Expanding America’s Capacity to Educate Nurses: Diverse, State-Level Partnerships are Creating Promising Models and Results

Experts predict that America will be short 260,000 registered nurses by 2025 unless it expands nursing education capacity quickly and dramatically. A lack of clinical placements and faculty, as well as other capacity deficits have caused pre-licensure nursing programs nationwide to reject an estimated 400,000 qualified applications between 2005 and 2008 (see figure 1). Diverse, state-level partnerships are in dispensable to solving capacity problems. This issue of the series profiles the capacity innovations of 12 partnerships; all participated in extensive coalition-building and planning activities at two national “Nursing Education Capacity Summits” sponsored in 2008 and 2009 by the Center to Champion Nursing in America, the Department of Labor, and the Health Resources and Services Administration (HRSA), with funding and guidance from the Robert Wood Johnson Foundation. Policy tips appear on page 2.

Figure 1  
Capacity Problems Are Limiting Admissions to Pre-Licensure Nursing Programs

<table>
<thead>
<tr>
<th>Year</th>
<th>Accepted</th>
<th>Qualified not Accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>154,809</td>
<td>100,607</td>
</tr>
<tr>
<td>2007</td>
<td>158,073</td>
<td>99,165</td>
</tr>
<tr>
<td>2006</td>
<td>132,685</td>
<td>87,869</td>
</tr>
<tr>
<td>2005</td>
<td>131,200</td>
<td>101,774</td>
</tr>
</tbody>
</table>

Estimated Number of “Accepted” and “Qualified Not Accepted” Applications to Pre-Licensure RN Programs

Source: Based on a data display provided by the National League for Nursing. The number of “Qualified Not Accepted” applicants nationally is not available but would be less than the number of such applications because some applicants apply to more than one school. A 2009 study by the Oregon Center for Nursing found that application-level data overstated the number of “Qualified Not Accepted” applicants by 13 percent for the state’s 21 ADN and BSN programs.

The Value of Nursing Education

Clinical Placements
Two Florida International University nursing students check the vitals of a young patient during a pediatric clinical placement at Miami Children’s Hospital. Good clinical placements can offer students powerful skill-building opportunities with real patients and the health care team. A lack of clinical placements is the biggest barrier to expanding pre-licensure nursing programs, according to a 2009 survey conducted by the National League for Nursing (see page 2).

To use scarce clinical resources more efficiently, the Nursing Consortium of South Florida employs a regional centralized, electronic clinical placement system. To expand clinical education opportunities, experts recommend developing more clinical placements outside acute care settings, big cities, and traditional hours. Many schools are expanding the use of technology to build clinical skills, using simulation, virtual health care facilities, robot technology, and more (see pages 6–7).
Many states are already feeling the beginnings of unparalleled nurse and nurse faculty shortages—though most nursing schools are swamped with qualified applications, nursing jobs are projected to make up one of the largest single growth sectors in our wounded economy, and the first baby boomers are preparing to turn 65 in 2011.

If the country’s nursing educational capacity is to rise to these challenges and opportunities, it will have to overcome huge barriers in record time (see fig. 2). This will only be possible through a brave embrace of new partners—change, new educational paradigms, and new policy.

So say leading experts and 49 state-level coalitions who participated in two national “Nursing Education Capacity Summits” (June 26-27, 2008 and February 4-5, 2009).

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

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

The Center to Champion Nursing in America is providing technical assistance to 30 states now implementing plans. The following pages profile the innovations of twelve states with mature innovations. Together they exemplify success in all four critical Summit dimensions: Texas, Virginia, and Michigan in policy advocacy and diversifying partnerships (pp. 3-5); New York, North Carolina, Florida, North Dakota, Oregon, California, Massachusetts, Hawaii, and Mississippi in redesigning education and increasing faculty capacity and diversity (pp. 6-8).

For More Information
- Visit http://championnursing.org and select “Education Capacity” and “Resources” for access to a Summit white paper and two reports.

Policy Recommendations

Remove Capacity Barriers
- Use state, hospital, and health foundation funds to raise faculty salaries.
- Increase appropriations to nursing schools, using pay-for-performance legislative strategies that tie new funding to higher graduation rates and allow flexible spending to spur capacity innovation.
- Give tax credits to hospitals providing clinical placement sites and master’s-prepared instructors.
- Replicate the “Troops-to-Teachers” program for retired military nurses.
- Revise state board regulations to allow students pursuing MSNs and PhDs to teach as nursing faculty interns, while mentored by faculty.
- Recind state regulations that unnecessarily cap nursing class sizes.

Support New Technologies, Curricula, and Program Integration
- Fund regional electronic portals for clinical placement and faculty hiring.
- Support state nursing centers that collect workforce data to inform policy, foster collaboration and planning among nursing schools, and share curriculum and technology.
- Consolidate federal funding for nursing education and nursing workforce into block grants to states (like Maternal Child Health grants).
- Use nurse licensure fee earmarks to increase funds for nursing education.
- Institute a federal Nursing Faculty Corp with stipends and return-of-service agreements to accelerate MSN and PhD completion.
- Use state and federal funding to spread technologies such as simulation and online education; fund faculty training in their use.
- Support research to answer key education policy questions like, What is the appropriate balance of clinical, virtual, and simulation education in building clinical skills?
- Recind state regulations that prevent simulation from counting toward any clinical hours.
- Set 21st century national standards for curricula and clinical competency.
- Support residency requirements for newly-licensed nurses.
- Institute “BSN-in-Ten” policies.
- Integrate degree requirements and curricula across system schools to create seamless educational pathways that increase graduation rates from BSN and graduate programs.
Policy Strategies: Pay-for-Performance Funding
Texas

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

Expanding the Coalition
Fresh from the Capacity Summits, leaders of the Texas Workforce Shortage Coalition determined that they would have to at least double the 2008-2009 appropriation of $20.6 million in the next biennium, in order to double graduation rates by 2013.

To achieve such an unprecedented win from the state’s conservative legislature, the coalition radically expanded its membership to 100, attracting new representation from business in the form of the powerful Texas Association of Business (TAB) and many chambers of commerce.

“The coalition wasn’t coming to business after a legislative position was taken,” says Patti Clapp, V.P. of the Dallas Regional Chamber of Commerce. “We worked together to develop a position.” By all accounts the voice of business strongly influenced the direction of the coalition’s new legislative game plan.

A Pay-for-Performance Plan
“The TAB’s bottom line for support was that funding had to be pay-for-performance, and there had to be accountability,” says Ron Luke, PhD, president of RPC Consulting and chair of TAB’s health policy committee.

Using data provided by the Texas Nursing Workforce Center, the coalition zeroed-in on the graduation rates of the state’s 90 nursing programs, discovering a troubling range: 22 to 98 percent.

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

Charmed by the approach and a statewide publicity campaign and business-lead lobbying effort, the legislature appropriated 50.6 million to expand capacity.

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

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

A strong ally of nursing and results-based funding, Kolkhorst is monitoring the bill’s outcomes closely.

“I share concerns that schools with bigger appropriations could just steal faculty from poorer Texas schools.” The emphasis on “bodies” rather than quality, and short-term (biennial) thinking worries others, including the TNA. Yet Kolkhorst is upbeat: “The legislature is trying to move to pay for performance throughout higher education.”

For More Information
• To learn about New Jersey’s Business Alliance for Nursing, contact Dana Egreczky, dana@njchamber.com.
• For more on the Texas story, write ed.buchanan@thecb.tx.gov.us.

“Policy needs a metric to measure results.
So we told nursing schools, ‘We’ll fund you based on the number of graduates you produce.’ The coalition brought us this vision.”
State Representative Lois W. Kolkhorst (R-District 13)

<table>
<thead>
<tr>
<th>Bienniums Allocated</th>
<th>Bienniums Appropriated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002–03</td>
<td>2004–05</td>
<td>2006–07</td>
</tr>
<tr>
<td>Dramatic Enrollment Growth (Capacity Building)</td>
<td>$10.9 mil</td>
<td>$5.8 mil</td>
</tr>
<tr>
<td>Professional Nursing Shortage Reduction Fund (Capacity Building)</td>
<td>$6.0 mil</td>
<td>$14.7 mil</td>
</tr>
<tr>
<td>Tobacco Settlement Fund (Pilots, Research, Special Projects)</td>
<td>$3.1 mil</td>
<td>$4.9 mil</td>
</tr>
<tr>
<td>Student Financial Aid</td>
<td>$0.8 mil</td>
<td>$0.5 mil</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$14.8 mil</strong></td>
<td><strong>$11.2 mil</strong></td>
</tr>
</tbody>
</table>

*High-producing schools will receive approximately $20,000,000 in new funds over two years at the rate of $10,000 per additional enrollee per year, while lower producers will receive approximately $11,000,000 overall, apportioned by each school’s projected number of additional students graduated by the end of 2011.


Table 1
New Heights in Legislative Funding to Build Nursing Education Capacity
Leadership in a “Perfect Storm”
While many state nursing coalitions must look outside government for funding and leadership, Governor Jennifer M. Granholm has made nursing education a major priority. “Michigan is striving to lead the nation in investment, innovations and tangible outcomes from our initiatives to address the nursing shortage and the other workforce needs of our state.”

One of Granholm’s first investments was creating the Office of the Chief Nurse Executive and naming Jeannette Wrona Klemczak, RN, BSN, MSN, to the post in 2004.

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

Priming the Pipeline
Accelerated 2nd degree Programs.
“When legislators think about capacity, they think “seats” in nursing schools, but seats alone don’t solve the problem,” says Klemczak. “There have to be programs and supports in place to assist students with timely completion of degrees.”

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

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

The Michigan Nursing Corp. Half of the nursing faculty in many of the state’s nursing schools are now eligible to retire. Yet work obligations often prevent timely completion of graduate degrees. To counter these conflicting trends, the governor established the Michigan Nursing Corp (MNC), with $6.5 million in legislative appropriations (2008-2009), to rapidly educate clinical and classroom faculty. Participants receive tuitions and stipends in exchange for signed agreements to teach in Michigan nursing programs. At present 150 have either graduated or are competing MSNs and PhDs.

Web-Based Management of Clinical Placements. Two Web-based systems developed by the Michigan Nursing Center (MNC) are reducing inefficiencies in orienting and matching students to clinical sites in Southeastern Michigan. By laying out all options electronically, the “Ace-in-Place” system drove a 30 percent increase in sites for 2008-2009, says Carole Stacy, MNC’s executive director. “Two or three faculty and hospital staff used to do this manually.”

The “Passport System” offers students one-time, online orientation modules that fulfill various federal training requirements and are accepted by all six member hospitals. The system also inputs required student data like immunization records. More than 4,700 students used the system in 2008-2009.

Proposed Policy and Regulation
With Klemczak’s guidance, a special task force has recommended far-reaching changes to modernize nursing (and public health) policy and regulation. When implemented, these changes will require all nursing programs to achieve national accreditation, mandate nursing residency programs, embed quality and safety in nursing curricula, increase the numbers of APRNs, and reform nursing education financing.

The $2 earmark on the biannual nurse licensing fee that funds the OCNE has been quadrupled to cover the cost of policy changes and increase student scholarships.

For More Information

• For information on the CNE or CNE initiatives, visit www.michigan.gov/mdch/ocne or www.michigancenterfornursing.org
• See issue 8 of the CNF series (p. 5).
Using “Standardized Patients” to Teach Cultural Competence

Graduating nursing students able to care for the diverse patient populations of the twenty-first century is a major goal of new nursing curricula. Their aim is not to produce superficial political correctness but rather to create awareness and sensitivity to how the culture and ethnicity of patients may relate to disease development and treatment.

Old Dominion University (Norfolk, Virginia) is “at the forefront of nursing schools enhancing students’ cultural competency,” says Richardean Benjamin, PhD, Associate Dean of the College of Health Sciences.

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

While the use of Standardized Patients is common in medical schools, ODU’s application is pioneering.

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

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

Policy Strategies: A “Kitchen Cabinet”

Virginia

While Michigan’s nursing policy nerve center is firmly established in the executive branch of state government, Virginia’s is informal and largely outside government. In fact, the state’s so-called “Kitchen Cabinet” began in 1995 as a social club with a distinct lack of grand schemes.

“Originally it had to do with people getting together over drinks to have some fun,” says Rebecca Bowers-Lanier, EdD, MSPH, MSN, a founding member and then executive director of the Virginia Nurses Association.

Bowers-Lanier would go on to become the deputy director of Col leagues in Caring, a Robert Wood Johnson Foundation grant program aimed at creating collaboratives to build the nursing workforce and establish nursing data centers (1996-2002).

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

The evolving group’s first initiative was healing splits in nursing and getting the state’s nursing groups to agree to stop fighting publicly about policy. The Cabinet also resolved to be wholly nonpartisan, recruiting members from all parties and sectors.

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

For a summary of Cabinet state policy achievements, see “Policy Wins” in column 3. To read about an important Virginia nursing education innovation, see “Using Standardized Patients to Teach,” below.

Virginia Nursing Policy Wins

The “Kitchen Cabinet” has made major contributions to state policy wins:

• a 50 percent increase in nursing education capacity since 2005.
• a 10 percent raise for all faculty in public colleges and universities;
• significant scholarship appropriations and prevention of cuts in scholarship funds for graduate education;
• a nurse-directed workforce data center;
• Peopling key state leadership positions with nurses and Kitchen Cabinet members (e.g., Secretary of Health and Human Resources).
• A clear, credible nursing policy agenda and advocacy mechanism.

The Value of Nursing Education

“Standardized Patients”

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

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

Creating a “Seamless Pathway”
This regrettable turf war is headed for the history books in western North Carolina and New York, thanks to a demonstration project called “rib-bon” (RIBN: Multi-Regional Model to Increase the Number of Baccalaureate Nurses in the U. S.). Urban academic partners are Queensborough Community College and Hunter College and the City University of New York (CUNY); rural partners are Asheville Buncombe Technical Community College and Western Carolina University (WCU).

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

The model is marrying community colleges’ strengths—large diverse classes, highly supportive learning environments, and a focus on practical skills—with the BSN’s additional benefits for patient safety and for accessing graduate education as well as faculty and leadership roles.

“We are trying to build a graduate who gets the best of both worlds,” says Vincent Hall, PhD, RN, CNE, director of WCU’s School of Nursing. RIBN organizers expect the new model to dramatically increase the number of their students completing the BSN (from 34 to 70 percent in five years) and to boost ethnic diversity. They also predict that RIBN will be widely replicated and ease the nurse and nurse faculty shortages.

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

The Center is managing the project with a matching $250,000 grant from Partners Investing in Nursing’s Future (PIN), a collaboration of the Robert Wood Johnson Foundation, the Northwest Health Foundation, and many community foundations including the North Carolina Foundation for Nursing Excellence (for RIBN PIN funds).

RIBN Nuts and Bolts
RIBN cohorts begin classes in 2010, dually enrolled in the ADN and BSN programs. Students will spend years 1-3 on their community college campus and year 4 at their university, after passing the NCLEX. Both regions have hired “success counselors” to provide intensive mentoring. The North Carolina Nurse Scholar’s Commission will award NC-RIBN students full scholarships; NY-RIBN students will pay community college tuition for all years.

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

“RIBN is system change in the educational environment,” says Margaret McClure, EdD, RN, FAAN, one of the grant’s co-directors. “And the urban-rural mix will show it can succeed anywhere.”

*RIBN is modeled in many respects on The Oregon Consortium for Nursing Education (OCNE), a statewide coalition of eight community colleges and five university nursing programs.

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

The Value of Nursing Education

Most nursing programs and many hospitals use electronic simulator mannequins to teach a variety of clinical skills from basic to complex. The two nursing students (above) are demonstrating “patient” vital signs and __________—without the safety risks, limitations, and downtime often present in real clinical settings. Faculty develop their own simulation scenarios or purchase scenarios from vendors. They may also make or purchase videotaped simulations for classroom use and uploading to course Web sites where students may view them anytime.
“You can’t tell state legislators that you need money for nursing education unless you can say, ‘This is what we know about the nursing workforce,’” says Virginia’s Becky Bowers-Lanier.

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

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

Center surveys on the top causes of these shortages mirror national studies: limited clinical sites and barriers to hiring faculty (see figure 2, page 2).

In addition to defining key problems, FCN is working to eliminate them. With a $470,000 PIN grant from the Blue Foundation for Healthy Florida, the Robert Wood Johnson Foundation, and the Northwest Health Foundation, FCN has recently embarked on a two-year “Gap Analysis” to discern Florida’s current utilization of simulation and to maximize its use for both practicing and new nurses,” says Mary Lou Brunell, FCN’s executive director and co-leader of Summit Team Florida (see “Using Technology” below).

Brunell sees potential for simulation training to move med-surg nurses up the career ladder into specialties with the biggest shortages. This could also help retain experienced nurses and make room for new nurses. Greater use of simulation in pre-licensure nursing programs could reduce the need for clinical sites. The Florida Board of Nursing allows 25 percent of clinical education to be conducted through simulation, but no one knows if this option is being used, says Brunell. Nor are simulation resource needs clear.

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

For More Information
• Visit www.flcenterfornursing.org.
• See CNF issue 2 on state data centers.

Using Technology to Expand Capacity

“Smart Hospitals”/“Sim Centers”
Some states have large interdisciplinary facilities that simulate the medical conditions of entire acute care units and have multidisciplinary skill-building scenarios for new employees or students pursuing different health professional degrees (e.g., OT, PT, RN, and MD).

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

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

Online Classrooms and Schools
Web 2.0 Tools for “Second Life” allow schools to create virtual clinical worlds where, for example, students can practice doing “in-home” patient assessments and patient nutritional education, using voice-activated conversations with avatars or actors.

Faculty can offer complex “Webquest” problem-solving assignments to teams of students working on long-term projects that require interdisciplinary study (visit: http://www.questgarden.com/51/22/4/0760809011/index.htm for a sample assignment).

To reduce the workload of clinical instructors, some nursing educators are using or contemplating the use of online voice thread technologies like wikis, blogs, and social networking sites for holding discussions between students, patients and clinical experts on particular cases and for disseminating program information. Web-hosted patient support groups and chat rooms conducted by retired nurse clinical experts are also being imagined as new ways to give students more contact with patients and extend scarce clinical resources. Online learning management systems allow for posting assignments, class notes, grades, tests, and course documents, and can grade exams instantly and accept clinical paperwork.

Web-based nursing degree programs are proliferating. The Western Governor’s University, for example, is a nonprofit private school, offering a variety of majors, including six different undergraduate and graduate nursing degrees. Students do most of their coursework online but complete tests and assessments at special centers, and arrange clinical placements locally (visit: www.WGU.com).

Proposed Technology Centers
Some nursing leaders are calling for centers that promote sharing of new curricula and technology.
New Curricula and Technology: Reaching Rural and Ethnic Communities

North Dakota

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

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

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

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

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

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

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

The Value of Nursing Education

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

Robert Wood Johnson Foundation

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Photo: UND-RAIN Program

Though North Dakota has 28,000 Native American residents and is home to five reservations, only 19 Native Americans had earned BSN degrees from the University of North Dakota (UND) as recently as 1990. UND is the state’s primary center for professional education and training.

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

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

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

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

As its 20th anniversary approaches, RAIN boasts 139 BSN and 34 MSN graduates—the highest such numbers in the country. Anderson is seeking increased, sustainable funding for RAIN and sees it as a template for other vulnerable populations.