Preparing Nurses For Emerging Roles

By BETH A. BROOKS, PhD, RN, FACHE

It's happening again: peaks and valleys in the supply of and demand for registered nurses. We read the headlines, and educators at schools of nursing — including Resurrection University in Chicago, where I am president — wonder if we are poised to respond to changing circumstances in both health care and the economy. Our students have a more basic question — am I going to find a job?

It's all part of a pattern that goes like this: For a few years during the recession of 2007-2009, we saw a relatively low demand for registered nurses. Now a pending shortage of RNs is in the news. The Illinois Department of Financial and Professional Regulation released this statement in May 2015: "The 2014 Illinois Registered Nurse Workforce Study conducted by the Illinois Department of Financial and Professional Regulation concluded that the state may soon face a critical shortage of registered nurses as more and more baby boomers retire."

The pattern has been remarkably consistent. The economy weakens into recession, unemployment increases and talk begins circulating in the media about RN layoffs. Newly displaced workers turn to health care as an industry with job security, and applications to nursing schools increase. At the same time, health care hiring slows while admissions waiting lists to colleges of nursing grow. The lack of sufficient faculty to teach the aspiring RNs results in a shortage of RN graduates. Then the economy improves, RN hiring increases, there are not enough nursing graduates — and stories again appear about an impending shortage.

SUPPLY AND DEMAND

According to the country's foremost authorities on RN supply and demand, the latest shortage is neither a new nor an unexpected phenomenon. But the numbers are frustratingly uncertain. Depending on whose study you read, these experts have predicted everything from a shortage of 500,000, to a nearly balanced labor market, to a surplus of 300,000 RNs over the last decade.[1]

The conflicting information is due to a number of factors: international migration, whether RNs choose to work full- or part-time, when RNs choose to retire, the number of nursing graduates, the decline of manufacturing jobs and the types of, or how data is used in, workforce studies.[2, 3] The National Council for State Boards of Nursing found that the number of first-time nursing license test-takers (NCLEX-RN) increased by roughly 8 percent a year during the mid-2000s, but over the last few years the rate has slowed to about 5 percent annually.

A significant increase in the number of nursing schools, which over the last decade has doubled

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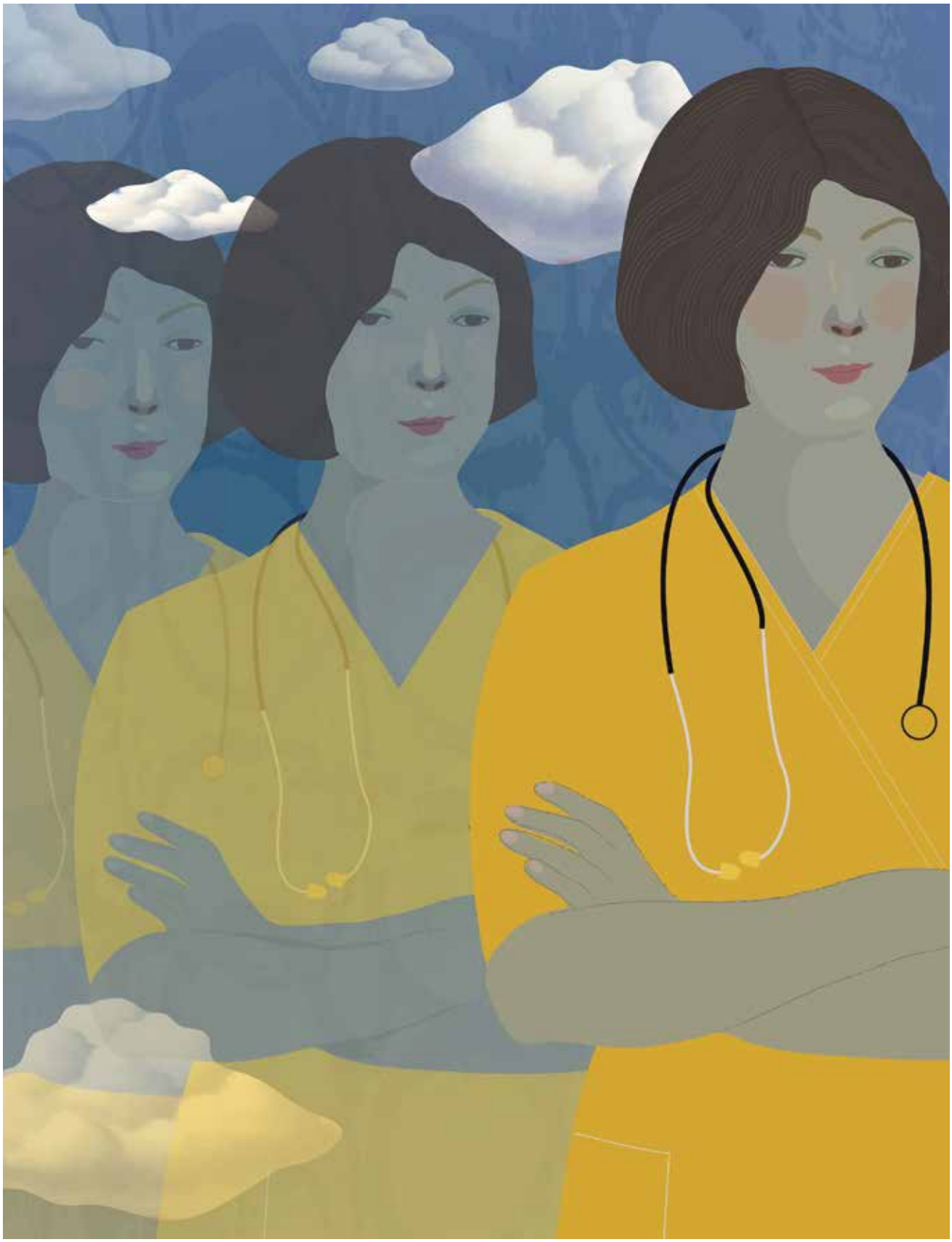

enrollment and the number of graduates, could lull us all into a false sense of security.[4,5] However, a recent study indicates that almost 40 percent of our existing RNs are baby boomers who will retire by 2030 and will need to be replaced.[6]

So, the growing U.S. population, increasing numbers of people with chronic diseases (stroke, heart disease, obesity, diabetes) and insurance expansion all will impact demand for nurses, but it remains unclear how many RNs actually will be needed.[7]

And speaking of numbers, the unprecedented number of aging baby boomers entering the health care system as patients, plus health care coverage expansions under the Affordable Care Act (ACA) that have increased the volume of patients requiring care by both RNs and advanced practice RNs, make it even more difficult to predict RN demand.

THE VIEW FROM ACADEME

Graduates with an associate degree in nursing (ADN) outnumbered Bachelor of Science in Nursing (BSN) graduates until 2011, when BSN graduates exceeded ADNs for the first time. Because we now know a more highly educated nursing workforce improves patient outcomes,[8,9] health care employers prefer to hire BSN graduates.[10] This helps explain the growth in both BSN degree enrollment and the number of BSN graduates.

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Not only do acute care hospitals prefer to hire BSN-prepared RNs, some also may give clinical placement priority to BSN degree programs. That makes it difficult for community colleges to secure clinical placement opportunities, and ADN-prepared RNs find it increasingly difficult to secure employment in acute care settings unless they agree to return to school to complete a BSN.[11]

Another development: Nearly all clinical nursing experiences used to occur in acute care, hospital-based settings. As the ACA moves patient care into home, community and outpatient environments, the hospital-based patient census continues to fall. In addition, payment incentives designed to reduce unnecessary admissions also have resulted in fewer hospital inpatients. This series of events has created significant challenges for nursing education. Acute care hospitals have both the infrastructure and resources to support student clinical learning, while outpatient and community settings traditionally have not. The result is a dwindling capacity for clinical experiences in acute care hospitals that can no longer accommodate schools seeking clinical placements for students.

Also unclear are new roles for RNs that may emerge as a result of the ACA, irrespective of demand. Nurses are experts at coordinating care, helping patients and families navigate the health care system, and implementing and evaluating health promotion and disease prevention interventions to help patients and families live healthy lives. Although the vast majority of nursing graduates continues to be women, the number of men graduating from nursing school increased from 3 percent to 13 percent between 2002 and 2012.[12] We are making strides to have a more diverse nursing workforce, but more work is needed so that the nursing workforce reflects the patient population.

WHAT IS NOT DIFFERENT?

The lack of capacity in colleges and schools of nursing is one thing that remains the same. Applicants once again are being turned away from nursing programs; colleges of nursing have waiting lists. According to an American Association of Colleges of Nursing survey, "U.S. nursing schools turned away 68,938 qualified applicants from baccalaureate and graduate nursing programs in 2014 due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints."[13]

Almost two-thirds of the nursing schools responding to the survey pointed to faculty shortages as a reason for not accepting all qualified applicants into baccalaureate programs. The average age of nursing faculty with an earned doctoral degree is 53.5 years, so the number of baby boomer faculty nearing retirement also is growing. The nursing school faculty shortage will increase.

EDUCATORS MUST TAKE ACTION

Educators must work quickly to adapt to the evolving health care delivery system and ensure nursing graduates are well prepared to meet the challenges ahead. Education programs must innovate in the classroom, move clinical learning into the community and increase technology-assisted learning such as simulation and Web-based learning to make up for the lack of acute care clinical placements — all the while maintaining high quality required by accreditors, regulators, employers and students. Nursing licensing exam pass rates cannot suffer, and graduates must be prepared to deliver high-quality, patient-centered care.

Schools must vigorously hire faculty. Resurrection University is fortunate to be located in a large metropolitan area that supports our efforts to recruit faculty who are focused on teaching. This past year, we hired 16 new faculty, half of whom have earned doctorates. Nearly all of our faculty work all year, the majority on 12-month contracts. This enables us to admit students, during fall, spring and summer semesters in both our accelerated, four-semester day and five-semester evening and weekend programs.

From a recent higher education salary survey, we learned that our faculty enjoys a 4.4 percent premium above the national average.[14] Merit raises, promotions in rank, terminal degree and certification bonuses and support for attending conferences and professional development enable us to recruit, hire and retain the best. We also are supporting six faculty with work release time and tuition reimbursement to complete doctoral degrees. High-performing alumni, especially those with a desire to teach, are actively recruited. Securing Health Resource and Services Administration Nurse Faculty Loan Program funding enabled us to accelerate efforts to grow our own faculty.

EDUCATION PEDAGOGY MUST CHANGE

In our college of nursing, we are working quickly to find solutions to the dwindling number of acute care clinical placements, including increasing the use of simulation for clinical education. Currently at our university, the hours allocated for simulation account for 10 percent or less of class or clinical time. With the current relocation and expansion of our simulation learning center, our goal is to increase the simulation training that can be substituted for traditional clinical experience to 25 percent in the next three to five years. This goal is supported by the 2014 National Council of State Boards of Nursing simulation study that concluded up to 50 percent of clinical time can be substituted with simulation. It also showed groups that use simulation for 25-50 percent of their clinical time have raised their standardized testing scores.

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A generous donor endowed a chair for interprofessional education (IPE), so we recruited a professor to lead our College of Allied Health and College of Nursing Curricular, Simulation and Clinical Activities in IPE. IPE, a relatively new concept, emphasizes the education of students from two or more professions in health care and social services together during all or part of their professional training. The object is to cultivate collaborative practice.

A second generous donor's gift resulted in our new interprofessional simulation center, which we tripled in size.

Schools must revise curricula constantly to more closely resemble the emerging practice realities — in particular, re-conceptualizing degree programs to reflect the new care delivery models such as community-based care, health coaching, disease prevention and health promotion (which nursing curricula always have included), and population health. Our nursing administration master's degree program is now called Health Systems Leadership, and it puts an emphasis on leading and managing systems of care outside of acute care. It fully integrates competencies and knowledge (business communication, finance, strategy, human resources, etc.) within every course rather

than separating them into discrete, single-topic courses. The delivery format resembles that of an executive MBA program.[15]

Our faculty members believe that their role is to help students learn how to think. Curricular changes that include the knowledge our students need to be successful in the reformed health care system are essential. Practice is changing so quickly that it can be difficult for educators to balance new community-based practice realities with licensing exam content that predominately emphasizes acute care practice.

Two years ago, we brought a pedagogy expert from Apple Inc. to campus. Apple's education division works with K-12 and higher education institutions to create learning ecosystems by providing hardware, software and consulting support. After presenting to the university's board of directors, Apple's Jon Landis, PhD, a former high school chemistry teacher, made a presentation to the faculty and staff about the "flipped classroom." A relatively new teaching method in higher education, the flipped classroom means students are expected to complete video and/or audio lectures and reading assignments prior to attending class. During class time, faculty use group exercises, discussion, games and simulation for students to "work" with the content.

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Landis proposed three new roles for faculty: *truth vetting* — helping students check facts, examine evidence-based information and critique its quality and accuracy; *meaning making* — helping students interpret and use this information correctly; and *problem solving* — helping students to think critically in order to define a problem accurately and find the best solution.

Because flipping the classroom requires more technology support, we now employ 1.5 full-time equivalent instructional designers. We have classrooms equipped with AppleTV, and every faculty member has a tablet and laptop.

In addition, one faculty member is assuming the role of nurse content curator.[16] This new role supports nursing faculty in the use of open-source content, finding and vetting the vast amount of free information available online to supplement learning in the classroom. In addition, instructional designers and faculty attend national conferences on teaching and learning.

FORMING PARTNERSHIPS

Finally, everyone is seeking new and interesting clinical partnerships both within and beyond the health care system. In the last year, we have embarked on a number of new community-based partnerships with Rainbow Hospice, Catholic Charities in Chicago, the Special Olympics, Easter Seals, MOBILE Care Asthma Van, St. Leonard's Ministries, the Chicago Marathon, Illinois Action for Children and retail clinics. We are refocusing our students, faculty and staff to think outside the familiar acute care health care delivery model. One of our learning assessment teams even suggested creating "calling cards" for all the faculty and staff in order to introduce ourselves to potential clinical partners that we are currently developing.

Those of us in education must move quickly to prepare nurses for the reality of a reformed health care delivery system. Moving quickly can be difficult in academia. However, we know that nurses who can manage the health of populations, coordinate care, promote health and wellness, prevent diseases, and function in inter-professional, patient-centered teams will be most in demand.

Doubts in forecasts about job supply and demand will continue. We have no doubts about the need to innovate in the classroom and in our clinical education settings to prepare the next generation of nurses.

BETH A. BROOKS is president of Resurrection University in Chicago and was a Robert Wood Johnson Foundation Executive Nurse Fellow in the 2012-2015 cohort. Resurrection University is a part of Presence Health.

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