This may be an opportunity for consideration at the BRN's upcoming Fall 2018 NEWAC committee meeting.

Over the past couple of years, the Board has received public testimony in relation to approval of new RN programs, the impact of increased program enrollment by existing approved programs in some regions, and increasing instances of denial of long-established clinical placements for some programs. Most recently, testimony was provided by a number of Associate Degree Nursing Program Directors reporting some agencies the programs had partnered with for years were no longer accepting AD students' placements or were limiting clinical placements if AD program students were co-enrolled in a BSN program.

To address the clinical placement concerns being reported to the Board, the Board has recently required nursing programs requesting program expansion, to obtain written letters "in support" or "not in support" and other detailed clinical scheduling evidence to ensure the Board's approval of program expansions and new program approvals adheres to current regulations (CCR 1420 -1432). Board has also received public comments that these more recent requirements has added an additional level of tension between community colleges and universities.

**Board Curriculum Regulations**

The Board's minimum curriculum requirements are listed below. As mentioned earlier in the Colleges and Universities Nursing Education Program section of this document, each Board approved nursing education program makes the final determination in regard to the total number courses, units, and hours required beyond the Board's minimum requirements as listed below.

**§ 1426. Required Curriculum**

(a) The curriculum of a nursing program shall be that set forth in this section, and shall be approved by the board. Any revised curriculum shall be approved by the board prior to its implementation.

(b) The curriculum shall reflect a unifying theme, which includes the nursing process as defined by the faculty, and shall be designed so that a student who completes the program will have the knowledge, skills, and abilities necessary to function in accordance with the registered nurse scope of practice as defined in code section 2725, and to meet minimum competency standards of a registered nurse.

(c) The curriculum shall consist of not less than fifty-eight (58) semester units, or eighty-seven (87) quarter units, which shall include at least the following number of units in the specified course areas:

(1) Art and science of nursing, thirty-six (36) semester units or fifty-four (54) quarter units, of which eighteen (18) semester or twenty-seven (27) quarter units will be in theory and eighteen (18) semester or twenty-seven (27) quarter units will be in clinical practice.

(2) Communication skills, six (6) semester or nine (9) quarter units. Communication skills shall include principles of oral, written, and group communication.

(3) Related natural sciences (anatomy, physiology, and microbiology courses with labs), behavioral and social sciences, sixteen (16) semester or twenty-four (24) quarter units.

(d) Theory and clinical practice shall be concurrent in the following nursing areas: geriatrics, medical-surgical, mental health/psychiatric nursing, obstetrics, and pediatrics. Instructional outcomes will focus on delivering safe, therapeutic, effective, patient-centered care; practicing evidence-based practice; working as part of interdisciplinary teams; focusing on quality improvement; and using information technology. Instructional content shall include, but is not limited to, the following: critical thinking, personal hygiene, patient protection and safety, pain management, human sexuality, client abuse, cultural diversity, nutrition (including therapeutic aspects), pharmacology, patient advocacy, legal, social and ethical aspects of nursing, and nursing leadership and management.

(e) The following shall be integrated throughout the entire nursing curriculum:

(1) The nursing process;

(2) Basic intervention skills in preventive, remedial, supportive, and rehabilitative nursing;

(3) Physical, behavioral, and social aspects of human development from birth through all age levels;

(4) Knowledge and skills required to develop collegial relationships with health care providers from other disciplines;

(5) Communication skills including principles of oral, written, and group communications;

(6) Natural science, including human anatomy, physiology, and microbiology; and

(7) Related behavioral and social sciences with emphasis on societal and cultural patterns, human development, and behavior relevant to health-illness.

(f) The program shall have tools to evaluate a student's academic progress, performance, and clinical learning experiences that are directly related to course objectives.

(g) The course of instruction shall be presented in semester or quarter units or the equivalent under the following formula:

(1) One (1) hour of instruction in theory each week throughout a semester or quarter equals one (1) unit.

(2) Three (3) hours of clinical practice each week throughout a semester or quarter equals one (1) unit. With the exception of an initial nursing course that teaches basic nursing skills in a skills lab, 75% of clinical hours in a course must be in direct patient care in an area specified in section 1426(d) in a board-approved clinical setting. Note: Authority cited: Sections 2715 and 2786.6, Business and Professions Cod. Reference: Sections 2785-2788, Business and Professions Code

**Healthcare/Clinical Agencies/Industry Partners**

Total hospital numbers in California have remained flat between 2014 and 2018, from a high of 443 in 2016 to a low of 441 in 2018. The number of licensed and staffed beds decreased slightly between 2016-2017, by 417 licensed beds and 503 staffed beds.

| California | 2014 CALENDAR YR | 2015 CALENDAR YR | 2016 CALENDAR YR | 2017 CALENDAR YR | 2018 3Q2017-1Q2018 |
|---|---|---|---|---|---|
| Licensed Beds | 78,800 | 78,187 | 79,033 | 78,616 | 78,631 |
| Staffed Beds | 57,682 | 58,147 | 58,641 | 58,138 | 59,742 |
| Discharges | 2,981,246 | 3,009,509 | 3,093,912 | 3,054,542 | 3,055,336 |
| Patient Days | 16,079,987 | 16,432,227 | 16,914,156 | 16,603,301 | 16,599,776 |
| Occupancy Rate - Available Beds | 59.9 | 61.5 | 62.9 | 62.0 | 62.0 |
| Length of Stay | 5.4 | 5.5 | 5.5 | 5.4 | 5.4 |
| Acute Length of Stay | 4.5 | 4.6 | 4.6 | 4.6 | 4.6 |
| All Other Length of Stay | 13.9 | 14.1 | 14.2 | 14.1 | 14.1 |
| Outpatient Visits | 44,675,128 | 46,427,046 | 48,299,507 | 47,560,174 | 47,974,379 |

Overwhelmed by internal demands (e.g., meeting quality indicators, hiring new graduate employees, census reductions) and rethinking hiring preferences for ADN vs BSN new graduates, there are anecdotal reports and May 2018 BRN survey results indicating some information about some clinical agencies (e.g., medical centers) reduction in the number of clinical placements available for any nursing program. This may be more of a trend in heavily populated cities and especially in highly sought after teaching clinical practice settings, and less of an issue in rural areas. Although there is a sense clinical placement issues are occurring throughout California, this is probably not the case.

**Universities & Community Colleges**

There has been a 6% increase in the number of nursing programs across the state between 2007- 2017 (132-141); however, in the past 5 years, there has been a decrease by 1 program (142-141). This has generated an additional 2,531enrolled nursing students in the same time period, with almost all of the growth happening in one region of the state. (2016-2017 BRN Pre-licensure Schools Report)

In 2017, 77 of the 141 nursing programs (54.6%) reported being denied clinical space; however, 31 programs were offered alternative sites by industry partners. The remaining lack of clinical space resulted in a loss of 302 clinical placements, units or shifts, which affected 2,147 students, a number that has remained relatively stable over the last several years (2016-2017 BRN Pre-licensure Schools Report).

Reasons cited in the California Board of Registered Nursing 2016-17 Annual School Report for clinical placement denial were: 1) staff nurse overload or insufficient qualified staff (51%); 2) displacement by another academic program (50.8%);3) competition for clinical space due to increase in number of nursing students per region (49%); 4) Joint Commission or other agency visit (33.8%); 5) no longer accepting ADN students(27.2%); 6) nurse residency program (26%); 7) change in facility management (24.7%); 8) Magnet designation (15.6%) ;9) EHR implementation (13%); 10) facility change in location (2.6%); 11) facility fee charge (1.3%). It is important to note that both community colleges and universities have lost traditional clinical placements in acute medical centers, and that these data represent the opinions of programs of nursing. The clinical agencies may identify different reasons for lost space than nursing education programs. Currently, there is no identified organization or established processes or tool to collect this type of clinical placement data from clinical agencies on an annual basis. This may be an important area to pursue moving forward.

Programs of nursing have long had a preference for clinical placements able to accommodate larger cohorts of students in traditional rotations (medical-surgical, pediatrics, obstetrics, behavioral health, etc.) rather than in placements of individual/small groups in nontraditional settings (ambulatory clinics, homeless shelters, programs, etc.) It may also be the case that nursing programs and clinical agencies alike may not understand BRN clinical placement approval processes, and or may have misinformation, misperceptions, or misunderstandings about BRN regulations regarding clinical facility placements and clinical site approvals.

The table below displays the reduction or increase in students enrolled by various regions around the state (BRN 2017):

## California Nursing Programs & Student Census by Region

| School Years | # of Nursing Programs | | | Student Census | | |
|---|---|---|---|---|---|---|
| | ADN | BSN + ELM | Total | ADN | BSN + ELM | Total |
| **Bay Area** | | | | | | |
| 2012-2013 | 18 | 12 | 30 | 1872 | 3393 | 5265 |
| 2013-2014 | 18 | 12 | 30 | 1826 | 3156 | 4982 |
| 2014-2015 | 18 | 12 | 30 | 1789 | 3233 | 5022 |
| 2015-2016 | 18 | 12 | 30 | 1718 | 3216 | 4934 |
| 2016-2017 | 18 | 12 | 30 | 1795 | 3211 | 5006 |
| **Central Coast** | | | | | | |
| 2012-2013 | 5 | 0 | 5 | 354 | 37 | 393 |
| 2013-2014 | 5 | 0 | 5 | 361 | 44 | 405 |
| 2014-2015 | 5 | 0 | 5 | 385 | 0 | 385 |
| 2015-2016 | 5 | 0 | 5 | 408 | 0 | 408 |
| 2016-2017 | 5 | 0 | 5 | 393 | 0 | 393 |
| **Central Sierra (Zero Programs in Region)** | | | | | | |
| 2012-2013 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2013-2014 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2014-2015 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2015-2016 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2016-2017 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Greater Sacramento** | | | | | | |
| 2012-2013 | 6 | 1 | 7 | 604 | 539 | 1143 |
| 2013-2014 | 6 | 1 | 7 | 582 | 467 | 1049 |
| 2014-2015 | 7 | 1 | 8 | 541 | 314 | 855 |
| 2015-2016 | 6 | 3 | 9 | 534 | 393 | 927 |
| 2016-2017 | 6 | 3 | 9 | 532 | 509 | 1041 |
| **Northern California** | | | | | | |
| 2012-2013 | 3 | 1 | 4 | 165 | | 165 |
| 2013-2014 | 3 | 0 | 3 | 158 | 0 | 158 |
| 2014-2015 | 3 | 0 | 3 | 170 | 0 | 170 |
| 2015-2016 | 3 | 0 | 3 | 175 | 0 | 175 |
| 2016-2017 | No Data | No Data | No Data | No Data | No Data | No Data |
| **Northern Sacramento Valley** | | | | | | |
| 2012-2013 | 2 | 2 | 4 | 286 | 259 | 545 |
| 2013-2014 | 2 | 2 | 4 | 264 | 261 | 525 |
| 2014-2015 | 2 | 2 | 4 | 279 | 258 | 537 |
| 2015-2016 | 2 | 2 | 4 | 280 | 265 | 545 |
| 2016-2017 | No Data | No Data | No Data | No Data | No Data | No Data |
| **San Joaquin Valley** | | | | | | |
| 2012-2013 | 10 | 5 | 15 | 1681 | 982 | 2663 |
| 2013-2014 | 10 | 5 | 15 | 1479 | 1129 | 2608 |
| 2014-2015 | 10 | 5 | 15 | 1799 | 969 | 2768 |
| 2015-2016 | 10 | 4 | 14 | 1574 | 1033 | 2607 |
| 2016-2017 | No Data | No Data | No Data | No Data | No Data | No Data |

## California Nursing Programs & Student Census by Region

| | | | | | | |
|---|---|---|---|---|---|---|
| Southern Border | | | | | | |
| 2012-2013 | 7 | 6 | 13 | 949 | 1480 | 2429 |
| 2013-2014 | 7 | 6 | 13 | 962 | 1396 | 2378 |
| 2014-2015 | 7 | 6 | 13 | 964 | 1851 | 2815 |
| 2015-2016 | 7 | 6 | 13 | 823 | 1652 | 2475 |
| 2016-2017 | 7 | 5 | 12 | 994 | 1955 | 2949 |
| Los Angeles Area | | | | | | |
| 2012-2013 | 24 | 17 | 41 | 4089 | 3841 | 7930 |
| 2013-2014 | 24 | 16 | 40 | 3754 | 3436 | 7190 |
| 2014-2015 | 25 | 17 | 42 | 3972 | 5270 | 9242 |
| 2015-2016 | 25 | 16 | 41 | 4019 | 5623 | 9642 |
| 2016-2017 | 27 | 15 | 42 | 3963 | 5119 | 9082 |
| Inland Empire | | | | | | |
| 2012-2013 | 13 | 11 | 24 | 2068 | 3730 | 5798 |
| 2013-2014 | 14 | 10 | 24 | 2096 | 3592 | 5688 |
| 2014-2015 | 13 | 9 | 22 | 2128 | 1892 | 4020 |
| 2015-2016 | 13 | 9 | 22 | 1982 | 1981 | 3963 |
| 2016-2017 | 13 | 9 | 22 | 2205 | 2048 | 4253 |
| Total | | | | | | |
| 2012-2013 | 88 | 53 | 148 | 12070 | 14261 | 26331 |
| 2013-2014 | 89 | 52 | 141 | 11502 | 13481 | 24983 |
| 2014-2015 | 90 | 52 | 142 | 12027 | 13787 | 25814 |
| 2015-2016 | 89 | 52 | 141 | 11508 | 14163 | 25671 |
| 2016-2017 | 91 | 50 | 141 | 11965 | 14116 | 26081 |

| Region | Counties |
|---|---|
| Bay Area | Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma |
| Central Coast | Monterey, San Benito, San Luis Obispo, Santa Barbara |
| Central Sierra* | Alpine, Amador, Calaveras, Inyo, Mariposa, Mono, Tuolumne |
| Greater Sacramento | El Dorado, Placer, Sacramento, Sutter, Yolo, Yuba |
| Northern California | Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Sierra, Siskiyou, Trinity |
| Northern Sacramento Valley | Butte, Colusa, Glenn, Shasta, Tehama |
| San Joaquin Valley | Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare |
| Southern Border | Imperial, San Diego |
| LA Area | Los Angeles, Ventura |
| Inland Empire | Orange, Riverside, San Bernardino |

**Students**

Students are aware of clinical placement issues. They know getting clinical placements is a challenge and that sustaining placements is tenuous. Programs report they receive feedback from students of a strong preference for acute care clinical experience, despite the BRN reporting that 43.9% of RNs work outside of in-patient or emergency department settings. (BRN, 2016)

**Regional Nursing Summits**

**Bridging the Gaps in Pre-licensure RN Clinical Education Capacity**

**Issue Summary**

**Issue Statement in Brief**

The demand for pre-licensure RN clinical education capacity is outpacing current acute care capacity for all pre-licensure nursing programs, ADN, BSN, and Entry Level Masters (ELM). This year, California experienced issues highlighting the need for reexamination of all aspects of academic and practice educational coordination and programming. These issues are inclusive of RN educational effectiveness and strain on organizational efficiencies. How can the organizations responsible for safe, quality nursing care and optimal health for California citizens not only supply enough nurses to meet demands, but assure the educational pipeline is producing the correct number of highly prepared professional RNs in hospitals and across the care continuum?

**Interrelated Clinical Capacity Issues**

➢ Multiple complex issues comprise successful RN education, such as educational goals, accreditation, regulations, practice sites, faculty and preceptor requirements, etc.

➢ An increasing body of evidence recommends that the BSN-or-higher prepared RN increases the quality and safety of care and is best prepared to work across the care continuum.

➢ The Nursing Education Plan White Paper and Recommendations for California, (HealthImpact, 2016), recommends: 1) providing transformative learning opportunities that prepare nurses for evolving roles in rapidly changing interprofessional practice environments, including non-acute settings; and 2) providing academic progression for all RNs to obtain a BSN or higher degree by 2030.

➢ External review for accreditation is valuable and it is recommended that nursing programs be nationally accredited.

➢ To create efficient educational pathways that minimize student burden (including debt), maximum credit units should be 70 units for ADN and 120 units for BSN programs to avoid programmatic variability and even out need for clinical space.

➢ Existing best practices, including clinical placement systems/consortiums, will be used as templates for future planning if appropriate to local and regional settings.

➢ The ongoing tension about clinical placements has had a negative impact on clinical practice and academic work settings to include nursing students.

➢ New approaches to clinical immersion experiences for pre-licensure nursing students are needed.

Spector, N., Hooper, J., Silvestre, J., & Qian, H. (2018). Board of Nursing approval of Registered nurse education programs. *Journal of Nursing Regulation*. 8(4):22-31. DOI: 10.1016/S2155-8256(17)30178-3.

National Council State Boards of Nursing 2012) NCSBN Model Act. Chicago, IL

# Attachment C

## Quad Council Letter

April 2, 2018

Dr. Joseph Morris
California Board of Registered Nursing
PO Box 944210
Sacramento, CA 94244-2100

Dear Dr. Morris,

On behalf of the Association of California Nurse Leaders (ACNL), the American Nurses Association of California (ANA\C), the California Association of Colleges of Nursing (CACN), and the California Organization for Associate Degree Nursing Program Directors (COADN) Boards of Directors and our memberships, we are writing to express our concerns related to the clinical displacement issue that has been widely discussed by the BRN and has affected both associate and baccalaureate degree nursing program education in California. We stand collectively committed to uniting professional nursing education and practice in California, versus splitting and dividing our voice, as this issue has significant impact on education and practice, and ultimately the health of Californians.

**Support for collaboration between nursing programs and clinical agencies.**
ACNL, ANA\C, CACN, and COADN are in support of a collaborative approach to clinical placements for all California nursing students. This type of approach would allow us to address clinical placements from a position of solidarity, versus one of division. We support the clinical agency's right to build clinical alliances with schools of nursing to meet the needs of their patient population, hospital staffing needs, and organizational goals, while also supporting the tenants of successful clinical consortium agreements in place throughout California. We promote the development of innovative educational pathways that will foster diversity and quality in California's future nursing workforce. We support the need for a collaborative versus legislative approach for problem solving, when possible. As clinical placements are a problem that requires all partners (school deans and directors, hospital chief nursing officers, and BRN representatives) to work together for the best solution for California, we support inclusion of all stakeholders in considering solutions to this issue.

**Consider findings from the Academic Progression in Nursing Program (APIN) work and successful models from other states in fostering innovative educational pathways.**
Our organizations work from a national perspective using evidence from multiple sectors. APIN and other nationwide data suggest that structured educational alliances between ADN and BSN programs offer the best approaches to educational progression for nurses, and that these alliances can facilitate clinical relationships that best serve ADN students. As current alliances have not been successful in quickly and systematically moving ADN graduates into obtaining BSN degrees on a large scale, we promote Concurrent Enrollment Program (CEP) models that have been successfully implemented in many other states such as Arizona, Florida, Oregon, and Washington as a potential solution to increasing the number of BSN graduates in California, resolving clinical agencies concerns about having BSN students in their agencies, minimizing clinical displacement, and ensuring the education of diverse, socio-economically disadvantaged, and first-in-college nursing students. Finally, we suggest that schools engaged in such collaboratives, collect program outcome data (e.g. time to degree for both ADN and BSN degree programs) to validate and showcase effective and efficient pathways of student progression from ADN to BSN programs with timely degree completion.

**Incentivize national accreditation for all nursing programs.**
We recognize the need for a professional nursing workforce that can coordinate and lead healthcare teams across the continuum of care. To achieve this outcome, we encourage the BRN to consider ways to "incentivize" ADN programs to becoming nationally accredited. Accreditation is a nationally recognized method for validating the rigor and quality of nursing programs and many of the ADN programs in California meet accreditation standards. There are fiscal and organizational barriers that should be addressed to facilitate nursing programs in California obtaining national nursing accreditation. We encourage the BRN to consider methods such as timing BRN site visits to coincide with national accreditation visits (up to 10 years apart) and accepting a single self-study that addresses both BRN and national criteria as possible ways to encourage ADN programs to obtain this objective. These strategies are also successfully used in other states, without decreasing quality outcomes of nursing graduates.

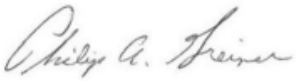
**Support nursing program enrollment management**.
As noted by Dr. Joanne Spetz at the February 2018 BRN meeting, California nursing programs are currently producing the correct number of nurses that are needed for California over the next several years. There remains, however, nursing shortages in underserved areas of the state and there is a clear need to support academic progression through CEP models. While we support the BRN prohibiting the rapid growth of existing, new, and out-of-state programs, we do encourage planned and approved enrollment growth in underserved geographic areas where more nurses are needed. We recognize that expansion of clinical experiences in non-acute, community-based, and ambulatory settings, as well as innovative educational modalities, can provide valuable alternatives to acute care clinical experiences for many nursing programs. We unanimously support collaborative efforts to quickly move ADN graduates into becoming BSN graduates in various seamless, non-repetitive, timely, and cost-effective ways.

We recognize the tremendous work and efforts of the BRN in supporting nursing practice and education in the state of California. We are at a critical point where nurse educators and clinical agencies need to unite to seek innovative approaches for the education of our future RN workforce. ACNL, ANA\C, CACN, and COADN are committed to working with the BRN, professional nursing, and healthcare facilities to address this issue to ensure that our nurses are well prepared to care for Californians across the continuum of care.

Respectfully submitted,

Association of California Nurse Leaders (ACNL)

American Nurses Association of California (ANA\C)



California Association of Colleges of Nursing (CACN)

California Organization for Associate Degree Nursing Program Directors (COADN) – North

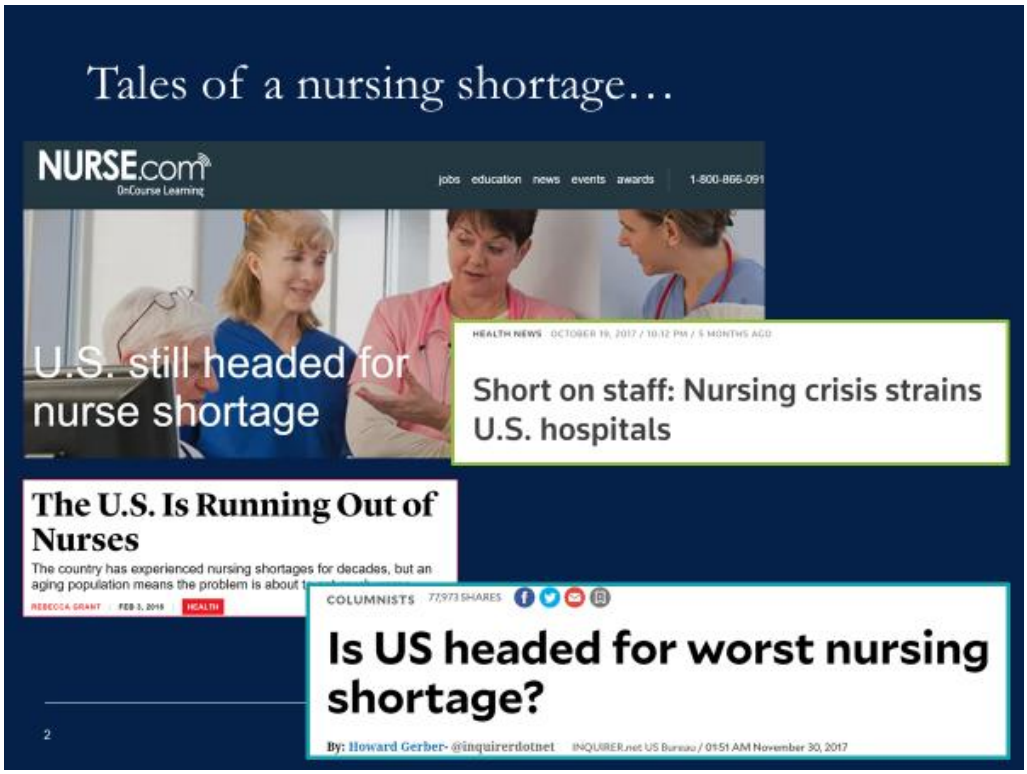
California Organization for Associate Degree Nursing Program Directors (COADN) - South


# Attachment D

## Supply & Demand of RNs

Sacramento & Northern Regions
LA -Orange-Ventura Regions
Central Valley & Sierra Regions
Inland Empire
Southern Border Region
San Francisco Bay Area


UCSF
University of California
San Francisco
Supply & Demand of RNs in the Sacramento & Northern regions
Joanne Spetz, PhD, FAAN
Professor, Philip R. Lee Institute for Health Policy Studies
Associate Director for Research, Healthforce Center
University of California, San Francisco
September 2018

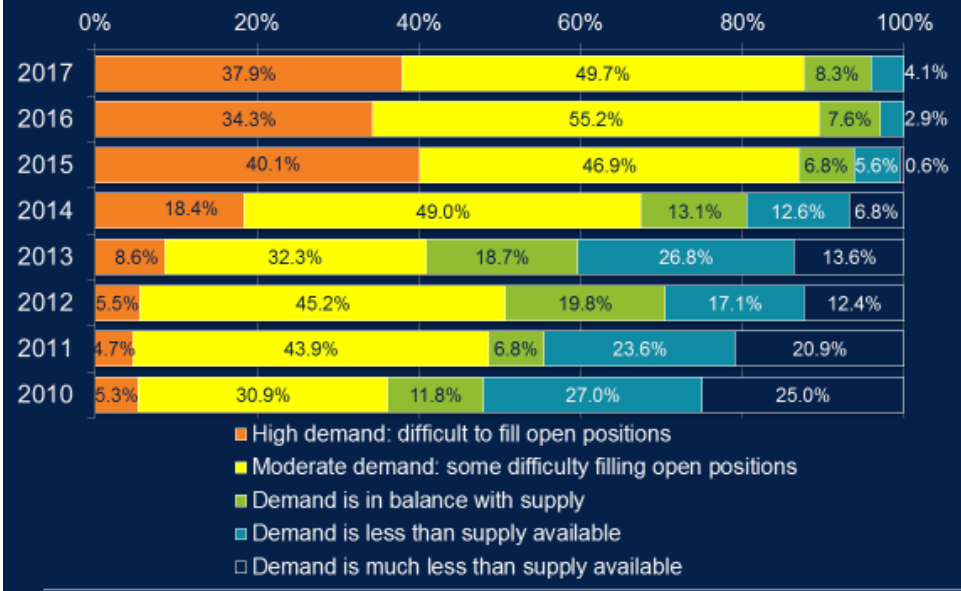

Tales of a nursing shortage…
NURSE.com
OnCourse Learning
jobs education news events awards
1-800-866-091
U.S. still headed for nurse shortage
HEALTH NEWS
Short on staff: Nursing crisis strains U.S. hospitals
The U.S. Is Running Out of Nurses
The country has experienced nursing shortages for decades, but an aging population means the problem is about
COLUMNISTS
Is US headed for worst nursing shortage?
By: Howard Gerber- @inquirerdotnet
2

## Forecasting future RN supply & demand

- National forecasts: market is balanced
  - National Center for Health Workforce Analysis, 2017
    - National surplus of 293,800 RNs by 2030 (8.2%)
    - Assumes supply = demand in 2014
  - Auerbach et al. 2015 – 128,000 RN shortage by 2025 (4%)
- California
  - NCHWA 2017 – 44,500 short (11.5%)
  - Auerbach et al. 2017 – only 0.7% per capita supply growth in Pacific region
  - Spetz 2017 – no shortage overall, but skills & regional imbalance

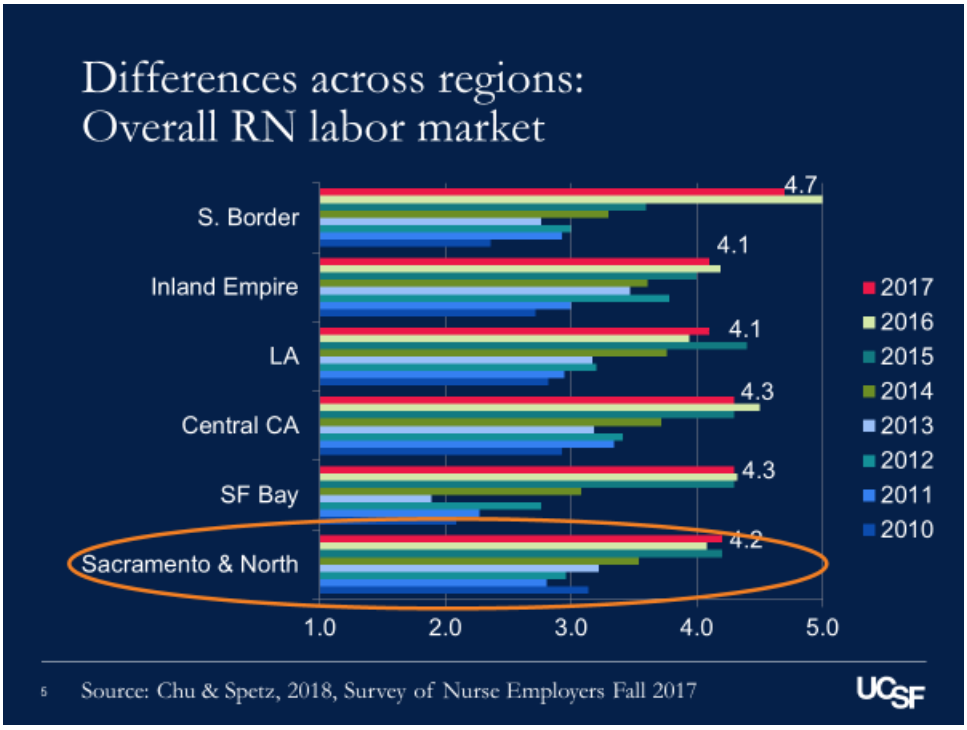
UCSF

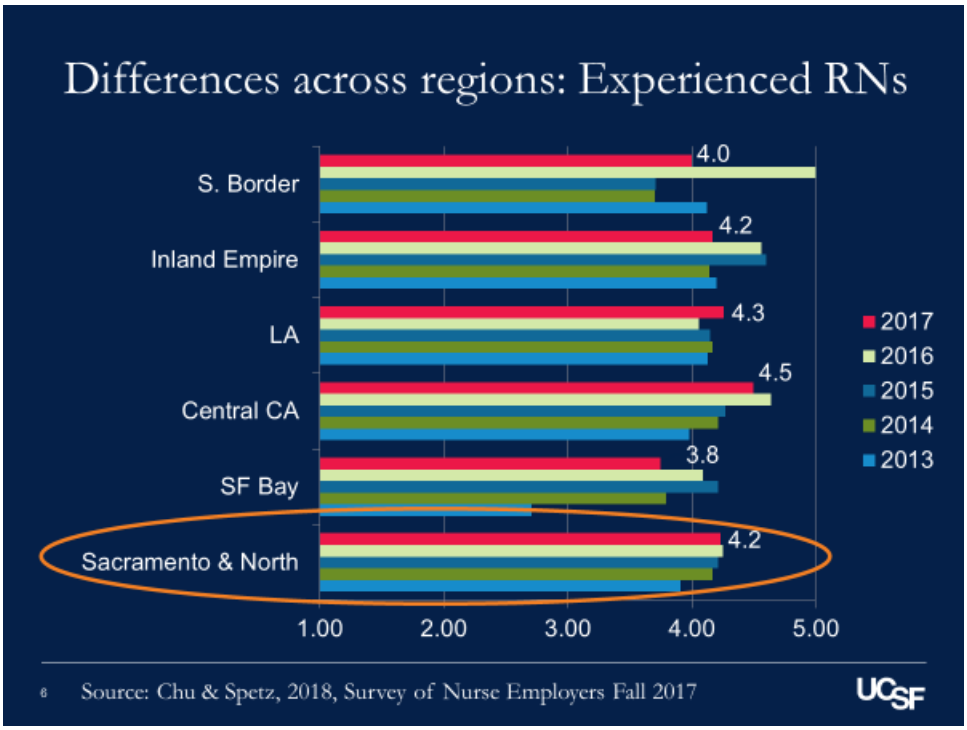
## Perceptions of employers: Overall labor market

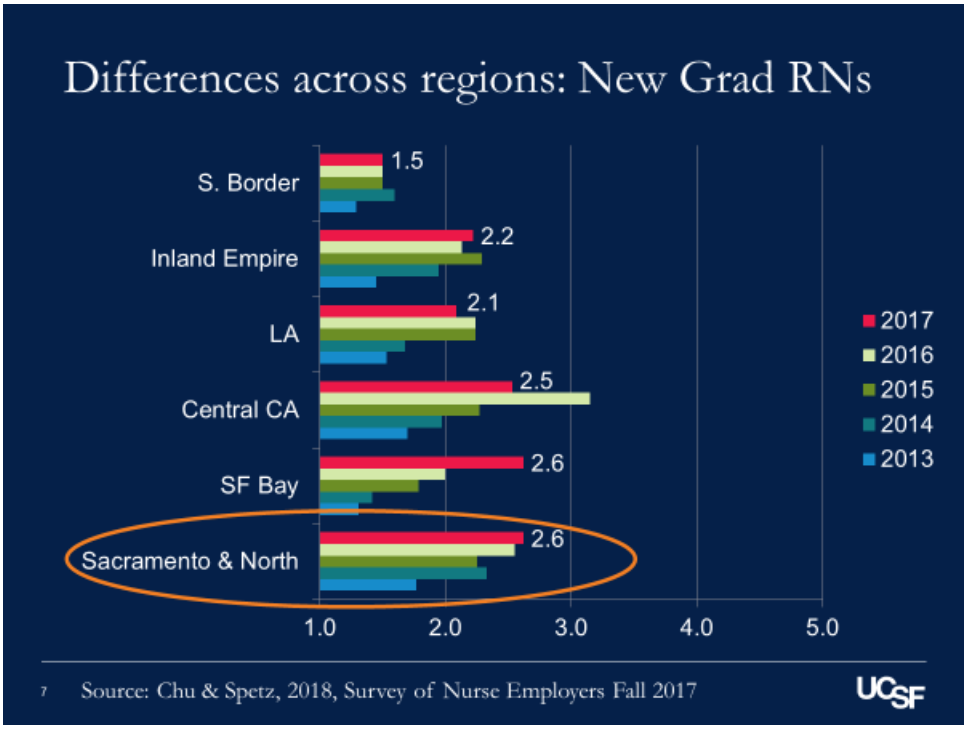


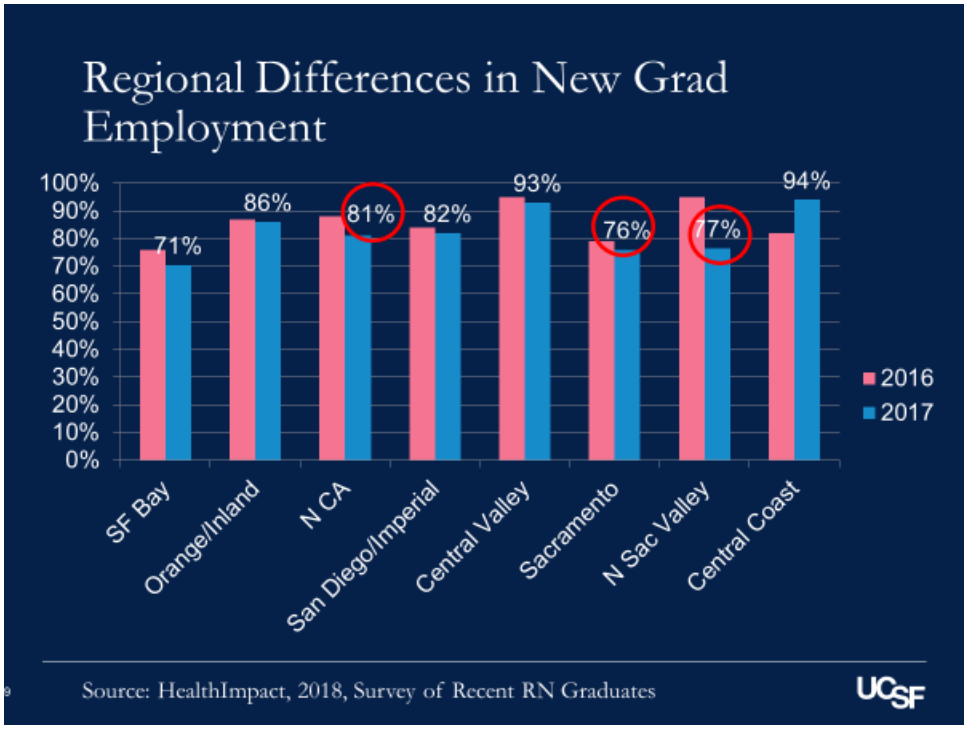

4 Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017

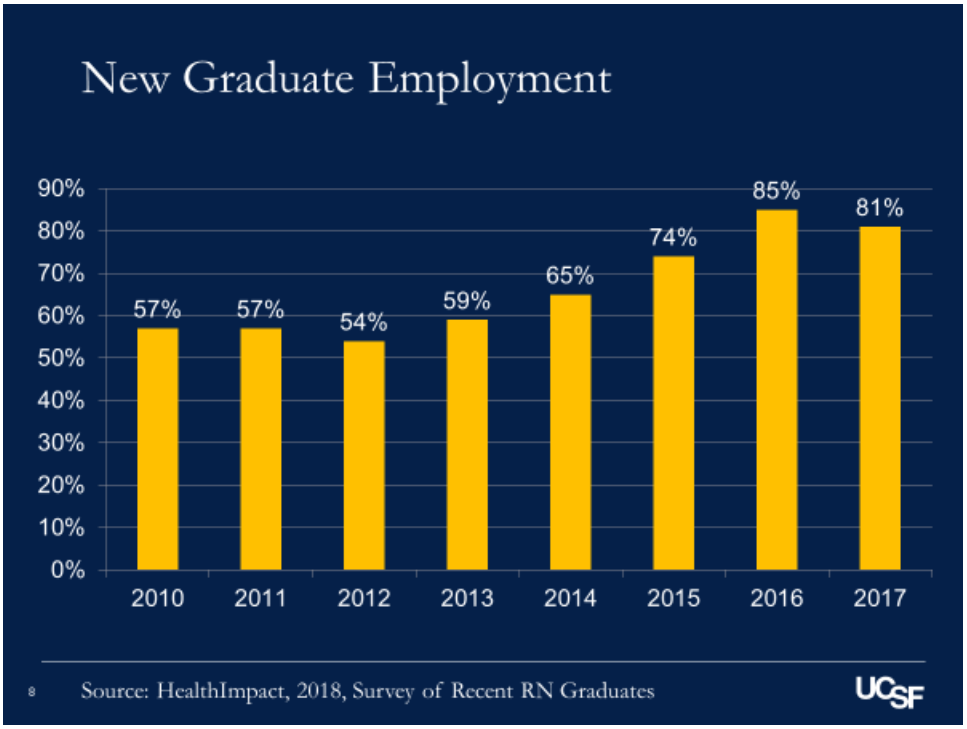
UCSF

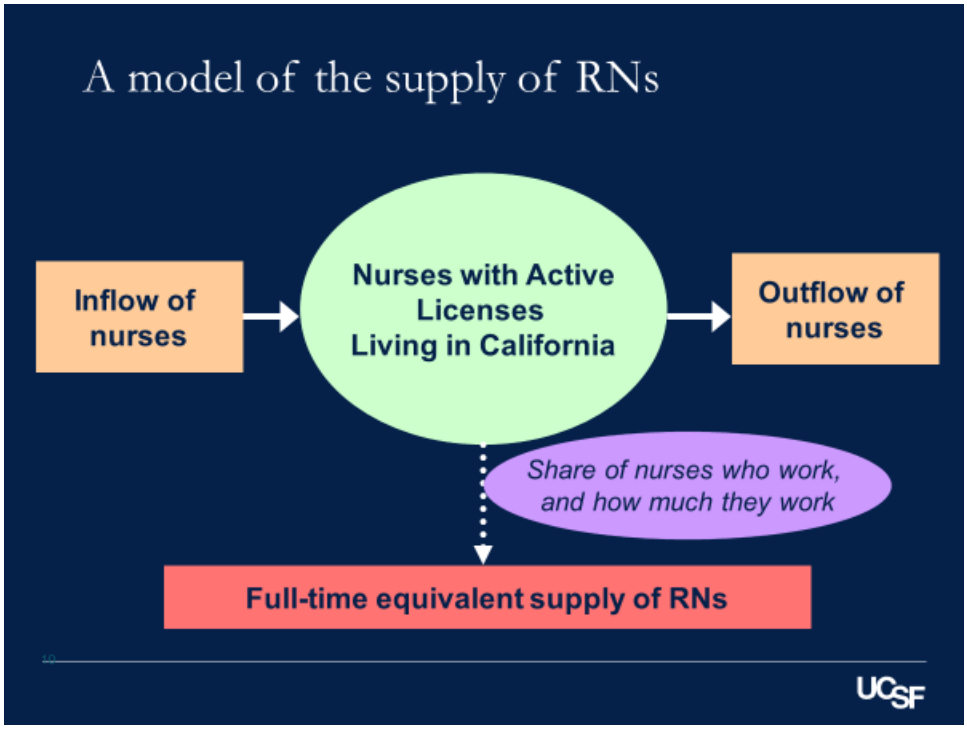

Differences across regions:
Overall RN labor market
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
4.7
4.1
4.1
4.3
4.3
4.2
1.0
2.0
3.0
4.0
5.0
2017
2016
2015
2014
2013
2012
2011
2010
5
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


Differences across regions: Experienced RNs
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
4.0
4.2
4.3
4.5
3.8
4.2
1.00
2.00
3.00
4.00
5.00
2017
2016
2015
2014
2013
6
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


Differences across regions: New Grad RNs
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
1.5
2.2
2.1
2.5
2.6
2.6
1.0
2.0
3.0
4.0
5.0
2017
2016
2015
2014
2013
7
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


Regional Differences in New Grad Employment
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
86%
81%
82%
93%
76%
77%
94%
SF Bay
Orange/Inland
N CA
San Diego/Imperial
Central Valley
Sacramento
N Sac Valley
Central Coast
2016
2017
Source: HealthImpact, 2018, Survey of Recent RN Graduates
UCSF


New Graduate Employment
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
57%
57%
54%
59%
65%
74%
85%
81%
2010
2011
2012
2013
2014
2015
2016
2017
Source: HealthImpact, 2018, Survey of Recent RN Graduates
UCSF

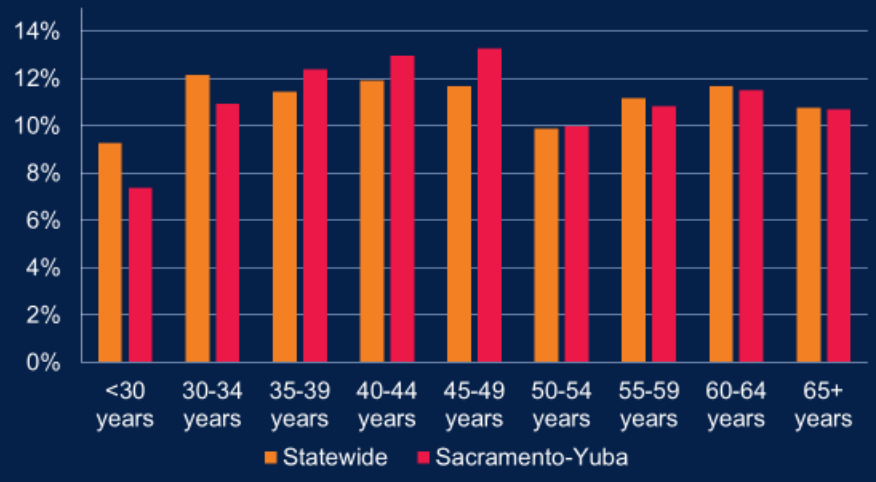

A model of the supply of RNs
Inflow of nurses
Nurses with Active Licenses Living in California
Outflow of nurses
Share of nurses who work, and how much they work
Full-time equivalent supply of RNs
UCSF

## Forecasting demand is harder

- Number of nurses per capita
  - What is the target?
    - National average?
    - Some arbitrary benchmark?
    - Estimates of how many providers are needed to provide XYZ?
- Demand-based models can be based on economic demand models
  - Easier said than done….

UCSF

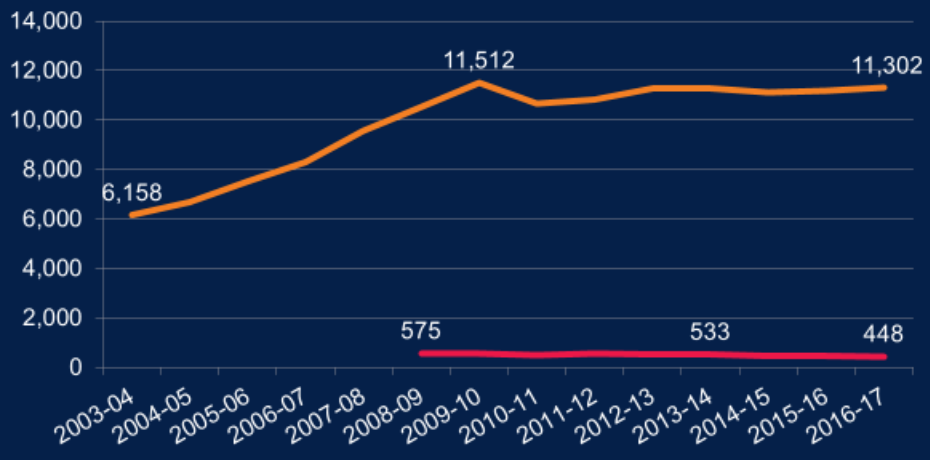
## Age distribution of licensed RNs - Sacramento




Source: Spetz et al., 2016 California Survey of RNs

UCSF

## RN graduations per year - Sacramento




**These numbers do not include satellite campuses**

13 Source: California Board of Registered Nursing, Annual Schools Reports UCSF

## Statewide graduations are expected to hold steady

| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2014-2015 | 13,318 | 12,162 | 13,347 | 11,119 |
| 2015-2016 | 13,152 | 13,110 | 12,177 | 11,191 |
| 2016-2017 | | 13,862 | 13,236 | 10,761 |
| 2017-2018 | | | 14,219 | 10,627 |
| 2018-2019 | | | | 11,200 |
| 2019-2020 | | | | 11,489 |

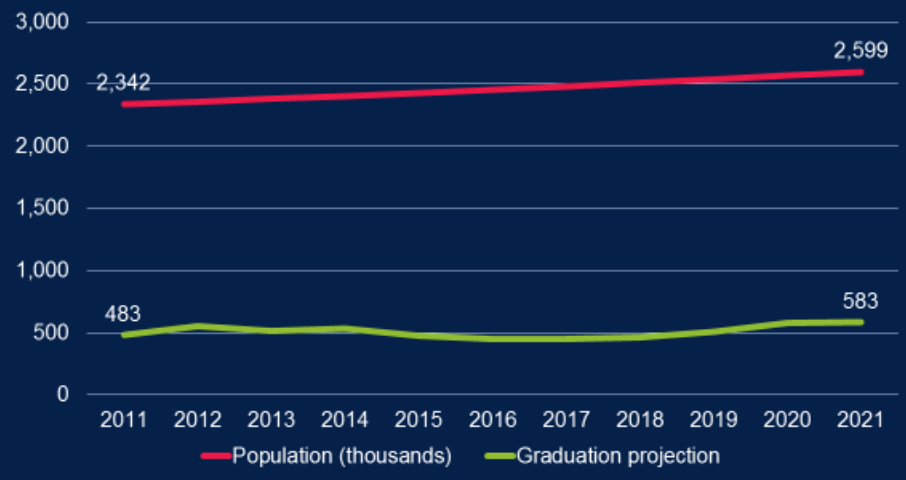
Source: California Board of Registered Nursing Annual Schools Report, 2016-2017 UCSF

## Sacramento-Yuba graduations are projected to grow

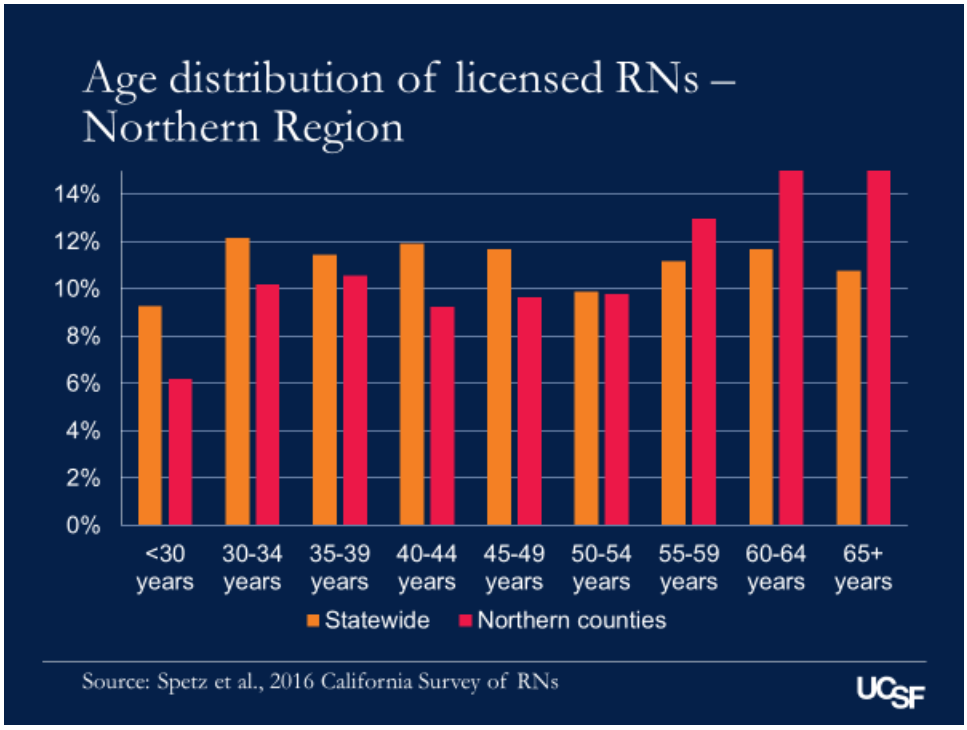
| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2015-2016 | 563 | 478 | 668 | 452 |
| 2016-2017 | 620 | 624 | 493 | 448 |
| 2017-2018 | | 708 | 632 | 461 |
| 2018-2019 | | | 712 | 507 |
| 2019-2020 | | | | 579 |
| 2020-2021 | | | | 583 |

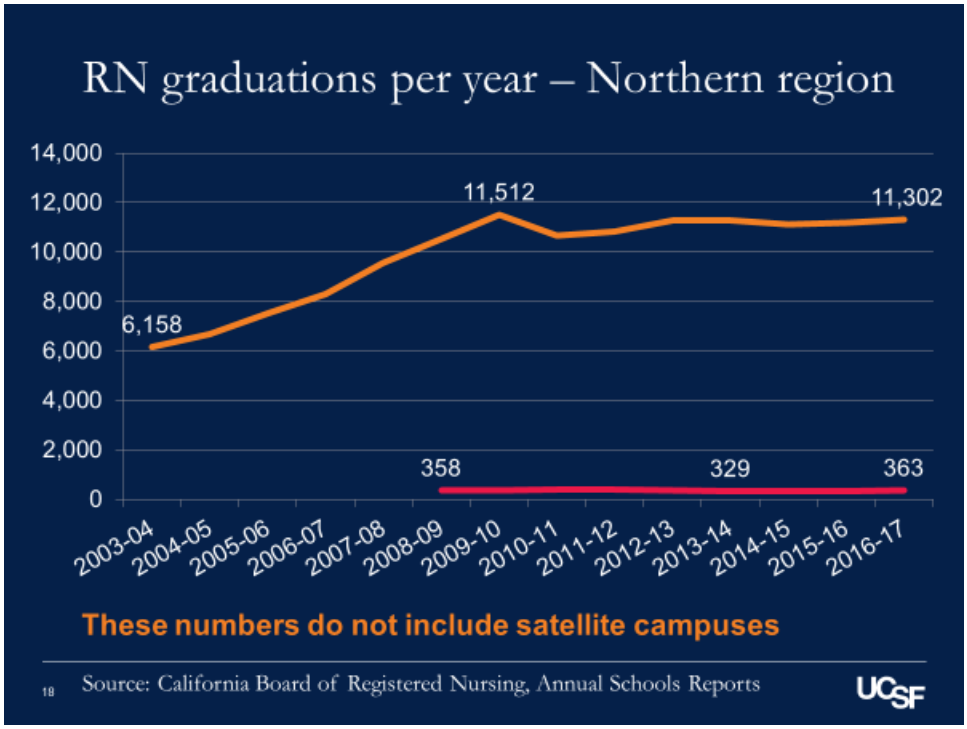
Source: California Board of Registered Nursing Annual Schools Report, 2017-2018 UCSF

## What is projected population growth in the Sacramento region?




18 UCSF


Age distribution of licensed RNs – Northern Region
14%
12%
10%
8%
6%
4%
2%
0%
<30 years
30-34 years
35-39 years
40-44 years
45-49 years
50-54 years
55-59 years
60-64 years
65+ years
Statewide
Northern counties
Source: Spetz et al., 2016 California Survey of RNs
UCSF

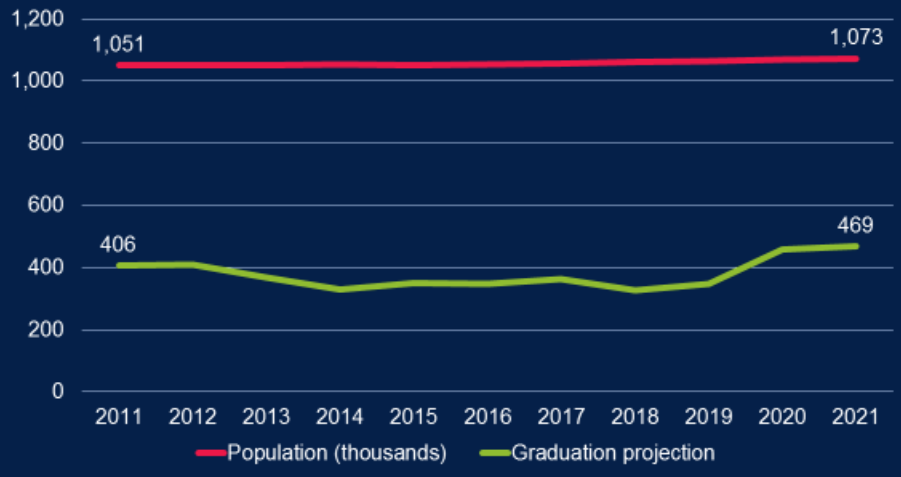

RN graduations per year – Northern region
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
6,158
11,512
11,302
358
329
363
2003-04
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17
These numbers do not include satellite campuses
19
Source: California Board of Registered Nursing, Annual Schools Reports
UCSF

## Northern region graduations are projected to grow

| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2015-2016 | 351 | 365 | 367 | 347 |
| 2016-2017 | 373 | 382 | 356 | 363 |
| 2017-2018 | | 493 | 385 | 326 |
| 2018-2019 | | | 505 | 347 |
| 2019-2020 | | | | 458 |
| 2020-2021 | | | | 469 |

Source: California Board of Registered Nursing Annual Schools Report, 2017-2018 UCSF

## What is projected population growth in the Northern region?




20

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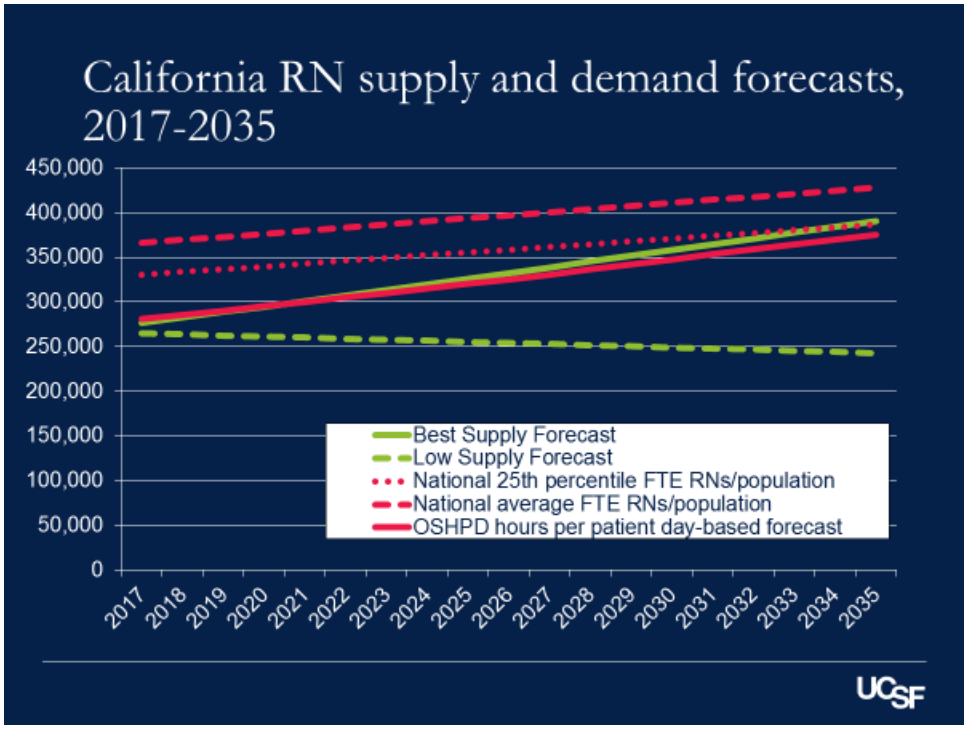
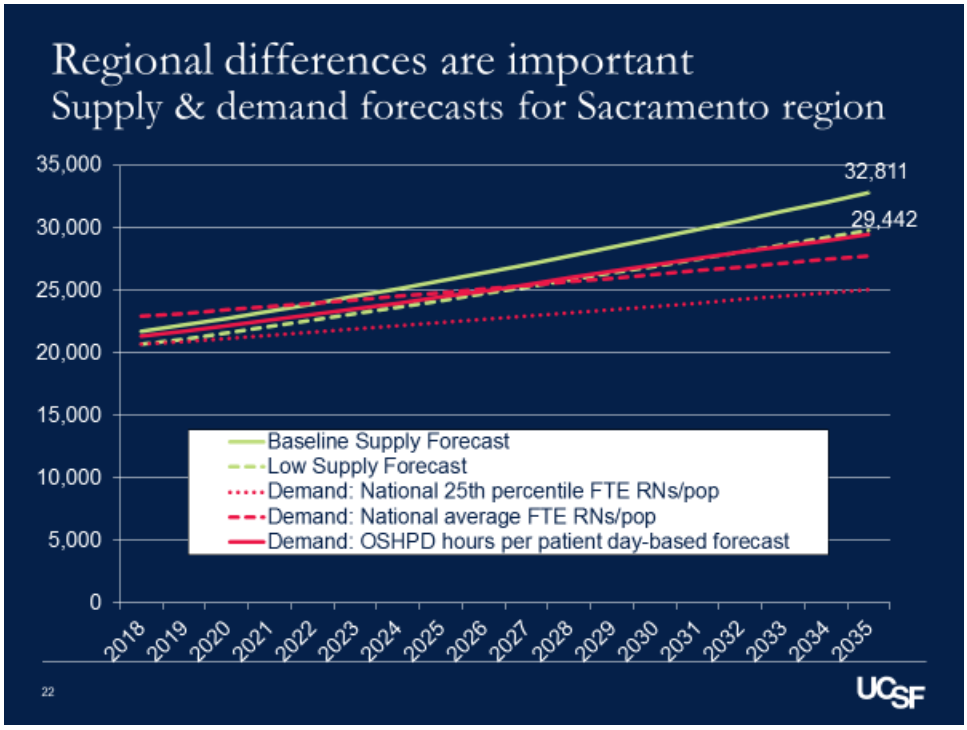
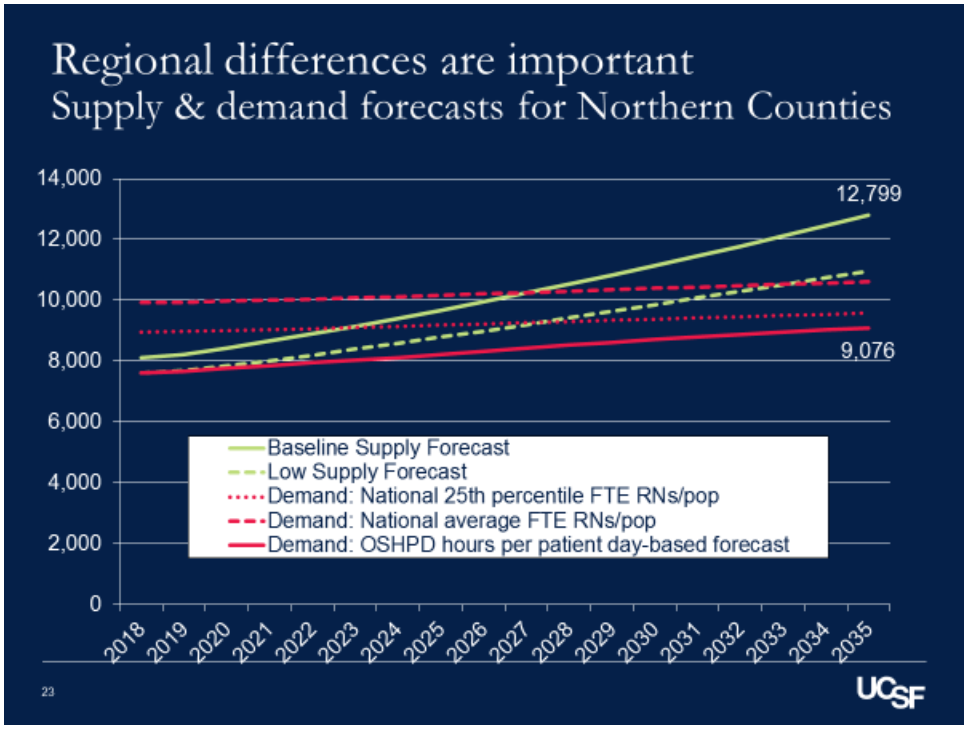
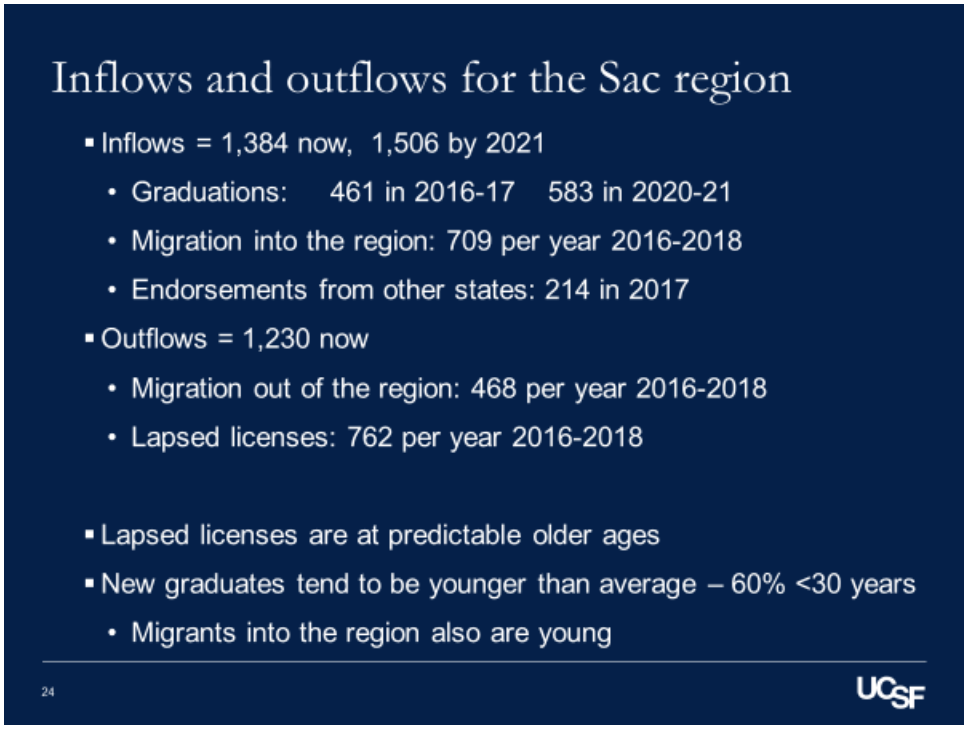

California RN supply and demand forecasts, 2017-2035
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
Best Supply Forecast
Low Supply Forecast
National 25th percentile FTE RNs/population
National average FTE RNs/population
OSHPD hours per patient day-based forecast
UCSF


Regional differences are important
Supply & demand forecasts for Sacramento region
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
32,811
29,442
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
Baseline Supply Forecast
Low Supply Forecast
Demand: National 25th percentile FTE RNs/pop
Demand: National average FTE RNs/pop
Demand: OSHPD hours per patient day-based forecast
22
UCSF


Regional differences are important
Supply & demand forecasts for Northern Counties
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
12,799
9,076
Baseline Supply Forecast
Low Supply Forecast
Demand: National 25th percentile FTE RNs/pop
Demand: National average FTE RNs/pop
Demand: OSHPD hours per patient day-based forecast
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
23
UCSF


Inflows and outflows for the Sac region
Inflows = 1,384 now, 1,506 by 2021
Graduations: 461 in 2016-17 583 in 2020-21
Migration into the region: 709 per year 2016-2018
Endorsements from other states: 214 in 2017
Outflows = 1,230 now
Migration out of the region: 468 per year 2016-2018
Lapsed licenses: 762 per year 2016-2018
Lapsed licenses are at predictable older ages
New graduates tend to be younger than average – 60% <30 years
Migrants into the region also are young
24
UCSF

## Inflows and outflows for the Northern region

- Inflows = 669 now, 812 by 2021
  - Graduations: 326 in 2016-17 469 in 2020-21
  - Migration into the region: 239 per year 2016-2018
  - Endorsements from other states: 104 in 2017
- Outflows = 772 now
  - Migration out of the region: 288 per year 2016-2018
  - Lapsed licenses: 484 per year 2016-2018
- Older nurses keep their licenses longer than average
- New graduates tend to be younger than average – 53% <30 years

25

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## Balanced labor markets!

- No need for program growth – models assume 1.5% per year
- Anticipated growth of graduations in northern counties might be more than needed, but not something to worry about
- Will these new RNs move to other regions or states?
  - >50% of recent RN grads work within 40 miles of high school

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How do we address the challenge?
Labor market overall is fairly well balanced
Younger graduates will support the workforce for many years in the future
Long working lives of nurses in Northern Counties will be important
27
UCSF

UCSF
University of California
San Francisco

# Supply & Demand of RNs in the LA-Orange-Ventura region

*Joanne Spetz, PhD, FAAN*
*Professor, Philip R. Lee Institute for Health Policy Studies*
*Associate Director for Research, Healthforce Center*
*University of California, San Francisco*

September 2018

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## Tales of a nursing shortage…


HEALTH NEWS OCTOBER 19, 2017 / 10:12 PM / 5 MONTHS AGO

**Short on staff: Nursing crisis strains U.S. hospitals**

**The U.S. Is Running Out of Nurses**

The country has experienced nursing shortages for decades, but an aging population means the problem is about t

REBECCA GRANT FEB 3, 2018 HEALTH

COLUMNISTS 77,973 SHARES

**Is US headed for worst nursing shortage?**

By: Howard Gerber- @inquirerdotnet INQUIRER.net US Bureau / 01:51 AM November 30, 2017

2

# Forecasting future RN supply & demand

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    - National surplus of 293,800 RNs by 2030 (8.2%)
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  - NCHWA 2017 – 44,500 short (11.5%)
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UCSF

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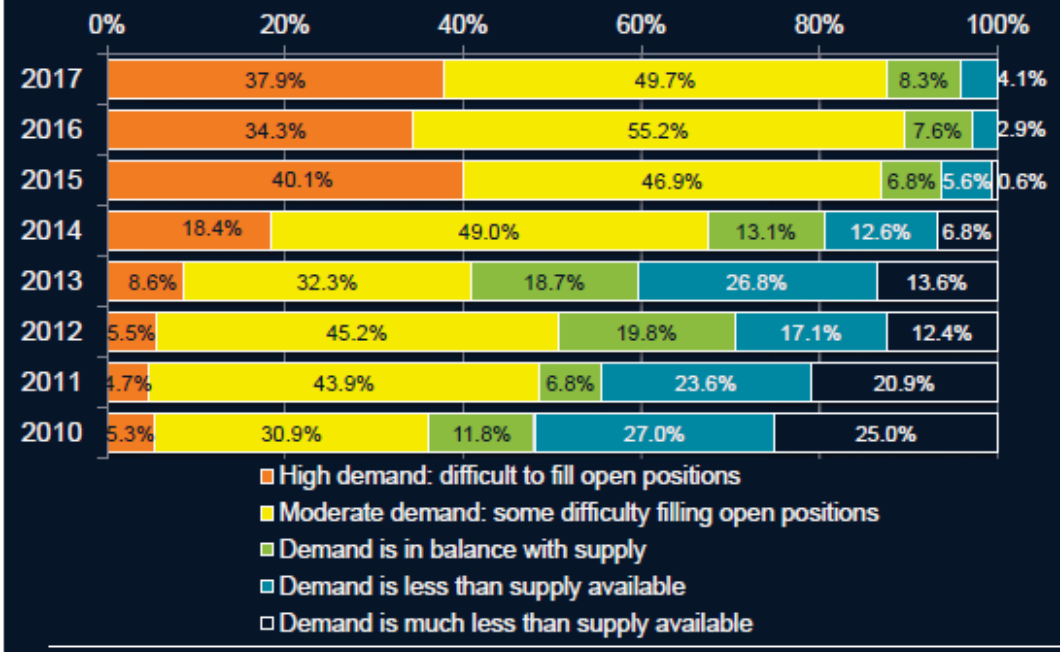


4 Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017

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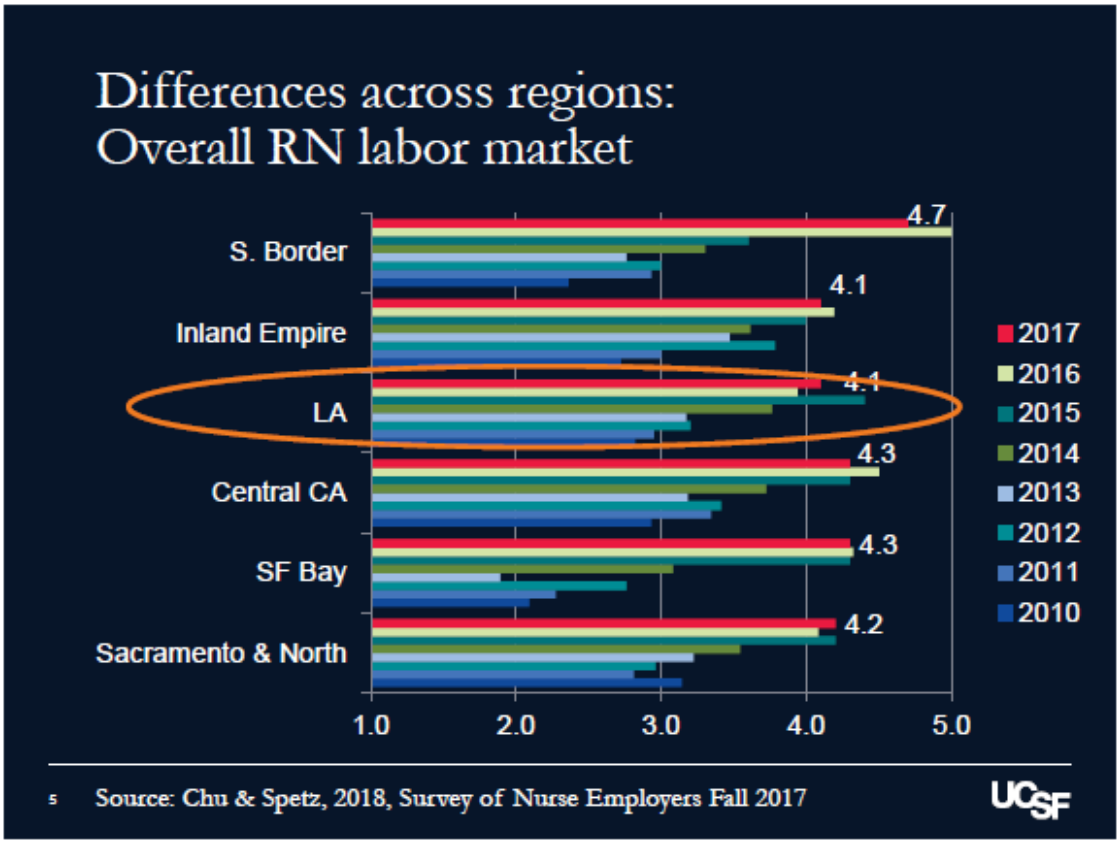
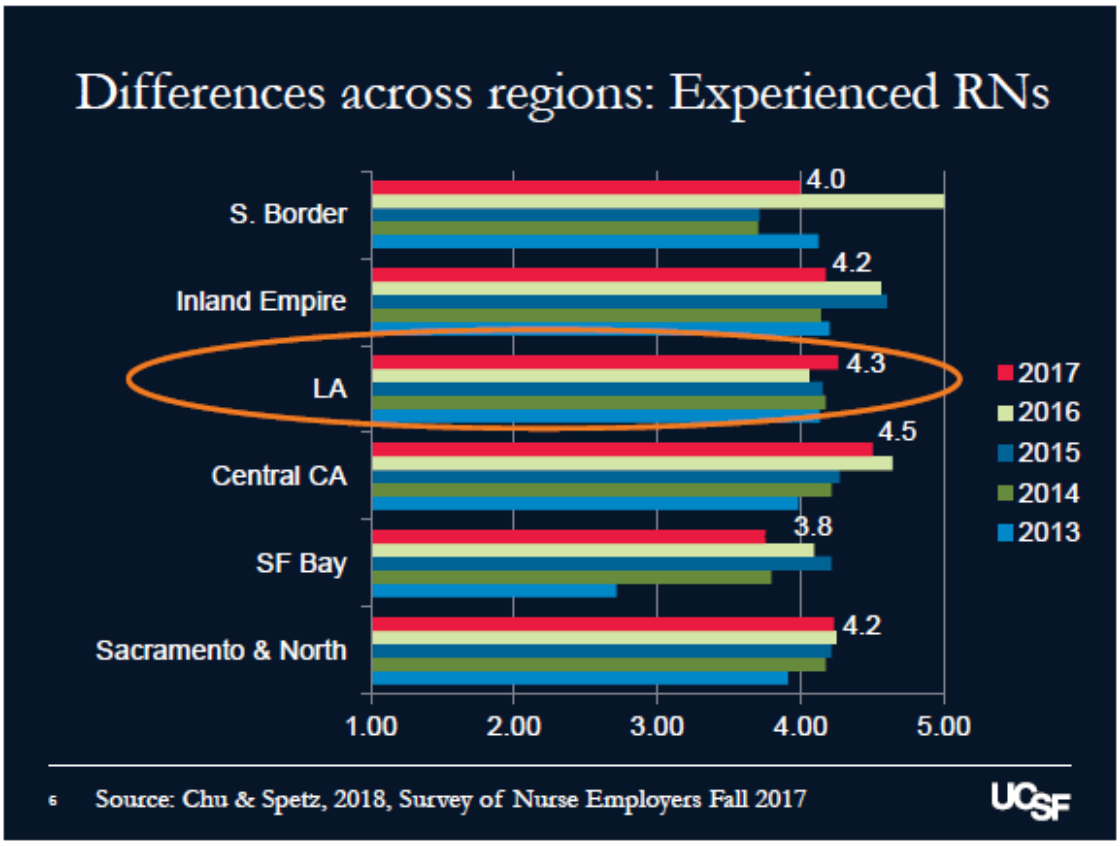
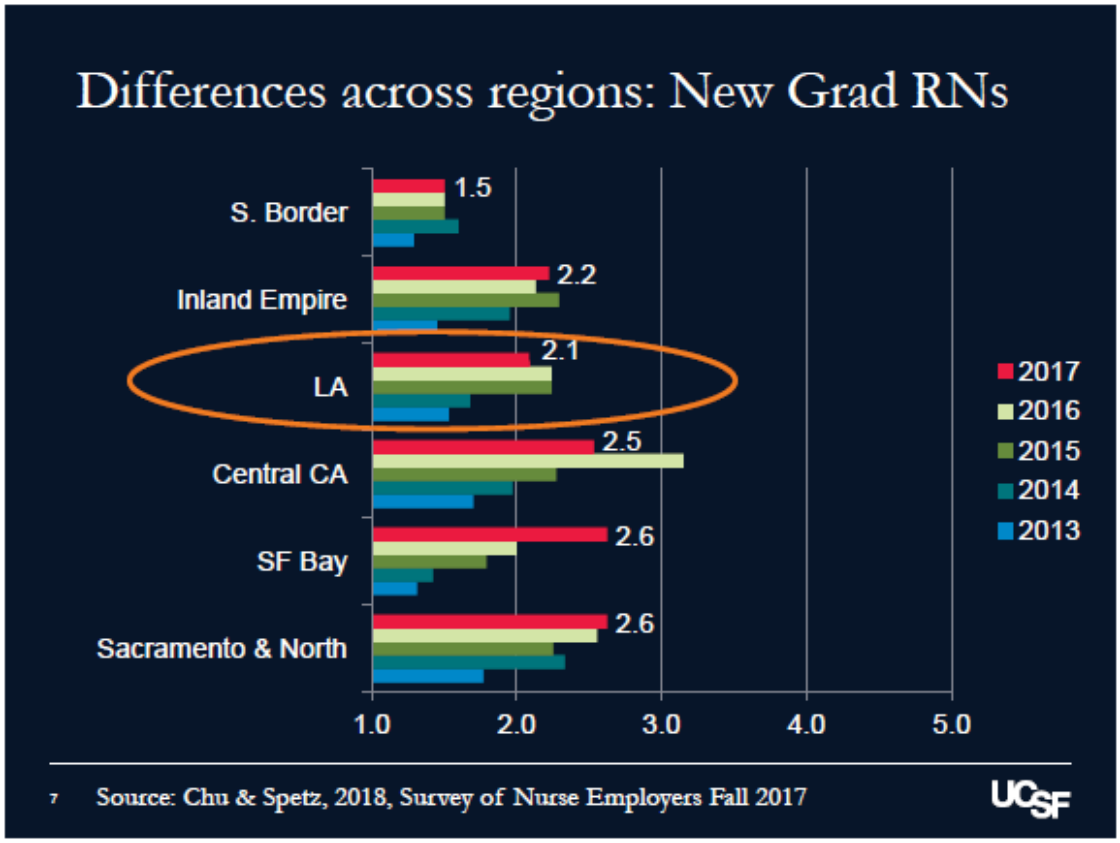
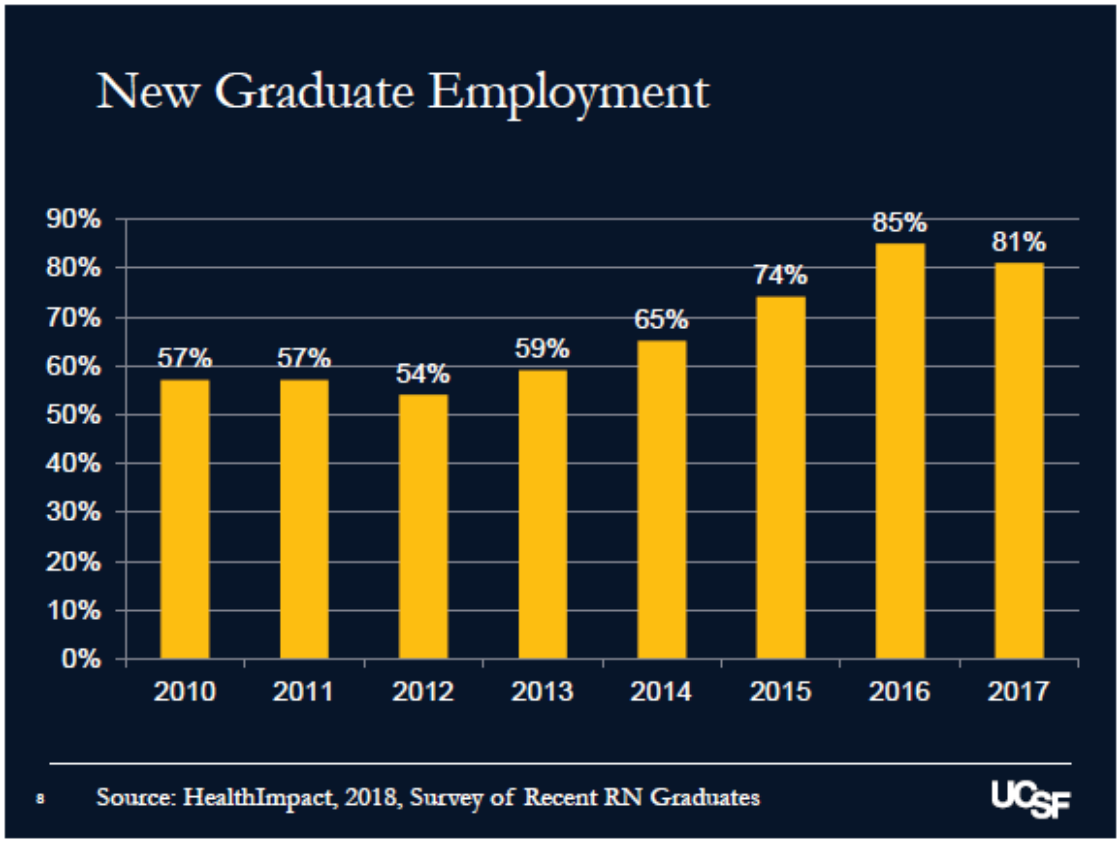
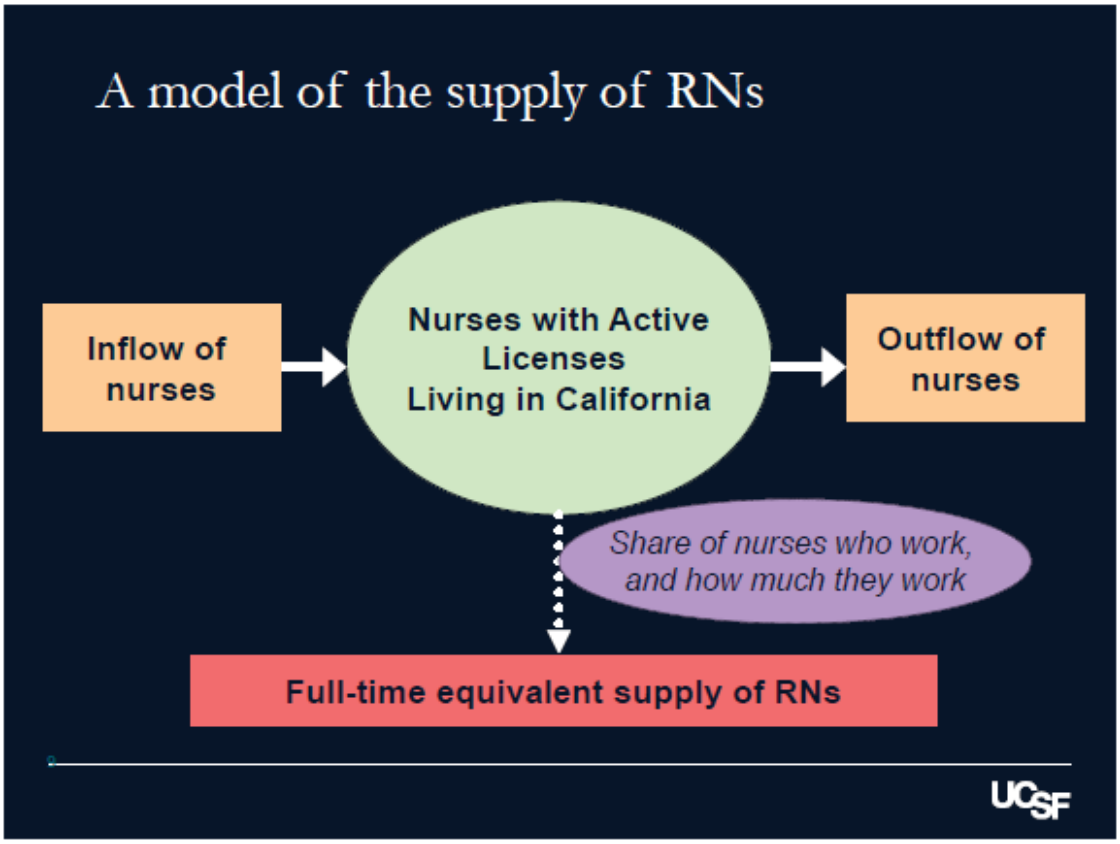

Differences across regions:
Overall RN labor market
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
4.7
4.1
4.1
4.3
4.3
4.2
1.0
2.0
3.0
4.0
5.0
2017
2016
2015
2014
2013
2012
2011
2010
5
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


Differences across regions: Experienced RNs
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
4.0
4.2
4.3
4.5
3.8
4.2
1.00
2.00
3.00
4.00
5.00
2017
2016
2015
2014
2013
6
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


Differences across regions: New Grad RNs
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
1.5
2.2
2.1
2.5
2.6
2.6
1.0
2.0
3.0
4.0
5.0
2017
2016
2015
2014
2013
7
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


New Graduate Employment
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
57%
57%
54%
59%
65%
74%
85%
81%
2010
2011
2012
2013
2014
2015
2016
2017
8
Source: HealthImpact, 2018, Survey of Recent RN Graduates
UCSF




## Forecasting demand is harder

- Number of nurses per capita
  - What is the target?
    - National average?
    - Some arbitrary benchmark?
    - Estimates of how many providers are needed to provide XYZ?
- Demand-based models can be based on economic demand models
  - Easier said than done….

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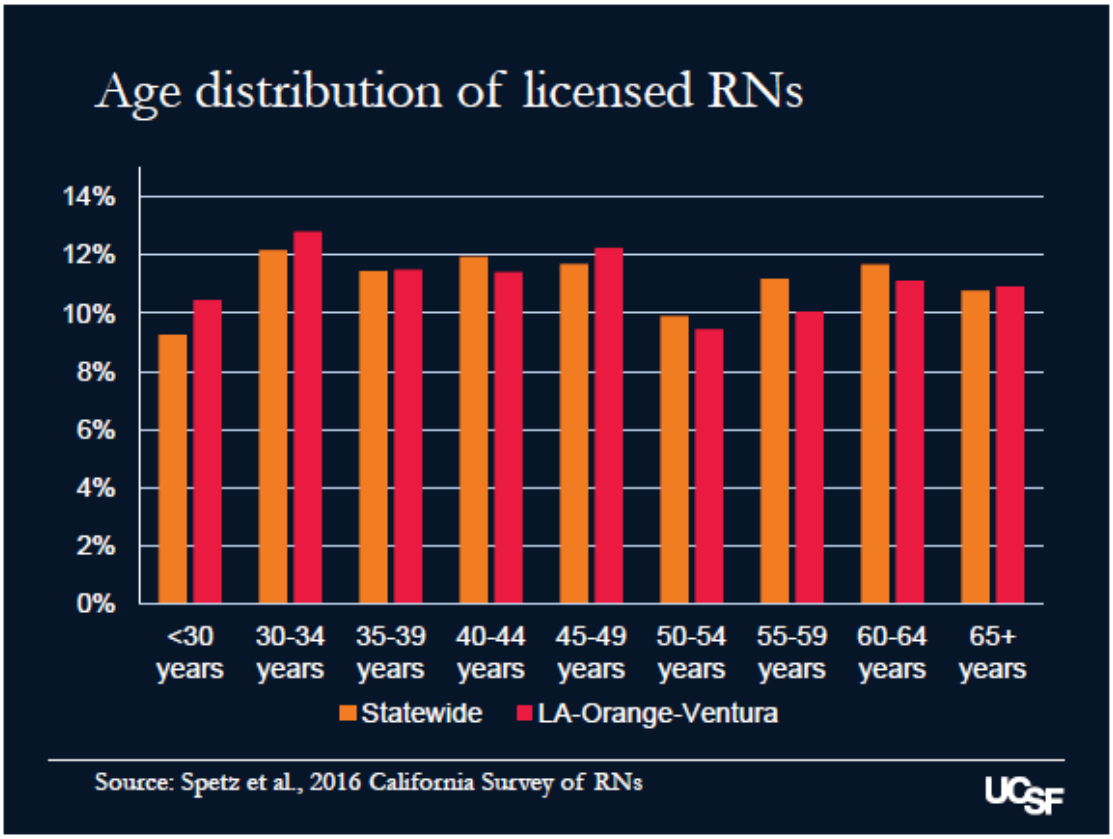
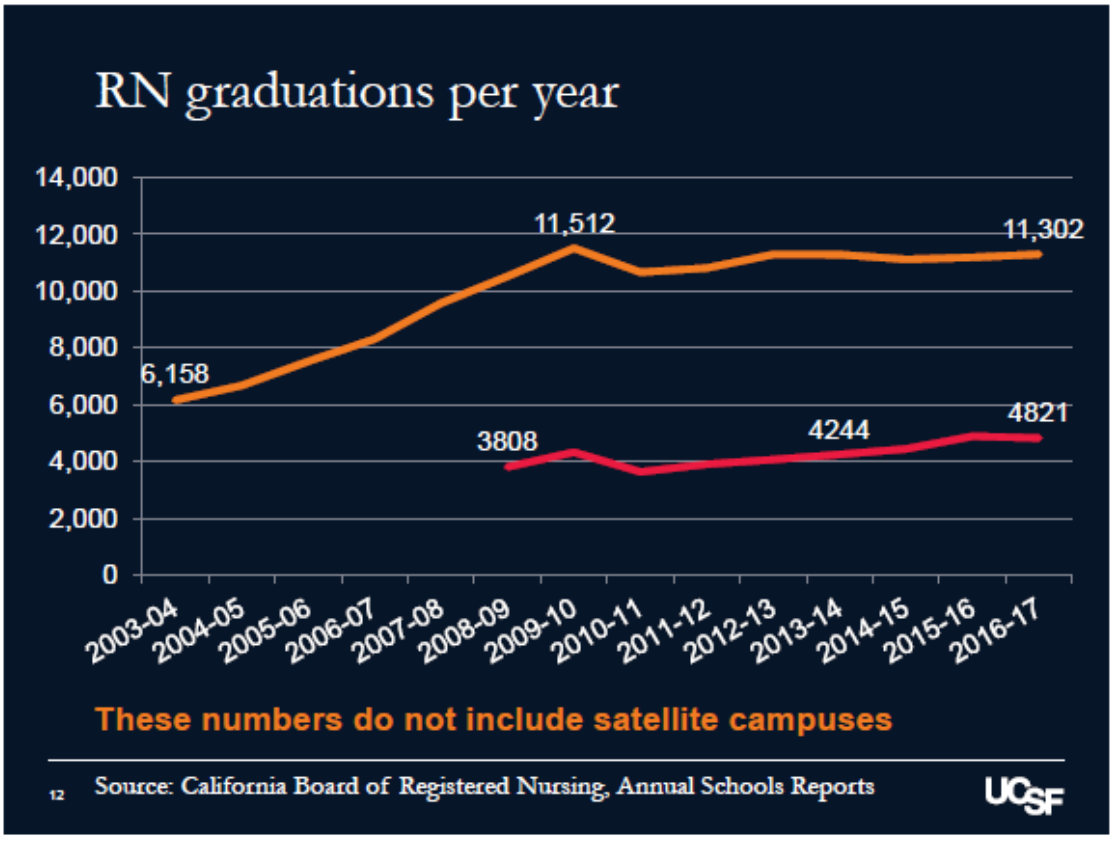

Age distribution of licensed RNs
14%
12%
10%
8%
6%
4%
2%
0%
<30 years
30-34 years
35-39 years
40-44 years
45-49 years
50-54 years
55-59 years
60-64 years
65+ years
Statewide
LA-Orange-Ventura
Source: Spetz et al., 2016 California Survey of RNs
UCSF


RN graduations per year
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
6,158
11,512
11,302
3808
4244
4821
2003-04
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17
These numbers do not include satellite campuses
12
Source: California Board of Registered Nursing, Annual Schools Reports
UCSF

## Statewide graduations are expected to hold steady

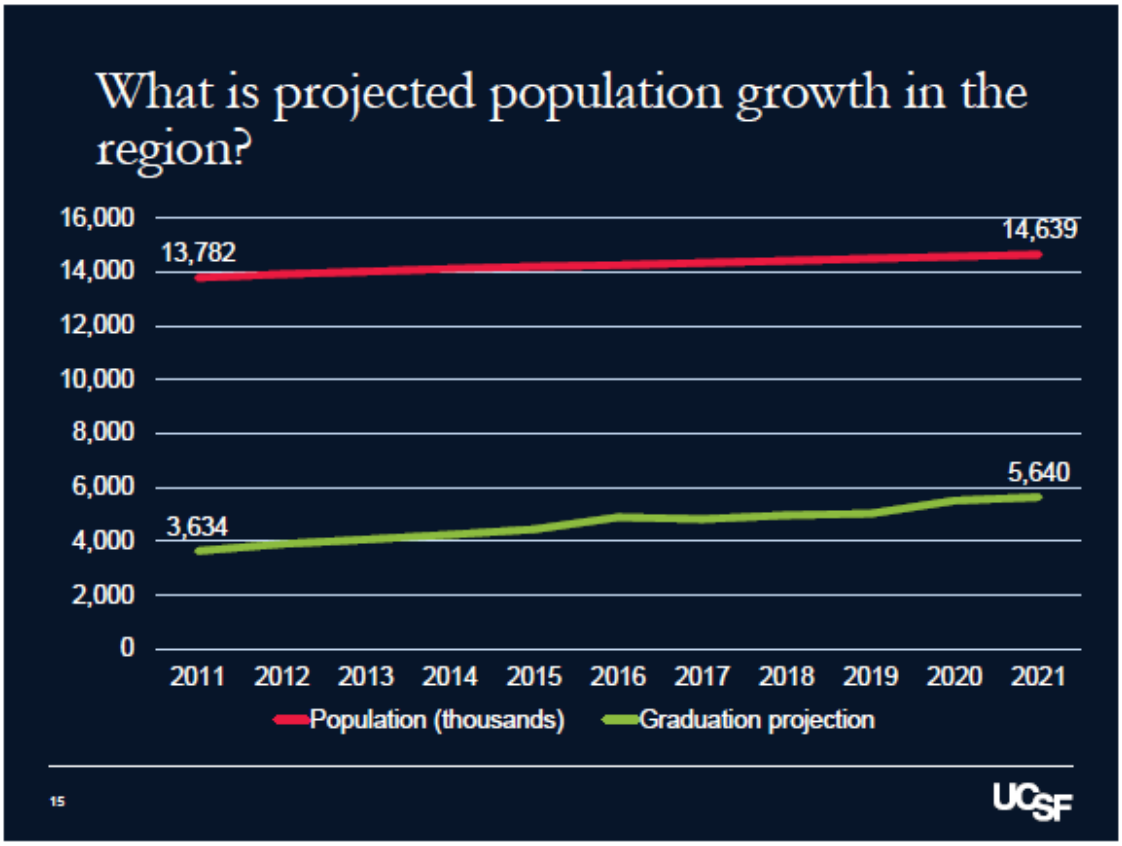
| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2014-2015 | 13,318 | 12,162 | 13,347 | 11,119 |
| 2015-2016 | 13,152 | 13,110 | 12,177 | 11,191 |
| 2016-2017 | | 13,862 | 13,236 | 10,761 |
| 2017-2018 | | | 14,219 | 10,627 |
| 2018-2019 | | | | 11,200 |
| 2019-2020 | | | | 11,489 |

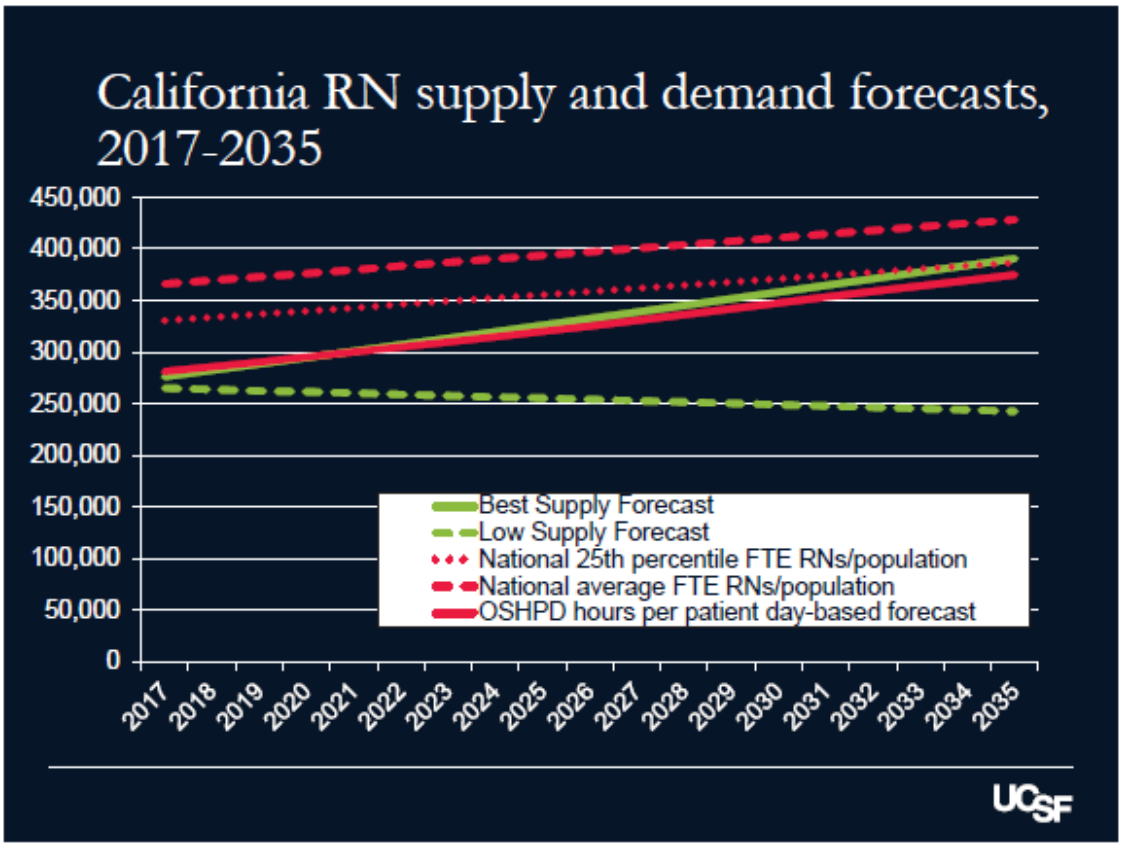
Source: California Board of Registered Nursing Annual Schools Report, 2016-2017 UCSF

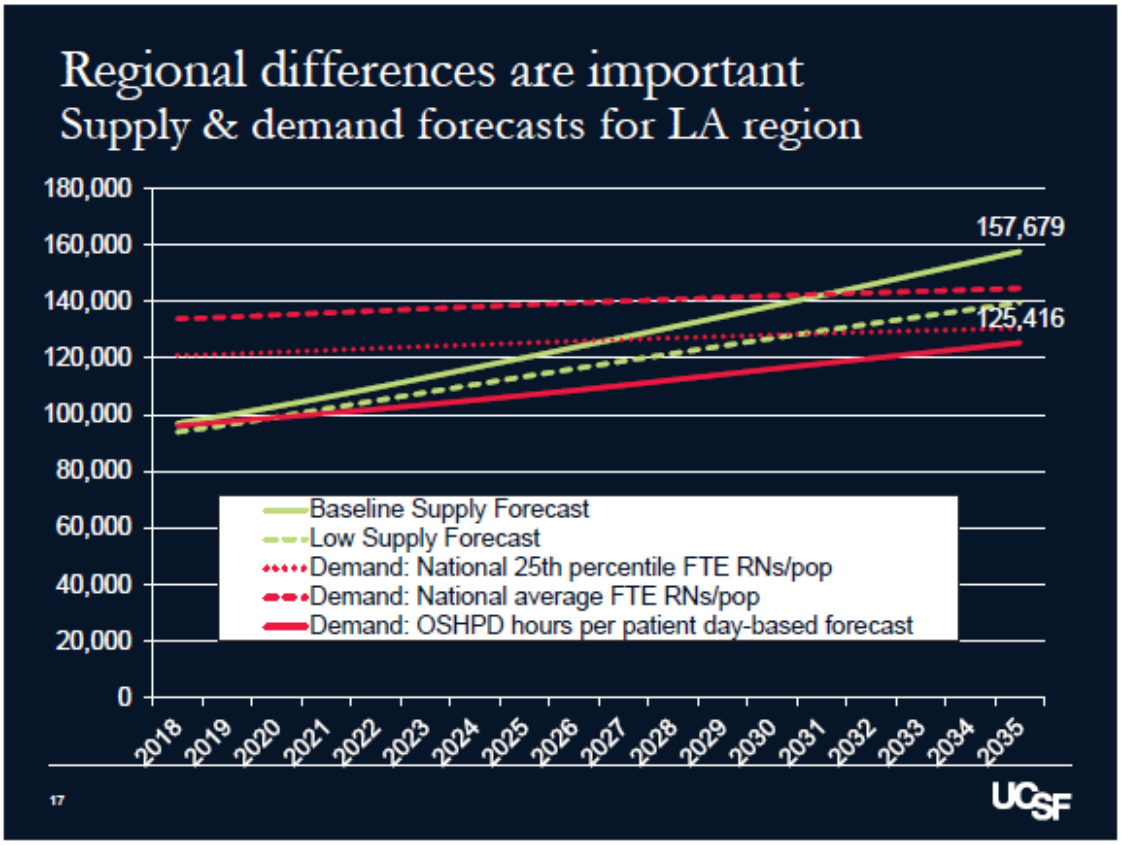
## LA-Orange-Ventura graduations are projected to continue to grow

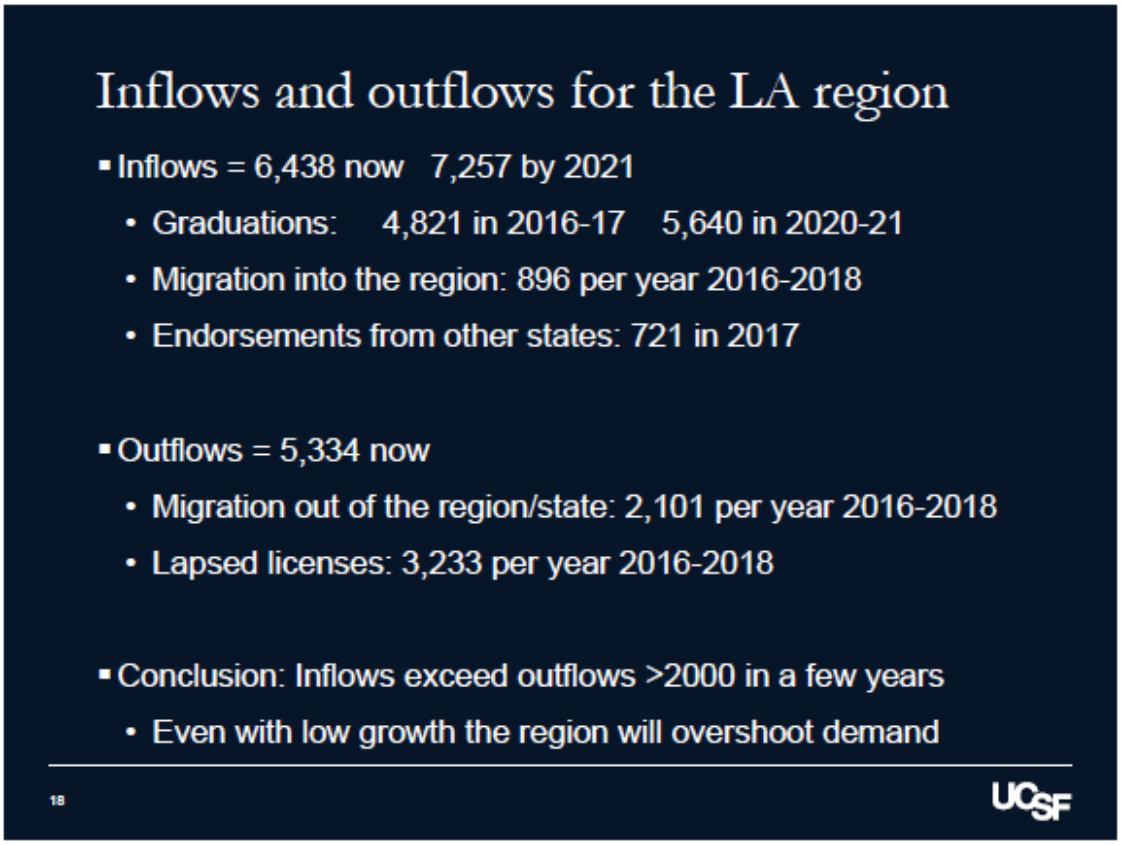
| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2015-2016 | 5,966 | 5,561 | 4,483 | 4,886 |
| 2016-2017 | 6,040 | 5,837 | 5,590 | 4,821 |
| 2017-2018 | | 6,619 | 6,101 | 4,963 |
| 2018-2019 | | | 6,780 | 5,024 |
| 2019-2020 | | | | 5,506 |
| 2020-2021 | | | | 5,640 |

Source: California Board of Registered Nursing Annual Schools Report, 2017-2018 UCSF


What is projected population growth in the region?
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
13,782
14,639
3,634
5,640
2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021
Population (thousands)
Graduation projection
15
UCSF


California RN supply and demand forecasts, 2017-2035
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
Best Supply Forecast
Low Supply Forecast
National 25th percentile FTE RNs/population
National average FTE RNs/population
OSHPD hours per patient day-based forecast
2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035
UCSF


Regional differences are important
Supply & demand forecasts for LA region
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
157,679
125,416
Baseline Supply Forecast
Low Supply Forecast
Demand: National 25th percentile FTE RNs/pop
Demand: National average FTE RNs/pop
Demand: OSHPD hours per patient day-based forecast
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
17
UCSF


Inflows and outflows for the LA region
Inflows = 6,438 now 7,257 by 2021
Graduations: 4,821 in 2016-17 5,640 in 2020-21
Migration into the region: 896 per year 2016-2018
Endorsements from other states: 721 in 2017
Outflows = 5,334 now
Migration out of the region/state: 2,101 per year 2016-2018
Lapsed licenses: 3,233 per year 2016-2018
Conclusion: Inflows exceed outflows >2000 in a few years
Even with low growth the region will overshoot demand
18
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## Impact of oversupply

- Unemployed new graduates
- Greater competition for clinical space than needed
- Will these new RNs move to other regions or states?
  - >50% of recent RN grads work within 40 miles of high school
  - This can be an opportunity to address shortages in other regions

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## How do we address the challenge?

LA-Orange-Ventura region faces a large surplus

Projected new graduate growth is much higher than needed

Competition for clinical space

Need to encourage graduates to move elsewhere

20

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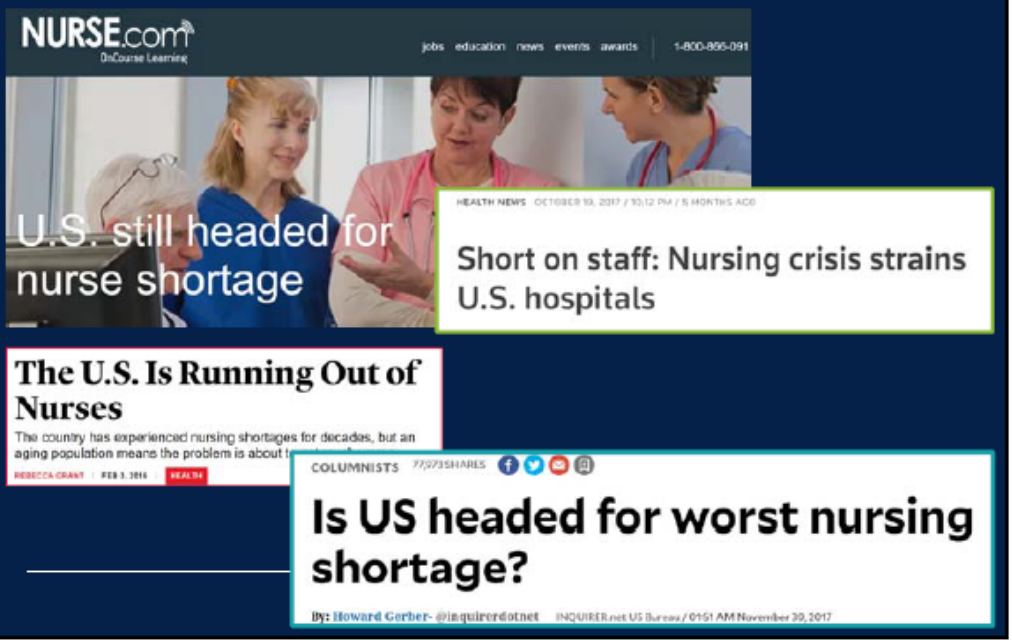
# Supply & Demand of RNs in the Central Valley & Sierra region

*Joanne Spetz, PhD, FAAN*
*Professor, Philip R. Lee Institute for Health Policy Studies*
*Associate Director for Research, Healthforce Center*
*University of California, San Francisco*

September 2018

## Tales of a nursing shortage…



## Forecasting future RN supply & demand

- National forecasts: market is balanced
  - National Center for Health Workforce Analysis, 2017
    - National surplus of 293,800 RNs by 2030 (8.2%)
    - Assumes supply = demand in 2014
  - Auerbach et al. 2015 – 128,000 RN shortage by 2025 (4%)
- California
  - NCHWA 2017 – 44,500 short (11.5%)
  - Auerbach et al. 2017 – only 0.7% per capita supply growth in Pacific region
  - Spetz 2017 – no shortage overall, but skills & regional imbalance

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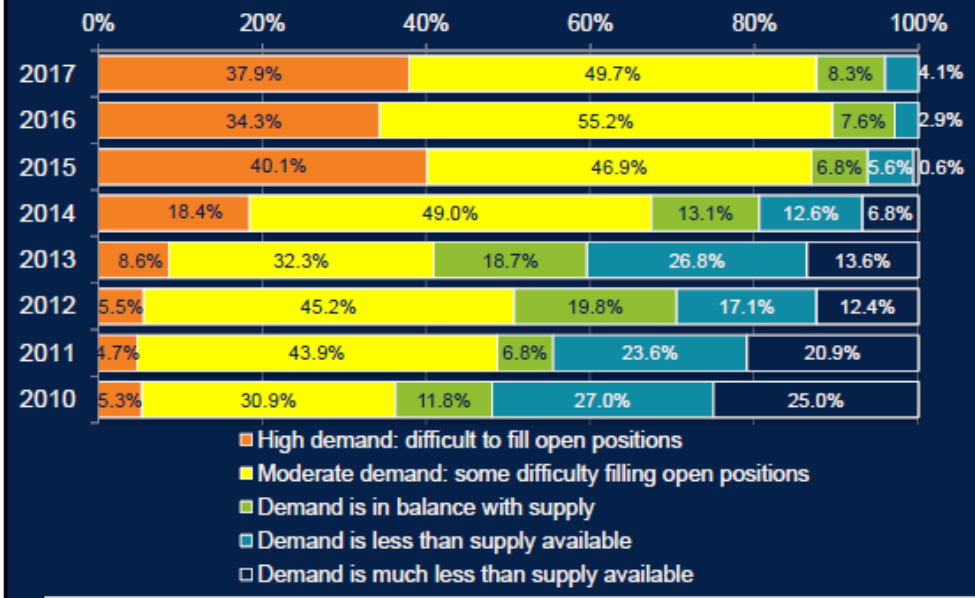
## Perceptions of employers: Overall labor market




Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017

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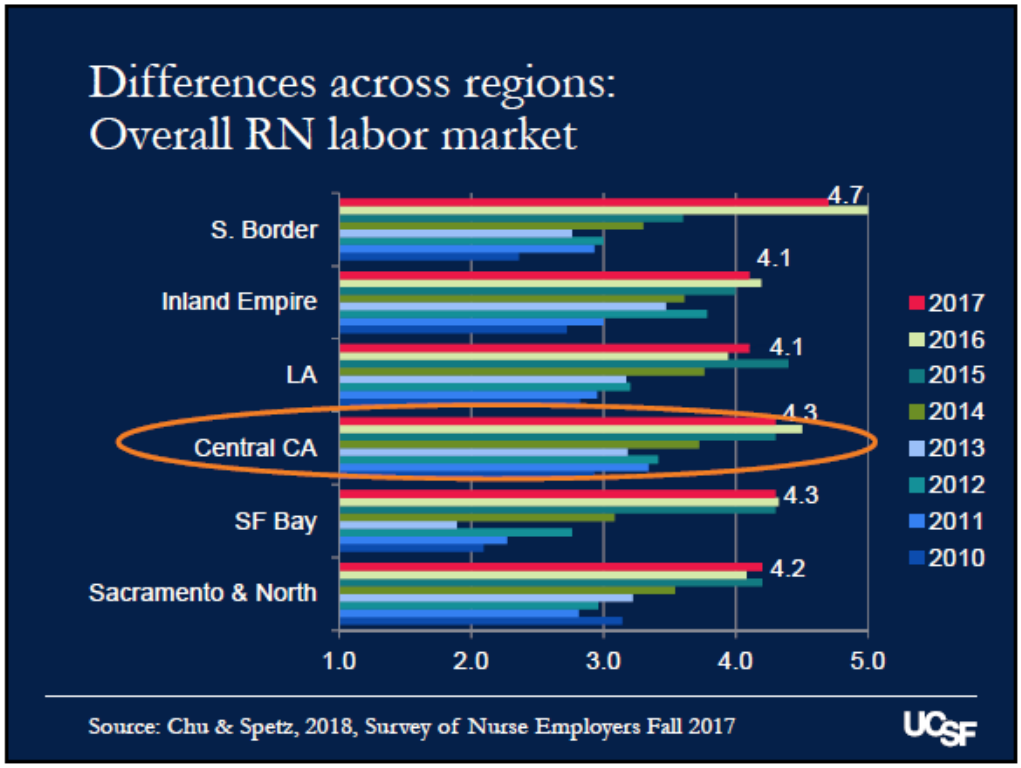
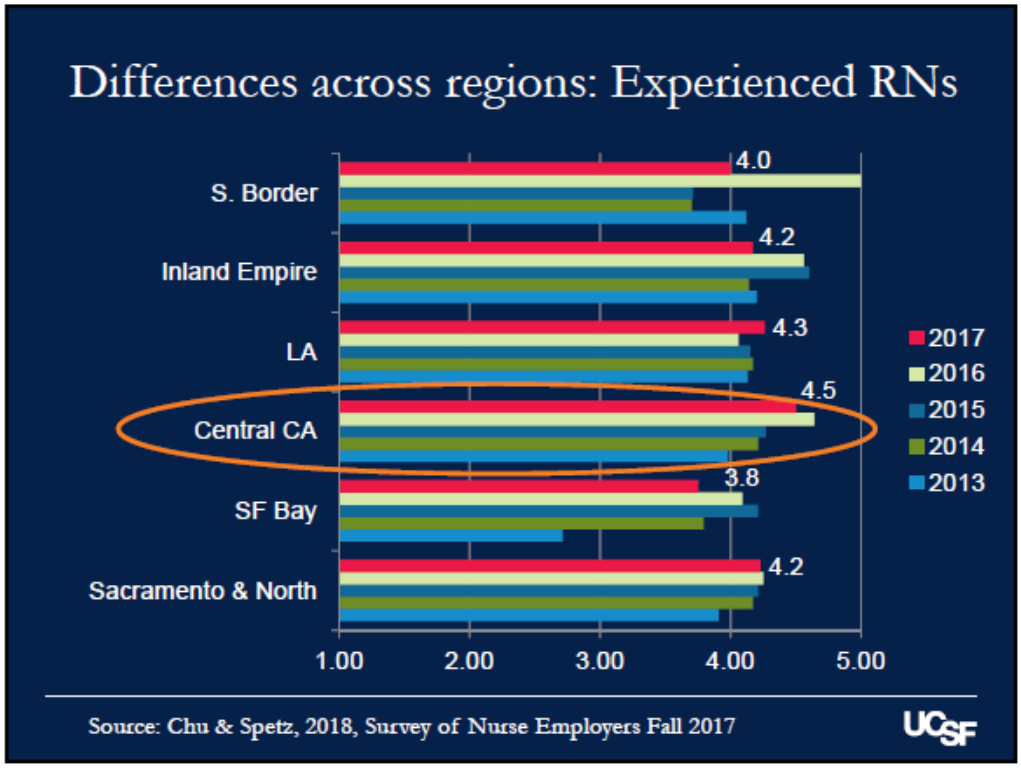
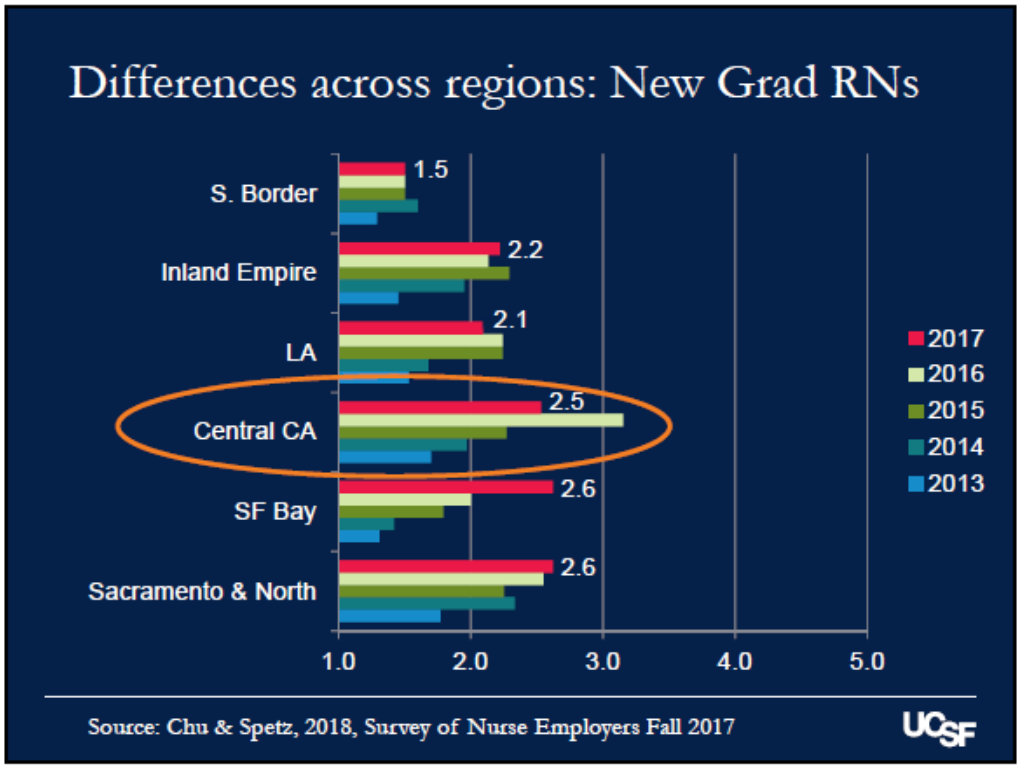
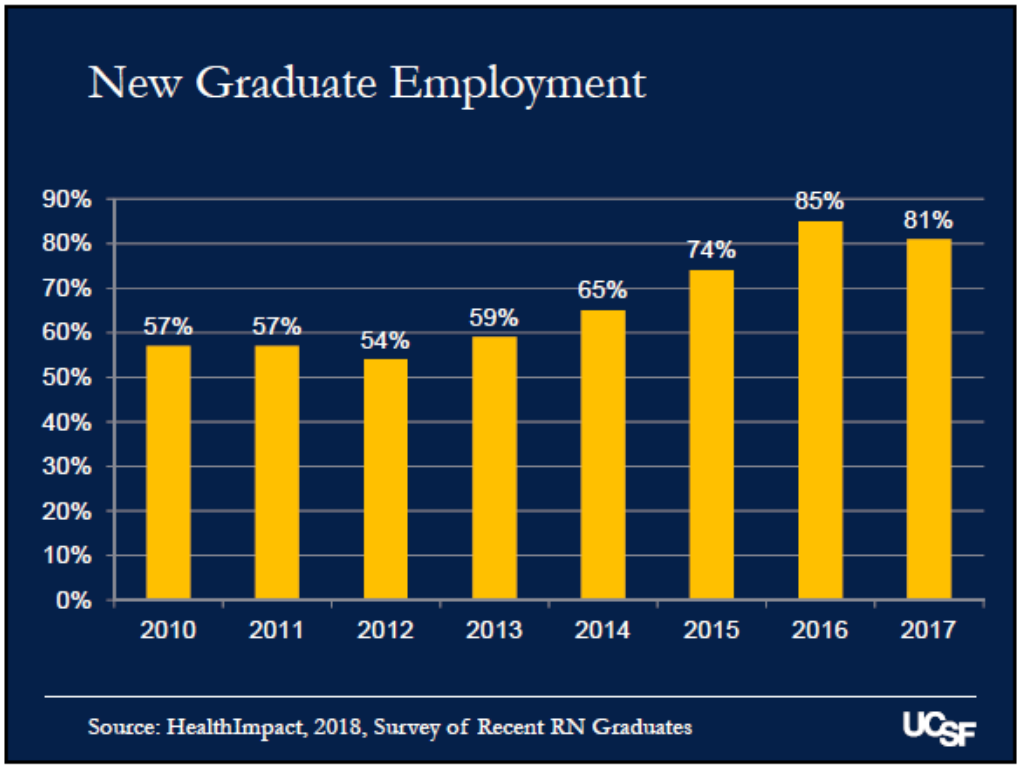
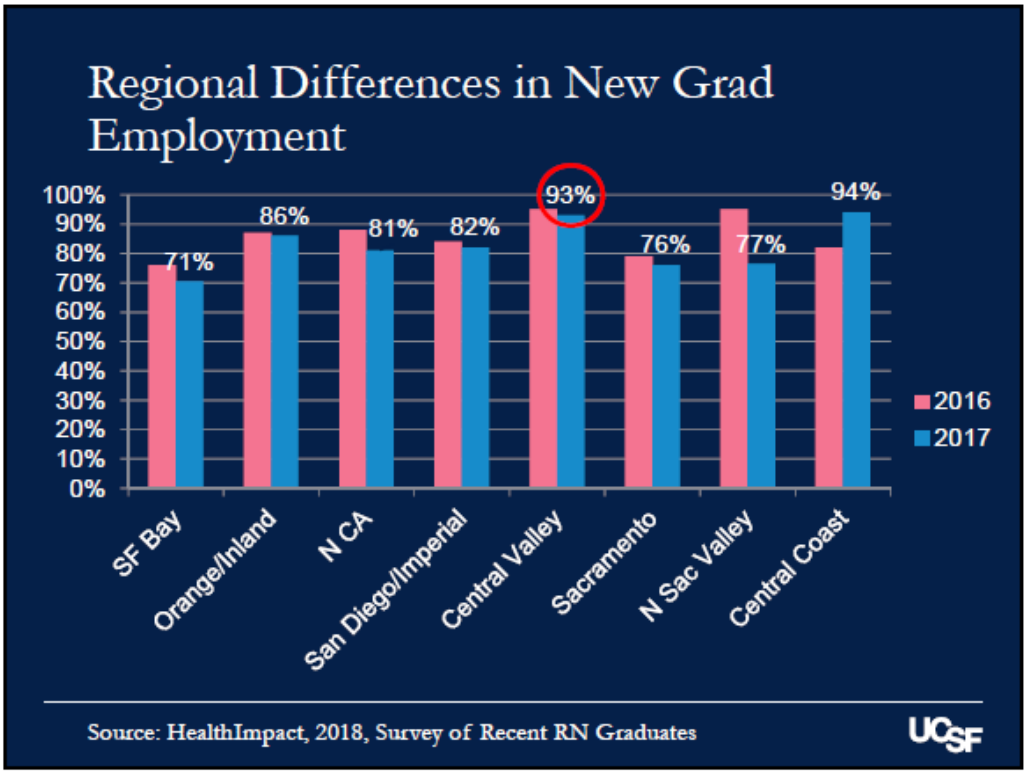
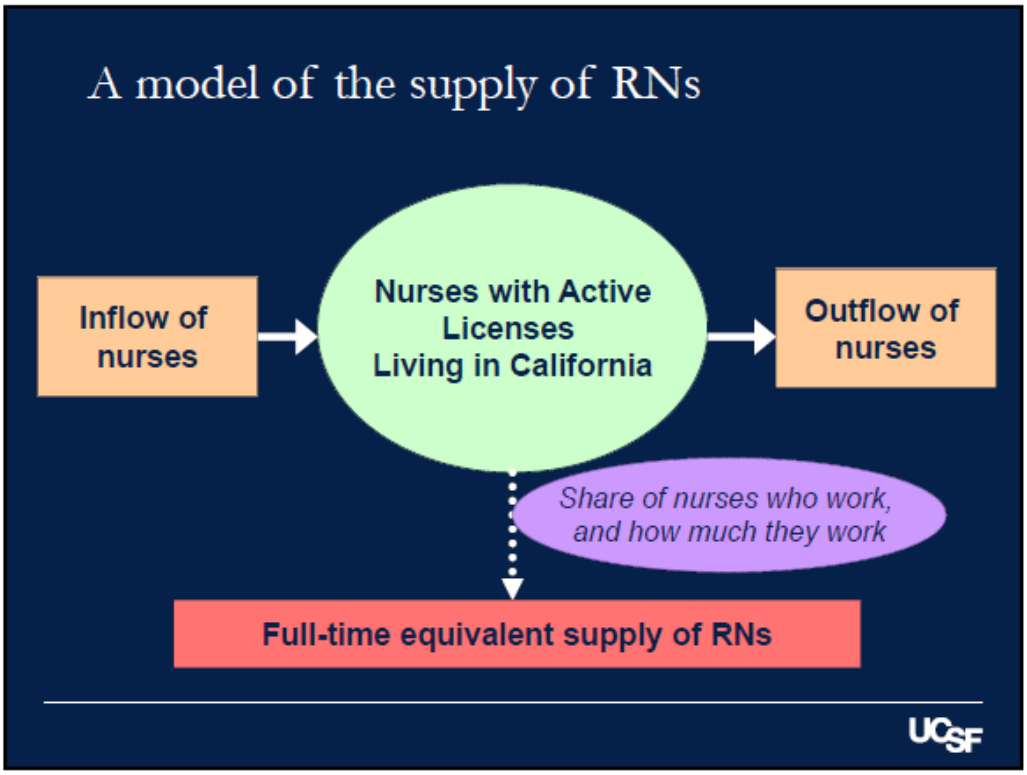

Differences across regions:
Overall RN labor market
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
4.7
4.1
4.1
4.3
4.3
4.2
2017
2016
2015
2014
2013
2012
2011
2010
1.0
2.0
3.0
4.0
5.0
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


Differences across regions: Experienced RNs
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
4.0
4.2
4.3
4.5
3.8
4.2
2017
2016
2015
2014
2013
1.00
2.00
3.00
4.00
5.00
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


Differences across regions: New Grad RNs
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
1.5
2.2
2.1
2.5
2.6
2.6
1.0
2.0
3.0
4.0
5.0
2017
2016
2015
2014
2013
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


New Graduate Employment
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
57%
57%
54%
59%
65%
74%
85%
81%
2010
2011
2012
2013
2014
2015
2016
2017
Source: HealthImpact, 2018, Survey of Recent RN Graduates
UCSF


Regional Differences in New Grad Employment
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
86%
81%
82%
93%
76%
77%
94%
2016
2017
SF Bay
Orange/Inland
N CA
San Diego/Imperial
Central Valley
Sacramento
N Sac Valley
Central Coast
Source: HealthImpact, 2018, Survey of Recent RN Graduates
UCSF


A model of the supply of RNs
Inflow of nurses
Nurses with Active Licenses Living in California
Outflow of nurses
Share of nurses who work, and how much they work
Full-time equivalent supply of RNs
UCSF

## Forecasting demand is harder

- Number of nurses per capita
  - What is the target?
    - National average?
    - Some arbitrary benchmark?
    - Estimates of how many providers are needed to provide XYZ?
- Demand-based models can be based on economic demand models
  - Easier said than done….

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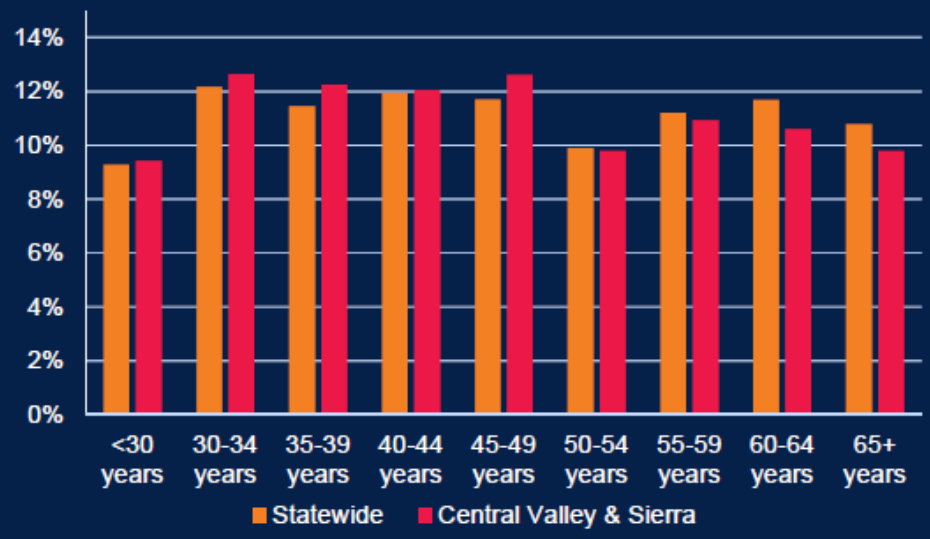
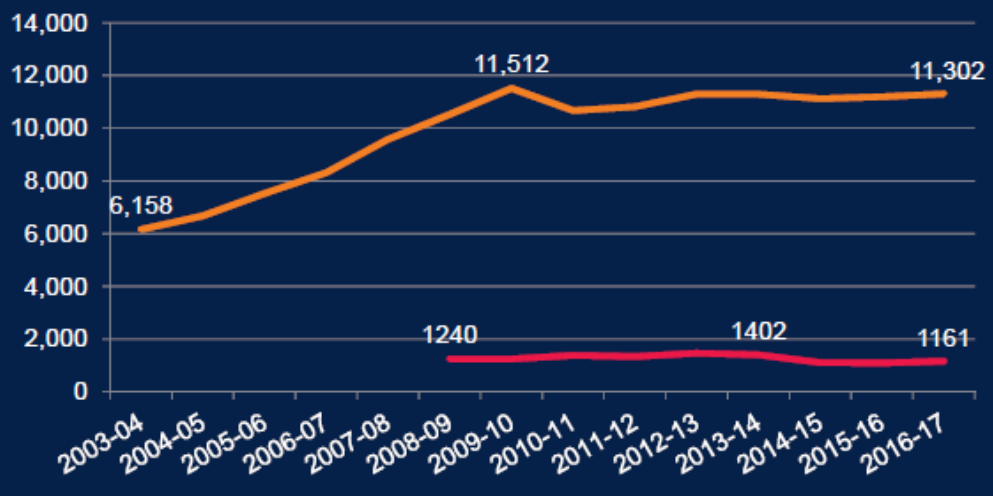
## Age distribution of licensed RNs




Source: Spetz et al., 2016 California Survey of RNs

UCSF

## RN graduations per year




**These numbers do not include satellite campuses**

Source: California Board of Registered Nursing, Annual Schools Reports

UCSF

## Statewide graduations are expected to hold steady

| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
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| 2017-2018 | | | 14,219 | 10,627 |
| 2018-2019 | | | | 11,200 |
| 2019-2020 | | | | 11,489 |

Source: California Board of Registered Nursing Annual Schools Report, 2016-2017

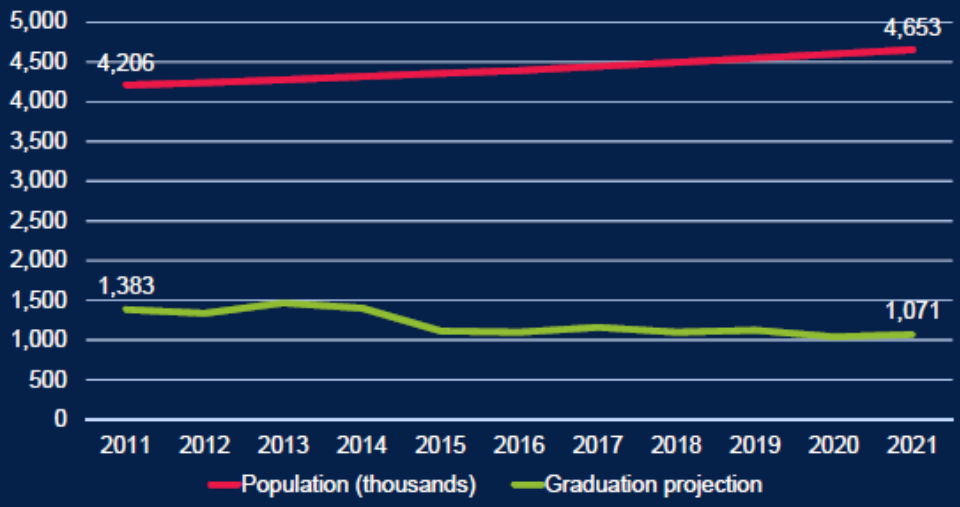
UCSF

## Central Valley & Sierra graduations are projected to remain steady

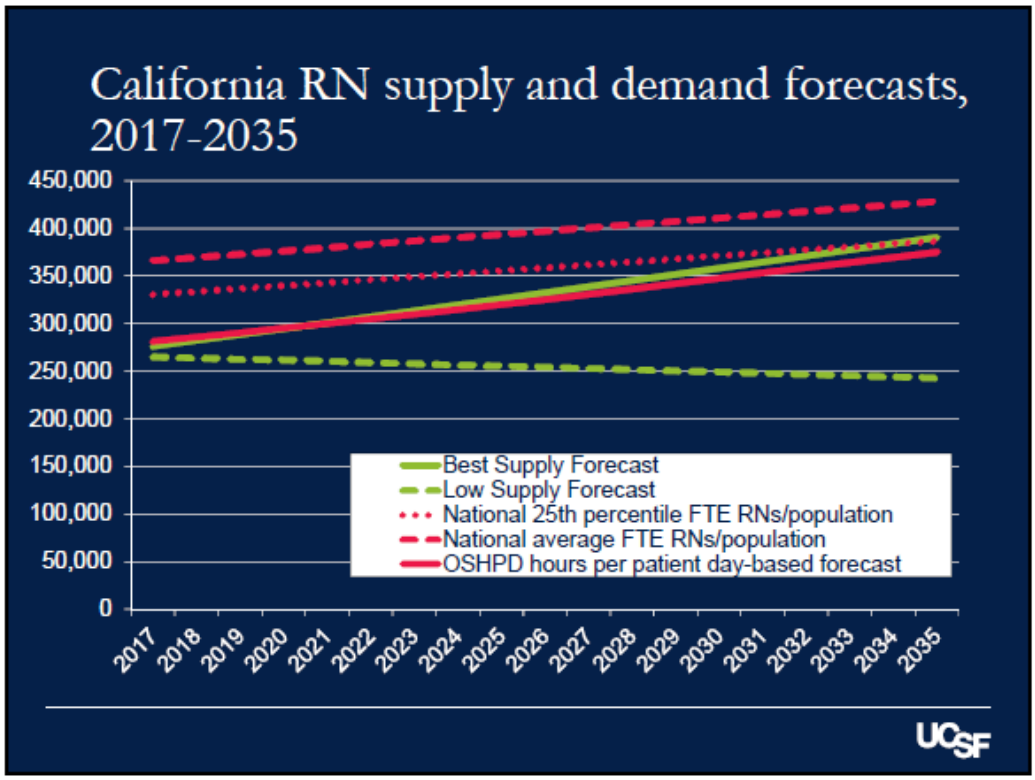
| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2015-2016 | 1,276 | 1,101 | 1,094 | 1,097 |
| 2016-2017 | 1,305 | 1,099 | 1,101 | 1,161 |
| 2017-2018 | | 1,208 | 1,122 | 1,099 |
| 2018-2019 | | | 1,244 | 1,124 |
| 2019-2020 | | | | 1,040 |
| 2020-2021 | | | | 1,071 |

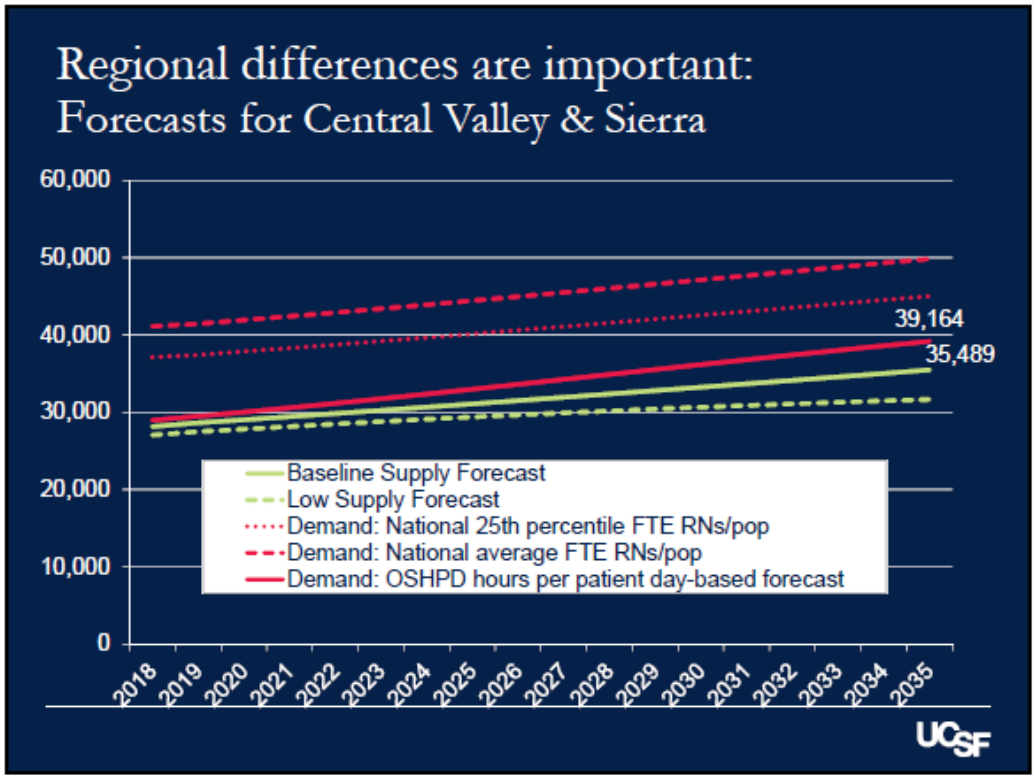
Source: California Board of Registered Nursing Annual Schools Report, 2016-2017 UCSF

## What is projected population growth in the region?




UCSF


California RN supply and demand forecasts, 2017-2035
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
Best Supply Forecast
Low Supply Forecast
National 25th percentile FTE RNs/population
National average FTE RNs/population
OSHPD hours per patient day-based forecast
UCSF


Regional differences are important:
Forecasts for Central Valley & Sierra
60,000
50,000
40,000
30,000
20,000
10,000
0
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
39,164
35,489
Baseline Supply Forecast
Low Supply Forecast
Demand: National 25th percentile FTE RNs/pop
Demand: National average FTE RNs/pop
Demand: OSHPD hours per patient day-based forecast
UCSF

## Inflows and outflows for the Central region

- Inflows = ~1,830 now
  - Graduations: ~1,100 per year
  - Migration into the region: 529 per year 2016-2018
  - Endorsements from other states: 204 in 2017
- Outflows = 1,740 now
  - Migration out of the region: 777 per year 2016-2018
    - Concentrated among younger nurses
  - Lapsed licenses: 963 per year 2016-2018
- Conclusion: Outflows exceed inflows & population is growing
  - Not enough new graduates

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## Costs of shortages and turnover

- Productivity losses due to instability in the workforce
- Premiums paid to temporary RN staff
- Losses when beds are closed, patients are deferred
- Expense of overtime pay
- Training and orientation costs
- Patient safety failures when understaffed

Source: Cheryl Jones, Nursing Outlook, 2004

UCSF


How do we address the challenge?
Central Valley & Sierra faces a shortage of about 10% by 2035
Rapid population growth projected ➔ workforce needs to keep up
Younger RN workforce, but not enough new graduates
Relatively small changes in graduations can fill the gap
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# Supply & Demand of Registered Nurses in the Inland Empire

*Joanne Spetz, PhD, FAAN*
*Professor, Philip R. Lee Institute for Health Policy Studies*
*Associate Director for Research, Healthforce Center*
*University of California, San Francisco*

September 2018

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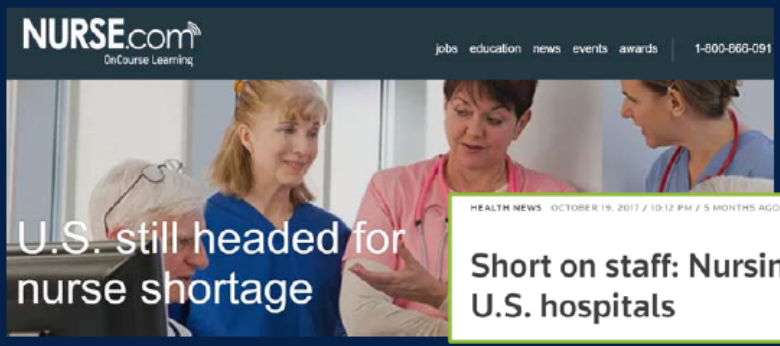
## Tales of a nursing shortage…




HEALTH NEWS OCTOBER 19, 2017 / 10:12 PM / 5 MONTHS AGO

**Short on staff: Nursing crisis strains U.S. hospitals**

**The U.S. Is Running Out of Nurses**

The country has experienced nursing shortages for decades, but an aging population means the problem is about t

REBECCA GRANT FEB 3, 2016 HEALTH

COLUMNISTS 77,973 SHARES

**Is US headed for worst nursing shortage?**

By: Howard Gerber- @inquirerdotnet INQUIRER.net US Bureau / 01:51 AM November 30, 2017

2

## Forecasting future RN supply & demand

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    - National surplus of 293,800 RNs by 2030 (8.2%)
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  - NCHWA 2017 – 44,500 short (11.5%)
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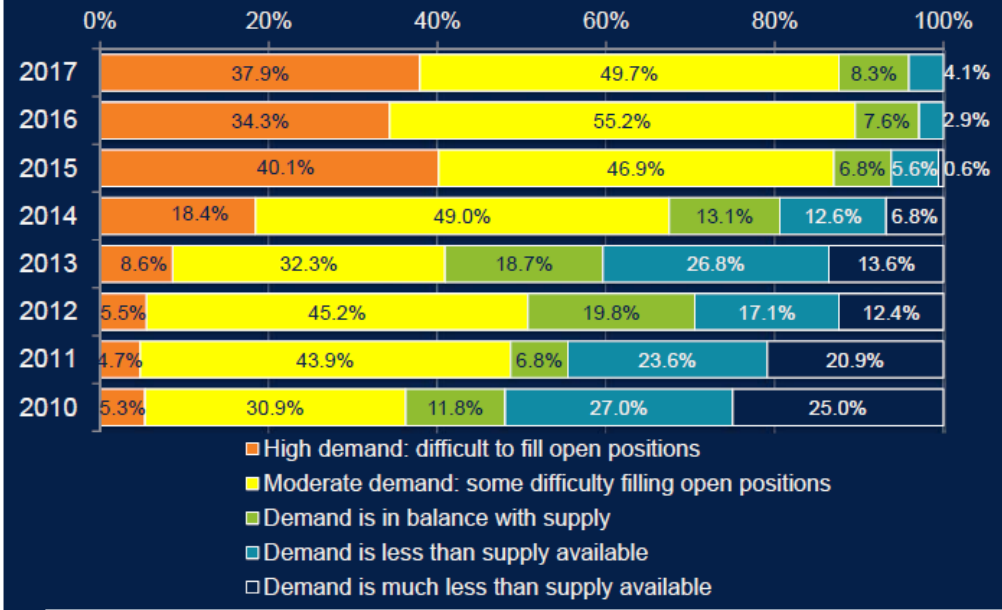


4 Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017

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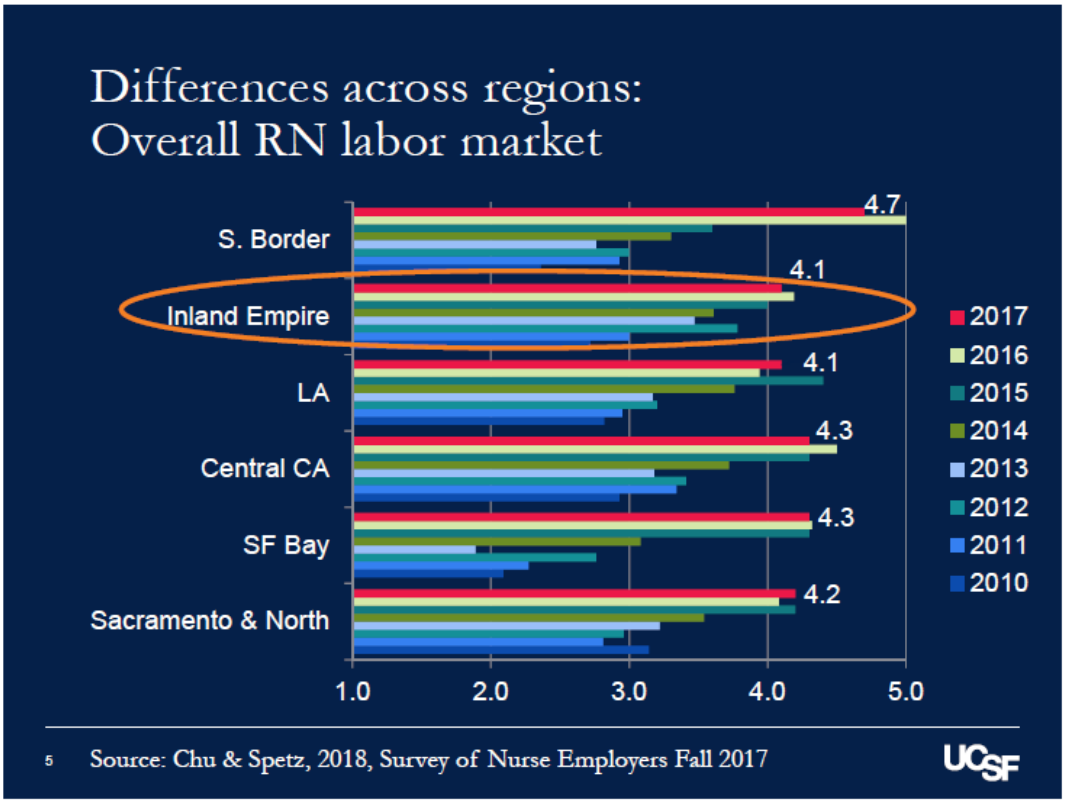
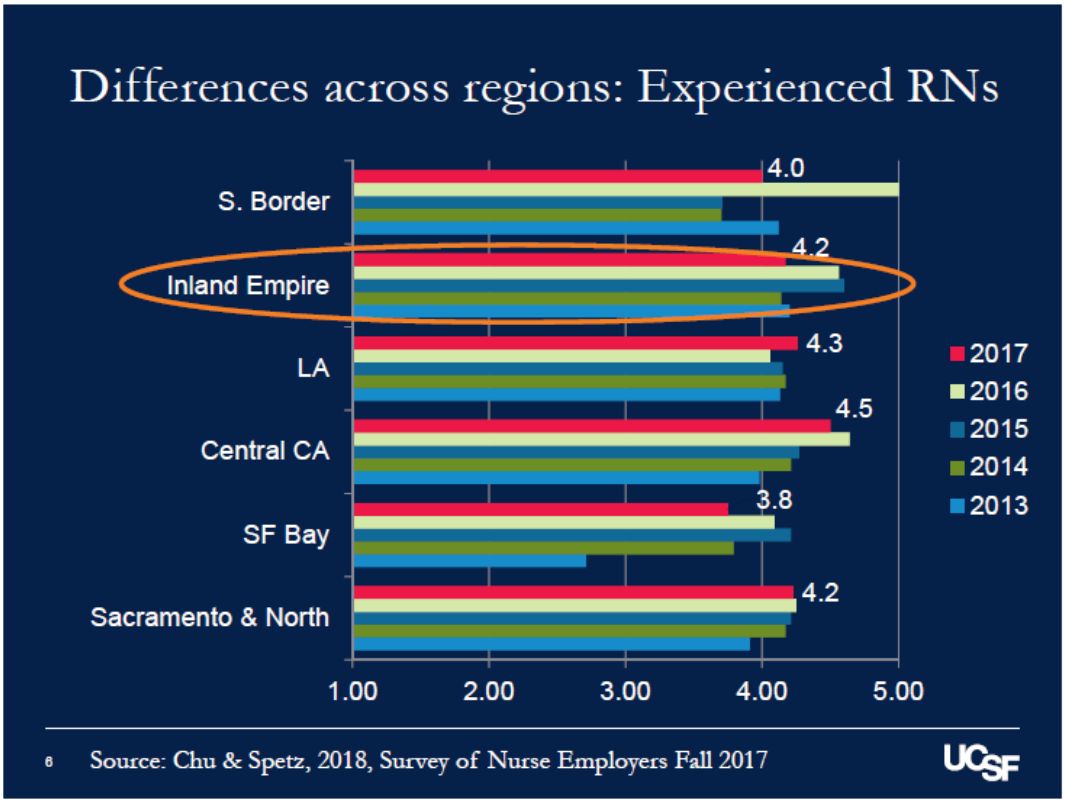
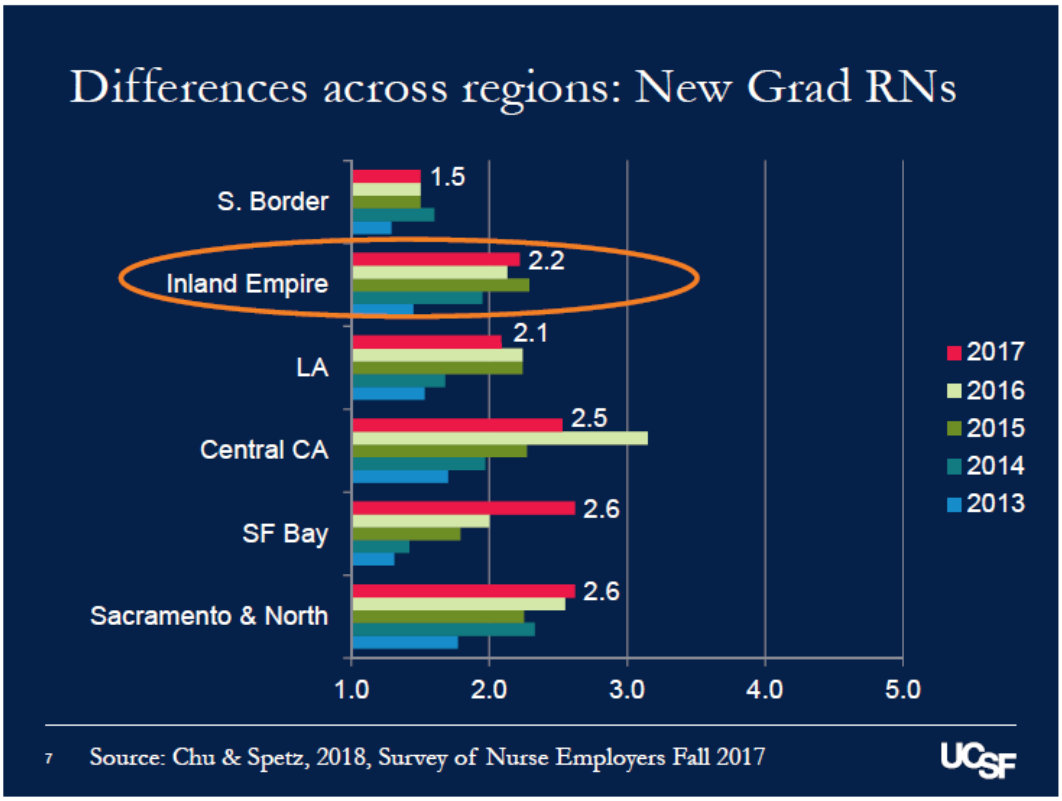
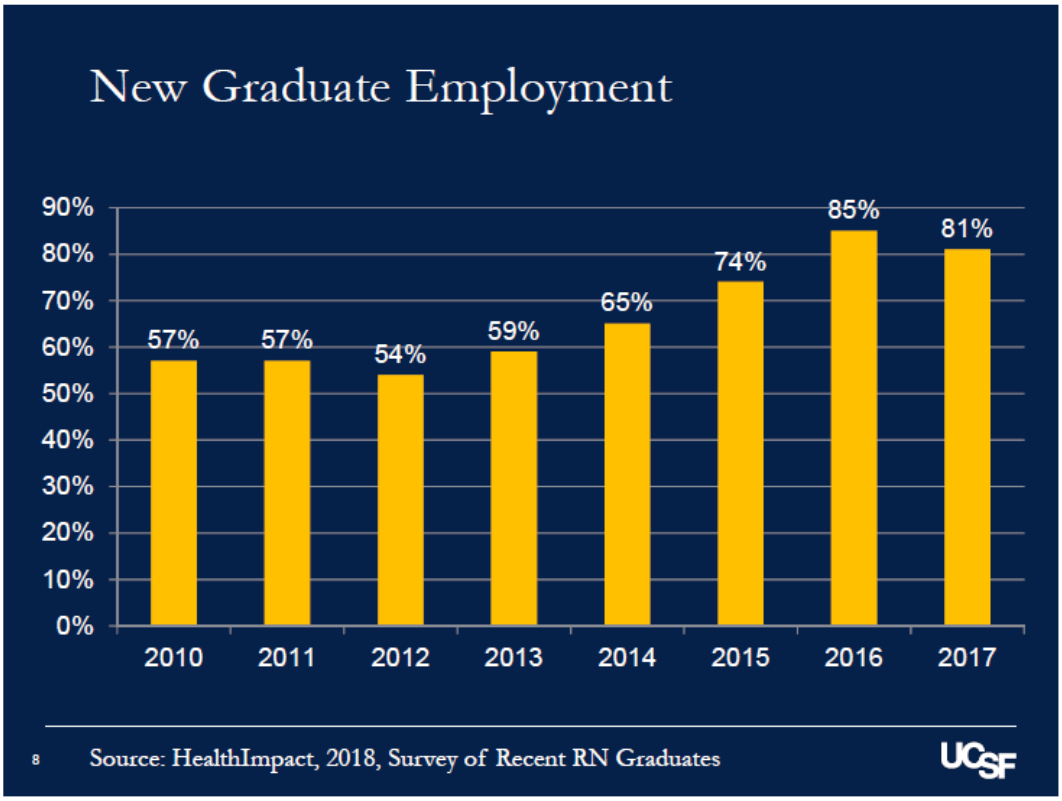

Differences across regions:
Overall RN labor market
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
4.7
4.1
4.1
4.3
4.3
4.2
1.0
2.0
3.0
4.0
5.0
2017
2016
2015
2014
2013
2012
2011
2010
5 Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


Differences across regions: Experienced RNs
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
4.0
4.2
4.3
4.5
3.8
4.2
1.00
2.00
3.00
4.00
5.00
2017
2016
2015
2014
2013
6 Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF


Differences across regions: New Grad RNs
S. Border
Inland Empire
LA
Central CA
SF Bay
Sacramento & North
1.5
2.2
2.1
2.5
2.6
2.6
1.0
2.0
3.0
4.0
5.0
2017
2016
2015
2014
2013
7
Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
UCSF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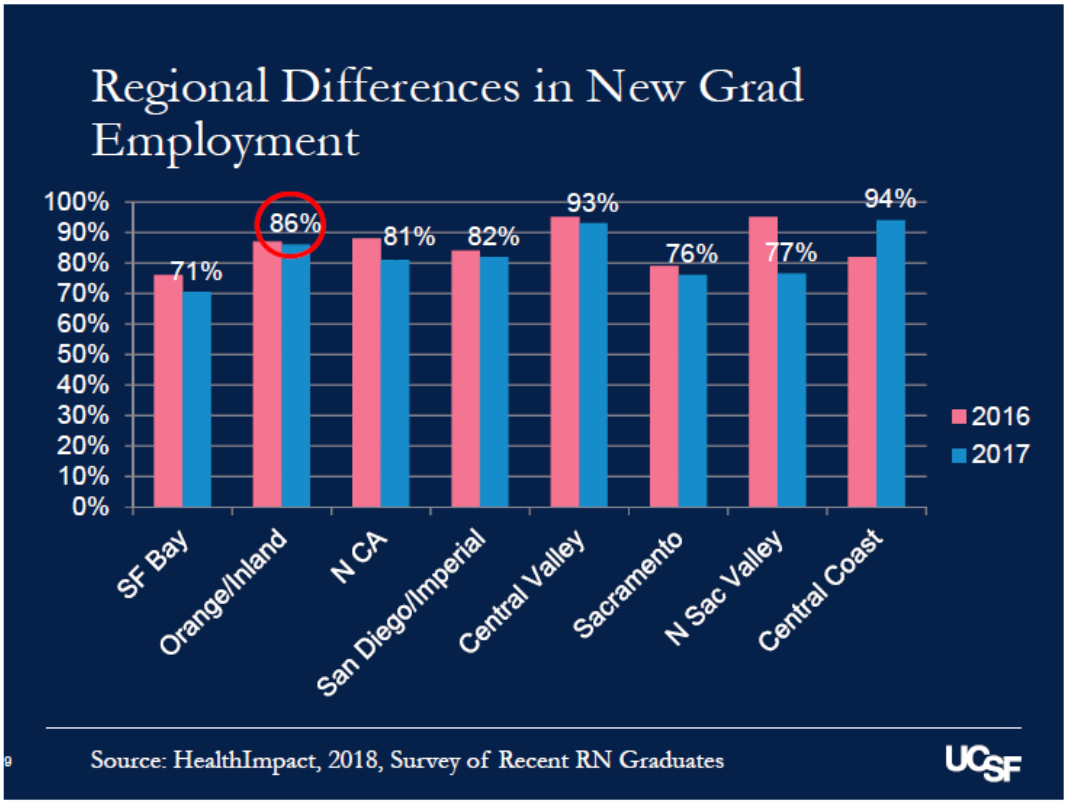
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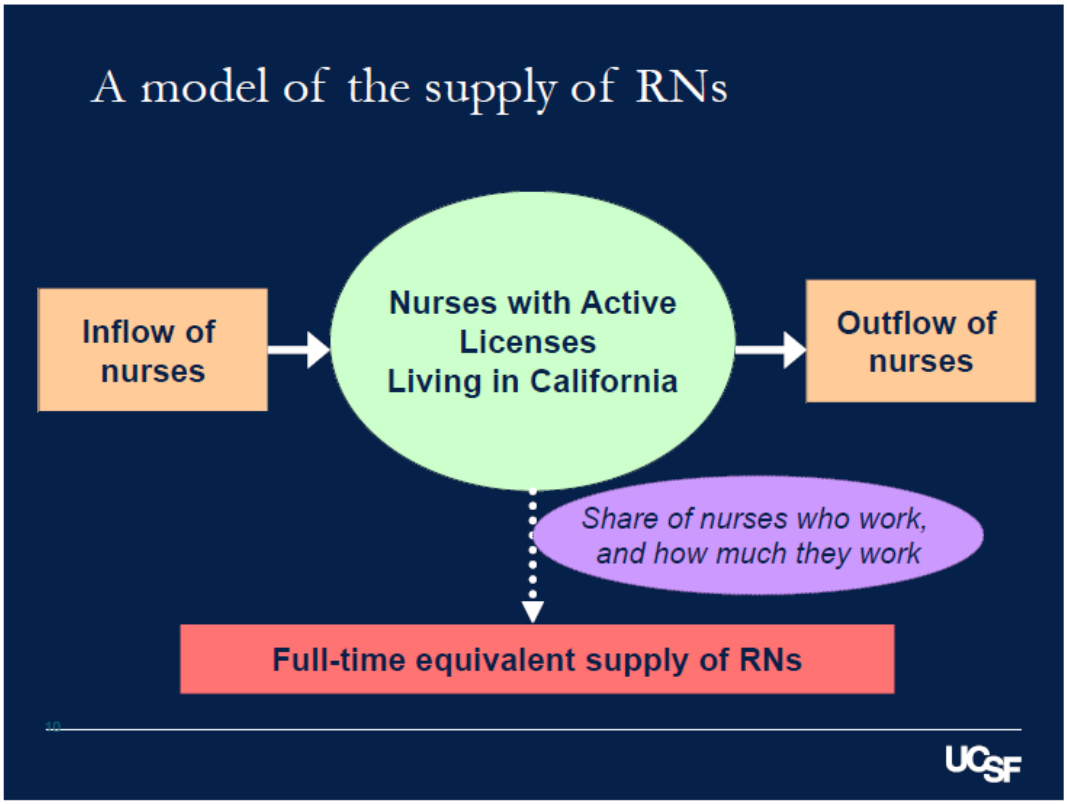
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UCSF

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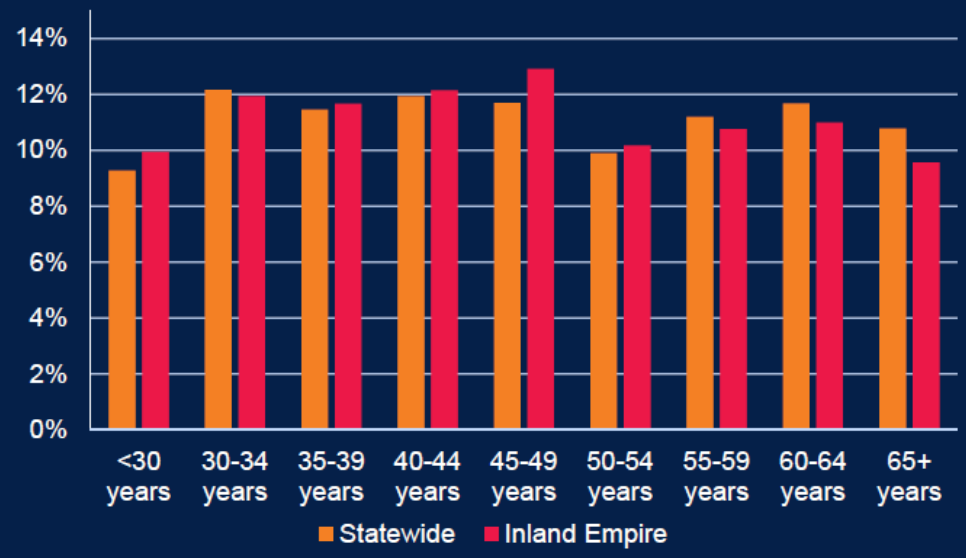


Source: Spetz et al., 2016 California Survey of RNs

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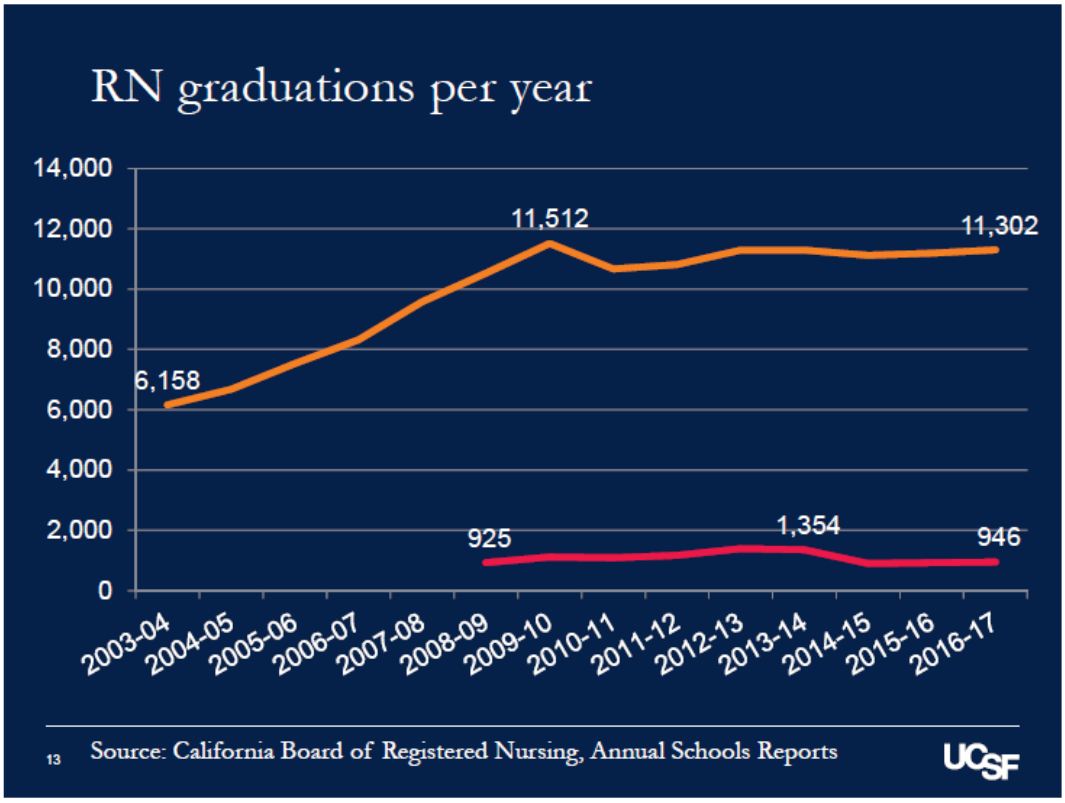
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Source: California Board of Registered Nursing, Annual Schools Reports
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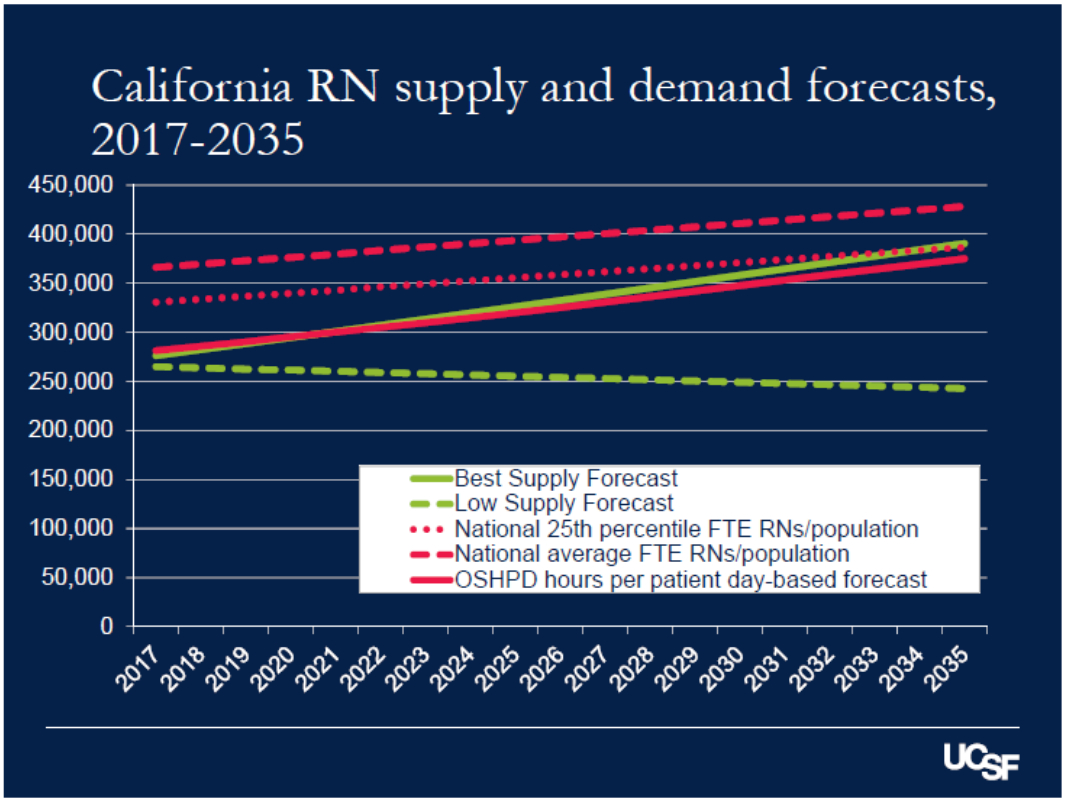
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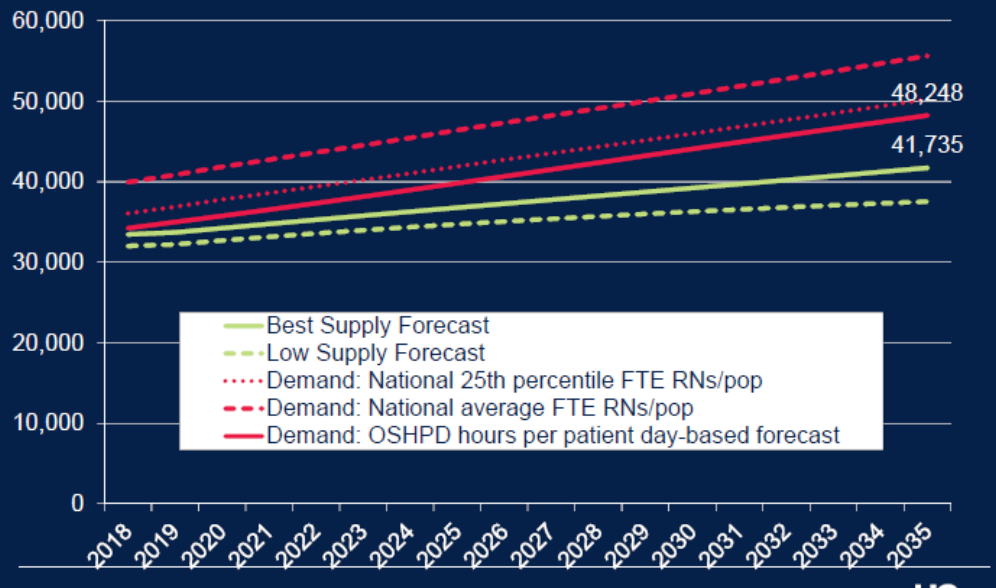
UCSF

## Regional differences are important
### Supply & demand forecasts for Inland Empire

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## Statewide graduations are expected to hold steady

| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2014-2015 | 13,318 | 12,162 | 13,347 | 11,119 |
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| 2016-2017 | | 13,862 | 13,236 | 10,761 |
| 2017-2018 | | | 14,219 | 10,627 |
| 2018-2019 | | | | 11,200 |
| 2019-2020 | | | | 11,489 |

Source: California Board of Registered Nursing Annual Schools Report, 2016-2017

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## Inland Empire graduations are too low – and projected increases aren't enough

| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2015-2016 | 1,067 | 1,048 | 1,661 | 923 |
| 2016-2017 | 954 | 1,300 | 1,048 | 946 |
| 2017-2018 | | 1,444 | 1,309 | 778 |
| 2018-2019 | | | 1,451 | 696 |
| 2019-2020 | | | | 1,053 |
| 2020-2021 | | | | 1,058 |

Source: California Board of Registered Nursing Annual Schools Report, 2017-2018 UCSF

## Other sources of RNs to the Inland Empire

- Migration from other regions to the Inland Empire:
  - 863 per year 2016-2018
- Endorsements from other states: 213 in 2017
- Migration out of the Inland Empire: 888 per year 2016-2018
- Lapsed licenses: 1,121 per year 2016-2018
- Conclusion: Not enough new graduates to keep up with population growth

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## Costs of shortages and turnover

- Productivity losses due to instability in the workforce
- Premiums paid to temporary RN staff
- Losses when beds are closed, patients are deferred
- Expense of overtime pay
- Training and orientation costs
- Patient safety failures when understaffed

Source: Cheryl Jones, Nursing Outlook, 2004

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## How do we address the challenge?

Inland Empire faces a shortage of ~15%

Rapid population growth projected → workforce needs to keep up

Younger RN workforce, but not enough new graduates

20

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University of California
San Francisco

# Supply & Demand of Registered Nurses in the Southern Border region

*Joanne Spetz, PhD, FAAN*
*Professor, Philip R. Lee Institute for Health Policy Studies*
*Associate Director for Research, Healthforce Center*
*University of California, San Francisco*

September 2018

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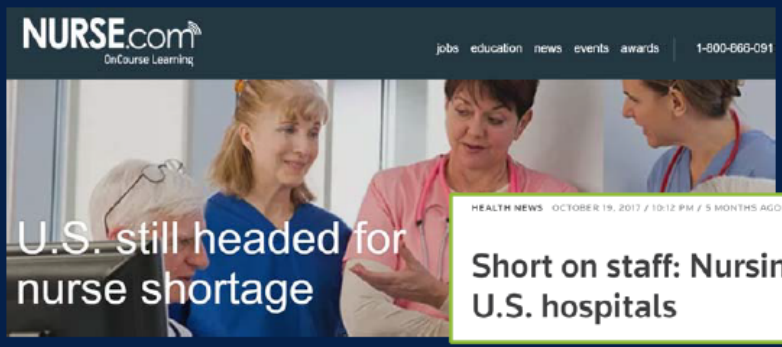


HEALTH NEWS OCTOBER 19, 2017 / 10:12 PM / 5 MONTHS AGO

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REBECCA GRANT | FEB 3, 2016 | HEALTH

COLUMNISTS 77,973 SHARES

**Is US headed for worst nursing shortage?**

By: Howard Gerber- @inquirerdotnet INQUIRER.net US Bureau / 01:51 AM November 30, 2017

2

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    - National surplus of 293,800 RNs by 2030 (8.2%)
    - Assumes supply = demand in 2014
  - Auerbach et al. 2015 – 128,000 RN shortage by 2025 (4%)
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  - NCHWA 2017 – 44,500 short (11.5%)
  - Auerbach et al. 2017 – only 0.7% per capita supply growth in Pacific region
  - Spetz 2017 – no shortage overall, but skills & regional imbalance

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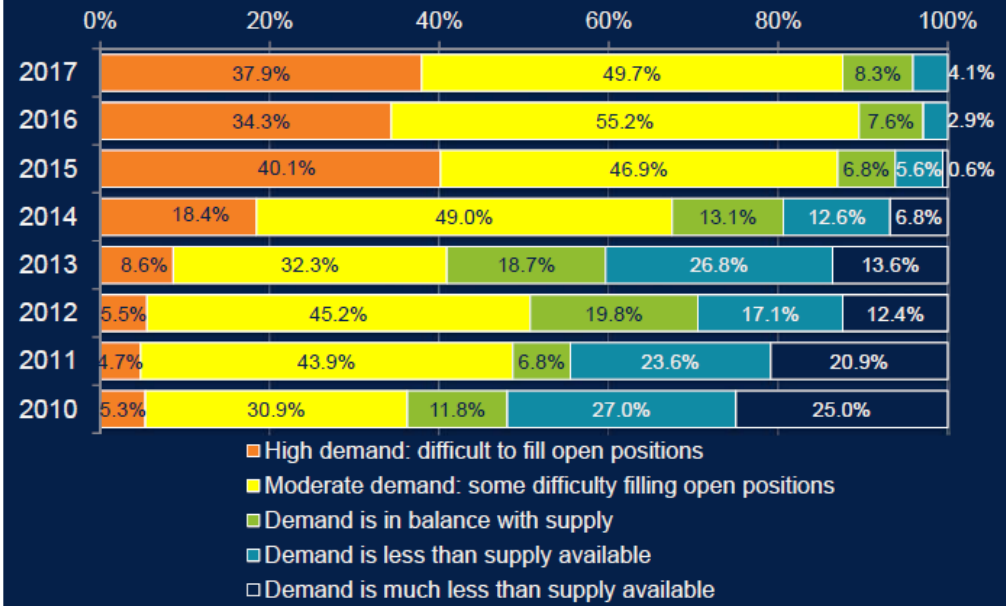
## Perceptions of employers: Overall labor market




4 Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017

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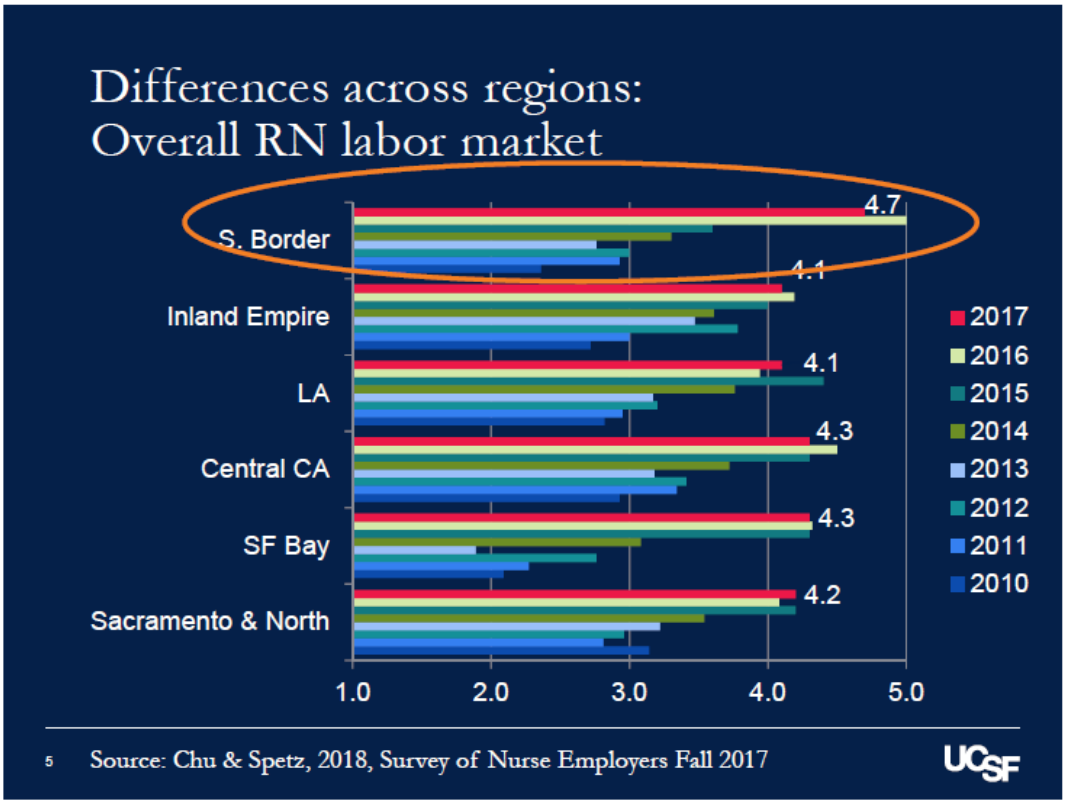
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Overall RN labor market
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Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017
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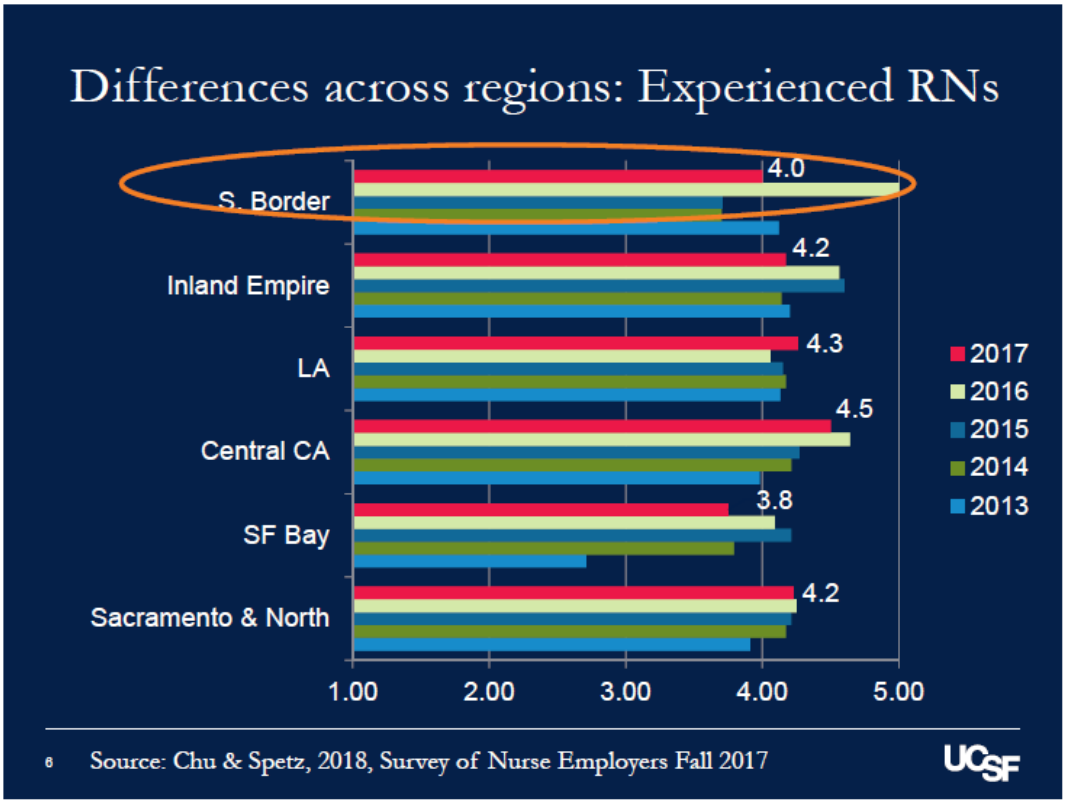
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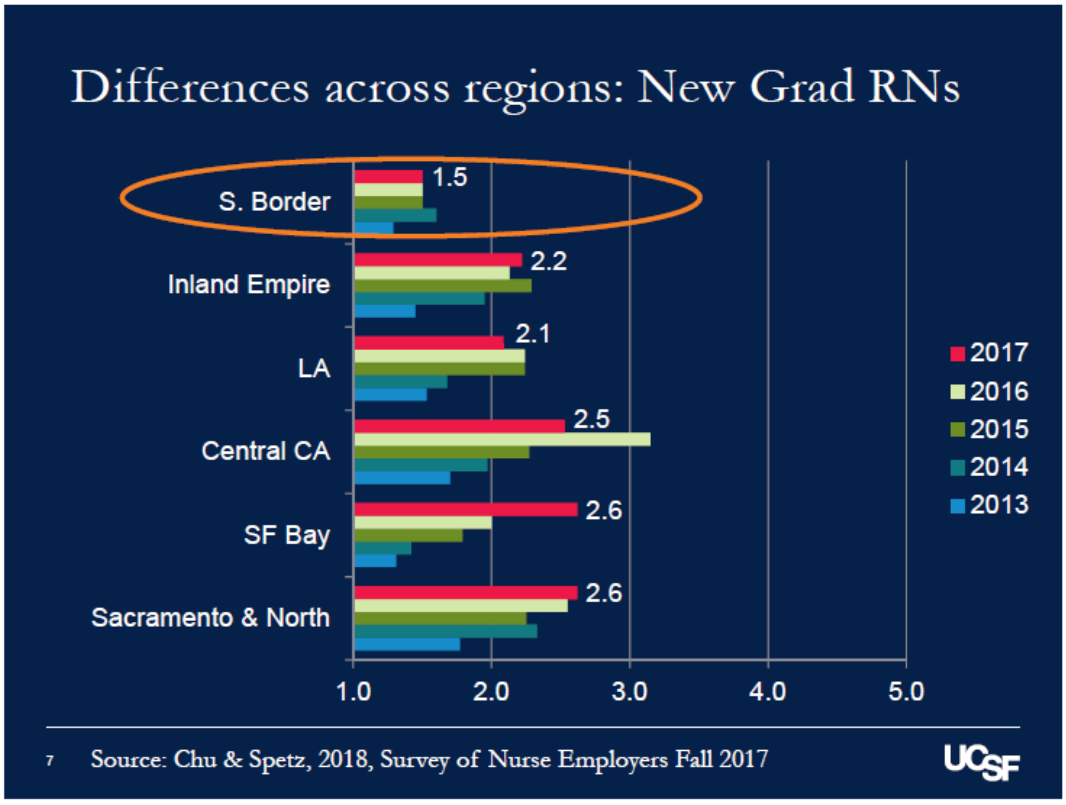
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2.1
2.5
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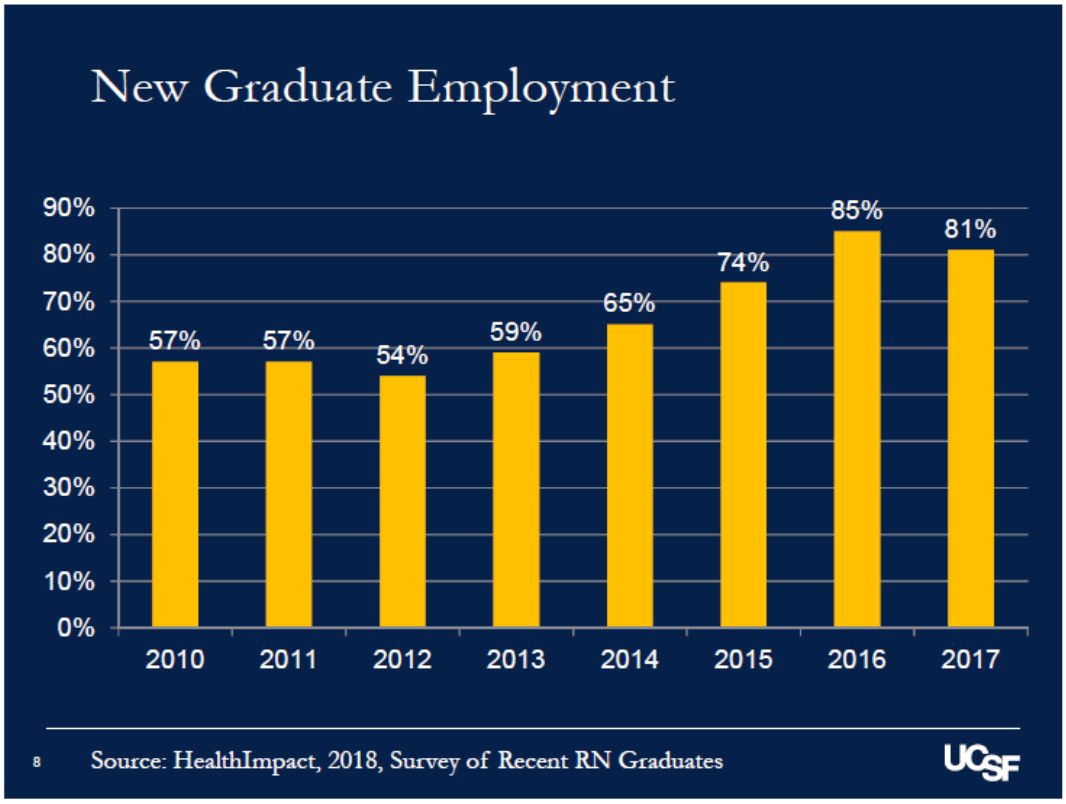
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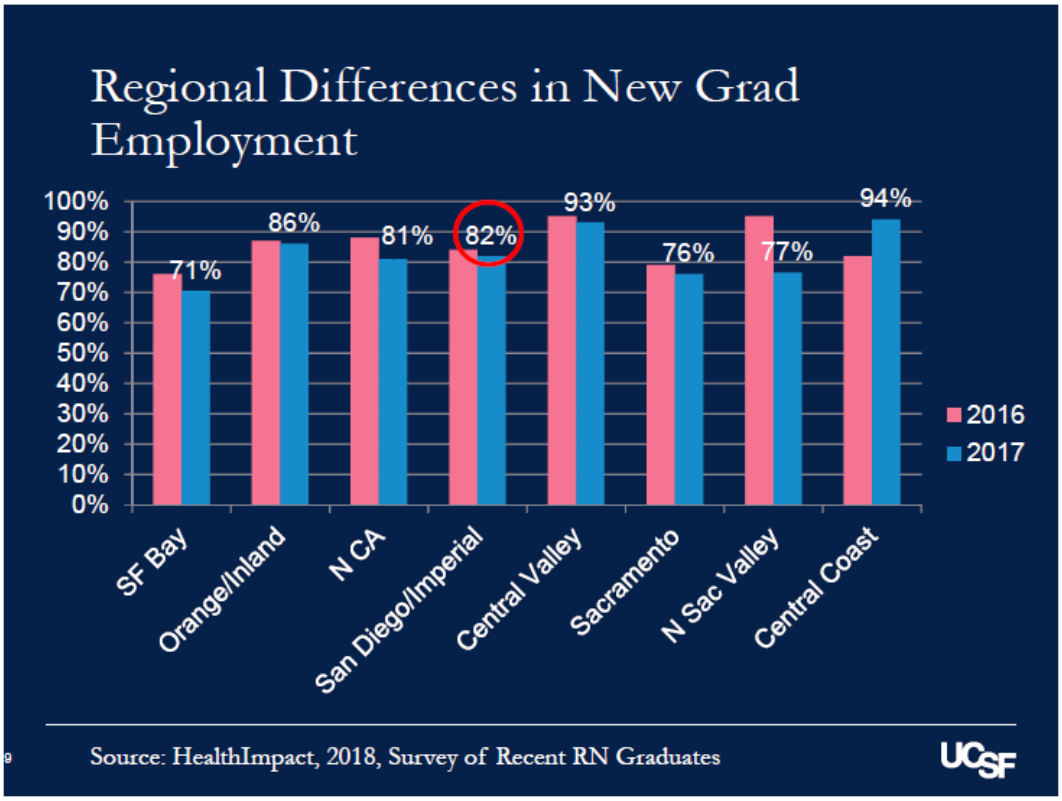
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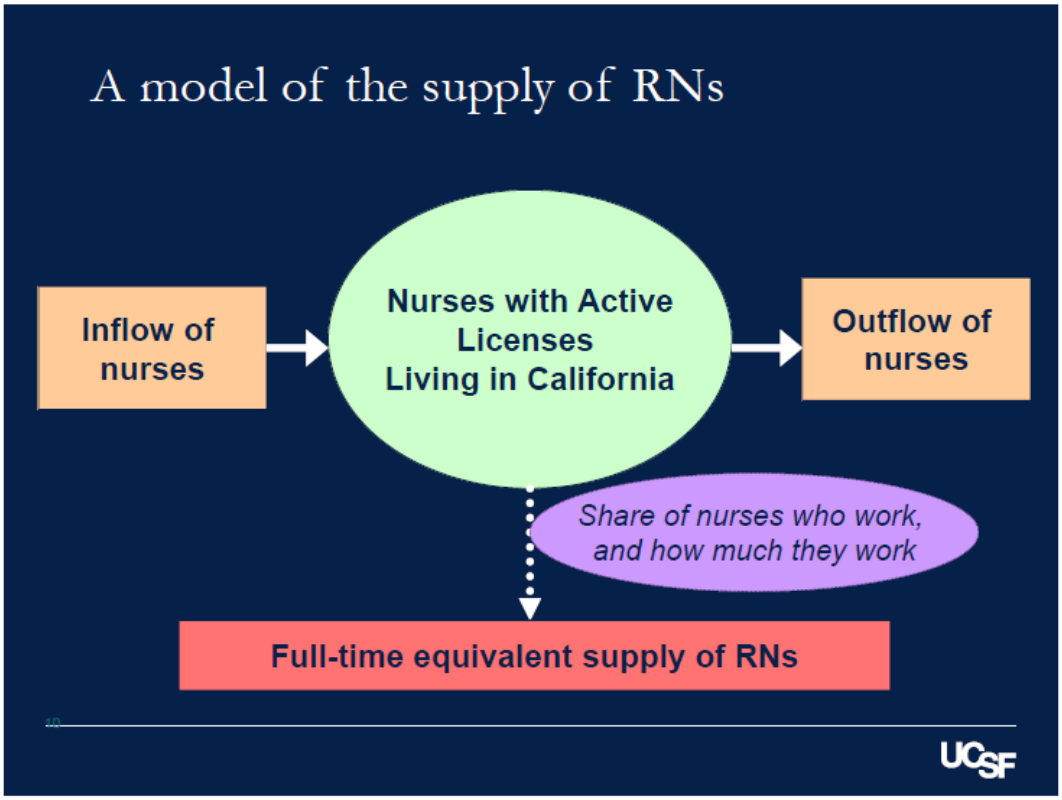
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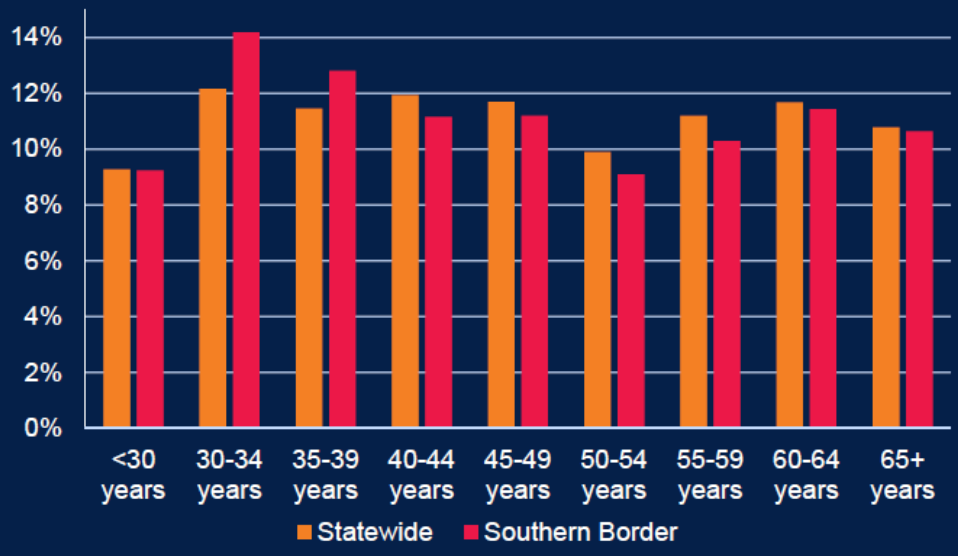


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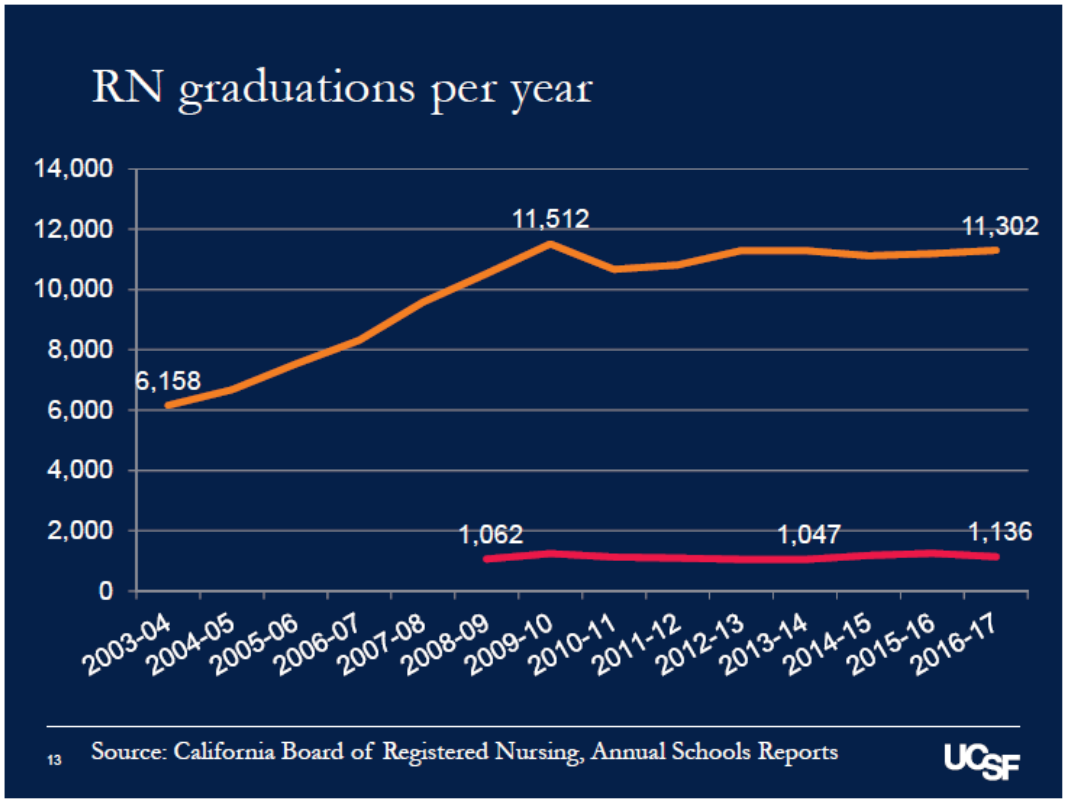
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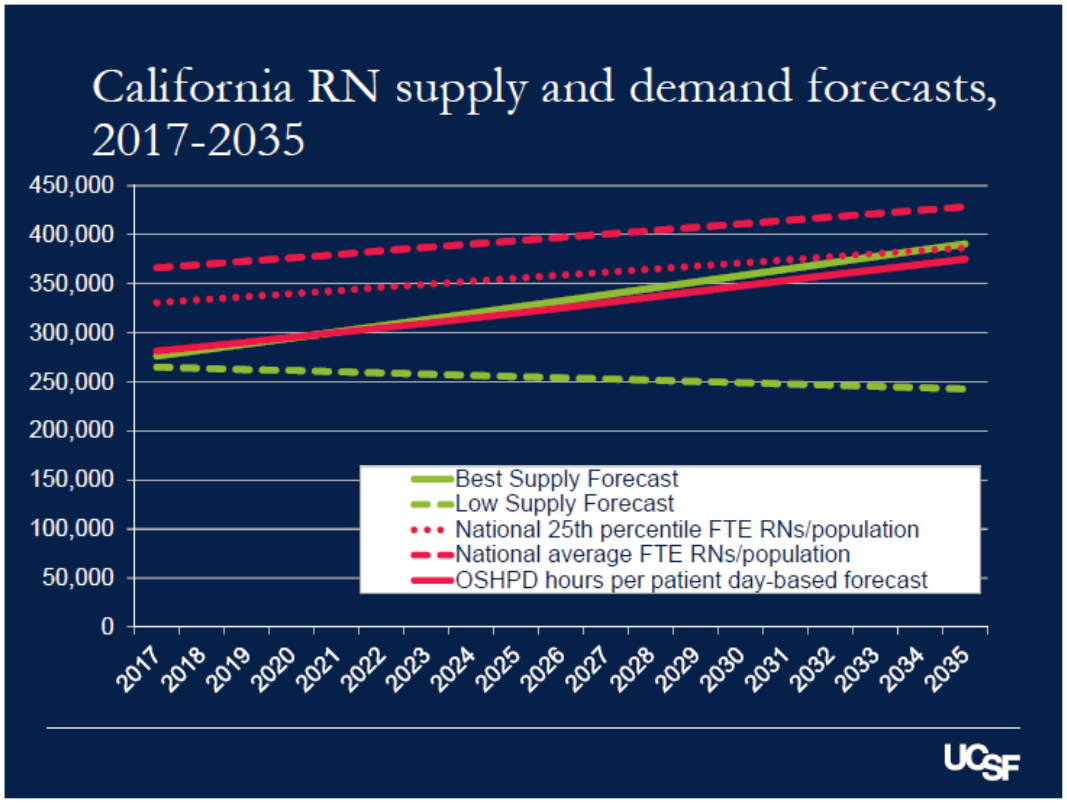
Source: California Board of Registered Nursing, Annual Schools Reports
UCSF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UCSF

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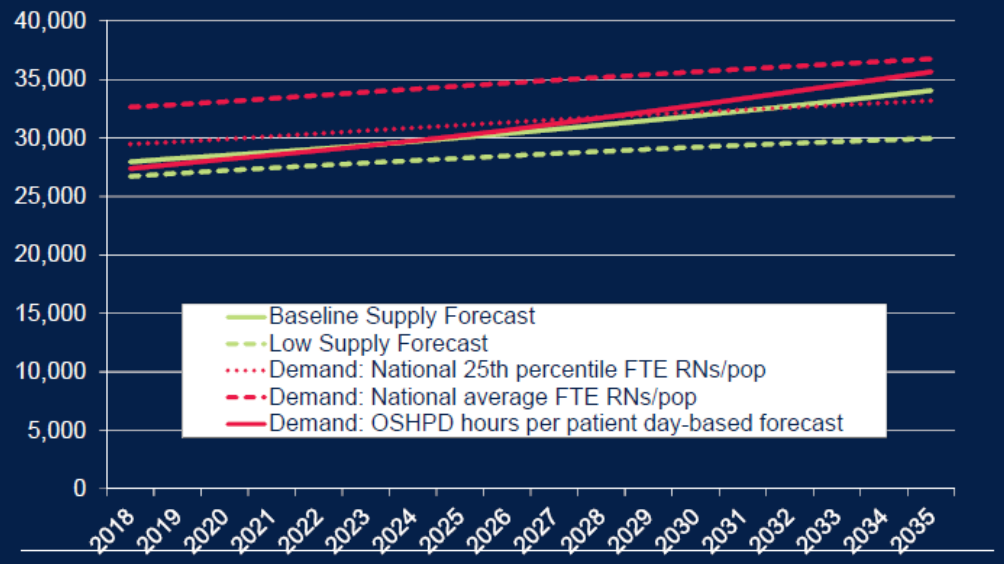
### Supply & demand forecasts for Southern Border

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Source: California Board of Registered Nursing Annual Schools Report, 2016-2017

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## Border region graduations are steady

| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
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| 2015-2016 | 1,354 | 1,350 | 1,322 | 1,250 |
| 2016-2017 | 1,394 | 1,405 | 1,345 | 1,136 |
| 2017-2018 | | 1,406 | 1,405 | 1,210 |
| 2018-2019 | | | 1,406 | 1,246 |
| 2019-2020 | | | | 1,257 |
| 2020-2021 | | | | 1,257 |

Source: California Board of Registered Nursing Annual Schools Report, 2017-2018 UCSF

## Inflows and outflows for the Border region

- Inflows = ~2,150 now
  - Graduations: ~1,200 per year
  - Migration into the region: 478 per year 2016-2018
  - Endorsements from other states: 475 in 2017
- Outflows = ~2,351 now
  - Migration out of the region: 1,139 per year 2016-2018
    - Concentrated among younger nurses
  - Lapsed licenses: 1,212 per year 2016-2018
- Conclusion: Almost perfectly balanced labor market!!

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How do we move forward?
San Diego has a very well-balanced labor market
Population growth projected & education is keeping up
Employers indicate there are too many new graduates – but the region needs them & they want to stay
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San Francisco

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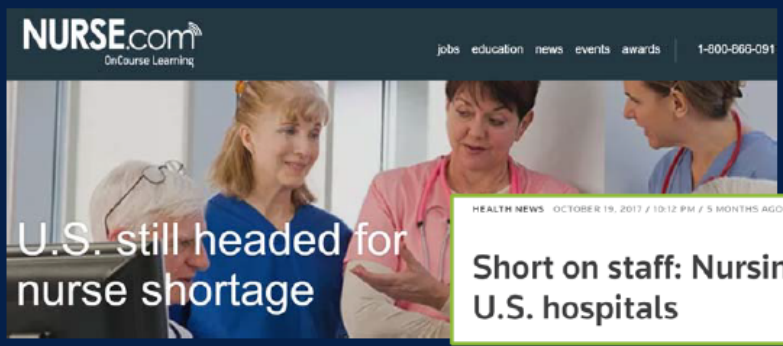


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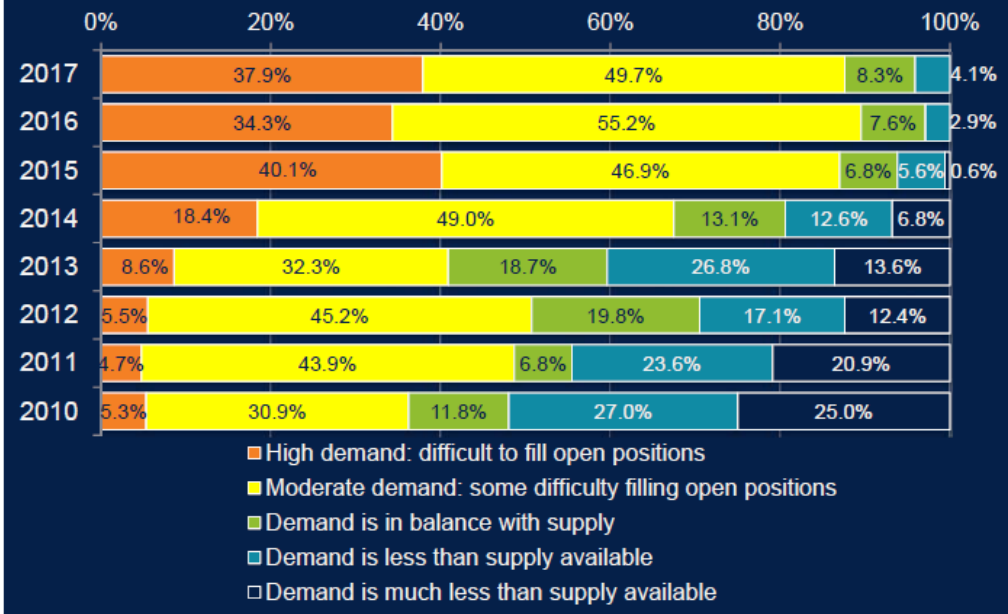


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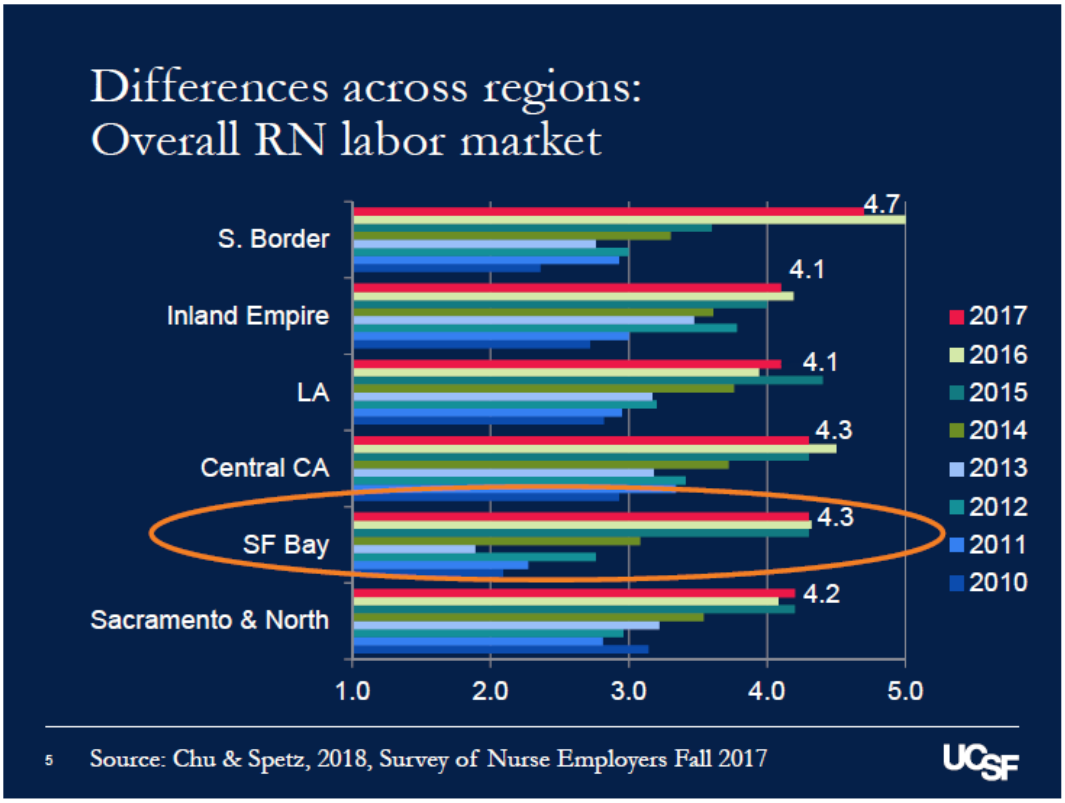
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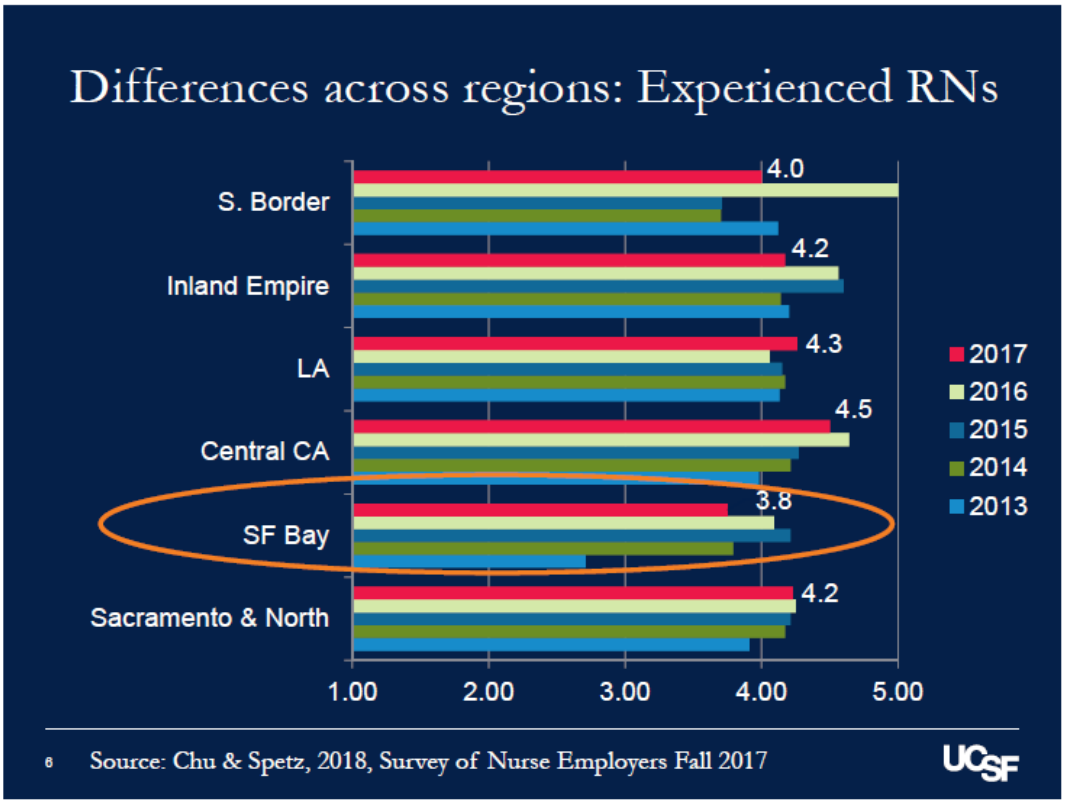
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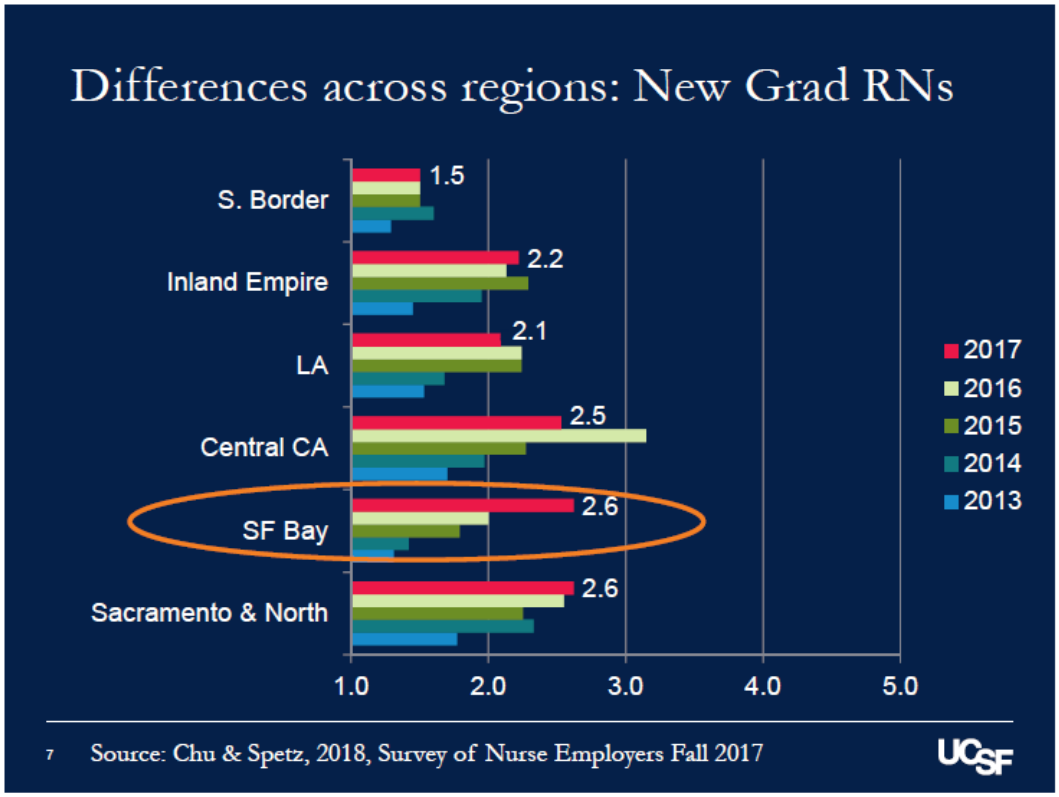
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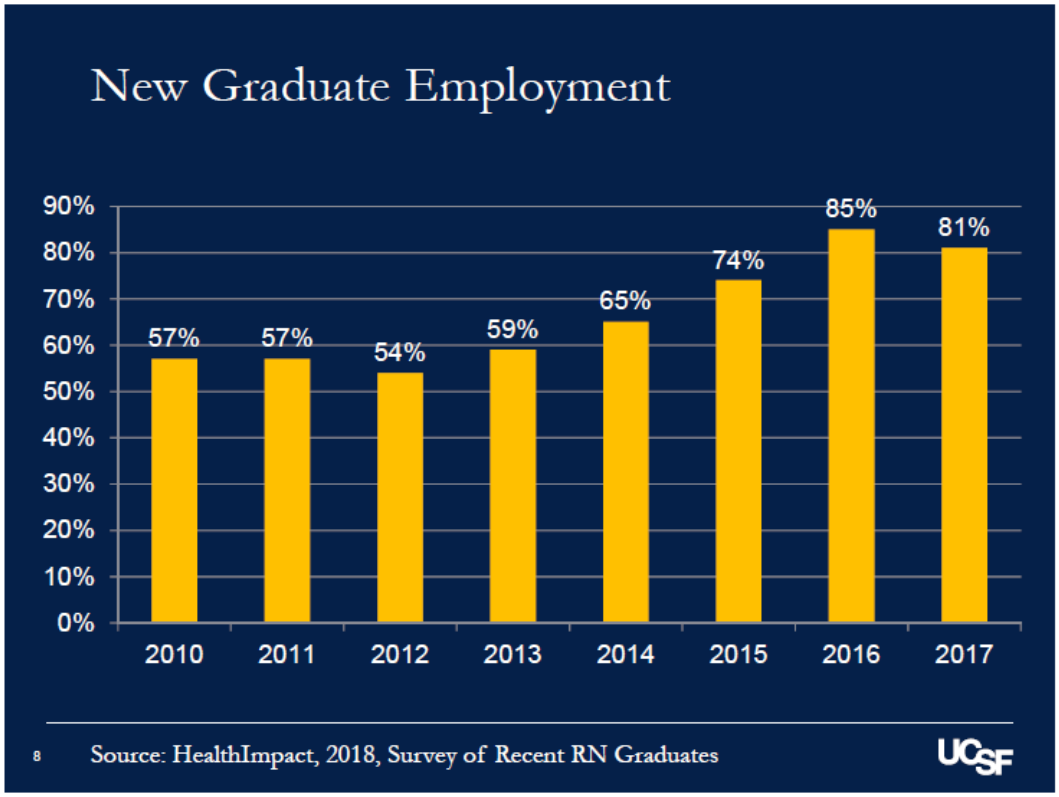
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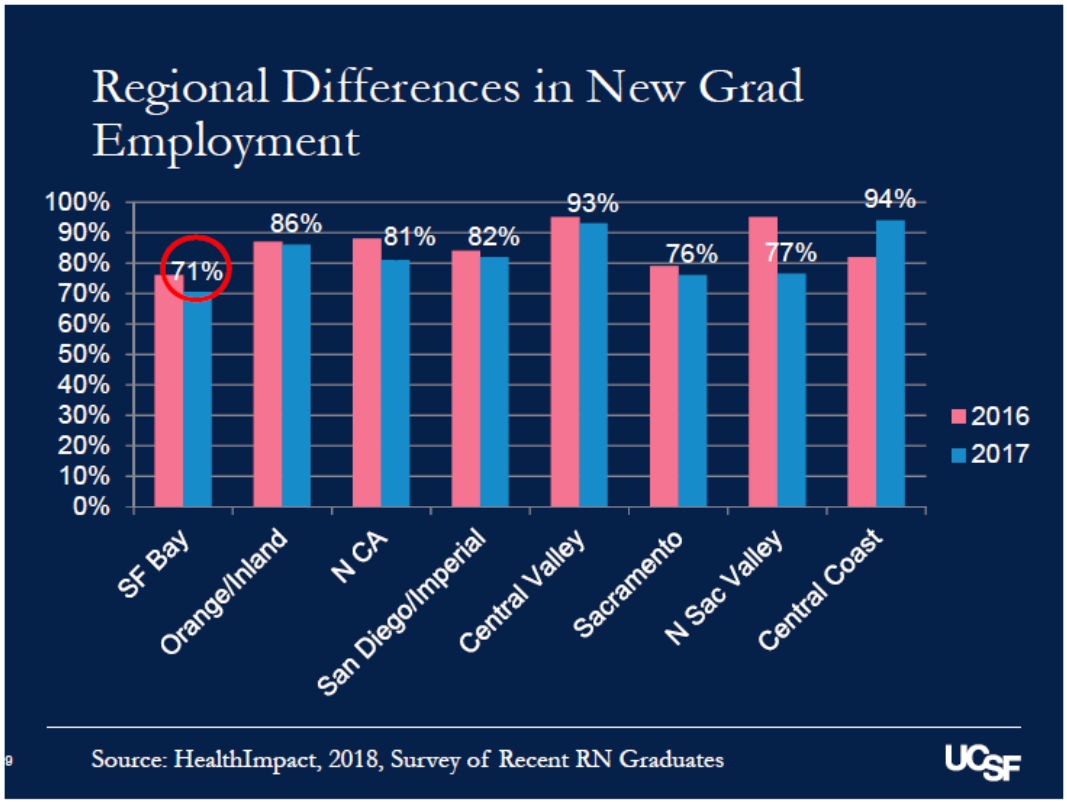
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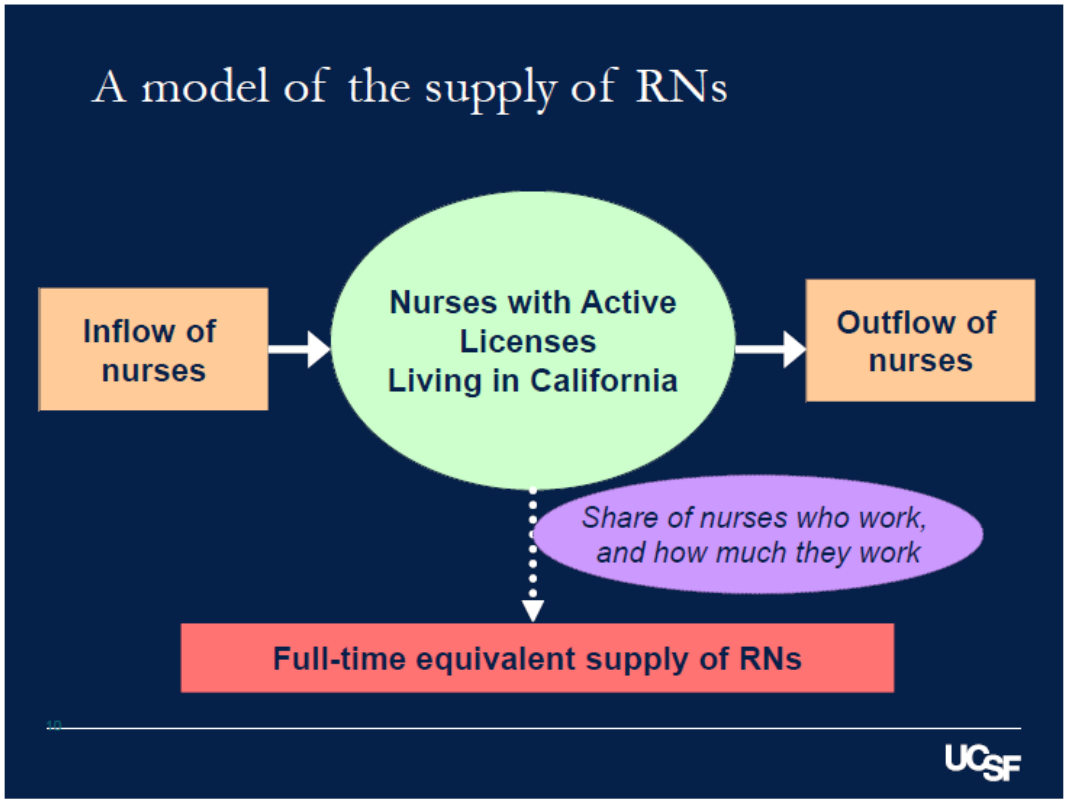
N Sac Valley
Central Coast
Source: HealthImpact, 2018, Survey of Recent RN Graduates
UCSF

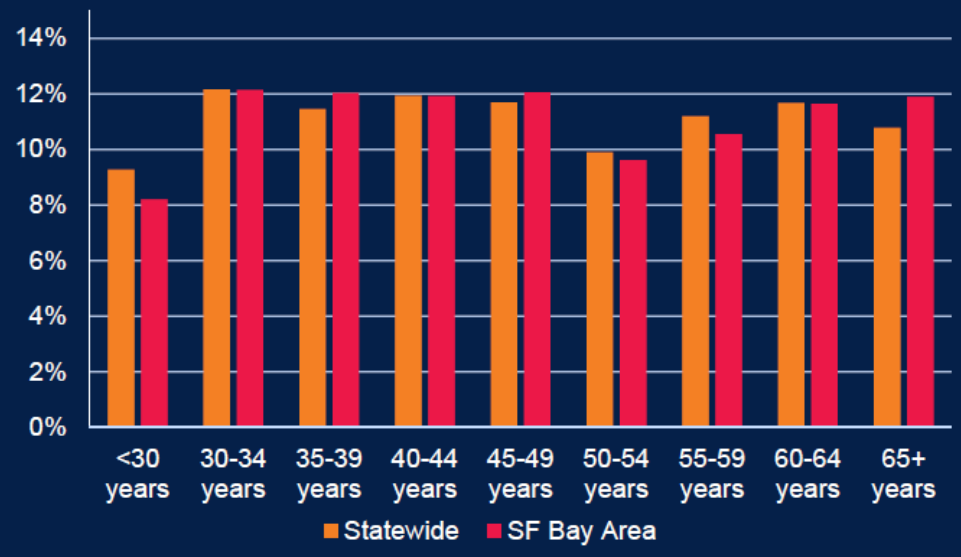

A model of the supply of RNs
Inflow of nurses
Nurses with Active Licenses Living in California
Outflow of nurses
Share of nurses who work, and how much they work
Full-time equivalent supply of RNs
UCSF

## Forecasting demand is harder

- Number of nurses per capita
  - What is the target?
    - National average?
    - Some arbitrary benchmark?
    - Estimates of how many providers are needed to provide XYZ?
- Demand-based models can be based on economic demand models
  - Easier said than done….

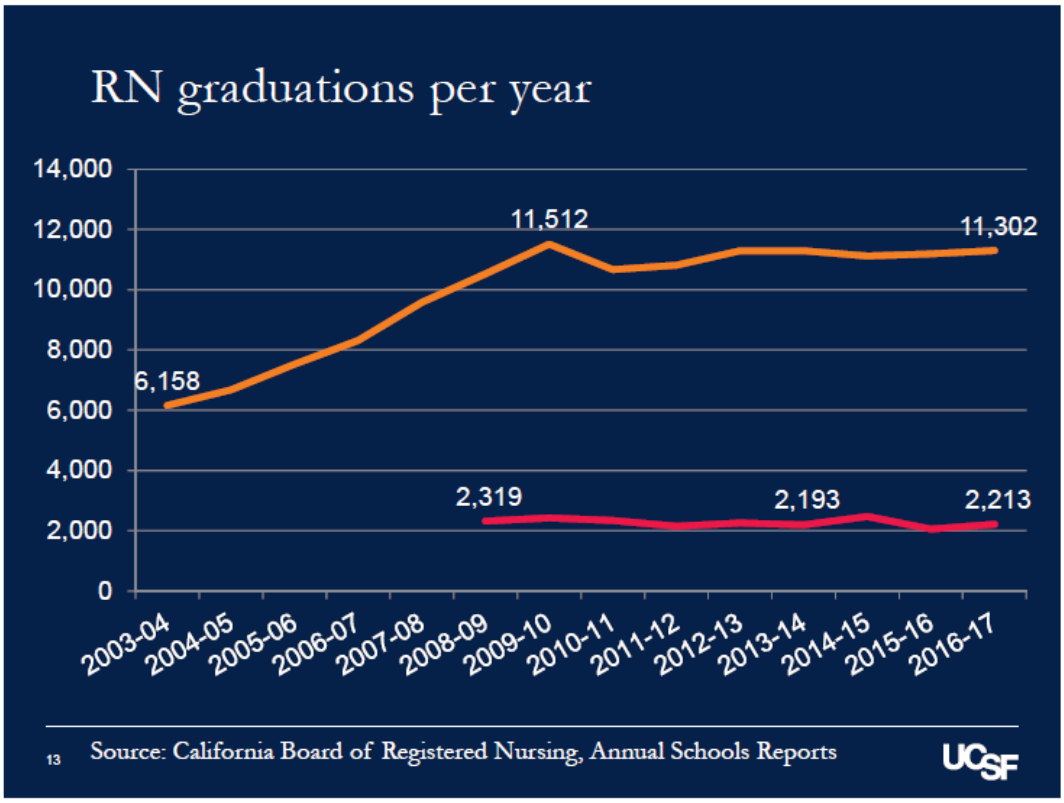
UCSF

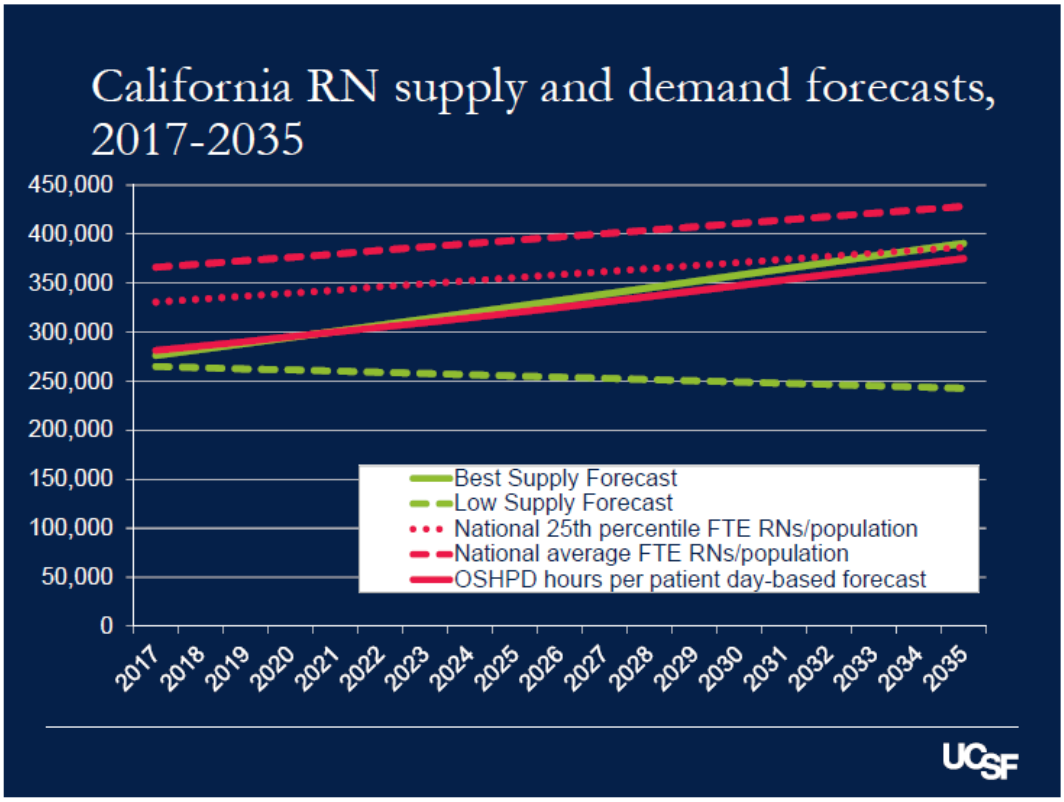
## Age distribution of licensed RNs



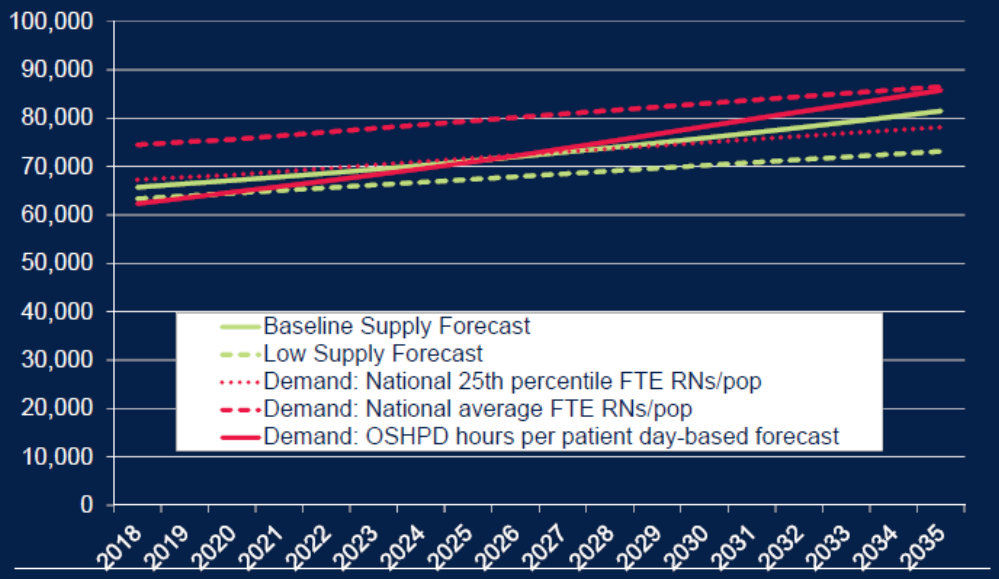

Source: Spetz et al., 2016 California Survey of RNs

UCSF


RN graduations per year
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
11,512
11,302
6,158
2,319
2,193
2,213
2003-04
2004-05
2005-06
2006-07
2007-08
2008-09
2009-10
2010-11
2011-12
2012-13
2013-14
2014-15
2015-16
2016-17
13
Source: California Board of Registered Nursing, Annual Schools Reports
UCSF


California RN supply and demand forecasts, 2017-2035
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
Best Supply Forecast
Low Supply Forecast
National 25th percentile FTE RNs/population
National average FTE RNs/population
OSHPD hours per patient day-based forecast
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
UCSF

## Regional differences are important
### Supply & demand forecasts for SF Bay Area




15

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## Statewide graduations are expected to hold steady

| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2014-2015 | 13,318 | 12,162 | 13,347 | 11,119 |
| 2015-2016 | 13,152 | 13,110 | 12,177 | 11,191 |
| 2016-2017 | | 13,862 | 13,236 | 10,761 |
| 2017-2018 | | | 14,219 | 10,627 |
| 2018-2019 | | | | 11,200 |
| 2019-2020 | | | | 11,489 |

Source: California Board of Registered Nursing Annual Schools Report, 2016-2017

UCSF

## SF Bay area graduations are growing a bit

| | New enrollment | Projected enrollment from 1 yr | Projected enrollment from 2 yrs | Graduations |
|---|---|---|---|---|
| 2015-2016 | 2,349 | 2,974 | 2,327 | 2,054 |
| 2016-2017 | 2,581 | 2,978 | 3,070 | 2,213 |
| 2017-2018 | | 2,562 | 3,028 | 2,085 |
| 2018-2019 | | | 2,618 | 2,291 |
| 2019-2020 | | | | 2,274 |
| 2020-2021 | | | | 2,324 |

Source: California Board of Registered Nursing Annual Schools Report, 2017-2018 UCSF

## Inflows and outflows for the SFBA region

- Inflows = ~3,654 now
  - Graduations: ~2,200 per year, but growing
  - Migration into the region: 791 per year 2016-2018
  - Endorsements from other states: 663 in 2017
- Outflows = ~4,120 now
  - Migration out of the region: 1,622 per year 2016-2018
  - Lapsed licenses: 2,497 per year 2016-2018
- Conclusion: Projected growth in graduations will balance inflows and outflows

18 UCSF


How do we move forward?
San Francisco Bay Area is moving toward a balanced labor market
Population growth projected & education is keeping up
Employers are more interested in new graduates than in many other regions of the state – this is good strategy
19
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# Attachment E

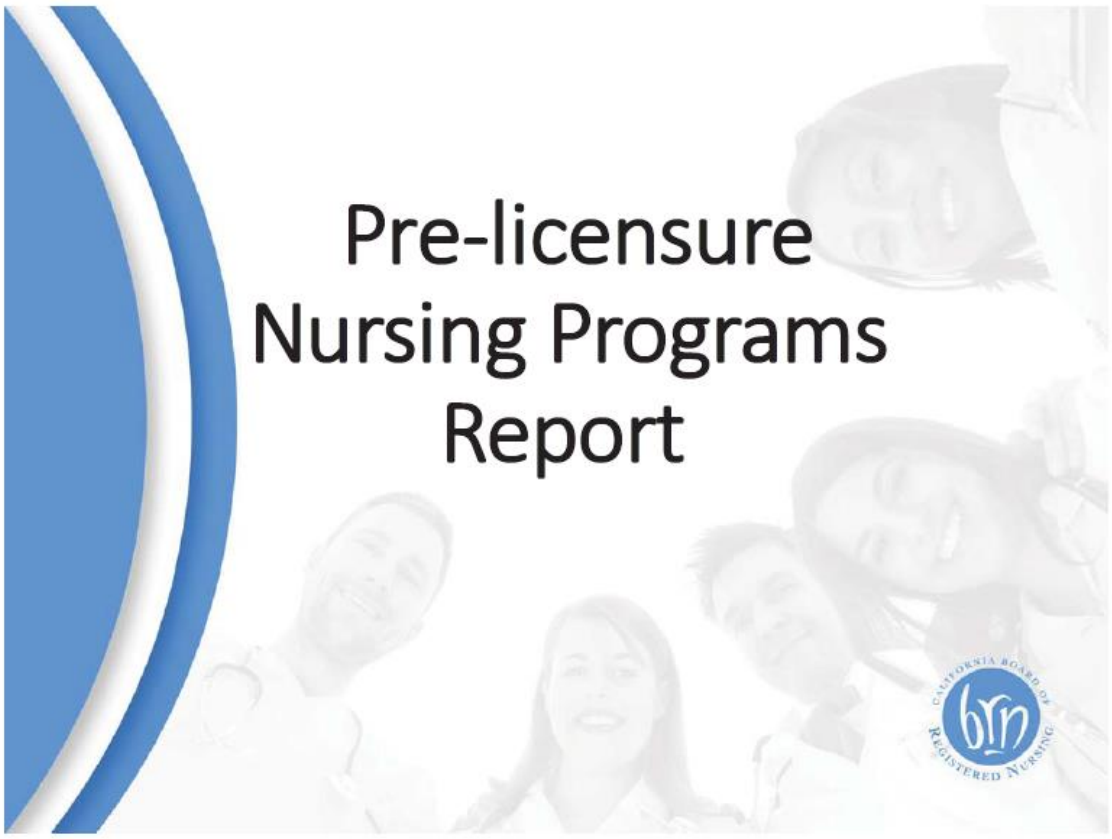
## BRN Pre-Licensure RN Clinical Education Capacity Survey Report


## Objectives:

1. Report the May 2018 survey results of Clinical Capacity/Clinical Displacement Survey as reported by California Pre-licensure Nursing Education Programs and Clinical Agencies

2. Share the reported Impact of clinical capacity issues/clinical displacement on Nursing Education Programs and Clinical Agencies

3. Highlight the proposed solutions/comments provided by Nursing Education Programs and Clinical Agencies responding to the May 2018 surveys

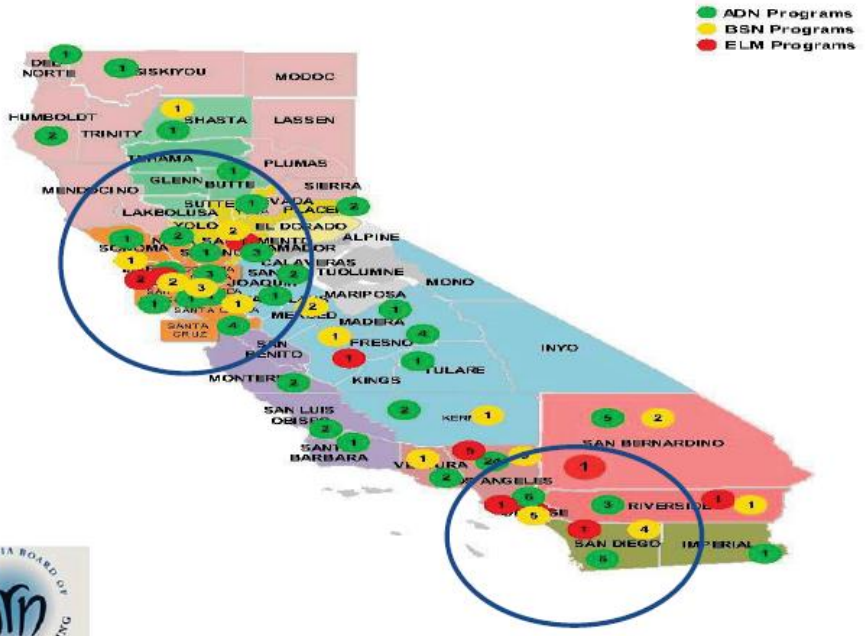



## Scope: Total Number of Pre-licensure Nursing Education Programs in California

Type of Nursing Program:

| | |
|---|---|
| Associate Degree Nursing Programs | = 91 |
| Baccalaureate Degree Nursing Programs | = 37 |
| Entry Level Master's Degree Programs | = 13 |
| Total | = 141 |

## Scope: Location of Nursing Education Program by Region




## Scope: Pre-licensure Nursing Education Programs Annual School Survey

**Trends:**

**According to trended results for the CA Annual School Survey reporting periods 2012-2017 (5 years of reported data):**

- **Total enrollment across all degree types (i.e. ADN, BSN, ELM) ranged from approximately 25,000 to 26,000 students annually**
- **Student academic year completions rates for all types of programs (AD, BSN, ELM) ranged from 11,292-11,302**

## Scope: Pre-licensure Nursing Education Programs-NCLEX-RN Passing Rates

**Trends:**

**Reporting period July 1, 2017-June 30, 2018**

- **California had a total of 11,655 first-time test takers take the NCLEX-RN Exam**
- **Overall passing rate for first-time CA testers was 90.79% vs. 87.80% US and Territories**
- **Consistently highest or second highest NCLEX passing rates for US educated first time testers when compared with other US state boards of nursing with comparable numbers of US educated first time testers on a quarterly and annual basis**

## Scope: BRN Nursing Education Programs Pertinent Statutes & Regulations

**Nurse Practice Act:**

- **All Board approved pre-licensure RN programs are required to comply with current laws:**
  - **(**Business & Professions Code 2785-2789, 2798)
  - (California Code of Regulations 1420-1432)
- **Programs are required to provide clinical experiences/hours in the five particular specialty areas:**
  - Geriatrics
  - Medical-Surgical
  - Obstetrics
  - Pediatrics
  - Psych/Mental Health
- **Clinical hours are determined by each program**
- **BRN requires a min. of 18 semester or 27 quarter units for clinical practice**

## Scope: Sample of Current Pre-licensure Nursing Programs (ADN)

| Quarter or Semester | Degree type | Weeks | Theory | Clinical | Clinical Hours | Total Units | Communication | Science | Total for licensure | Total for graduation | 2017-2018 NCLEX |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | ADN | 10 | 34 | 28 | 840 | 62 | 9 | 24 | 95 | 99 | 74.63% |
| Semester | ADN | 16.4 | 21 | 26 | 1279.2 | 47 | 6 | 24 | 77 | 87 | 94.03% |
| Quarter | ADN | 10 | 31.5 | 30.2 | 906 | 62 | 10 | 25 | 97 | 108 | 71.93% |
| Semester | ADN | 17 | 21 | 20 | 1020 | 51 | 6 | 23 | 80 | 88 | 94.68% |
| Quarter | ADN | 10 | 32 | 29 | 870 | 61 | 10 | 30 | 101 | 116 | 98.04% |
| Semester | ADN | 17.5 | 20 | 23 | 1207.5 | 43 | 7 | 18 | 68 | 80 | 96.10% |
| Quarter | ADN | 12 | 28.5 | 30.5 | 1098 | 59 | 13 | 37 | 109 | 125 | 91.67% |
| Semester | ADN | 18 | 21.75 | 22.75 | 1228.5 | 44.5 | 6 | 22 | 72.5 | 77.5 | 100% |
| Quarter | ADN | 10 | 40 | 30 | 900 | 70 | 9 | 30 | 107 | 118 | 91.92% |
| Quarter | ADN | 10 | 49.5 | 28.5 | 855 | 78 | 9 | 28.5 | 116 | 119.5 | 100% |
| Semester | ADN | 16 | 21 | 21 | 1008 | 42 | 7 | 24 | 73 | 80 | 100% |
| Semester | ADN | 18 | 27 | 21.5 | 1161 | 48.5 | 6 | 30 | 84.5 | 89.5 | 96.88% |

- **Theory and Clinical Units: 18 Semester or 27 Quarter Units**
- **Clinical Hours: 1 Semester or Quarter Unit:**
  **3 Practice Clinical Hours x Number of Weeks in the Semester /Quarter**

## Scope: Sample of Current Pre-licensure Nursing Programs (BSN & ELM)

| Quarter or Semester | Degree type | Weeks | Theory | Clinical | Clinical Hours | Total Units | Communication | Science | Total for licensure | Total for graduation | 2017-2018 NCLEX |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter | BSN | 10 | 50 | 39 | 1170 | 89 | 15 | 40 | 144 | 189 | 94.64% |
| Semester | BSN | 15 | 28 | 22 | 990 | 6 | 50 | 25 | 81 | 120 | 86.92% |
| Semester | BSN | 15 | 27 | 24.5 | 1102.5 | 81.5 | 9 | 22 | 82.5 | 132.5 | 91.49% |
| Semester | BSN | 15 | 38 | 22 | 990 | 90 | 12 | 31 | 103 | 129 | 90.14% |
| Semester | BSN | 15 | 30 | 21 | 945 | 1 | 6 | 27 | 84 | 120 | 92.00% |
| Semester | BSN | 16 | 20 | 25 | 1200 | 5 | 9 | 32 | 86 | 130 | 93.77% |
| Semester | BSN | 15 | 38 | 23 | 1035 | 61 | 9 | 20 | 90 | 120 | 87.18% |
| Quarter | BSN | 10 | 38 | 30 | 900 | 68 | 12 | 35 | 115 | 185 | 94.00% |
| Semester | BSN | 15 | 39 | 20 | 900 | 59 | 6 | 21 | 86 | 120 | 97.22% |
| Semester | ELM | 15 | 35 | 22 | 990 | 57 | 9 | 28 | 94 | 131 | 83.78% |
| Quarter | ELM | 10 | 66 | 28 | 840 | 94 | 11 | 27 | 131 | 180 | 97.73% |

## Scope: Clinical Capacity vs. Clinical Displacement

**Definition:**

- **Clinical Displacement**: A student or a cohort of students enrolled in a nursing education program and placed in a site to gain clinical experience who are **replaced** by a **student and/or cohort of students** from another nursing education program for a shift, unit, entire placement or fewer preceptorships

- **Clinical Capacity**: Sufficient **supply and demand** of safe competent RN nursing education program graduates to meet California's **workforce needs** now and in the future

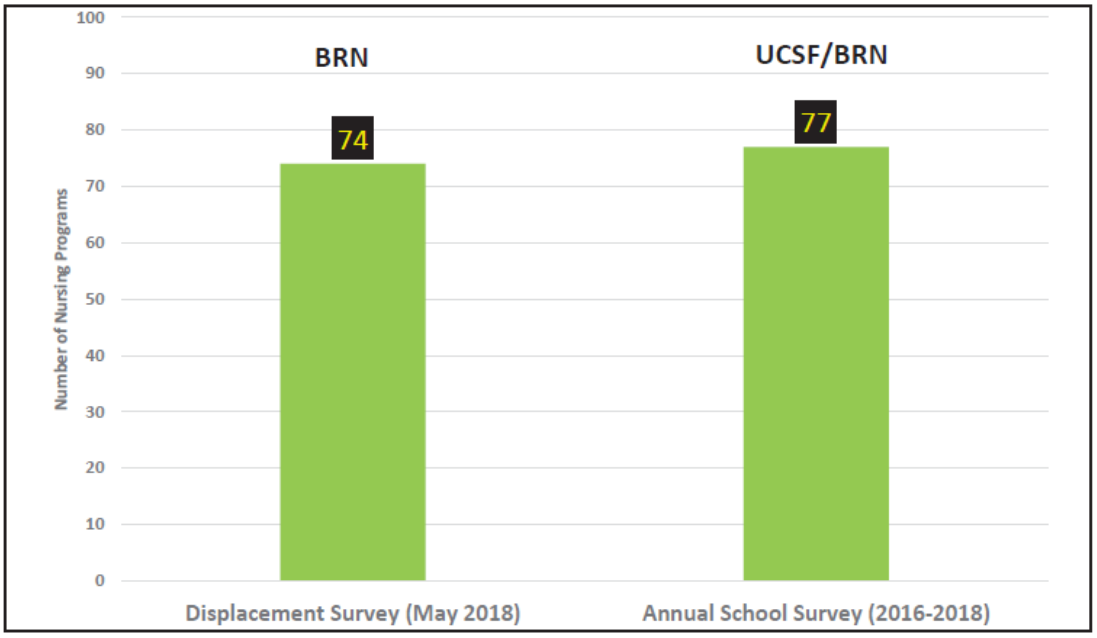
## Scope: May 2018 Survey Results from Nursing Education Programs

**Survey:**

- A 27-item
- Online link was sent to **141** Pre-licensure RN education programs
- A total of **134** programs responded:
  - **91** ADN
  - **30** BSN
  - **13** ELM programs

- *Note: some survey respondents included schools/programs that offer more than one degree option*

## Scope: Comparison of Annual School Survey and Displacement Survey




## Scope: Regions Where Nursing Education Programs reported Highest Number of Denied Clinical Spaces

**Ranking of Counties:**

1. **LA Area:** Los Angeles & Ventura
2. **Inland Empire**: Orange, Riverside, & San Bernardino
3. **Bay Area:** Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, & Sonoma
4. **Southern Border:** Imperial and San Diego

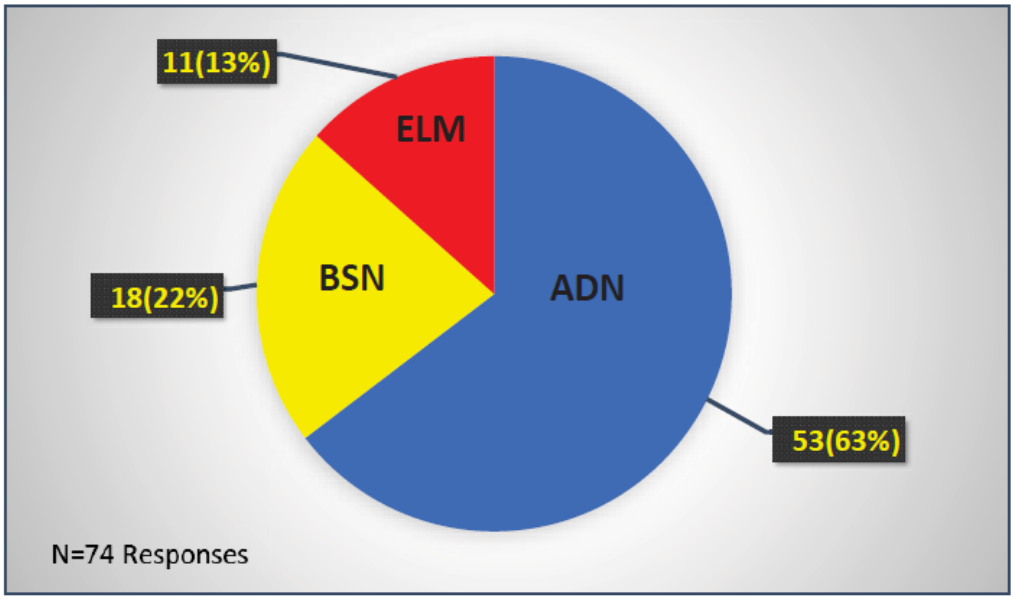
## Scope: Total Number of Reported Clinical Displacements by Counties

| County | # of Displacements | County | # of Displacements |
|---|---|---|---|
| LASSEN | | SISKIYOU | |
| LOS ANGELES | 23 | SOLANO | 2 |
| MADERA | | SONOMA | 2 |
| MARIN | 2 | STANISLAUS | 2 |
| MARIPOSA | | SUTTER | |
| MENDOCINO | | TEHAMA | |
| MERCED | | TRINITY | |
| MODOC | | TULARE | |
| MONO | | TUOLUMNE | |
| MONTEREY | 1 | VENTURA | 1 |
| NAPA | 1 | YOLO | |
| NEVADA | | YUBA | |

N = 99 responses

| County | #of Displacements | County | # of Displacements |
|---|---|---|---|
| ALAMEDA | 4 | ORANGE | 12 |
| ALPINE | | PLACER | 1 |
| AMADOR | | PLUMAS | |
| BUTTE | 1 | RIVERSIDE | 1 |
| CALAVERAS | | SACRAMENTO | 7 |
| COLUSA | | SAN BENITO | |
| CONTRA COSTA | 3 | SAN BERNARDINO | 9 |
| DEL NORTE | | SAN DIEGO | 11 |
| EL DORADO | 1 | SAN FRANCISCO | 3 |
| FRESNO | 1 | SAN JOAQUIN | 3 |
| GLENN | | SAN LUIS OBISPO | |
| HUMBOLDT | | SAN MATEO | 2 |
| IMPERIAL | | SANTA BARBARA | |
| INYO | | SANTA CLARA | 2 |
| KERN | 3 | SANTA CRUZ | |
| KINGS | | SHASTA | 1 |
| LAKE | | SIERRA | |
| LASSEN | | SISKIYOU | |

## Scope: Percentage & Number of Programs That Experienced Displacement August 1, 2016-July 1, 2017



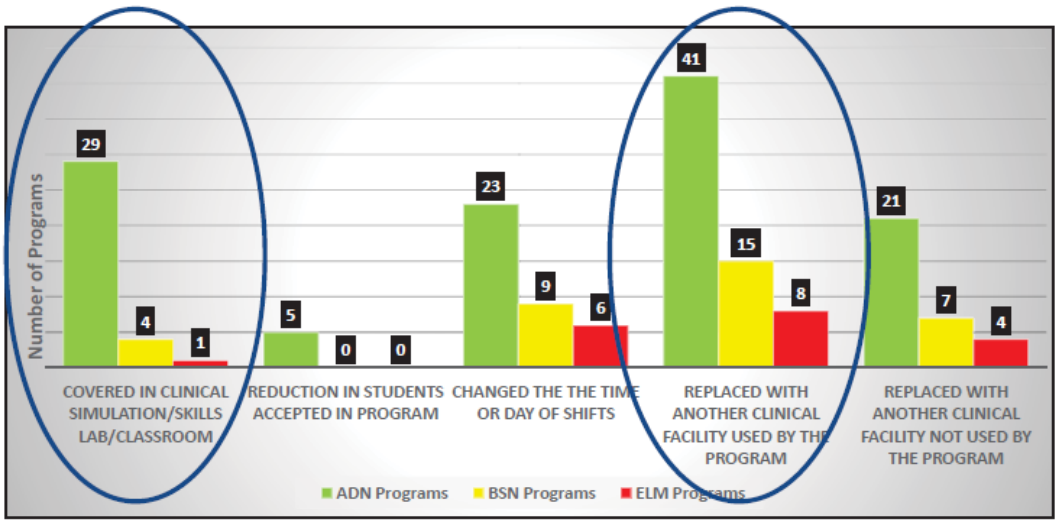

## Scope: Top 3 Ranked Clinical Areas Nursing Education Programs Reported Displacement

| | Med-Surg. | Pediatrics | Psych | ICU/CCU | Obstetrics |
|---|---|---|---|---|---|
| ADN | 27 (**Rank-1**) | 13 (Rank-2) | 6 (Rank-3) | | |
| BSN | 5 (**Rank-1**) | 6 (Rank-2) | | 2 (Rank-3) | |
| ELM | 3 (Rank-2) | 4 (**Rank-1**) | 1 (Rank-3) | | 1 (Rank-3) |

## Scope: Programs Most Common Perceived Reasons for Clinical Displacement

| N = 144 Responses | ADN | BSN | ELM |
|---|---|---|---|
| Decrease in patient census or volume of care | 5 | 3 | ★ 5 |
| Closure or consolidation of units within the organization | 16 | 2 | 2 |
| Clinical RN staff workload, fatigue, or other internal practice issues | 18 | ★ 16 | 4 |
| Need to distribute fewer students per unit/area and/or utilize more units/areas per student cohort group due to clinical staff workload/pace | 5 | 5 | 1 |
| Need to distribute fewer students per unit/area and/or utilize more units/areas per student cohort group due to limited/variable level of clinical staff experience, number of newly licensed/newly hired RN's or staff vacancies | 9 | 3 | 3 |
| Accepting more students from one or more existing clinical program(s) historically affiliated with hospital (growth in selected existing program(s) impacting placement capacity for other affiliated schools | ★ 23 | 4 | 0 |
| Administrative decision to shift or redistribute available clinical educational opportunities from one or more ADN program(s) to one or more BSN or ELM programs consistent with hiring needs/practices/Magnet designation or decision to recruit/hire RN's with a minimum of a BSN required | 18 | 1 | 1 |

## Solutions: Most Frequent Ways Nursing Programs Addressed Lost/Denied Clinical Placements




N = 173 Responses

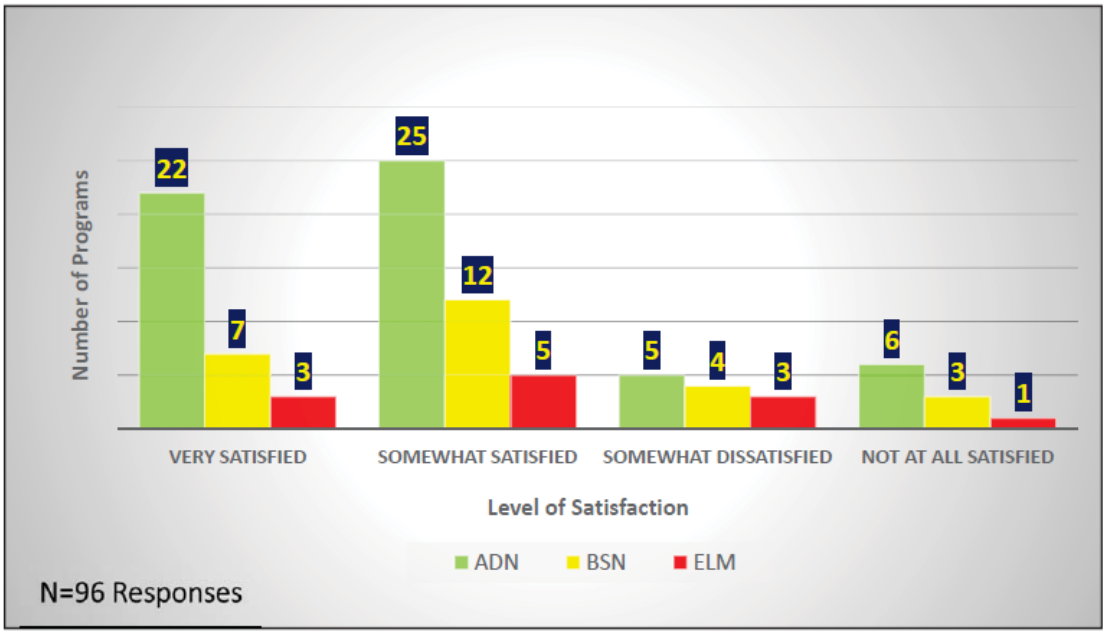
**ADN reported use of simulation/skills lab significantly more than BSN & ELM**

## Solutions: Nursing Education Programs Use of Clinical Consortiums/Clinical Placement Systems

| Consortium Name | ADN | BSN | ELM |
|---|---|---|---|
| Health Community Forum Greater Sacramento | 5 | 3 | 1 |
| CCPS (Bay Area) | 14 | 3 | 3 |
| CCPS (San Joaquin Valley) | 6 | 0 | 0 |
| CCPS (Bakersfield) | 1 | 1 | 0 |
| CCPS (Los Angeles) | 11 | 1 | 2 |
| CCPS (Long Beach) | 7 | 6 | 0 |
| My Clinical Exchange | 1 | 1 | 0 |
| Orange County Long Beach Consortium | 7 | 6 | 2 |
| Inland Empire Healthcare Education Consortium | 3 | 1 | 1 |
| Inland Empire Clinical Placement Consortium for Nursing | 1 | 0 | 0 |
| San Diego Nursing and Allied Health Education Consortium | 6 | 4 | 3 |
| Total | 62 | 26 | 12 |

**Note: 6-7 different type of student clinical placement/consortium systems for formal and informal placement decisions**

## Solutions: Nursing Programs Satisfaction Levels With Consortiums/Clinical Placement Systems



## Solutions: Nursing Education Programs Reasons for Not Participating in Consortium(s)/Clinical Planning Systems

**Qualitative Responses:**

- **Fees not affordable**
- **Difficult to use**
- **Lack of knowledge**
- **Historical placements not approved**
- **Not all hospitals belong to the consortium**
- **Not all areas regularly meet or have a consortium**

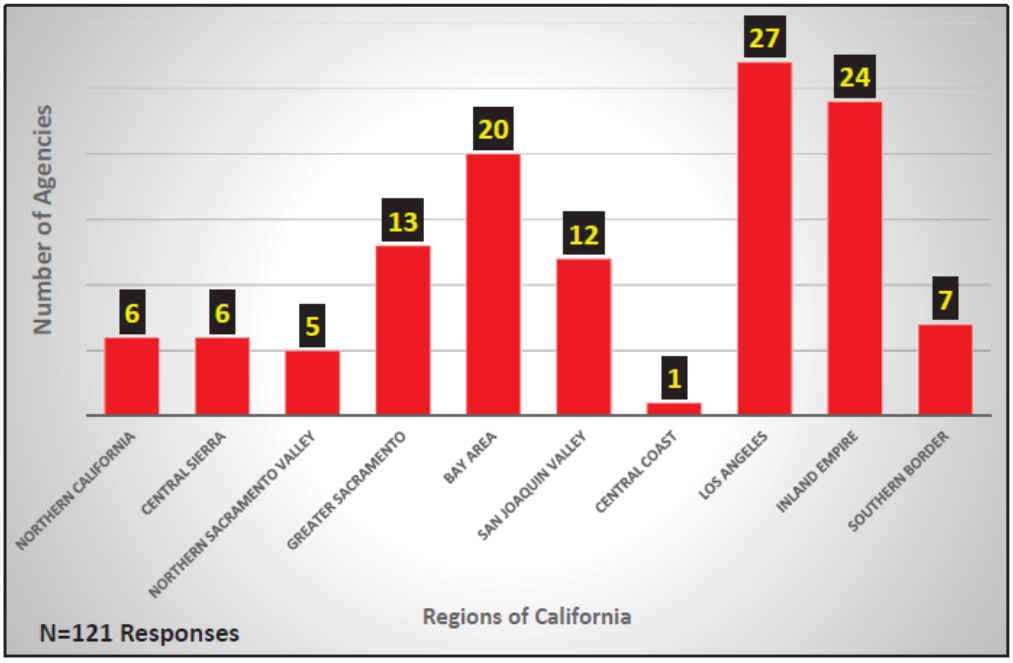
## Clinical Agencies Report

## Scope: Clinical Agencies Report

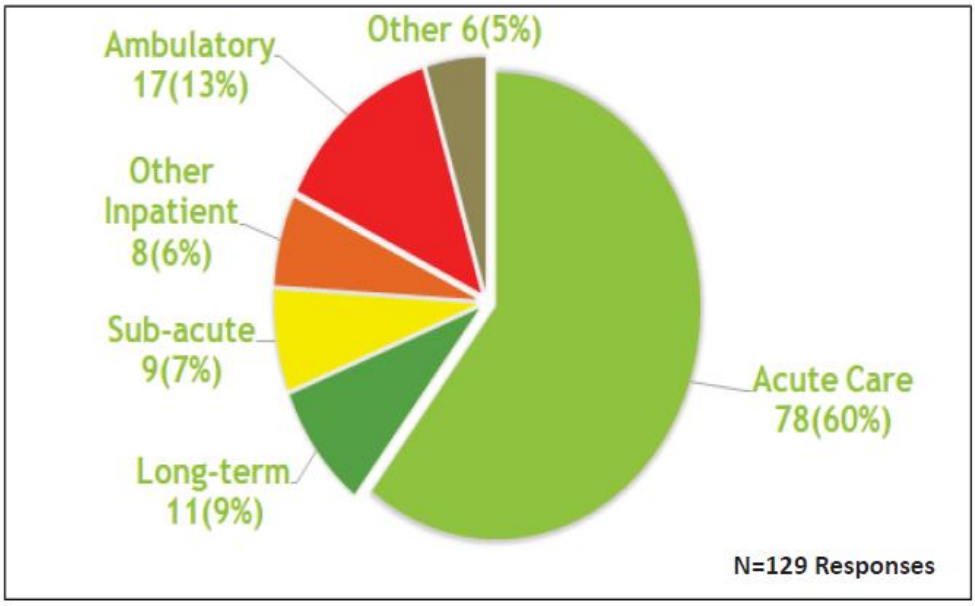
**Background**

- About 400 clinical agencies were invited to participate in the online survey
- 91 responded to the 30-items survey
- Majority (78) of clinical agencies were identified as an acute care facility
- Note:
  - Not all agencies responded to all the questions
  - Some agencies had multiple responses to the questions

## Scope: Clinical Agencies that Responded to Survey By Region

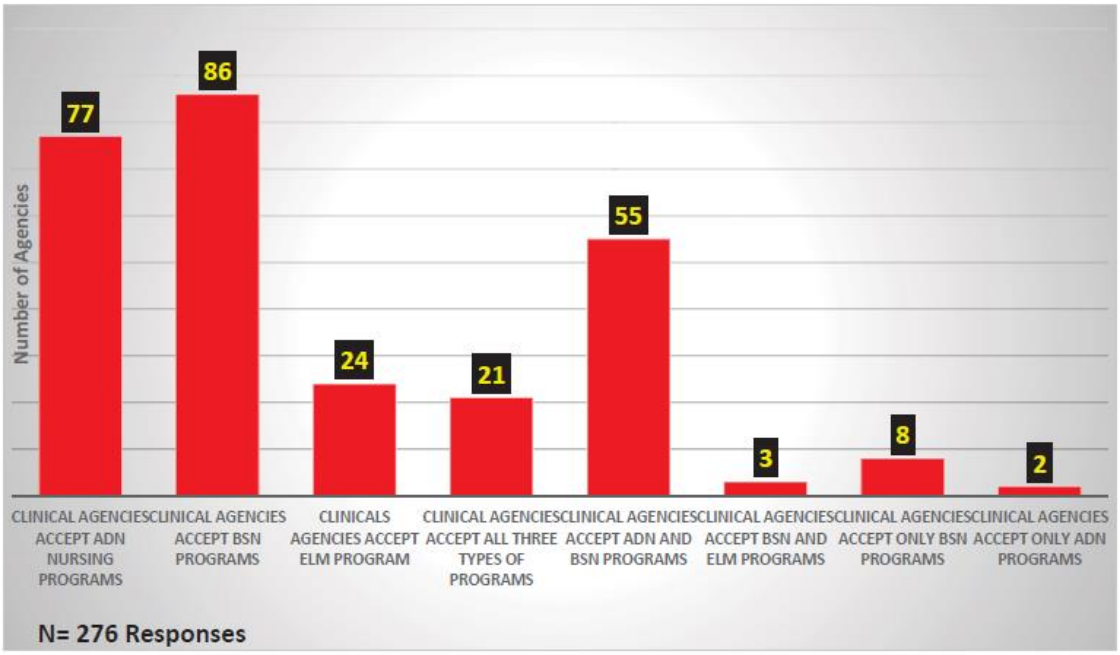


## Scope: Types of Services Clinical Agencies Provide

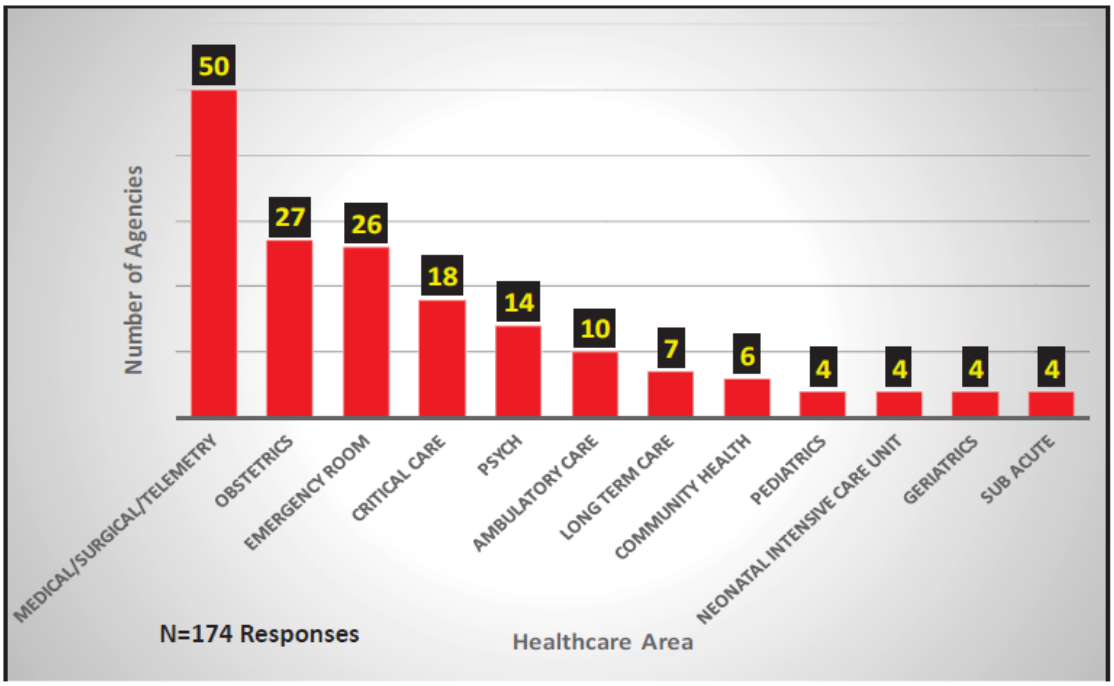



*This slide illustrates the variety of clinical placement opportunities available to students

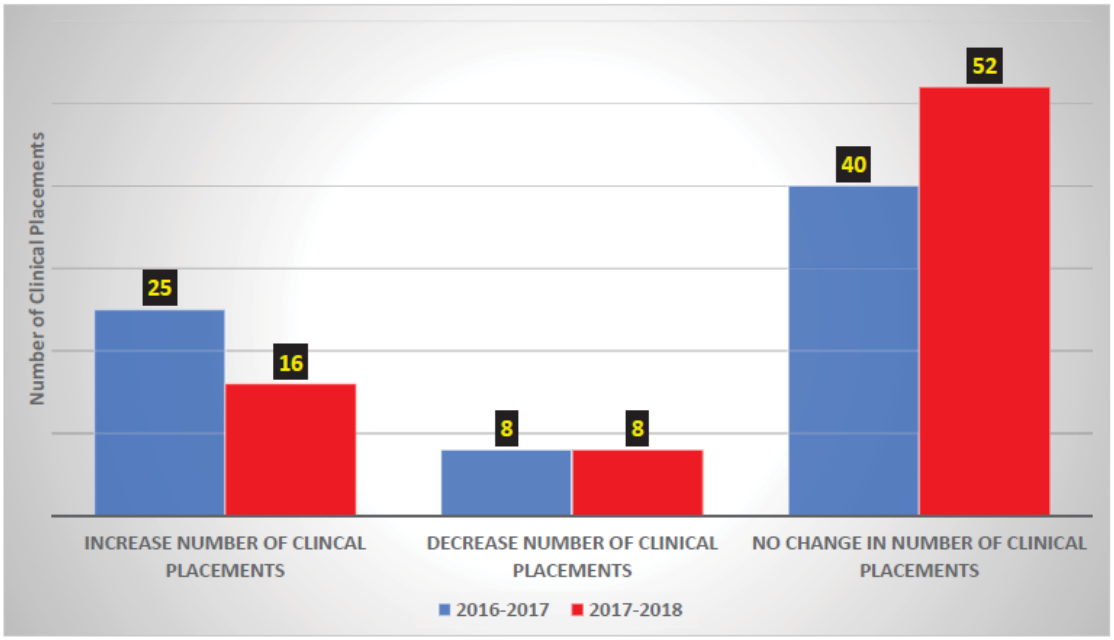
## Scope: Types of Nursing Education Programs Accepted by Clinical Agencies



## Scope: Clinical Agencies Report of Greatest Areas in Demand From Schools




## Impact: Changes in Clinical Agencies Number of Placements Provided by Academic Years 2016-2018

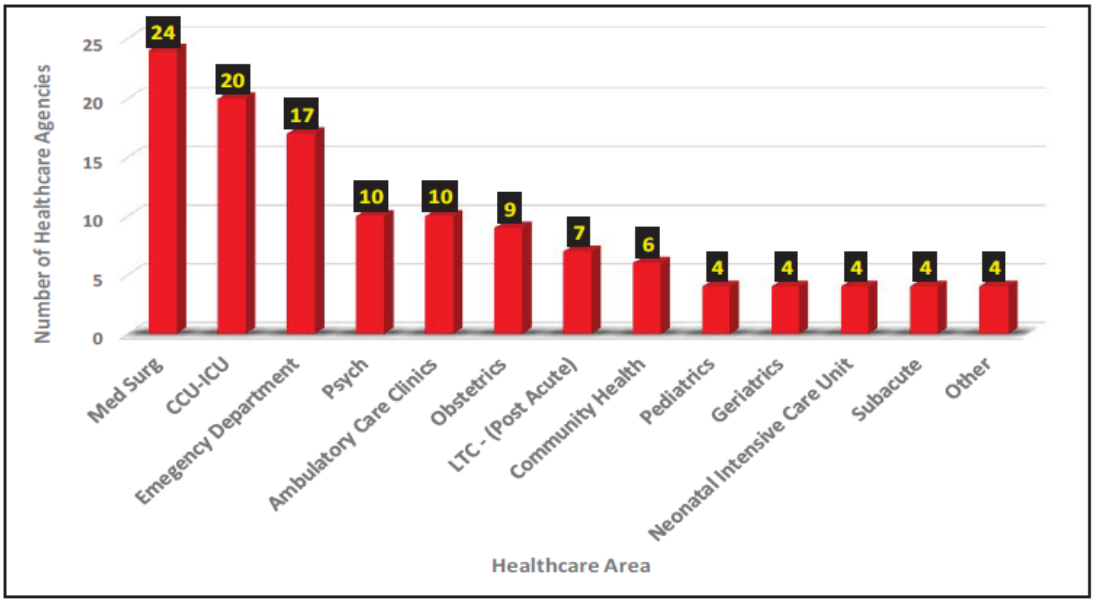


## Impact: Factors Contributing to Decreased or Planned Decreases in the Number of Clinical Placements

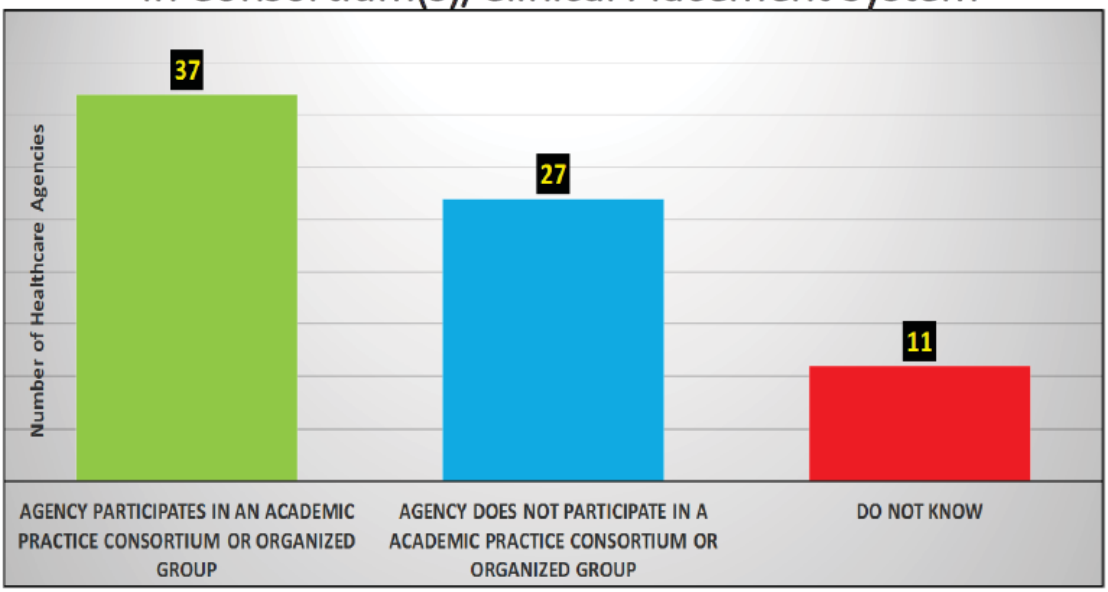
**Qualitative Responses:**

- **Rn clinical staff workload increase**
- **Less experienced RN clinical staff**
- **The number of newly licensed/hired RNs or staff unit vacancies**
- **Decreased patient census/volume of care/closure consolidation of units**
- **Complexity of patient care**
- **Administrative decision to shift/re-distribute clinical placement opportunities from ADN to BSN/ELM based on hiring needs**

## Solutions: Number of Healthcare Agencies with Some Opportunity for Additional Clinical Capacity on "Selected" Days/Hours/Shifts



## Solutions: Healthcare Agencies Participation in Consortium(s)/Clinical Placement System




N=75 Responses

## Solutions: Summary of Nursing Programs & Clinical Agencies Qualitative Survey Comments

- Academia and Clinical agencies should identify ways to improve communication, collaboration, cooperation/compromise that promotes fairness of clinical placement decisions/processes
- Schools should use of a variety of inpatient, outpatient, community-based, and ambulatory care clinical learning experiences
- Schools should increase their scheduling flexibility for needed clinical placements

## Solutions: Summary of Nursing Programs & Clinical Agencies Qualitative Survey Comments

- Nursing education programs should pursue standardization of curriculum units and hours
- Encourage the Board of Registered Nursing to pursue, if necessary, nursing education regulation changes, including mechanisms that promote opportunities for innovation/pilot projects
- Encourage the Board of Registered Nursing to consider regulations that speak to out of state nursing programs seeking clinical placements in California


## Solutions: Summary of Nursing Programs & Clinical Agencies Qualitative Survey Comments

- Use Evidence Based Practice (EBP) such as with skills/simulation labs to augment (i.e. up to 25%) but not replace actual patient care experiences
- Explore ways to address clinical agency RN staff "fatigue" associated with student placements 24/7:
  - limit number of students/clinical unit
  - RNs should take fewer patients when assigned to students
  - Less experienced RN staff not be assigned to students
  - Funding incentives for agencies providing placements

## Solutions: Summary of Nursing Programs & Clinical Agencies Qualitative Survey Comments

- **Standardize/streamline consortiums and clinical placement planning systems and processes**
- **Continue to carefully monitor, manage, and regulate the impact that increased student enrollments and new program approvals**

## Conclusion: Essential Activities to Achieving Positive Clinical Capacity Solutions/Outcomes

1. **Communication:** interactions among parties involved in all aspects of clinical placement decision including planning, scheduling, on-boarding, providing needed direct care clinical hours/learning experiences, and evaluation of placements
2. **Collaboration:** working jointly together in a respectful, non-competitive, non-adversarial manner to provide sufficient clinical placements for CA's Board approved nursing education programs
3. **Cooperation/Compromise:** concessions and agreements made to ensure sufficient clinical capacity and clinical placements available

## Influences that Potentially Impact Clinical Placement Capacity for Nursing Programs

**Other Key Stakeholders**
- Professional Nursing Organizations
- Labor groups
- NCSBN
- New RN Programs
- Clinical Partners

**Pre-Licensure RN Programs**
- Public/Private Inst.
- Students/Faculty/Staff
- Board of Trustees
- CA. Chancellors Dept.
- Advisory Councils
- Consortiums/Clinical Planning Groups

**Regional Summits**


"It Takes a Village……."

**Clinical Partners**
- Public/Private Inst.
- Students/Faculty/Staff
- CA. Chancellors Dept.
- Advisory Councils
- Hosp./LTC/Amb. Assoc.
- Dept. of Public Health
- Dept. of Corrections
- Other Healthcare agencies and Accrediting bodies

**Board of Registered Nursing**
- Department of Consumer Affairs
- Business and Consumer Services
- Governor's Office
- Legislature
- OSHPD

## Thank You……Questions?

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

February 5, 2019

TO: CNO Advisory Committee Members

FROM: BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing and Clinical Services, CHA

SUBJECT: BRN Employer Reporting of Nurse Practice Act Violations in California

**SUMMARY**

The California Bureau of Research finalized its report on voluntary RN reporting as required by SB 799 (Hill), Chapter 520. As required by the statue, the report includes a review of existing laws that require reporting in California and in other states, a list of laws permitting, prohibiting, encouraging or discouraging voluntary reporting to the nursing board, a summary of employer reporting requirements in other board within the department of Consumer Affairs and options the state could consider for consistent and reasonable reporting mechanisms.

**DISCUSSION**

1. What are your thoughts about the recommendations of the report?
2. How do you report presently?
3. How do you suggest we advise the BRN regarding the recommendations?

**ACTION REQUESTED**

- *Discussion and recommendations*

Attachment: Employer reporting of Nurse Practice Act Violations in California, January 2019

BJB:br

# Employer Reporting of Nurse Practice Act Violations in California

January 2019

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## Author

Patrick Rogers

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# Executive Summary

## Background

Chapter 520, Statutes of 2017 (SB 799, Hill) requires the California Research Bureau to prepare a report examining voluntary reporting of disciplined nurses by employers to the California Board of Registered Nursing (Nursing Board). As required by the statute, the report also must include a review of existing laws that require reporting in California and in other states, a list of laws "permitting, prohibiting, encouraging, or discouraging voluntary reporting" to the Nursing Board, a summary of employer reporting requirements in other boards within the Department of Consumer Affairs, under which the Nursing Board is housed, and options the state could consider for "consistent and reasonable reporting mechanisms." This report contains the Research Bureau's analysis of these issues. The report does not include a required analysis of employer reports to the Nursing Board. Though the Nursing Board maintains significant amounts of data, the relationship of the person reporting to the registered nurse who is the subject of the report is not currently collected. The Research Bureau found that this was also the case in three other states with which it collected detailed interviews.

## Reporting Practices

The primary purpose of professional licensing in healthcare centers on protecting the public from fraudulent and/or substandard care. Regulatory oversight can be broadly divided into two forms, prospective regulation that actively seeks out violations (e.g. police patrols), and reactive regulation that relies on reports of violations from the larger community (e.g. fire alarms). Among nursing boards in the United States, including in California, the standard practice is to adopt a "fire alarm" approach toward the oversight of registered nurses. Aside from established requirements when renewing their license, once a registered nurse has received their license, they interact little with their state boards unless a complaint is made. Where states differ is in when, how, and who they require to submit a report of a violation.

Eighteen states (36 percent), including California, have no mandatory reporting rules for registered nurses. If someone believes a registered nurse has violated some portion of the Nurse Practice Act, that person has discretion about whether or not to report the alleged violation. Thirty-two states (64 percent) require mandatory reporting by one or more groups. This includes the nurse's employer (19, or 38 percent), fellow nurses (27, or 54 percent) and/or other licensed medical professionals (8, or 16 percent). Taken together, the data shows no strong relationship between a state having or not having mandatory reporting rules, and the rate of complaints per licensee.

The non-mandatory approach adopted for registered nurses in California is fairly standard for other boards within the Department of Consumer Affairs, with only a few exceptions, including the Board of Chiropractic Examiners, the Respiratory Care Board and the Board of Vocational Nursing and Psychiatric Technicians.

## Barriers to Reporting

To begin an investigation, nursing boards must learn about alleged violations. For this to happen, employers, nurses and others must contend with multiple barriers. In a 2018 study,

37.2 percent of nurse executives stated experiencing some form of barrier that prevented them from reporting alleged violations, including uncertainty about what is reportable and having a non-punitive facility culture. Managers also have incentives to avoid strict reporting policies, including the impact that such reporting has on employee morale and turnover. Registered nurses can be reticent to report a colleague if they feel the error was unintended, or they could have easily made it themselves. In cases where a nurse has committed a medical error, the error can also have a systemic cause outside nurses' control—such as inadequate staffing, frequent overtime, and intershift fatigue. Decentralized and fragmented medical healthcare delivery means cause of error can be spread over multiple practitioners, or due to poor communication and coordination. In such cases a licensee can be reticent to report a colleague if the error was not solely due to individual negligence or misconduct, but due to such systemic causes.

**Options for Reporting Mechanisms**

Given these barriers to reporting, there are several options the state can consider to provide for more "consistent and reasonable reporting mechanisms."

- **Maintain current reporting practices:** Within the healthcare profession, there exists a norm of safeguarding patient health, and reporting dangers to patient safety. Furthermore, the data does not show a strong difference in the number of reports made among the 18 states with voluntary regimes, compared to the 19 states with mandatory employer reporting or the 13 states with some other form of mandatory licensee reporting. The only data that points to potential underreporting is in Connecticut, where the drug and mental health diversion program for healthcare professionals saw a 30 percent increase the year mandatory reporting was instated.
- **Expand training and outreach efforts** (independently, or in conjunction with one of the other two options): One of the most significant barriers reported by nursing administrators was uncertainty about which behaviors constituted a reportable offense. This

*Table 1: Count of States and Registered Nurses by Nurse Practice Act Violation Reporting Regime*

| | **No Mandatory Reporting (i.e. Voluntary Reporting)** | **Mandatory Reporting by Healthcare Professionals** | | |
|---|---|---|---|---|
| | | **Mandatory Reporting for Employers** | **Mandatory Reporting for Registered Nurses** | **Mandatory Reporting for other Health Professionals** |
| States | 18 | 19 | 27 | 8 |
| Licensees (RNs) | 1,855,351 | 1,933,801 | 2,133,695 | 728,758 |

Note: Some states have more than one mandatory reporting regime and can appear in multiple columns. Because comparable data was not available, the District of Columbia and Puerto Rico have been omitted from this review.
Source: License counts are drawn from the National Nursing Database, 2017 Active RBN Licenses (https://www.ncsbn.org/6161.htm).

indicates there is an opportunity to capture more unreported violations by increasing the level of outreach provided on the California Nursing Practice Act, with a particular focus on identifying violations and how to report them.

- **Enact mandatory reporting requirements:** These can vary by who is being required to report—employers, fellow registered nurses, or all licensed medical professionals more broadly—as well as in regard to the criteria used to trigger a mandatory report. The draft language included in early versions of SB 799 included one of the least restrictive approaches—only requiring employers to report dismissals, suspensions, or "resignations in lieu of dismissal." Other states, such as Oregon, Florida and Connecticut, use a broader standard, including requiring employers to report to their nursing boards if a nurse is "unable to practice his or her profession with reasonable skill or safety" under a variety of circumstances (Connecticut), if a "nurse's behavior or practice presents a potential for, or actual danger to, a client or to the public's health, safety and welfare" (Oregon), or "any person who the licensee knows is in violation of this chapter" (Florida). Oregon is also implementing a Complaint Evaluation Tool, first created by the State of North Carolina, to assess and provide guidance and clarity about when and how to report a potential violation to the board. Oregon hopes that having a more objective criteria for reporting will both reduce the number of reports made to the board that are later found to lack merit, while also encouraging some valid complaints that might have historically gone unreported due to uncertainty about whether they should have initially been reported.

# Mandatory Employer Reporting Practices for Registered Nurses

## Introduction

The California Board of Registered Nursing (Nursing Board or Board), along with the Board of Vocational Nurses and Psychiatric Technicians (Vocational Nursing Board), is tasked with protecting the health and safety of Californians by licensing and regulating the practice of nursing in the state.

As part of a 2016 review of the Nursing Board, the California State Auditor assessed the Board's investigations and enforcement program. The audit noted a discrepancy between mandatory reporting requirements for licensed vocational nurses[1]—regulated by the Vocational Nursing Board—and registered nurses, regulated by the Nursing Board. Employers of vocational nurses are required to report to the Vocational Nursing Board when they suspend or dismiss a licensed vocational nurse, or if one resigns in lieu of dismissal. No such requirement exists for registered nurses in the state.

The audit recommended that the Legislature update the Nursing Practice Act to include a requirement that employers of registered nurses "report to BRN [Board of Registered Nursing] the suspension, termination, or resignation of any registered nurse due to alleged violations of the Nursing [Practice] Act" (California State Auditor, 2016). Earlier versions of the bill requiring this report, Senate Bill 799 (Hill, 2017), included language implementing this recommendation, although the provisions were ultimately removed and replaced with a requirement for a report by the California Research Bureau. SB 799 required the Research Bureau to prepare a report "that evaluates to what extent employers voluntarily report disciplined nurses to the board and offers options for consistent and reasonable reporting mechanisms." It also required the report to "include, but be limited to…:

> (a) A review of existing mandatory reporting requirements that alert the board to nurses who may have violated this chapter.
>
> (b) A review of existing laws permitting, prohibiting, encouraging, or discouraging voluntary reporting to the board.
>
> (c) An analysis of the number of employer reports to the board, the number of those reports investigated by the board, and the final action taken by the board for each report.
>
> (d) Employer reporting requirements of other boards within the department.
>
> (e) Nursing reporting requirements of other states." (Cal. Bus. and Prof. Code § 2761.5, 2017).

[1] Referred to as Licensed Practical Nurses in every state with the exception of California and Texas.

# Background

## Early Licensure

Nursing as a formal occupation developed out of the professionalization of traditional patient-centered care-taking roles. While the role of a doctor is to focus on and treat the disease, the role of the nurse is to support and care for the patient, so they can recover and heal (Nightingale, 1876; Shaw, 1993). Recognizing that "unprepared or incompetent practitioners" posed a risk to public health, states began to regulate medical professions—including nursing—in the early 20th century (Russell, 2017). North Carolina passed the first Nurse Practice Act in 1903 (Wyche, 1938; Smith, 2009), which created a State Board of Examiners of Nurses and instituted an exam and licensure for nurses wishing to use the title "registered nurse." New Jersey, New York and Virginia followed with similar statutes later the same year. California passed a similar law on March 20, 1905.

North Carolina's nursing law included provisions allowing the board "to revoke any license issued by them for gross incompetency, dishonesty, habitual intemperance, or any other act in the judgment of the board derogatory to the morals or standing of the profession of nursing"; however, the law did not formally address how to report such violations, including specifying whether any reports would be mandatory.

Early nursing laws had other limitations as well. They did not restrict the practice of nursing under a title other than registered nurse,[2] formally define nursing, nor describe a scope of practice. Within a few decades, the need for further regulation was recognized, and the first "modern" Nurse Practice Act with such provisions passed in New York State in 1938 (Smith, 2009; Russell, 2017). The primary provisions of California's current nursing law were enacted soon after, in 1939. By the 1970s, all states had this form of a Nurse Practice Act. Unlike California, most states regulate registered nurses and practical/vocational nurses through a single Board of Nursing—California, Louisiana and West Virginia are the only states to split oversight between two separate boards.

# Current Reporting Practices

The primary purpose of professional licensing in healthcare is centered on protecting the public from fraudulent and/or substandard care. To achieve this, the traditional role of the nursing board is to: (1) evaluate and certify educational programs, (2) verify the skills, training and education of new licensees, and (3) to identify and discipline individuals whose professional practice is deficient (Cooke, 2006).

Regulatory oversight can be broadly divided into two forms, prospective regulation that actively seeks out violations (e.g. police patrols), and reactive regulation that relies on reports of violations from the larger community (e.g. fire alarms) (McCubbins & Schwartz, 1984). Based on the Research Bureau's review of nursing boards across the United States, it appears that the standard practice is to adopt a proactive "police patrols" model for monitoring the quality of educational programs, but to adopt the "fire alarm" approach toward the oversight of practicing nurses. Aside from continuing education requirements, once a registered nurse has received their license, they interact little with their state boards outside of regular licensure renewal, unless a complaint is made.

[2] North Carolina amended its nursing law in 1917 to remove this loophole, specifying that "no one shall represent herself or himself, or in any way assume to practice as a trained, graduate, licensed or registered nurse in North Carolina without obtaining a license through the Nurses' Examining Board" (Wyche, 1938).

*Table 1: Count of States and Registered Nurses by Nurse Practice Act Violation Reporting Regime*

| | No Mandatory Reporting (i.e. Voluntary Reporting) | Mandatory Reporting by Healthcare Professionals | | |
|---|---|---|---|---|
| | | Mandatory Reporting for Employers | Mandatory Reporting for Registered Nurses | Mandatory Reporting for other Health Professionals |
| States | 18 | 19 | 27 | 8 |
| Licensees (RNs) | 1,855,351 | 1,933,801 | 2,133,695 | 728,758 |
| Note: Some states have more than one mandatory reporting regime and can appear in multiple columns. Because comparable data was not available, the District of Columbia and Puerto Rico have been omitted from this review.<br>Source: License counts are drawn from the National Nursing Database, 2017 Active RBN Licenses (https://www.ncsbn.org/6161.htm). | | | | |

Where states differ is in when, how, and who they require to submit a report of a violation.

All states have mechanisms to receive and investigate reports of violations of their Nurse Practice Act (See Table 1, above). Eighteen states (36 percent), including California, have no mandatory reporting rules for registered nurses. If someone believes a registered nurse has violated some portion of the Nurse Practice Act, that person has discretion about whether or not to report the alleged violation. Thirty-two states (64 percent) require mandatory reporting by one or more groups. This includes the nurse's employer (19, or 38 percent), fellow nurses (27, or 54 percent) and/or other licensed medical professionals (8, or 16 percent). Table A-1, in the appendix, provides a detailed list of the reporting practices for each state, along with the number of registered nurses licensed by their boards, as of December 31, 2017. Taken together, the data shows no strong relationship between a state having or not having mandatory reporting rules, and the rate of complaints per licensee. On balance, this appears to indicate that there is not a large pool of unreported violations to capture by stricter reporting rules. However, because the data is so limited, it is not possible to discount other explanations for the patterns or to draw any causal conclusions.

## California

There are no universal reporting requirements for the three groups in Table 1 (employers, registered nurses and other healthcare professionals). However, there are specific conditions under which other entities are required to report information to the Nursing Board. These broadly fall into three categories, which are also generally standard across other states and include criminal conviction, discipline by other licensing agencies, or for child and elder abuse. Other than these specific instances, there are no statutory or regulatory requirements for a person or organization to report an alleged Nursing Practice Act violation in California. Nor are employers required to report if they fire, discipline or otherwise restrict the practice privileges of a registered nurse.

Court clerks in California are required to report to the Board if a registered nurse has been found to have "committed a crime, or is liable for any death or personal injury resulting in a judgment for an amount in excess of thirty thousand dollars ($30,000) caused by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services" (Cal. Bus. and Prof. Code § 803, 2012). Licensees are also required to self-report in a number of specific instances. They are required

to report any conviction, as well as any disciplinary action they are subject to from another licensing entity, including those in California, other states, or at the federal level (Cal. Code Regs. tit. 16, § 1441, 2018). Licensees are also mandated reporters for child, dependent adult or elder abuse (Cal. Penal Code § 11166, 2016; Cal. Welf and Inst. Code § 15630, 2013). A registered nurse must report any abusive conduct by another licensee.

Two other circumstances may result in a report of an alleged violation to the Board of Registered Nurses.

- State law requires healthcare facilities to report specific adverse events to the California Department of Public Health within five days of the event, or within 24 hours if "an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors" (Cal. Health and Safety Code. § 1279.1, 2007). The director of the department "may" then send any evidence of nursing care violations discovered during its investigations on to the Board of Registered Nursing, for additional investigation and discipline (Cal. Health and Safety Code. § 1280.20, 2014).
- In California, hospitals are required to report the loss of any controlled substances to the Board of Pharmacy within three days (Cal. Code Regs. tit. 16, § 1715.6, 2018). The Board of Pharmacy is also required to report to the Board of Nursing when it receives a complaint about dangerous dispensing practices of certified nurse-midwives or nurse practitioners (Cal. Bus. and Prof. Code § 4175, 2017). The Board of Registered Nurses licenses both nurse-midwives and nurse practitioners. Both have the authority to prescribe medication. The statute does not, however, cover the largest pool of licensees at the Board—registered nurses—as they do not have the authority to prescribe medications.

## Practices of Other Professional Licensing Boards at the Department of Consumer Affairs

This non-mandatory approach in Table 1 is common for other boards within the Department of Consumer Affairs, with some exceptions:

- The California Board of Chiropractic Examiners requires licensees to report any violations by another licensee (Cal. Code Regs. tit. 16, § 314). Furthermore, unlicensed individuals cannot own a chiropractic practice in California. This means that all chiropractors in the state are either self-employed, or employed by another licensee. As a result, chiropractors who are not self-employed are subject to mandatory employer reporting (Cal. Code Regs. tit 16, § 312.1, 2018).
- Employers of respiratory care practitioners in the state are required by statute—rather than regulation—to report if they fire or suspend a licensee (Cal. Bus. and Prof. Code § 3758).
- The Board of Vocational Nursing and Psychiatric Technicians, which has oversight of licensed vocational nurses—the other large group of professional nurses in the state—defines the failure to report a violation of the Vocational Nursing Practice Act (Cal. Bus. and Prof. Code § 2840-2895.5, 2018) by any licensee as unprofessional conduct (Cal. Bus. and Prof. Code § 2878, 2004). Licensed vocational nurses can face discipline for unprofessional conduct, including having their license revoked. Furthermore, any employer of a licensed vocational nurse is also required to report "the suspension or termination for cause, or resignation for cause" of any licensed

vocational nurse they employ (Cal. Bus. and Prof. Code § 2878.1, 2012). Both reporting requirements were added to statute in 2003. However, employers are not required to report if they discipline in a more limited fashion—for example, if they restrict a licensed vocational nurse's privileges, or if they impose additional education or training requirements on a vocational nurse.

## Non-Mandatory (Voluntary) Reporting by Employers

It is not possible with the existing data to measure how often employers report violations to the Board of Nursing. While the Board does collect copious amounts of information relevant to investigating alleged violations, the precise relationship between the complainant and the target of a report is often unknown. However, there is reason to believe that—even without mandatory reporting requirements—employers of registered nurses in the state often voluntarily report dangerous or impaired actions. When the California Hospital Association surveyed its members, the association determined that most California hospitals have established processes for handling the reporting of alleged violations resulting in a firing, resignation or suspension, if at varying levels of formality (California Hospital Association, 2018). In some cases, the employers have formally documented policies and procedures. In other cases, there are established practices they follow, based on how they have handled such issues before. Hospitals also vary in who is responsible for making the decision to report. Decisions to report are typically made either by the chief nursing officer, or through the human resources staff, although reporting decisions may also go through risk management.

## Reporting Practices in Three Comparison States

To provide an in-depth comparison to California's Nursing Board, the Bureau conducted phone interviews with staff from the boards of three other states that have different reporting structures: Connecticut, Florida and Oregon.

### *Connecticut*

Among states that have mandatory employer reporting provisions, most codify the requirement within their individual Nurse Practice Act and limit the requirement to the nurse's employers. However, some take a broader approach, expanding the mandatory reporting requirement to cover most if not all healthcare professions licensed by the state. Connecticut is an example of this. Until 2015, Connecticut had no mandatory reporting, i.e. it was a voluntary reporting state. That year, the state changed its laws to require that any "health care professional" or "hospital" report (to the state board of nursing) if any other healthcare professional "is, or may be, unable to practice his or her profession with reasonable skill or safety" for any of the reasons quoted below:

> *(A) Physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process;*
>
> *(B) emotional disorder or mental illness;*
>
> *(C) abuse or excessive use of drugs, including alcohol, narcotics or chemicals;*
>
> *(D) illegal, incompetent or negligent conduct in the practice of the profession of the health care professional;*
>
> *(E) possession, use, prescription for use or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes;*
>
> *(F) misrepresentation or concealment of a material fact in the obtaining or*

> *reinstatement of a license to practice the profession of the health care professional; or*
>
> *(G) violation of any provision of the chapter of the general statutes under which the health care professional is licensed or any regulation established under such chapter.* (CGA § 19a-12e(3)(b), 2015)

The law went into effect on October 1, 2015, potentially offering a window into the likely impacts of transitioning from a voluntary reporting regime to a comprehensive mandatory one. Unfortunately, the Connecticut Department of Health does not track when employers are the source of violations reports, making it impossible to directly measure the impact of the law on employer reporting. From 2015 to 2016, the first year of implementation and the last year for which any data is available, the health department reported that the overall increase in reports of nursing violations was not substantial. This is not the result anticipated when the change was being debated. The department raised concerns that it might be overwhelmed by new reports, and be "unable to investigate the number of complaints generated within current resources" (Connecticut Public Health Committee, 2015).

In fact, due to separate budgetary issues, the department reduced the staff assigned to investigations of complaints against licensees between 2015 and 2016. While board complaints for healthcare professionals do not appear to have significantly increased, Connecticut's alternative to discipline program, the Heath Assistance InterVention Education Network (HAVEN) did see an increase in program enrollment. HAVEN provides a mechanism for nurses to undergo treatment for drug or alcohol addiction or mental illness without going through the traditional board disciplinary process. Connecticut's HAVEN program reported a 30 percent increase in enrollment between 2015 and 2016, necessitating the hiring of four additional staff. This increased enrollment in the HAVEN program is the only data to suggest that there is a pool of unreported violations that mandatory reporting rules could capture.

### *Florida*

Florida has a broad statute with mandatory reporting for all healthcare practitioners licensed by the Florida Department of Health (Florida Statutes 456.072(1)(i), 2018):

> *(i) Except as provided in s. 465.016, failing to report to the department any person who the licensee knows is in violation of this chapter, the chapter regulating the alleged violator, or the rules of the department or the board. However, a person who the licensee knows is unable to practice with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.*

Unlike Connecticut, Florida's statute does not include a requirement for facilities to report—the state only has that requirement for licensed practitioners. Just as in California and Connecticut, Florida does not record the relationship between the individual making the report and the licensee. As a result, it is not possible to estimate probable impact of this policy difference on the reporting rate of hospitals or other employers. During interviews, staff indicated that Florida does not pro-actively monitor the mandatory reporting provisions, although it does enforce the statute when a failure to report is discovered as part of another investigation. The enforcement of the reporting rules is also contingent to a degree on the

severity of the initial violation, such as the presence or absence of patient harm (Florida Department of Health, 2018).

While the state does not have formal outreach or training on reporting rules for facility administrators, it does provide outreach and training as the opportunity arises. Furthermore, Florida has specific provisions requiring licensees to take two hours of training on laws and regulations as part of its biennial continuing education requirements (Florida Department of Health, 2018).

### *Oregon*

Licensees in Oregon are required to report any "licensed nurse whose nursing practice fails to meet accepted standards" as well as if they have "knowledge or concern that a nurse's behavior or practice presents a potential for, or actual danger to, a client or to the public's health, safety and welfare" (OAR. 851-045-0090, 2018). This effectively results in managers being subject to mandatory reporting, as the vast majority of practicing nurses in Oregon are under the supervision of another licensed nurse. Licensed healthcare facilities are required to report any "suspected violations" by licensees of the board of nursing, with the exception of nursing assistants (ORS 678.135, 2009). In fact, the majority of reports of alleged violations in Oregon come from nurse managers (Oregon Board of Nursing, 2018).

Oregon has recently adopted North Carolina's Complaint Evaluation Tool (North Carolina Board of Nursing, 2018; Oregon Board of Nursing, n.d.). The goal in adopting the tool is to provide guidance and clarity about when and how to report a potential violation to the board. The hope is that having more objective criteria for reporting will reduce the number of reports made to the board found later to lack merit, and also encourage valid complaints that have historically been under-reported due to uncertainty about whether they rise to the level of reportable violation. A copy of the Complaint Evaluation Tool is in the appendix.

Oregon's nursing board also focuses on training and outreach, providing educational presentations on Oregon's Nurse Practice Act including when and how to report alleged violations of the Act. Board staff regularly travel the state to provide training to nurses, nursing managers, and chief nursing officers. The board estimates this outreach has increased reports by about 20 percent (Oregon Board of Nursing, 2018).

## Barriers to Reporting Alleged Violations

### Employer Barriers

Facility administrators and other employers are in a position to know about the skill and competence of the licensees they employ. They are among the first to discover if a standard of care has been violated, or if a licensee suffers from an impairment—such as substance abuse or an untreated mental illness—with the potential to affect the quality of care. It is this privileged position that has led 19 states to add mandatory employer reporting as part of their regulatory toolkit. However, employers also face a number of barriers and disincentives to reporting (Hudspeth, 2008; Budden, 2011; Martin, Reneau, & Jarosz, 2018).

*Table 2: Barriers to Board Reporting Encountered by Nurse Executives*

| Barriers Encountered | Number Reporting | Percent Reporting |
|---|---|---|
| None | 277 | 62.8% |
| Uncertainty as to: | | |
| What is reportable | 83 | 18.8% |
| The reporting process | 53 | 12.0% |
| The legal ramifications | 55 | 12.5% |
| Non-punitive facility culture | 136 | 30.8% |
| Other facility policy | 128 | 29.0% |
| Concern for legal exposure | 40 | 9.7% |
| Concern for facility reputation | 17 | 3.9% |
| Source: Martin, Reaneau and Jarosz (2018). | | |

When researchers surveyed nurse executives on their reporting practices, a large minority—37.2 percent—stated experiencing some form of barrier that prevented them from reporting alleged violations to state nursing boards. Nurse executives reported a number of reasons preventing them from reporting (see Table 2); however, when Martin, Reneau and Jaosz (2018) conducted a combined multivariate analysis that looked at all barriers simultaneously, the two with the strongest evidence of impact were uncertainty about what is reportable and having a non-punitive facility culture. Executives at the nursing boards in California, Florida and Oregon all noted the challenge of employers understanding what is reportable, and each focused training resources on the issue. Non-punitive facility culture directly relates to job satisfaction and retention of nursing staff.

How organizations respond to medical errors influences perception of the work environment, and ultimately turnover. A strong error-management culture focuses on pro-actively detecting, analyzing and handling and/or resolving errors. Such organizations rely on open communication around those errors and reward nurses who participate in knowledge-sharing and other assistance (Guchait, Paşamehmetoğlu, & Madera, 2016). Whereas error-elimination cultures are typically more centralized and punitive, error-management cultures are more cooperative and believed to result in increased group cohesion, as well as reduced stress and nurse burnout. As a result, organizations with such cultures experience lower rates of nurse turnover (Bakker, Demerouti, & Verbeke, 2004).[3]

Another potential barrier to employer reporting is that, if possible, employers prefer to deal

[3] Unsurprisingly, job stress and perceived work demands have a negative effect on a nurse's reported job satisfaction (Ellenbecker & al, 2007). When nurses exiting the profession were interviewed about the reasons for their decision to change careers, they cited emotional exhaustion and problems with work design as key causes (Aiken L. H., et al., 2001). More broadly, nurses' perception of organizational climate were also correlated with turnover (Stone P. W., et al., 2007). Zhang, Punnet, Gore, et al (2014) identified four key features that reduced turnover: getting along with supervisors, getting along with co-workers, feeling respected, and being able to make decisions during the course of their work. Nurses who reported high scores in those four areas had a 77 percent reduction in their reported intention to leave nursing. This can include the perceived level of centralization in the organizational structure (less was reported as better, on average), the ability to have flexible hours, an emphasis on professional autonomy, and the presence of strong communication between management and staff (Aiken, Smith, & Lake, 1994;

internally with correctable errors and deficiencies among their nursing staff (Martin, Reneau, & Jarosz, 2018). Reporting alleged violations that they see are correctable might result in the loss of a valuable employee.[4] Recent trends in California expect the state to be able to meet the demand for registered nurses through at least 2035. However, even without a shortage of qualified nurses, turnover still represents an important cost to employers. Over a decade ago, Waldman, Kelly, Arora and Smith (2004) estimated a $15,582 average cost to replace a nurse lost to retirement or turnover. Hospitals and other employers of registered nurses invest in preventing unnecessary turnover among their nursing staff.

## Licensee Barriers (Self-Reporting or Colleague Reporting)

A report to a state board of nursing carries with it the potential for serious disciplinary consequences to the licensee. These consequences create strong disincentives against individuals self-reporting (Wolf & Hughes, 2008; Leape L. L., 1994). In addition, nurses can be reticent to report a colleague if they feel the error was unintended or they could have easily made it themselves (Cooper, et al., 2016). In cases where a nurse has committed a medical error, the error can also have a systemic cause outside nurses' control—such as inadequate staffing, frequent overtime, and intershift fatigue (Famolaro, Yount, Hare, Thornton, & al, 2018). Decentralized and fragmented medical healthcare delivery means cause of error may spread over multiple practitioners, or due to poor communication and coordination. This presents another barrier to reporting—a licensee can be reticent to report a colleague is if the error was not solely due to individual negligence or misconduct, but due to systemic causes.

When a complaint has been made against a nurse, the state's evaluates the nurse's actions to first verify that unsafe actions occurred, and if so, to what extent the violation threatened patient safety. In general, increased severity of unsafe actions results in the board imposing an increased severity of discipline. Such an approach works well when considering nursing

Buchan, 1994). A large part of the work environment is made up of the relationships nurses have with each other, with supervisors, and with other parts of the medical care team—particularly the doctor-nurse relationship. If these relationships interact to make the nurse feel supported and empowered, that will have a significant impact on improved job satisfaction (Breau & Rheaume, 2014). Recognizing the professional nature of nursing is consistently cited in the literature as reducing turnover. Moore (2001) found that a nurse's intention to quit could be mediated by a sense of professionalism. This reduced the impact of frustration at changing work conditions, perceptions of poor management, and reduced the impact of burnout. Spence Laschinger et al identified organizations with a high level of group cohesion and autonomy as having a high level of "structural empowerment," which was correlated with overall job satisfaction, and ultimately, lower turnover rates (Spence Laschinger, Finegan, Shamian, & Wilk, 2001; Manojlovich & Spence Laschinger, 2002). Even something as simple as a nurse's perception that they had a shared role in decision-making was correlated with job satisfaction.

[4] In California—as in most states—there are continuing concerns about maintaining a registered nurse workforce adequate to meet demand, although recent studies of the California registered nurse workforce leave some cause for optimism. Nursing school enrollments doubled between 2001 and 2010 (Waneka & Keane, 2012). Anecdotally, one explanation for this increase was that individuals who lost their jobs during the recession of 2007 chose to enter school programs instead of continuing to look for work. Additionally, the recession led practicing nurses to remain in the profession when they might have otherwise retired or changed careers (Spetz, 2017). As a result of recent trends in California, forecasters expect the state to be able to meet the demand for registered nurses through at least 2035.

as a highly professionalized practice, with a large degree of autonomy (Beardwood & French, 2004). In such cases, it is reasonable to assume that the nurse was uniquely at fault. However, nursing culture is shifting toward less individual autonomy, and a higher reliance on organizationally determined top-down rules. As this occurs, the importance placed on individual accountability can sometimes put board regulation in tension with the cooperative nature of nursing. It can also make it easy to overlook many of the systemic sources of error in healthcare. Recognizing this issue, nursing boards have begun adapting their processes to reflect the changing nature of the profession. An example of this is the Regulatory Decision Pathway, developed in 2012 by the National Council of State Boards of Nursing specifically to provide a tool for state nursing boards to use in making discipline decisions (Russell & Radtke, 2014). A key focus of the tool is determining to what extent the adverse event resulted from systemic failure vs. how individual nurse behavior contributed.

Emphasis on a systemic understanding of medical error is being driven—in part—by research into nursing and healthcare outcomes. Starting in the 1990s, research efforts have examined how treatment success is interdependent across the healthcare team, facility, and subject to influence by outside factors (IOM, 2000; IOM, 2001). Complicating the issue is the fact that there is not one single approach to measuring health outcomes (Doran, 2011). Many studies see adverse events as outcomes of interest (American Nurses Association, 2000; Aiken L. H., et al., 2001; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). While others look at more qualitative outcomes like functional status and/or mental and social well-being (Lush, 2001; Ditmeyer, Koepsell, Branum, Davis, & Lush, 1998), or a mix of both (McGillis Hall, et al., 2003).

A commonly adopted model of error in nursing literature is Reason's model of accident causation (Boysen, 2013). The potential for mistakes—what Reasons calls "latent failures"—exist because of organizational deficits or other systemic issues. These deficits lay dormant within the system, and are typically undiscovered. The conditions under which the error occur are either poorly understood, or when they are recognized, are dismissed as unlikely (i.e. "black swan" events). These latent errors are typically embedded in the system because of decisions made when the organization and its processes were designed, which can be far removed from day-to-day activities. To a certain extent, it is impossible to avoid the potential for all latent failures entirely, and the more complex a system is the more difficult it is to identify and predict where and when failures will occur. The presence of a latent failure can give otherwise innocuous actions and behaviors a greater potential for harm. Given this, it is unsurprising that a large proportion of nursing error include a systemic cause or contributor (IOM, 2000). The need to provide accountability toward individual nurses along with the need to create a reporting environment where mistakes are widely reported and used as opportunities to learn is broadly referred to as "just culture." More information on this topic is in *Appendix III: Just Culture*.

Indeed, individual error itself often has an underlying systemic contributory cause. A recent review of nursing care studies finds nurse well-being (operationalized as the level of stress, anxiety and depression, for example) and occupational burnout highly correlated with an increased risk of error and worse patient safety (Hall, Johnson, Watt, Tsipa, & O'Connor, 2016). Four important systemic sources of error are: (1) the level of nurse staffing and available time per patient, (2) the use of overtime to cover gaps, leading to burnout, (3) an organizational

culture that helps or hinders error avoidance, and (4) whether the implementation of nursing practice at a facility supports the cognitive needs of nurses.

### *Staffing and Time per Patient*

One reason a nurse might decide against reporting an alleged violation by a colleague is if inadequate staffing contributed to the error. A number of studies point to concerns that nurses are often required to cover more patients than is optimal for patient health outcomes. There is evidence that the time a nurse is able to give per patient is associated with improved medical outcomes (Penoyer, 2010). Other studies find associations between nurse-to-patient ratios and/or time per patient with a number of health outcomes, such as a lower risk of central line associated bloodstream infections (CLBSI), ventilator-associated pneumonia, 30-day mortality, and bed sores (decubiti) (Stone P. , et al., 2007); decubiti (bed sores) (Blegen, Goode, & Reed, 1998; Unruh, 2003); infections (Amaravadi, Dimick, Pronovost, & al, 2000; Kovner & Gergen, 2007; Sovie & Jawad, 2001; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002); other outcomes (Blegen M. , 2006); and general patient survival (Aiken L. H., Clarke, M., & al, 2002; Blegen, Goode, & Reed, 1998).

Lucero, Lake and Aiken (2010) found a large proportion of surveyed nurses reported being regularly unable to meet all nursing care requirements (Table 3).However, Some research has cast doubt on the robustness of these associations. Shekelle (2013) conducted a meta-analysis, and found that the bulk of the studies reporting an effect had substantial limitations. Among the studies they identified as “high-quality,” only a few could not rule out random chance as the cause of the observed data. Problems in publication bias toward positive results compound these results. In general, however, the literature links nurse ratios and health outcomes, and the larger issue is whether nurses themselves believe it to be true, and allow it to influence their decisions to report alleged violations.

### *Overtime and Burnout*

Understaffing not only influences the time nurses are able to spend with individual patients, but also impacts the ability of nurses to do their job effectively, particularly when short staffs are covered through regular use of overtime. A number of recent nursing care studies find that nurse well-being generally (i.e. stress, anxiety, depression) and burnout specifically were found to be highly correlated with the increased risk of error and/or worse patient safety (Bogaert, Kowalski, Weeks, Van Heusden, & Clarke, 2013; Kirawn, Matthews, & Scott, 2013; Koy, Yunibhand, Angsuroch, & Fisher, 2015; Hall, Johnson, Watt, Tsipa, & O'Connor, 2016). As a result, nurses might be

*Table 3: Barriers to Adequate Nursing Care Reported by Registered Nurses*

| Reported | Percent Reporting |
|---|---|
| Unable to consistently complete the development and/or updating of nursing care plans. | 41% |
| Unable to provide adequate comfort and interaction with patients. | 40% |
| Unable to provide needed back rubs/skin care. | 30% |
| Unable to adequately teach patients and family. | 29% |
| Unable to adequately document nursing care. | 22% |
| Unable to provide oral hygiene for patients. | 20% |
| Inadequate preparation of patients for discharge. | 12% |

less likely to report alleged violations if overwork or fatigue are contributing causes.

Nurses on 12-hour shifts get inadequate sleep and suffer from intershift fatigue—they do not fully recover between shifts, so they start each new shift with an increasing sleep deficit (Geiger-Brown, 2011). In surveys, nurses self-report higher rates of error due to fatigue from overtime (Rogers, Hwang, Scott, & al, 2004). Observational studies associate higher rates of catheter-associated urinary tract infections with decubiti [bedsores], for example (Stone P. , et al., 2007). Just working over 40 hours a week is associated with an increased rate of adverse events (Olds & Clarke, 2010).

There are caveats, however. The above studies are observational, and therefore it is difficult to draw definitive conclusions from them. For example, the same study that observed an increased risk of catheter-associated urinary tract infections and decubiti found a decreased risk of central line associated bloodstream infections (Stone P. , et al., 2007). Nonetheless, the preponderance of the literature shows that a nurse's likelihood of error or of adverse patient outcomes correlates with the number of hours they work per day and per week.

### *Organizational Culture*

Even more generally, research shows that nurses' perception of their workplace culture can be associated with improved patient outcomes and reduced likelihood of medical error (Braithwaite, Herkes, Ludlow, Testa, & Lamprell, 2017; Stone P. , et al., 2007). Effective and error-free clinical practice is not an individual effort, it relies on "social, cultural and organizational factors" much of which are outside of the individual nurse's control (Patel, Kannampallil, & Shortliffe, 2015).

Nurses who feel empowered, through the support and respect of fellow nurses, doctors and supervisors, also report higher perceived quality of care at their institutions (Breau & Rheaume, 2014). If they report that they had opportunities to specialize and report reduced occurrences of "backfilling" duties, their perception of their work environment improves, and they report better patient safety outcomes (Breau & Rheaume, 2014; Hopkins Duva & al, 2011). Awareness of the importance of organizational culture in nurse performance might also represent a mitigating factor that leads nurses to refrain from reporting alleged violations.

Much emphasis in this area of the nursing literature focuses on creating a "culture of safety" and "high-reliability organization." Reason and Hobbes (Reason & Hobbs, Managing Maintenance Error: A Practical Guide, 2003) highlight three values embodied by high-reliability organizations: trust, reporting and improvement. When nurses trust their peers and the larger organization, they feel safe reporting mistakes without fear of unfair treatment. They also feel safe reporting unsafe conditions, without the fear of retaliation or "blaming the messenger." Removing institutional barriers and disincentives against reporting, responding to reports quickly and widely communicating improvements establish trust. Chassin and Loeb (2013) argue that these three values create a self-reinforcing organizational culture.

These values are part of a larger shift among safety researchers away from error elimination and toward error recovery. Rather than requiring perfection, high-reliability organizations operate with the expectation that mistakes and errors will occur, and create systems to quickly recognize and recover from them before the errors result in adverse events. There is reason to believe that to do otherwise—focusing on the elimination of error, rather than identification and recovery—actually results in more error, and increases the

likelihood that errors will result in negative consequences (Patel, Kannampallil, & Shortliffe, 2015). Identifying individual responsibility is still a necessary part of such strategies, but the purpose is not to "pin the blame" or purely punitive. Even where there are individual causes of error they still need to be recognized as operating within a larger systemic context.

### *Cognitive Processing*

Organizational factors do not just influence propensity toward error through practices such as understaffing, overtime, insufficient training, or ineffective error monitoring. Safety researchers also recognize the importance of removing impediments to cognitive processing. Decades of research acknowledge the role of cognition in human and medical error (Reason, Human Error, 1992; Leape L. L., 1994).

Technology is often poorly adapted to human behaviors and processing models. The system forces humans to adapt to the technology, rather than the technology adapting to how humans think and work. This causes increased risk of error, particularly in high-stress environments (Norman, 2018). The typical response increases emphasis on training. Essential in fields where complex, but repetitive, tasks are common, training is also important where patients' needs are changing and/or uncertain (Dekker, 2007). However, training itself can be a source of error. Highly trained clinicians are more prone to "premature closure," a type of error where the first diagnostic hypothesis that fits is accepted rather than evaluating all possible alternatives (Patel, Kannampallil, & Shortliffe, 2015). This type of cognitive error can be difficult to identify because it so often does not result in an adverse event. Because they occur more frequently, some diagnostic hypotheses are easy to recall, meaning the use of such cognitive shortcuts results more often than not in a correct diagnosis. Premature closure resulting in an incorrect diagnosis is therefore comparatively rare. As a result, a diagnostician can commit this error many times before it results in an adverse event.

When error detection systems are put in place there is added benefit in bringing the potential for errors like premature closure to the forefront of clinical practice, reducing the likelihood of committing these errors in the first place (Patel, Kannampallil, & Shortliffe, 2015). Organizations that focus on post-hoc punishment of individual error can actually reduce the ability of practitioners to achieve that goal.

Concerns about cognitive processing are somewhat abstract and not always raised with this precise wording. These issues often appear in the literature as a concern about inadequate and/or ineffective training or as poorly designed technology.

## Options for Reporting Mechanisms

Given these barriers to reporting, below are several options for "consistent and reasonable reporting mechanisms" for consideration.

### Continue Current Reporting Practices

One approach to employer reporting is to maintain the current policy of voluntary reporting. Approximately a third of states have no mandatory reporting for registered nurses, including California.

Healthcare professional culture safeguards patient health by reporting dangers to patient safety. This is particularly true within the nursing profession, where the patient-centered tradition is a source of individual and collective pride. This explains why nurses report patient care violations at a comparatively higher rate compared to other medical professions (Wolf & Hughes, 2008).

In fact, there does not appear to be a strong difference in reporting between states with voluntary regimes, states with mandatory employer reporting or states with some other form of mandatory licensee reporting. The experience of Connecticut's HAVEN program—which saw a 30 percent increase in enrollment when the state first adopted mandatory reporting rules—indicates some instances of underreporting in substance abuse or mental illness, though it is possible there are other explanations for the increase.

### *Expand Training and Outreach*

Many barriers to reporting described by nursing administrators were due to uncertainty and lack of training. As enumerated in Table 3 above, managers said that uncertainty about which behaviors were potentially reportable violations to the board made them less likely to notify their state board. This offers an opportunity to capture unreported violations by expanding outreach provided on the California Nursing Practice Act, focusing on identifying violations and how best to report them. Recognizing this need, the Nursing Board has already increased outreach this past year, providing enforcement presentations to hospital staff as well as to deans and directors of nursing schools (California Board of Registered Nursing, 2018).

Beyond presentations, adopting tools similar to the Complaint Evaluation Tool used by North Carolina and Oregon could also provide clearer and objective guidelines on when and how to report potential violations. Expanding these activities into a formal outreach program extends their impact, and helps guarantee their continuance across board administrations.

## Mandatory Reporting for Alleged Violations of the Nurse Practice Act

Mandatory reporting states vary regarding who is required to report: employers, fellow registered nurses, or, more broadly, all licensed medical professionals. States with mandatory employer reporting provisions also vary according to criteria that trigger a mandatory report. Least restrictive versions only require employers to report dismissals, suspensions, or "resignations in lieu of dismissal" resulting from alleged violations. Draft language in SB 799 adopted this less restrictive approach. Earlier versions required employer reporting in the case of "the suspension or termination for cause, or resignation for cause, of any registered nurse in its employ." This level of mandatory reporting gives the facility leeway to provide internal discipline and training without requiring a report to the board that triggers an investigation, so long the nurse is not suspended, terminated or resigns.

States with more restrictive rules require employers to report if violations result in the imposition of restrictions on a nurse, or if other internal discipline is used, such as requiring supplemental training or placing additional oversight on the licensee. The strictest form of employer reporting requires reporting by the employer if they are aware of any practice act violations by a nurse they employ. Mandatory reporting rules that cover nurses or other licensed professionals are generally of this broader type, but sometimes limited by severity or type of reportable violation. Some states have narrower reporting requirements, only mandating a report if the nurse is fired due to an alleged violation. It is possible increased reporting requirements could be used as a retaliation or bullying tool. The literature indicates this most likely occurs in organizations with quasi-formal disciplinary processes, rather than in organizations with highly formalized mandated reporting structures. However, while mandatory reporting potentially reduces opportunity for arbitrary punishment, it also may worsen the impacts of retaliation when it does happen (See *Appendix IV: Management*

*Bullying and Retaliation in Nursing* for more information.)

To the extent stricter reporting requirements capture alleged violations otherwise unreported, they are also more likely to capture complaints of lower severity, and concomitantly, of lower priority for the board. Unfortunately, limited resources dictate that lower-severity complaints potentially go uninvestigated because staff focuses, by necessity, on higher-severity violations.

# Appendices

## Appendix I: Detailed Table

*Table A-4: Mandatory Reporting Rules, License Counts (2017), and Complaints (2017), by State*

| State | Employer | Registered Nurse | Other Practitioner | RN Licenses | LPN/LVN Licenses | Total | Complaints |
|---|---|---|---|---|---|---|---|
| AL | ○ | ● | ○ | 79,610 | 18,486 | 98,096 | 1,525 |
| AK | ● | ○ | ○ | 13,829 | 865 | 14,694 | 64 |
| AZ | ○ | ○ | ○ | 87,420 | 10,362 | 97,782 | 1,000 |
| AR | ○ | ○ | ○ | 41,636 | 15,287 | 56,923 | 1,904 |
| CA* | ○ | ○ | ○ | 427,892 | NA | 427,892 | 7,757 |
| CO | ● | ○ | ○ | 75,419 | 8,712 | 84,131 | 876 |
| CT | ● | ● | ● | 64,882 | 12,956 | 77,838 | NA |
| DE | ○ | ● | ● | 18,111 | 3,050 | 21,161 | NA |
| FL | ○ | ● | ● | 316,640 | NA | 316,640 | 2,637 |
| GA | ● | ● | ○ | 132,949 | 30,813 | 163,762 | 1,581 |
| HI | ○ | ○ | ○ | NA | NA | NA | NA |
| ID | ○ | ● | ○ | 21,362 | 3,747 | 25,109 | NA |
| IL | ○ | ○ | ○ | 195,399 | 26,820 | 222,219 | NA |
| IN | ○ | ○ | ○ | 111,129 | 25,385 | 136,514 | NA |
| IA | ○ | ○ | ○ | 54,415 | 10,517 | 64,932 | 779 |
| KS | ○ | ○ | ○ | 57,969 | 10,639 | 68,608 | 2,060 |
| KY | ● | ● | ● | 69,753 | 13,835 | 83,588 | 1,840 |
| LA* | ○ | ● | ○ | 65,914 | NA | 65,914 | 1,164 |
| ME | ○ | ○ | ○ | 25,026 | 2,242 | 27,268 | 361 |
| MD | ● | ● | ○ | 81,363 | 12,297 | 93,660 | NA |
| MA | ○ | ○ | ○ | 134,405 | 20,488 | 154,893 | NA |
| MI | ○ | ○ | ○ | 149,864 | 24,237 | 174,101 | 1,673 |
| MN | ● | ● | ● | 109,456 | 22,297 | 131,753 | 1,106 |
| MS | ○ | ● | ○ | 48,907 | 14,222 | 63,129 | NA |
| MO | ● | ○ | ○ | 108,321 | 25,375 | 133,696 | 2,354 |
| MT | ○ | ○ | ○ | 16,285 | 2,663 | 18,948 | 235 |
| NE | ○ | ○ | ○ | 29,930 | 5,842 | 35,772 | 583 |
| NV | ○ | ● | ● | 38,054 | 3,905 | 41,959 | 705 |
| NH | ● | ● | ○ | 22,777 | 3,130 | 25,907 | 142 |
| NJ | ● | ● | ○ | 124,991 | 23,435 | 148,426 | 343 |
| NM | ○ | ● | ○ | 28,422 | 2,758 | 31,180 | 343 |
| NY | ● | ○ | ○ | 322,755 | 76,928 | 399,683 | NA |
| NC | ○ | ○ | ○ | 134,738 | 22,605 | 157,343 | 1,448 |
| ND | ● | ● | ○ | 14,039 | 3,161 | 17,200 | 105 |
| OH | ● | ○ | ○ | 204,281 | 54,720 | 259,001 | 8,710 |
| OK | ○ | ● | ○ | 55,506 | 16,808 | 72,314 | 504 |
| OR | ● | ● | ○ | 60,230 | 5,381 | 65,611 | NA |
| PA | ○ | ○ | ○ | 220,583 | 53,989 | 274,572 | NA |
| RI | ○ | ○ | ○ | 20,529 | 2,008 | 22,537 | NA |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| SC | ● | ● | ○ | 69,799 | 12,682 | 82,481 | NA |
| SD | ○ | ○ | ○ | 18,162 | 2,617 | 20,779 | 196 |
| TN | ○ | ● | ○ | 100,817 | 30,216 | 131,033 | NA |
| TX | ● | ● | ○ | 314,920 | 105,655 | 420,575 | NA |
| UT | ● | ● | ● | 33,309 | 2,834 | 36,143 | NA |
| VT | ● | ● | ○ | 14,064 | 2,379 | 16,443 | NA |
| VA | ○ | ○ | ○ | 104,667 | 27,745 | 132,412 | 5,639 |
| WA | ● | ● | ● | 96,664 | 11,513 | 108,177 | NA |
| WV* | ○ | ● | ○ | 32,669 | NA | 32,669 | NA |
| WI | ○ | ● | ○ | 102,908 | 13,166 | 116,074 | NA |
| WY | ○ | ● | ○ | 15,579 | 1,465 | 17,044 | NA |

* Board regulates Registered Nurses only.

## Appendix II: NC Complaint Evaluation Tool

Also available online at: https://www.ncbon.com/vdownloads/cet/ce-tool.pdf

**North Carolina Board of Nursing (NCBON)**
**COMPLAINT EVALUATION TOOL (CET)**

**Allegation(s):** _____ **Licensee Name:** _____

| | Criteria | Human Error | At Risk Behavior | | | Reckless Behavior | | Score |
|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 4 | 5 | |
| G | General Nursing Practice | No prior written counseling for practice issues. | Prior written counseling for single non-related practice issue within last 12 months. | Prior written counseling for single related practice issue within past 12 months | Prior written counseling for various practice issues within the last 12 months | Prior written counseling for same practice issue within last 12 months | Prior written counseling for same or related practice issue within last 6 months with minimal to no evidence of improvement | |
| U | Understanding / level of experience | Has knowledge, skills, and ability. Incident was accidental, inadvertent or oversight. | Limited understanding of correct procedure. May be novice < 6 months experience in nursing or with current event / activity. | Limited understanding of options / resources. Aware of correct procedure but in this instance cut corners. May be advanced beginner – 6 months to 2 years experience in nursing or with current event / activity. | Aware of correct action / rationale but failed to apply in this incident. Did not obtain sufficient information or utilize resources before acting. May be competent > 2 years experience in nursing or with current event / activity. | In this instance there was intentional negligence or failure to act / not act according to standards. Risk to client outweighed benefits. May be in a position to guide / influence others. May be proficient > 5 years in nursing or with current event / activity. | In this instance there was intentional gross negligence / unsafe action / inaction. Licensee demonstrated no regard for client safety and harm almost certainly would occur. May hold a leader / mentor position. May be expert performer > 5 years in nursing or with event / activity. | |
| I | Internal policies / standards / orders | Unintentional breach or no policy / standard / order exists. | Policy / standard / order has not been enforced as evidenced by cultural norm (common deviation of staff) or policy / standard / order was misinterpreted. | Policy / standard /order clear but nurse deviated in this instance as a time saver. Failed to identify potential risk for client. No evidence of pattern. | Aware of policy / standard / order but ignored or disregarded to achieve perceived expectations of management, client, or others. Failed to utilize resources appropriately. May indicate a pattern. | Intentionally disregarded policy / standard / order for own personal gain. | Intentional disregard of policy / standard / order with understanding of negative consequences for the client. | |
| D | Decision/ choice | Accidental / mistake/ inadvertent error. | Emergent situation – quick response required to avoid client risk. | Non-emergent situation. Chose to act / not act because perceived advantage to client outweighed the risk. | Emergent or non-emergent situation. Chose to act / not to act without weighing options or utilizing resources. Used poor judgment. | Clearly a prudent nurse would not have taken same action. Unacceptable risk to client / agency / public. Intentional disregard for client safety. | Willful egregious / flagrant choice. Put own interest above that of client / agency / public. Intentionally neglected red flags. Substantial and unjustifiable risk. | |
| E | Ethics / credibility / accountability | Identified own error and self reported. Honest and remorseful. | Readily admitted to error and accepted responsibility when questioned. Identified opportunities and plan for improvement in own practice. | Reluctantly admitted to error but attributed to circumstances to justify action/ inaction. Cooperative during investigation and demonstrated acceptance of performance improvement plan. | Denied responsibility until confronted with evidence. Blamed others or made excuses for action/ inaction. Failed to see significance of error. Reluctantly accepted responsibility and denied need for corrective action. | Denied responsibility despite evidence. Indifferent to situation. Uncooperative, irrebondinate and / or dishonest during investigation. | Took active steps to conceal error or failed to disclose known error. Provided misleading information during investigation or destroyed evidence. May have inappropriately confronted others regarding investigation. | |
| | | | | | | | **Criteria Score** _____ | |

2011 – Version 2.0 @ NCBON-Permission Required Before Use

## North Carolina Board of Nursing (NCBON)
## COMPLAINT EVALUATION TOOL (CET)

| | Mitigating Factors -check all identified | | Aggravating Factors - check all identified | |
|---|---|---|---|---|
| | Communication breakdown (multiple handoffs, change of shift, language barrier | | Took advantage of leadership position | |
| | Limited or unavailable resources (inadequate supplies / equipment) | | Especially heinous, cruel, and / or violent act | |
| | Interruptions / chaotic environment / emergencies – frequent interruptions / distractions | | Knowingly created risk for more than one client | |
| | Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet agency needs | | Threatening / bullying behaviors | |
| | High Work volume / staffing issues | | Disciplinary action (practice related issues) in previous 13 – 24 months | |
| | Policies / procedures unclear | | Vulnerable client: geriatric, pediatric, mentally / physically challenged, sedated | |
| | Performance evaluations have been above average | | Worked in excess of 12 hours in 24 / or 60 hours in 40 to meet personal needs | |
| | Insufficient orientation / training | | Other (identify) | |
| | Client factors (combative / agitated, cognitively impaired, threatening) | | | |
| | Non-supportive environment – interdepartmental conflicts | | | |
| | Lack of response by other departments / providers | | | |
| | Other (identify) | | | |
| | Total # mitigating factors identified | | Total # aggravating factors identified | |

**Criteria Score from page 1** _____

| No Board Contact Required | Board Consultation Required | Board Report Required |
|---|---|---|
| Contact with NCBON is not required if:<br>○ 3 or more criteria in green OR<br>○ Criteria score of 6 or less | Consult with NCBON if:<br>○ 3 or more criteria in yellow OR<br>○ Criteria score 7 – 15<br>Call- 919-782-3211 ext 256 or 226 | Mandatory report to NCBON if<br>○ 2 or more criteria in red OR<br>○ Criteria score 16 or more OR<br>○ Incident involves fraud, theft, drug abuse, diversion, sexual misconduct, mental / physical impairment.<br>Go to website: (www.ncbon.com) or Call 919-782-3211 ext 282 for assistance |

CET Completed by : _____ Facility Name: _____

Contact Number & Email address: _____

Date of Consultation with NCBON _____ NCBON Consultant: _____ Action Taken: _____

## Appendix III: Just Culture

In the 1970s, researchers started making greater effort to understand causal models of medical error. The primary driver behind this research was a growing concern around increasing medical malpractice lawsuit rewards (Hiatt & al., 1989). It had become clear that the current malpractice insurance system exposed insurers to significant liability and/or would require increased insurance premiums dramatically above what doctors were used to paying, or could afford. Much of what researchers now know about the sources of medical error came out of this literature. The most widely cited of such studies was the Harvard Medical Practice Study, the results of which were first published by the New England Journal of Medicine in 1991 (Brennan & al., 1991). The Harvard study drew "a weighted sample of 31,429 records of hospitalized patients from a population of 2,671,863 non-psychiatric patients discharged from [51] nonfederal acute care hospitals in New York in 1984." The researchers then used this sample to estimate an overall rate of adverse events, and further estimated the proportion of medical injuries that were the result of negligent or otherwise substandard care. Of the original 31,429 records sampled, the researchers identified 1,278 hospitalizations with at least one adverse advent. Of those, 306 were determined to have occurred due to negligence or substandard care.

When researchers weighted and adjusted those numbers to match the broader patient population in New York State, they estimated that approximately 3.7 percent (with a 95 percent confidence interval of 3.2 percent and 4.2 percent) of hospitalizations result in an adverse event. They further estimated that 1.0 percent (95 percent confidence interval of 0.8 percent to 1.2 percent) of hospitalizations result in hospitalizations that were due to negligence or substandard care. This implies that the largest portion—73.0 percent—of adverse events occurred without evidence of negligence. An earlier—but smaller—California study found similar results (Mills, 1987).

Ten years after the Harvard Medical Practice Study, the Institute of Medicine's (IOM), Quality of Health Care in America Committee published *To Err is Human*, produced with the goal of identifying the causes of medical error and providing effective strategies to reduce them. One key conclusion of the report was that the majority of medical errors were not the result of an individual or group's recklessness (IOM, 2000). In other words, eliminating "bad apples" and/or maintaining more stringent standards of practice would not eliminate more preventable adverse events:

> "More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them…. [M]istakes can best be prevented by designing the health system at all levels to make it safer—to make it harder for people to do something wrong and easier for them to do it right. Of course, this does not mean that individuals can be careless. People still must be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error."

To the extent that disciplinary action is primarily punitive—i.e. fear of consequences is meant to deter lax behavior—safety researchers have argued that such punishment is ineffective in cases where most (if not all) practitioners would have made the same mistake (Miller B. , 2008; Miller, Griffith, & Vogelsmeier, 2010). Even in cases where readily identifiable human error

occurred and contributed to an adverse event, it can be more valuable to identify the systems that failed to recognize and prevent the error (Whittingham, 2003; Kerfoot, 2008). Focusing on individual punishment also carried the risk of forestalling needed systemic improvements. If there are systemic contributions to the medical error, prioritizing the identification of the individual(s) to blame can lead to premature closure. This is a cognitive error where the first viable explanation is adopted, preventing the full consideration of alternative explanations. Once an individual has been blamed, and the disciplinary process is underway, additional causes can be overlooked—and therefore any systemic issues that contributed to the error will remain uncorrected (Ebright & Rapala, 2003).

These concerns are often cited by the many studies that focus on organizational changes to reduce medical error, and improve patient safety. There is a significant body of literature that has identified replacing the punitive culture with a culture of safety as the most important piece of effective patient safety policy (Wolf & Hughes, 2008; Force, Deering, Hubbe, & al, 2006; Stump, 2000; Boysen, 2013). This shift away from a pure punitive approach began about the same time that the healthcare industry began reducing individual autonomy in healthcare provision, shifting away from one that emphasized the individual professional role toward a more systematized group care model. This occurred largely because of changes to the industry outside of the patient safety-medical error purview—primarily the changes were a response to increasing medical costs and the emergence of HMOs and industry consolidation to control costs. But whatever the impetus, the result was a reduction in individual autonomy for licensed health providers, a change which effected nurses to a significant degree (Boysen, 2013). In this new environment, systemic concerns are more important than ever.

Importantly, when surveyed, most hospital leaders reported that mandatory reporting to nursing boards deters reporting patient safety incidents to internal reporting systems. They were also concerned that the non-confidential nature of such systems could also encourage lawsuits (Weissman, Annas, Epstein, & al, 2005). Patients, on the other hand, support mandatory reporting (Blendon, DesRoches, Brodie, Benson, & al, 2002).

In response to these divergent and opposing concerns, the patient safety community has coalesced around a series of policy preferences and cultural values called “just culture.” Just culture attempts to balance the need to provide accountability toward individual nurses with the need to create an environment where mistakes are widely reported and learned from (Marx, 2001; Miller B. , 2008; Kerfoot, 2008). It draws heavily from the “highly reliable organizations” model, building on the key concepts that: 1) human error cannot be avoided 100 percent of the time, 2) even well-designed organizational systems can fail, and 3) risk is everywhere.

The IOM (2000) report recommended adopting mandatory reporting, but with an emphasis on adverse events resulting in serious harm or death. Recognizing that mandatory reporting systems involved both learning and accountability mechanisms, it suggested conducting “root cause” analyses of the health delivery system as a whole. Under such an approach, individual blame—and ultimately board discipline—is contingent on whether the individual error was the root cause of the practice breakdown, and whether error is due to 1) unavoidable human error, 2) at-risk behavior, or 3) reckless behavior (Boysen, 2013).

A number of state boards of nursing embrace approach. Ohio’s Board of Nursing explicitly adopted just culture principles in its “Patient Safety Initiative” (Ohio Board of Nursing).

Ohio's goal is to improve overall reporting of error, create a statewide patient safety database, and improve opportunities for employer-sponsored remediation and alternative discipline programs. Missouri's "Just Culture Collaborative" places focus on learning and implementing the principles of just culture (Miller, Griffith, & Vogelsmeier, 2010). The collaborative currently has 67 members, including business, government and professional associations. California took similar steps. Formed in 2007, the California Patient Safety Action Coalition introduced state healthcare leaders to just culture. Active for a number of years, they ultimately felt they met their educational goals and have since disbanded. While no organization in California is currently dedicated to advancing just culture, the California Hospital Patient Safety Organization invests resources and works in this area.

## Appendix IV: Management Bullying and Retaliation in Nursing

Punishment models in an employer-employee context, historically, increase the "docility" of the workforce (Knight & Latreille, 2000). Nurses, expected to be advocates for their patients, may at times find themselves in opposition to managers and employers. Discipline that punishes nurses' fulfilling their role as patient advocates causes the disciplinary process to work at odds with patient health outcomes. A rhetoric of correction, then, could effectively mask punishment. This is a recognized phenomenon within professional nursing (Fenley, 1998; Cooke, 2006).

The larger workplace retaliation literature offers helpful detail. The typical pattern for workplace retaliation is for punishment to take place through small repetitive acts, occurring over an extended period, often with escalating harassment (Glasø, Løkke Vie, & Hoel, 2010). Typically, retaliatory acts do not come from a single individual, but from diverse sources (Miceli, Near, & Dworkin, 2008). Coworkers, even those sympathetic, add to isolation felt by targeted individuals when they pull away from professional and personal relationships to avoid being targeted themselves (Beardshaw & Thorold, 1981, p. 37; Bjørkelo & Matthiesen, Preventing and Dealing with Retaliation Against Whistleblowers, 2011).

Retaliatory bullying creates significant additional stressors in the work environment (Wilson, 1991; Adams & Crawford, 1992; Zapf, Knorz, & Kulla, 1996), with negative consequences for physical health (Soeken & R., 1987), psychological health (Rothschild & Miethe, 1999), and triggers symptoms analogous to post-traumatic stress disorder (Bjørkelo, Ryberg, Matthiesen, & Einarsen, 2008). When workplace retaliation includes reports to a state nursing board, the potential for such stress increases. Lodging a complaint has an "immediate and devastating impact on their feelings about nursing and their confidence in their professional skills" (Beardwood & French, 2004). If the complaint results in practice restrictions, the impacts on a nurse's career and personal well-being are profound. A recent review of Australian nursing boards shows that reports coming from one's employer are taken more seriously and have a higher likelihood of resulting in discipline (Spittal, Studdert, Paterson, & Bismark, 2016).

One concern about instituting mandatory reporting employer reporting requirements is its potential to influence the ability of managers to punish and retaliate against nurses for workplace organizing or for reporting for quality of care violations. Existing research does not specifically address this issue. Cooke (2006), however, points out that such use of punishment for worker-management disagreement is most common where the disciplinary processes are quasi-formal. In these situations, managers apply standard of care criteria more aggressively on targeted individuals than on staff as a whole. When managers have less discretion in when and how to apply discipline, the potential to use the disciplinary process for retaliation is more limited. If accurate, research indicates mandatory reporting reduces the amount of discretion managers have, therefore reducing their ability to target specific nurses for retaliation. However, while mandatory reporting potentially reduces the opportunity for arbitrary punishment, it could also worsen impacts of retaliation when punishment happens.

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# Communities Lifting Communities 2018 Accomplishments

## Secured almost $2M in Funding for 2018-2020

**Received $420,000 in grants from Blue Shield of California Foundation and The California Endowment for:**

- Hospital Strategic Leadership and Health Equity Training for hospital executive, hospital board and clinical teams
- Innovative, Sustainable Financing Models for Prevention to research best practices and emerging models and bring together experts to discuss strategies for implementation
- Strategic Community Planning and Investment to facilitate regional convenings of health care and public health stakeholders and explore alignment of community health improvement strategies

**Received a $484,000 sponsorship from Health Net to Improve African American Birth Outcomes in Los Angeles County**

- The African American Birth Outcomes Project in Antelope Valley and South-Central Los Angeles will develop effective partnerships, examine birth outcomes data, and recommend systemic changes and prevention practices

**HASC member hospitals and HASC's for-profit subsidiary, AllHealth, committed $1 million to CLC for 2018-2019**

- CLC hired an Executive Director and Project Manager to work with CLC Partners and subject matter experts to develop priority areas and community health improvement initiatives

## CLC Regional Activities

**Los Angeles County:** Supported the LA Hospital Partnership Diabetes Prevention Workgroup to identify models and partnership opportunities for a food recovery and redistribution program.

**Orange County:** Partnered with SpeedTrack to analyze and report ED encounters with behavioral health principle diagnoses in California and Orange County for Be Well initiative.

**Inland Empire:** Facilitated the launch of the 2019 Regional Community Health Needs Assessment with HC2 Strategies and 8 participating hospitals in Riverside and San Bernardino Counties.

**Ventura and Santa Barbara Counties:** Partnered with Ventura County Community Health Needs Assessment Collaborative and HealthBegins to plan an upstream quality improvement campaign for pre-diabetic patients with food insecurity.

CLC is collaborating on the 2019 HASC Region Behavioral Health Needs Assessment to identify opportunities to support behavioral health needs in Santa Barbara and other counties.

## CLC Partners

HC2 Strategies, Inc
HealthBegins
Hospital Association of Southern California
National Health Foundation
Public Health Alliance of Southern California
Public Health Institute
SpeedTrack

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

February 5, 2019

TO: CNO Advisory Committee Members

FROM: BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing and Clinical Services, CHA

SUBJECT: CHA 2019 Advocacy Priorities

**SUMMARY**

CHA had established its advocacy priorities for the year and as outlined on the attached slide, include Access/Coverage, Health Care Affordability, Financing, Workforce, Quality, Behavioral Health, Statutory and Regulatory Modernization and Labor. These specific areas are bundled into four larger buckets of Coverage, Access, Affordability and Collaboration.

**DISCUSSION**

1) Where do you see the priorities of the CNO Committee aligning with these priorities?
2) Do you feel we are on track with these priorities?
3) Do you have other suggestions?

**ACTION REQUESTED**

- *Discussion and determinations of next steps.*

Attachment: CHA 2019 Advocacy Priorities

BJB:br

# CHA 2019 Advocacy Objectives

## Access/Coverage

- Support Premium subsidies
- Protect ACA Implementation

## Quality

- Quality Reporting
- Value-Based Purchasing

## Health Care Affordability

- Broaden the discussion framework
- Revise the 2030 seismic standard
- Differentiate “integration” from “consolidation”

## Behavioral Health

- Raise awareness
- Create consistency in access to needed services
- Eliminate barriers for telehealth

## Financing

- Pursue changes to protect and augment state and federal funding to hospitals
- Expand coverage to the remaining uninsured

## Statutory and Regulatory Modernization

- Remove or modernize federal and state regulatory barriers to future health care delivery

## Workforce

- Practice to the workforce’s greatest potential and level of training
- Increase GME Funding

## Labor

- Create an effective workplace
- Work to reduce liability related to litigation

CALIFORNIA HOSPITAL ASSOCIATION

*Providing Leadership in Health Policy and Advocacy*

February 5, 2019

TO: CNO Advisory Committee Members

FROM: BJ Bartleson, MS, RN, NEA-BC
Vice President, Nursing and Clinical Services, CHA

SUBJECT: Roundtable Review of 2018 CNO Advisory Committee Topics

**SUMMARY**

The CHA CNO Advisory Committee has focused their efforts on several areas related to professional nursing practice, in addition to the regional summit educational initiative - 1) the Nursing Community Collaborative, 2) Nursing Diagnoses and, 3) Span of Control. To date the following activities are planned relative to each area:

1) Nursing Community Collaborative – working off the success of the regional summit work, we continue to encourage ACNL and ANA-C to dialogue on guiding principles and combined activities, particularly in the health policy arena. ANA-C has a lobbying arm and can be more focused on professional nursing issues, while CHA can focus on both on broad nursing and overall workforce and healthcare modernization.
2) Span of Control- several health systems and CNOs have graciously shared their research and activities that were show cased today at the ACNL Span of Control panel presentation.
3) Nursing Diagnoses – Dr. Kim from UC Davis and Anna Kiger have offered to work more closely on a potential research opportunity.

**DISCUSSION**

The group has had excellent dialogue on these topics with particular interest in the span of control work.

1) How would the group like to proceed with these topics?
2) Are there other areas that the group needs to prioritize, particularly with upcoming legislative and regulations?

**ACTION REQUESTED**

- *Discussion and determination of next steps.*

BJB:br

# When Did Span of Control Become a Dirty Word?

ACNL Annual Conference
February 5, 2019

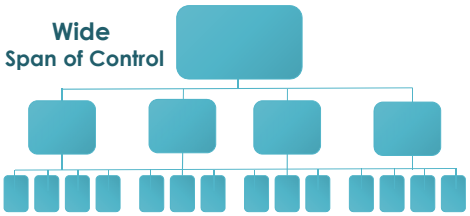
**Theresa Murphy, RN, MS, CENP**
*Chief Nursing Officer*
USC Verdugo Hills Hospital

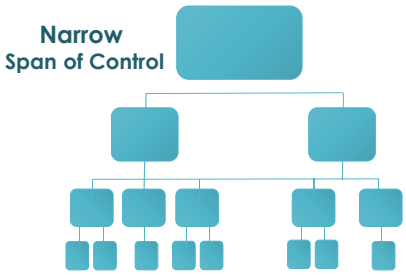
## A Day in the Life…

# Evolution of Healthcare: Why it matters …




# Span of Control



# My Thesis: Literature Search …

**Limited Healthcare Research**
- 1 Study from The Ottowa Hospital in the early 1990's
- Decision-making tool: nurse manager

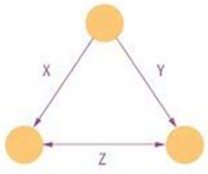
| Author | Implications | Recommendation |
|---|---|---|
| Graicunas | Number of direct reports = geometric growth of relationships to manage | No more than 6 |
| Gulick & Urwick | **Complexity**<br>**Stability of Staff**<br>Geographical distance of units | |
| Stieglitz | Similarity of function<br>**Geographic continuity**<br>**Complexity of function**<br>Direction and Control of subordinates (stability of staff)<br>Coordination of relationships<br>Planning and Organizational assistance | 4-11 |
| Flippo | Similarity<br>**Complexity**<br>Interdependence<br>**Stability**<br>Predictability<br>Independence of direct reports | |
| Bellis-Jones & Hand;<br>Ouchi & Dowling | Impact of non-supervisory tasks (projects) | More non-supervisory projects = Less volume of direct reports |
| House & Miner | Many of above plus:<br>Competency of the manager<br>Frequency of and degree of interaction required | More competent (EI; experience; managerial skill) = larger SOC<br>More independent the staff = larger SOC |
| Woodward; Meier & Bohte | Diversification<br>**Stability**<br>Space | |
| Military | Nature of the operation | Large regiments = power but sacrifice agility<br>Small units=agility; reconnaissance |
| Disaster Management; Incl | | |
| Command | | |
| Drucker | | |
| Call Center | | |
| Law Department | | |

**Non-Healthcare Research**:
- Emergent common themes useful for nursing-related decision-making
  - ✓ Complexity
  - ✓ Stability of Staff
  - ✓ Supervisory vs Project Work
  - ✓ Geography
  - ✓ Plus others …

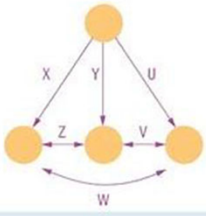
# 1 Emergent Theme … Complexity

**The Increasing Complexity of a Manager's Job as the Span of Control Increases**

A. The manager has 2 subordinates and must manage 6 relationships.




B. With the addition of just one more subordinate (for a total of 3), the manager has 18 relationships to handle



# High Consequence Industries and SoC





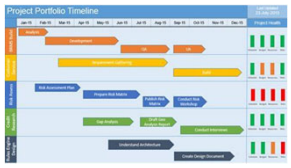

# Healthcare Considerations

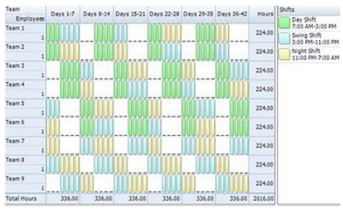
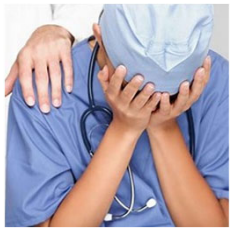





# More Considerations and Trade-Off's …



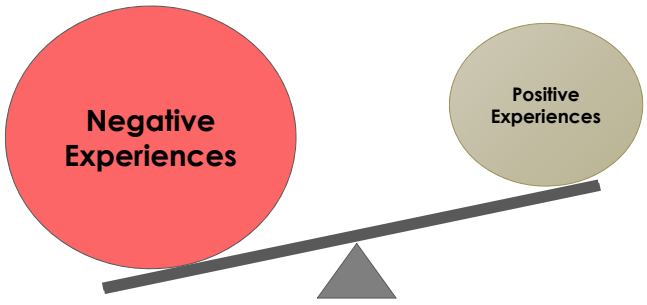

# A Decision-Making Tool …

| Unit | Staff | Program |
|---|---|---|
| **Complexity**<br>• Hours of operation<br>• Unpredictability<br>• Unit capacity<br>• Litigation & risk<br>• Quality improvement<br>• Complaints<br>• Incident reports<br><br>**Materials Management**<br>• Specialized equipment<br>• Maintenance<br>• Vendors | • Number of direct reports<br>• Experience of professional staff<br>• Percent of non-professional staff<br>• Turnover rate<br>• Absenteeism<br>• Diversity of staff (experienced, novice, student, others) | • Number of directors manager reports to (e.g. dual reporting with possibly competing demands)<br>• Number of units/departments<br>• # of Projects<br>• Physical distance between units<br>• Administrative and educator support |

# Additional Considerations …



# Consequences of Getting it Wrong …



# Making Decisions …

| Smaller Span of Control | Larger Span of Control |
|---|---|
| *Works when you have Higher:*<br>• Complexity<br>• Instability<br>• # of Projects<br>• Diversity of Worker Type<br>• Geographic distance between units | *Works when you have **Lower**:*<br>• Complexity<br>• Diversity of Worker Type/Reporting Structure<br>• Geographic dispersion of units<br>• # Projects |
| *Works when you have **Lower**:*<br>• Manager experience<br>• Manager professional development/personal maturity<br>• Clerical, Admin, Education Support | *Works when you have **Higher**:*<br>• Maturity of Leader and/or Staff<br>• Clerical, Admin, Educational Support<br>• Unit stability |

***Implications***
- While no optimal range exists, you can look at the key factors within your organization to determine span of control.
  - Strategic drivers
  - Revenues (shrinking or growing?
  - Quality metrics
  - Patient demands
  - Employee demands
  - Clinical and non-clinical projects
  - Clerical support

# Conclusions


# Future Study …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# Dignity Health Nursing Span of Control

**Connie Clemmons-Brown, RN, MBA**
System VP, Patient Care Services
Clinical Excellence and Professional Practice

Association of California Nurse Leaders
2019 Conference
February 5, 2019

Dignity Health

## I have a question……

Can mitigating nurse leadership structures improve patient-centered care and business outcomes (such as the staff/patient experience and clinical outcomes) given nurse leaders' demanding and complex clinical environments?

## Questions to Answer:

1. What do **great** High Span Dignity Health Nurse Directors and Managers **DO** that make them effective? In other words, what are their competencies?
2. Are the competencies needed in Low Span environments different?
   - Qualitative interviews + Survey = Development of Competency Model
3. Which competencies are we strong at as a system? Which ones do we need to develop?
   - Developed and administered a 360-degree feedback process

Dignity Health 3

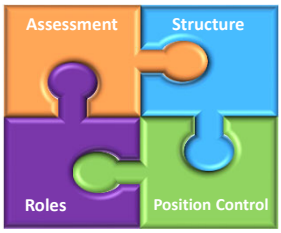
## Study Inputs

- Metrics
  - Productivity %
  - UOS
  - Productive FTE
  - Missed Meals and Breaks
  - Employee Experience
  - Voluntary Terms
  - HCAHPS Top Box
  - HCAHPS VBP Points
- Observations
- Survey – 360° evaluation of nurse leaders

Dignity Health 4

## Method - Operations

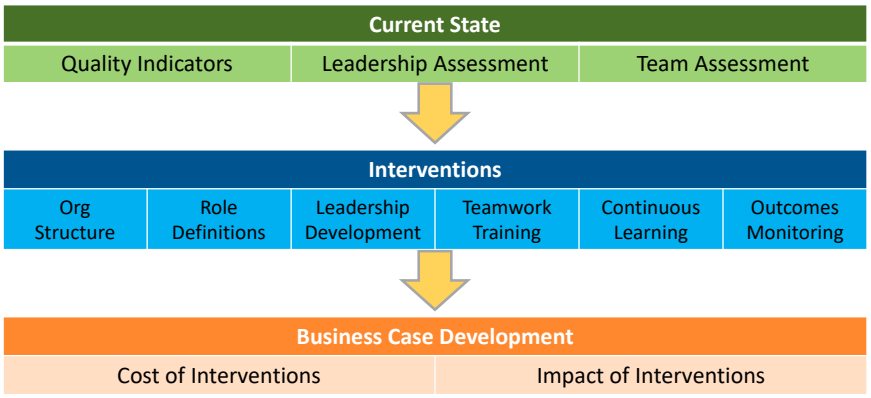
- Unit observational assessment – 39 metrics
  - Clinical Outcomes (7) (i.e. Falls, HAPIs, Med Errors/Unit)
  - Outcome Measures (13) (i.e. Absenteeism, Productivity %, LOAs, EE Engagement)
  - Process Measures (11) (i.e. Org structures, Tenure, Education, Task Orientation)
  - Span Indicators (8) (i.e. Occupied beds, Vacancies & fill times, business hours of ops)
- Assess and recommend nursing structure to drive leadership model knowing people leadership transforms to an engagement model
- Analysis of Position Control
- Strategic Duties and Operational Duties define roles
  - Director/Manager
  - Nurse Shift Manager




Dignity Health

5

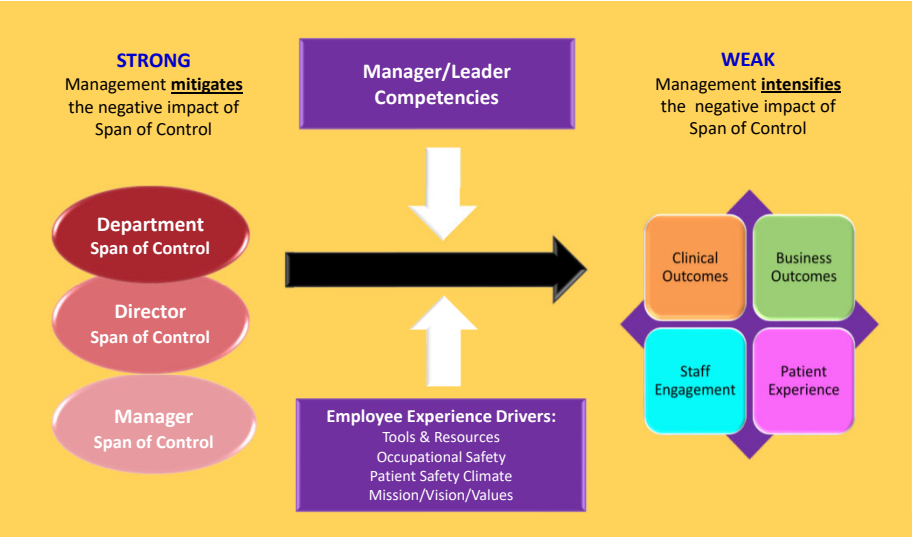
## Pilot




Dignity Health

6

## Study Results – Management Skills




Dignity Health

## High Span Nurse Director & Manager Heatmap


**Based on the team's findings: Partnerships, Communications, Performance and Change were the areas needing the most focus in order to drive business outcomes**

Dignity Health

## Competencies and Vital Behaviors

- **High Span of Control**
  - Managing People, Projects & Tasks
  - Communication
  - **Building Partnership & Teamwork**
  - Patient/Customer Focus
  - **Facilitating Change**
- **Low Span of Control**
  - Managing People, Projects & Tasks
  - Communication
  - **Mission, Vision & Values**
  - Patient/Customer Focus

Dignity Health 9

## LEADERSHIP DEVELOPMENT


Competencies & **Vital Behaviors** were identified.

**Leadership Development** approach designed.

Leadership development is an ongoing process of providing **mentoring** and **skill building opportunities** to support team management and successful business outcomes.

A three-pronged approach was recommended, which included the following components:

- **Learning Check-Ins**
- **Ongoing-Learning Activities**
- **Community Building**

Dignity Health 10

## EXAMPLE: LEADERSHIP DEVELOPMENT SCHEDULE

**RECOMMENDED LEADERSHIP DEVELOPMENT SCHEDULE**

**1. Identify the weekly topic.**

| Week 1 | Week 2 | Week 3 | Week 4 | Week 5 | Week 6 | Week 7 |
|---|---|---|---|---|---|---|
| **Managing People, Projects, & Tasks**<br>Topics include:<br>• Time management<br>• Empowerment and Delegation<br>• Building Partnership & Teamwork<br>• Coaching<br>• Feedback Essentials | **Leading Through Mission, Vision, & Values**<br>Topics include:<br>• Knowing your leadership style<br>• Motivating<br>• Strategic Vision | **Building Trust**<br>Topics include:<br>• Being visible & approachable<br>• Personality characteristics<br>• Communication<br>• Effective Leadership Communication Strategies<br>• Listening Essentials | **Patient/Customer Focus**<br>Topics include:<br>• | **Decision-Making & Critical Thinking**<br>Topics include:<br>• Problem Solving<br>• Prioritizing time and tasks<br>• Prioritizing goals | **Conflict Management**<br>Topics include:<br>• First Time Manager Challenges<br>• Managing Change | **Workforce Diversity Management**<br>Topics include:<br>• |

**2. Choose one of the on-going learning activities.**

| Conscious Practice | Ask a Friend | Video Watch | Meeting Segment | NSM Mentoring | Lunch and Learn | Reading Club |
|---|---|---|---|---|---|---|
| • Give NSMs a list of 2-3 behaviors each week.<br>• Encourage NSMs to practice these behaviors and report back the next week. | • Provide NSM with a topic and a list of questions.<br>• Ask NSMs to interview peers, leaders, or colleagues to learn from other's experience on the topic. | • Share a video with NSMs.<br>• Ask NSMs to identify one or two things they will do or do differently based on what they learned | • Commit a specific amount of time in your huddles or team meetings to discuss a topic.<br>• Encourage NSMs discuss the topic freely and to share learning with their peers | • Have NSMs check in with their nursing staff regarding the learning topic.<br>• Ask NSMs to report back with learning and potential feedback. | • Instruct NSMs to take a Mylourney online learning course on a specific leadership topic<br>• Host a Lunch and Learn to discuss what NSMs learned in the course and how they will apply that. | • Share an article or book excerpt with NSMs.<br>• Meet the following week to discuss what NSMs learned in the reading. |

**3. Ask the 7 minute learning check-in questions.**

- Since we last spoke, what new insights or skills have you discovered?
- In terms of what you are learning this week, what are your strengths on this topic?
- In what ways do you need to develop in this topic?
- What behaviors or skills will support your work on this topic?
- What do you need from me to support your efforts on this topic?

**4. Build a Community.**

- Allocate time each week/month to have NSMs gather for a meeting or brownbag lunch to socialize, ask questions, and share lessons learned
- Encourage NSMs to share questions, insights, or lessons learned on a breakroom bulletin board for community input
- Lead team building exercises with your NSMs to give them an opportunity to get to know each other
- Group NSMs together in pairs or triads to create a NSM "buddy system"

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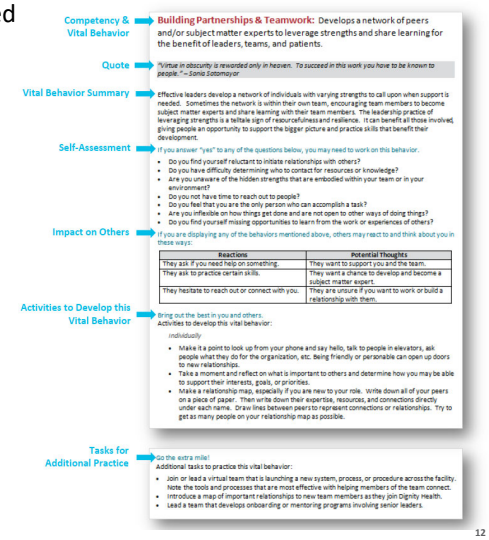
## Competency and Vital Behavior

- Each **Competency** has associated vital behavior(s)
- Each **Vital Behavior** includes:
  - Self Assessment
  - Impact on Others
  - Activities to develop this Vital Behavior
  - Tasks for additional Practice

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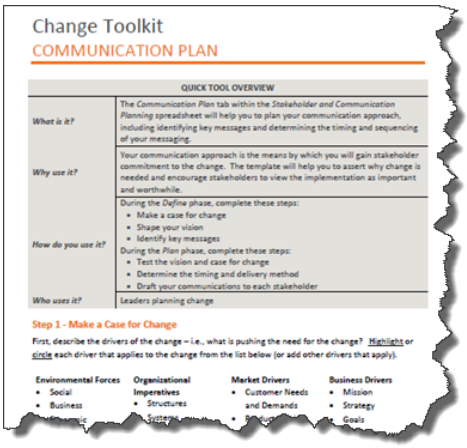
## Change ToolKit

- 10 change tools and accompanying spreadsheets
- Quick Tool Overview on each
- Step-by-step process
- Stakeholder engagement in use of the tools
- Consulting and support on tool usage is available for leaders


Change Toolkit
COMMUNICATION PLAN

QUICK TOOL OVERVIEW

| | |
|---|---|
| *What is it?* | The *Communication Plan* tab within the *Stakeholder and Communication Planning* spreadsheet will help you to plan your communication approach, including identifying key messages and determining the timing and sequencing of your messaging. |
| *Why use it?* | Your communication approach is the means by which you will gain stakeholder commitment to the change. The template will help you to assert why change is needed and encourage stakeholders to view the implementation as important and worthwhile. |
| *How do you use it?* | During the *Define* phase, complete these steps:<br>• Make a case for change<br>• Shape your vision<br>• Identify key messages<br>During the *Plan* phase, complete these steps:<br>• Test the vision and case for change<br>• Determine the timing and delivery method<br>• Draft your communications to each stakeholder |
| *Who uses it?* | Leaders planning change |

Step 1 - Make a Case for Change

First, describe the drivers of the change – i.e., what is pushing the need for the change? Highlight or circle each driver that applies to the change from the list below (or add other drivers that apply).

| Environmental Forces | Organizational Imperatives | Market Drivers | Business Drivers |
|---|---|---|---|
| • Social<br>• Business | • Structures | • Customer Needs and Demands | • Mission<br>• Strategy<br>• Goals |



## Current State – So where are we now?

- Transition from Span of Control to Leader development
- Roles and Responsibilities matrix – role clarity
- Linkage to AONE competencies for managers and CNEs
- Training and Leader Development Programs
  - Nurse Shift Manager Fundamentals I – Orientation, In-person & LMS
  - Nurse Shift Manager – Phase II – 7 modules on leader competencies, Project, Learning Check-ins and other activities
  - Manager/Director Leadership Program
  - CNE Leadership Development

Previously Proposed Model


AONE Model

## Lessons Learned

- Must lead with the **WHY**
- Stakeholder support is essential
- SOC vision/model transition between CNEOs is crucial
  - Historically has not happened at the facility level (or system level)
- Natural for new NSMs to function as previously (charge nurse/Patient Care Coordinator)
- Cannot focus/function as a NSM when covering meals and breaks
- Introduction of the NSM role shifts the dynamics in a unit and can be disruptive for staff



## Best Practices

- Socialize NSM role as a MANAGER and set expectations with non-nursing departments and Physicians regarding role, chain of command, etc.
- Establish (and treat) NSM as a member of the nursing leadership team
  - Include NSM in meetings with the rest of the leadership team on a regular basis (weekly, bi-weekly, monthly)
  - Host a meeting for NSMs only on a regular basis (monthly, bi-monthly, quarterly)
- Outline an orientation and training program that addresses the most critical needs first
- Clarify roles and responsibilities for ALL members of the nursing leadership team

## Questions

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## Thank You

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# When Did "Scope of Practice" become a dirty word?

What do we "know" from the evidence?

# Span of Control

- Outside of Healthcare, the average Span of Control for managers is nine direct reports.

  The Advisory Counsel, 2015.

- Largest number reported as the Span of Control for managers in the reviewed literature is 183

- Is not just a problem in the United States, research on Span of Control is available from Asia and Europe.

# In Healthcare, Span of Control is:

- Not just a nursing problem
  - Environmental Service Managers had a broad Span of Control in one nationwide assessment.
- But Nursing is the most impacted
  - Nurse managers have a higher span of control than managers hospital wide.
  - Since 2011, the gap with other managers in healthcare has widened.

The Advisory Counsel, 2015.

# Span of Control drives outcomes.

- Manager Outcomes
  - Multiple demands generate considerable stress resulting in work-life imbalance, negative health consequences and burn out (Shirey, 2009).
  - The issue is complex, however, as Brown demonstrated that span of control interacted with job satisfaction with managers who were in the position a shorter time having greater job satisfaction (Brown, et al, 2013).
  - Establishing a "right sized span of control" results in decreased turnover and time to fill vacant positions. (Jones, et al, 2015)
- Staff Outcomes
  - Doran et al. (2004) discovered higher SOC to be associated with higher staff turnover. Their findings indicated that "an increase of 1.6% unit turnover rate occurred for every additional ten individuals in a manager's SOC, such that a span of 100 predicts a turnover rate of 16%"(p.3).
- Patient Outcomes
  - Patient satisfaction was lower on units where managers had large numbers of staff reporting to them. (Doran, et al, 2004) (McCutcheon, 2009).

## Further Evidence Based Conclusions

- Because they care about the patients and the staff and nurse leaders stay in the role in face of feelings of inadequacy, exhaustion, failure, the actual cost to an organization is still unknown.
- As the Span of Control of increases, the impact of emotional intelligence decreases.
- Larger Span of Control make the manager less able to develop relationships, thereby increasing staff turnover with even 10 additional individuals. (Lucas, et al, 2008, secondary, McCutcheon, 2004 primary)
- No leadership type will overcome a large number of staff reporting to the managers. (Doran et al, 2004) (McCutcheon, 2009)
- Not having clerical and charge nurse support at the point of care with an associated large span of control results in the manager not being able to support processes that develop staff, manage the shift to shift patient flow and drive improvements in care issues.
- Those leaders who have higher level of knowledge, experience, self assessed higher personality characteristics manage larger SOC of control.

## Span of Control is *not* a single metric.

- It is not just the number of staff that report to a manager.

- It is also the:
  - ***Numbers of Beds***
  - ***Geography and physical space***
  - ***Operational hours***
  - ***Throughput complexity***
  - ***Support structures***
  - ***Staff skill mix***
  - ***Educational level of patients & staff.***
  - ***Competency[2]***
  - ***Number of Required Strategic Initiatives.***

Fenush, et al, 2014

# Measuring Span of Control

- Traditional Measurement (Kendall, 2018)
  - FTEs
  - Number of Direct Reports
- TOH Clinical Management of Span of Control (Monash, 2005): Indicators:
  - Unit Focused (Complexity, Materials Management)
  - Staff Focused (Volume, Skill level/Autonomy, Stability, Diversity)
  - Program Focused (Diversity, Budget/Statistical)
- University of Pittsburgh Scope and Span of Control Tool (Jones, et al, 2015)
  - Headcount
  - ADT or direct required hours
  - Hours of Operation
  - Cost centers
  - Controllable Expenses.

# Further thoughts on the Evidence

- Most organizational systems don't seem to monitor the number of direct reports by manager but at the micro level individuals know.
- Span of Control will impact the ability to of the manager to drive/support inter-professional care
- If we are going to be forced to have large Span of Control, that manager will need adequate clerical and clinical support of managers, including hands on support for new and evolving technology, clinical advancement, and support of existing coaching and consultation skills
- This is no longer just a HR issue. It is an important strategic, business issue that needs assessment and monitoring of data. That data should be tied to outcomes and incentives, ie, value based purchasing.

# Next Steps

- Future leaders are not going to take on the burdens of the previous generations. The way they will lead in the future will not be the way we lead currently.
- Span of Control is parked as a low priority item and it is assumed that whatever Span of Control you have, you can handle (After all, "No one is complaining."). It needs to be a higher priority for executive leadership including Nurse Executives.
- Invest in the conversation in how health care business is run today and how it should be run in the future. Support each other when faced with challenges to the agenda.
- If we don't get this right, the consequences will be exponential.

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