

The Nursing Agenda for Michigan: 2005 – 2010

Actions to Avert a Crisis

Coalition of Michigan Organizations of Nursing

2006

The complete Nursing Agenda for Michigan is available online at:
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Coalition of Michigan Organizations of Nursing COMON

January 24, 2006

The Honorable Jennifer M. Granholm
Governor of Michigan
George W. Romney Building
Lansing, Michigan 48933

Dear Governor Granholm:

The Coalition of Michigan Organizations of Nursing (COMON), representing our state's nursing community, is pleased to present to you a strategic plan for assuring a nursing workforce that is adequate in numbers and high in quality to meet the health care needs of our citizens today and into the future. **The Nursing Agenda for Michigan 2005-2010: Actions to Avert a Crisis** has been shaped by the ideas and experience of hundreds of nursing leaders and practicing nurses from a wide range of nursing specialties; it was developed in collaboration with the Office of Michigan's Chief Nurse Executive (Michigan Department of Community Health) and a broad array of other health care stakeholders.

The nursing shortage is an unprecedented one in both length and scope. It is anticipated that the shortage will be 30 years in duration. Nurses are in short supply at the state, national and global levels.

The nursing shortage is both a public health concern and an economic development issue for Michigan. The significant aging of both the nursing and the general populations, the recent catastrophic natural disasters and emerging infectious diseases intensify the need for nurses and the impact of the nursing shortage on the health and safety of Michigan citizens. From an economic perspective, Michigan's active nurses bring more than \$5 billion each year to their local and state economies. The nursing shortage represents both crisis and opportunity: the strategies needed to avert the nursing shortage will also aid in addressing our state's need for more professional, stable, well-paying jobs.

Previous solutions to nursing shortages will not work in this new and complex environment of demographic extremes, public health preparedness, health systems issues, and economic issues. These times call for bold, rapid actions and responses. We believe the plan we present to you today will move Michigan in the right direction.

We call upon you, your Executive Office and related Departments, our Michigan Legislature, as well as the stakeholders in the health care, education, business and philanthropic communities to join us in this strategic venture. We greatly appreciate the support you have already provided for the new hospital, education and Regional Skills Alliances partnerships in the **Accelerated Health Care Training Initiatives**.

COMON and the Michigan nursing community, 150,000 nurses strong, pledge our support in working with you to both retain our current nursing workforce and recruit and educate the needed future nurses to secure the health and safety of Michigan citizens, as well contribute to the state's economic "health".

Sincerely,

A handwritten signature in black ink that reads "Roberta P. Abrams, RN, MA, FACCE". The signature is written in a cursive style with a large initial 'R'.

Roberta Abrams, RN, MA, FACCE
President
Coalition of Michigan Organizations of Nursing

cc: COMON member organizations
J. Klemczak, CNE (MDCH)

**The Nursing Agenda for Michigan Was Created and Endorsed by:
The Coalition of Michigan Organizations of Nursing – COMON
Member Organizations Include:**

American Arab Nurses Association

American Association of Critical Care Nurses, Southeast Michigan Chapter

American Association of Occupational Health Nurses

Association of Women's Health, Obstetric, and Neonatal Nurses

Association of Rehabilitation Nurses, Michigan Chapter

Lambda Chi Chapter, Chi Eta Phi Sorority, Inc.

Detroit Black Nurses Association, Inc.

Maternal Newborn Nurse Professionals of Southeastern Michigan

Michigan Association for Local Public Health,
Health Department Nurse Administrators Forum

Michigan Association of Colleges of Nursing

Michigan Association of Nurse Anesthetists

Michigan Association of Occupational Health Nurses

Michigan Association of Occupational Health Professionals in Healthcare

Michigan Association of PeriAnesthesia Nurses

Michigan Association of School Nurses

Michigan Black Nurses Association, Inc.

Michigan Center for Nursing

Michigan Council of Nursing Education Administrators

Michigan Council of Nurse Practitioners

Michigan League for Nursing

Michigan Licensed Practical Nurses Association

COMON Member Organizations (continued)

Michigan Public Health Association, Public Health Nursing Section

Michigan Nurses Association

Michigan Organization of Nurse Executives

Michigan State Board of Nursing

National Association of Hispanic Nurses, Michigan Chapter

National Association of Pediatric Nurse Practitioners, Michigan Chapter

Philippine Nurses Association of Michigan

Other Organizations Endorsing the Nursing Agenda for Michigan

Michigan Department of Community Health
Office of the Michigan Chief Nurse Executive

Michigan Department of Labor & Economic Growth

Michigan Health Council

Michigan Home Health Association

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Preface

Why Do We Need a Nursing Agenda? Nursing care is a critical component of healthcare. Demand for healthcare – and therefore demand for nurses -- is increasing in all of the settings in which nurses practice. Michigan and the nation face a thirty-year shortage of nurses (Registered Nurses, Licensed Practical Nurses, and Advanced Practice Nurses), during which the demand for nursing services will be much higher than it is today.

We are at the beginning of a crisis. If we do nothing, our current workforce of nurses will attempt to provide preventive care and acute care for more and more people. This would be bad for the health and safety of both patients and nurses. The healthcare system as a whole would be severely impaired. Since healthcare is one of the largest segments of the Michigan economy, we all would suffer economic loss. We must act to prevent this.

How Did We Get to This Point? Our aging population increases the demand for healthcare and for nurses. The 76 million people of the Baby Boom generation now range from age 41 to 60, and already are stretching the resources of our healthcare system. Over the next thirty years, this generation will require healthcare for chronic diseases (such as diabetes), acute illness (such as heart attack and stroke), and end-of-life care. In addition, the chronic disease burden, and need for care, is increasing for people of all ages. Changes in the healthcare system have also increased the demand for nurses. Many conditions that led to hospitalization in the past now receive outpatient treatment. People admitted to hospitals today are much sicker than were people in hospitals ten years ago; their care is hi-tech, complex, and demanding. People are discharged from hospitals when they are still very sick, with recovery occurring in nursing homes or at home. In hospitals, nursing homes, home health, and other healthcare services, the majority of care is provided by professional nurses or staff supervised by professional nurses.

The supply of nurses is dependent upon the number of new nursing graduates entering the field, and the number of existing nurses remaining in the field. Over 92% of Registered Nurses are women. In the past 35 years, the range of occupations open to women has greatly expanded. Fewer young women have entered nursing than in the past, and many existing nurses have left the profession for opportunities in less physically demanding fields. The result has been a declining supply of nurses educated in the United States. Nurses from other countries have been recruited, but that is not a long-term solution. The Michigan nursing workforce is aging, with an average age of 46.1 years for Registered Nurses. The nursing faculty is older than the nursing workforce, with an average age of 51.1 years. Even if there is an increase in the number of young people seeking nursing degrees, we cannot increase nursing education's production of new nurses without additional nursing faculty.

What Do We Need To Do? The Coalition Of Michigan Organizations of Nursing (COMON) has created and endorsed the Nursing Agenda for Michigan, including the action steps we must take to ensure an adequate supply of well-prepared, high-quality professional nurses. Since the crisis has already begun, we need to take action quickly. Since the crisis will extend over the next thirty years, we need to begin actions now that will benefit all of us in the long term – so there will be nurses to care for all of us, today and in the future.

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Actions to Avert a Crisis

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Chapter 1: Why Do We Have a Nursing Workforce Crisis?

Decreasing Healthcare Resources, Increasing Healthcare Demand

The dollars available to pay for the current healthcare system in Michigan and the nation are inadequate. Public and private healthcare funding cannot keep up with increasing healthcare costs. Public health insurance, particularly Medicaid, is straining the ability of many state governments, including Michigan's, to meet the cost of healthcare for an increasing number of enrollees. Private health insurance costs are also steadily rising. Each year, additional employers find that they can no longer afford to pay for health insurance for their employees, or find that they must pass more of the premium cost to employees. Wage earners find that they cannot afford increasingly higher premiums, deductibles and co-pays.

One result of this trend is that about 15% of Americans -- more than 45 million -- are estimated to be without health insurance, a number that increases steadily. As the number of uninsured persons rises, the economic stress on the health care system increases. People with no health insurance have little access to healthcare and wait longer before seeking care. When the condition becomes acute, people with no insurance go to the emergency department of their local hospital. Emergency department treatment for acute conditions is much more expensive than primary care treatment at an earlier stage of the illness. Emergency departments are the healthcare providers of last resort.

This imbalance – expensive unpaid care for the uninsured increasing, while public and private insurance payments cover less and less of the costs – has led some healthcare systems to plan hospital closures or reductions in the ratio of staff to patients. Cost cutting efforts over the past ten years have led to increasing stress on health care providers and health care professionals. The economic buffers that used to provide a degree of protection for the American healthcare system have essentially disappeared over the past twenty years.

Adding to the seriousness of the situation are American demographics. Our population is aging, and older people need (and use) more health care. The very large Baby Boom generation (76 million born from 1945 through 1964) is now 41 to 60 years old, and already is stretching the resources of the healthcare system. Over the next thirty years, this generation will require extraordinary amounts of healthcare for chronic diseases (such as diabetes and cancer), acute illness (such as heart attack and stroke), and end-of-life care provided at home or in long-term care facilities, where LPNs are particularly important. The chronic disease burden (juvenile diabetes, for example) also is increasing for people of all ages.

An additional demand factor is the national concern about bio-terrorism, emerging infectious diseases, natural disasters, and health system preparedness (both public and private). All the strategic and operational plans for national and state responses to such threats rely on an adequate supply of healthcare services and healthcare professionals. *The nursing shortage is already at a level that has been upgraded from a health crisis to a security concern. The nation does not have adequate nurses for a situation with mass casualties or a situation threatening general public health.*¹ All of these factors – economic, demographic, emergency preparedness, and security are steadily increasing the demand for healthcare and for nurses.

One of the strategies for dealing with rising healthcare costs has been to expand the range of health conditions treated on an outpatient basis. Many conditions that previously led to hospitalization now receive outpatient treatment (ambulatory care). People admitted to hospitals today are much sicker than were the people admitted to hospitals ten years ago. The care of current hospital patients is complex and demanding, and involves increasing amounts of medical high technology. People are discharged from hospitals when they are still very sick, with recovery occurring in nursing homes or at home.

Who Provides the Majority of Healthcare?

Who provides the majority of healthcare and where is it provided? Nurses are Michigan's largest licensed healthcare professional group – 145,996 licensed in 2005 [119,152 Registered Nurses; 26,844 Licensed Practical Nurses]. In hospitals, rehabilitation centers, psychiatric mental health and substance abuse centers, public health centers, clinics, urgent care centers, physician offices, industrial health clinics, long-term care facilities, home health, prisons, State hospitals, schools, and other healthcare settings, the majority of care is provided by professional nurses, staff supervised by professional nurses, or family caregivers in the home, who are supported by nurses². Without adequate numbers of professional nurses, the healthcare system cannot function. Clinics, surgical suites and maternity units close and, as happened in California, entire hospitals close due to lack of nurses.

Why Don't We Just Get More Nurses?

Healthcare providers have expended large amounts of resources trying to “just get more nurses”. The nursing workforce nationally has failed to meet demand for the majority of the past 20 years, with fewer young people entering the profession, and more practicing nurses leaving the field or retiring. Healthcare providers have attempted to fill the gap by recruiting nurses from other countries, and by shifting some portion of nursing tasks to non-nursing staff. Both of these approaches are short-term solutions, with negative consequences for the long term. The Michigan Department of Labor & Economic Growth estimates that by 2010, Michigan demand will exceed supply by 7,000 nurses; by 2015, Michigan will need 18,000 more nurses than it will have³. We must start now if we are going to educate 7,000 new nurses in the next five years – and we must begin now to make the changes that will support education of 18,000 new nurses in the next ten years.

Preparation for nursing licensure requires from three to six years of demanding education and clinical experience. Nursing education requires that nursing faculty (both classroom and clinical) be well educated and available. Nursing faculty members are becoming scarce. The average age of nursing faculty in the United States is 51.1, and large numbers are retiring every year. In Michigan, 81% of full-time nursing faculty and 59% of adjunct nursing faculty are age 45 or older; 36% of full-time faculty and 19% of adjunct faculty are age 55 or older. A majority of Michigan nursing programs report that they have difficulty filling faculty positions⁴. The shortage of nursing faculty is much more acute than the shortage of professional nurses.

Why Hasn't Nursing Attracted More Young People?

Nursing education – and nursing as a profession – has had increasing difficulty in recruiting and retaining new members as other professional opportunities have opened up for women. From 1870 to 1970, the major professional occupations available for women were secretarial/clerical, K-12 teaching, and nursing. Women working outside the home traditionally had few respectable opportunities outside these fields. Historically, nursing and teaching have benefited from the capacities and energies of large numbers of women who could not take those capacities and energies anywhere else⁵. Historically, this narrow range of opportunities for women also has depressed salaries in nursing and teaching.

The range of career opportunities open to women has widened greatly over the past 35 years. The women of the Baby Boom generation, coming of age in the 1960s and '70s, built on the efforts of earlier advocates for women's rights and generally were successful in pursuing a wide range of educational and professional opportunities. Bright young women with good educations can now choose careers in investment banking, law, medicine, or chemical engineering (for example), or decide to start their own company in virtually any field. Nursing salaries are not competitive with those in many other fields. The women of the Baby Boom generation were the last generation to make a significant commitment to nursing; it is they who fill the ranks of nurses age 41 to 60, all of whom will be retired by 2030.

As career choices for women have widened, professional nurses already practicing have taken opportunities to move into better-paid, less physically demanding jobs in other fields. Direct-care nursing, particularly in hospitals, carries risks including: "infectious diseases ...and other dangers, such as those posed by radiation, accidental needle sticks, chemicals used to sterilize instruments and anesthetics. In addition, (nurses) are vulnerable to back injury when moving patients, shocks from electrical equipment, and hazards posed by compressed gases."⁶ As direct-care clinical nurses have become scarce, nurses committed to teaching have found that clinical nursing and nursing administration jobs pay up to 20 percent more than nursing education faculty jobs⁷.

Prestige does not make up for the salary deficits experienced by nurses. Physicians routinely rank number one in public ratings of prestige; nurses rank first in trust, but number 91 in terms of prestige⁸. Despite the many leadership roles for nurses, from intensive care unit administrators, to advanced practice nurses, to nurse-managed clinics, the image of nursing as manual labor primarily performed by women continues. Nursing is viewed "like motherhood – an essential but unpaid contribution to the work of society, with rewards that are largely intrinsic to the job."⁹ Even within nursing there are salary and respect differentials. Public health nurses, school nurses, and other community-based nurses often receive less compensation and respect than equally credentialed hospital-based nurses¹⁰.

National Workforce Changes: 1970-2004

The percentage of women (age 16 and over) in the national workforce has grown from 43% in 1970 to 59% in 2004 (a slight decline from the peak of 60% in 1999).¹¹ Over the same period, the percentage of men in the national workforce has declined from 80% to 73%. During this period, the percentage of employed women with four years or more of college increased from 11% to 33%; the comparable gain for men was from 16% to 32%. Since 1970, the growth

of the number of women in the civilian labor force has exceeded the growth of the number of men by nine million. The median salary for all employed women, as a percentage of the median for all men, rose over the past 25 years from 62% to 80%.¹² Women continue their traditional dominance in the education and healthcare professions, holding 73% of jobs in both fields. However, their jobs are not the higher paying jobs. Women are 92% of RNs and 91 % of LPNs, but only 22% of dentists and 29% of physicians¹³.

Over the period from 1970 to 2004, women have increased their participation in virtually every field represented in the US Bureau of Labor Statistics tabulations for “professional & related occupations”, and now hold more than 56% of such jobs. This increasing range of career opportunities has lessened women’s participation in the traditional women-dominant professions of teaching and nursing, but participation by men in these fields has remained low. Male nurses account for only 8% of the national nursing workforce; in Michigan, about 8% of RNs and 6 % of LPNs are male.

Nationally, RNs held about 2.3 million jobs in 2002; they constitute the largest healthcare professional group. The job outlook for RNs is projected to be very good, with many new types of jobs emerging within nursing. “Employment of Registered Nurses is expected to grow faster than the average for all occupations through 2012...more new jobs are expected to be created for RNs than for any other occupation. Thousands of job openings also will result from the need to replace experienced nurses who leave the occupation.”¹⁴ The U.S. Bureau of Labor Statistics projects that “the number of new jobs created for RNs will increase by 27.3% between 2002 and 2012 from 2,284,000 to 2,908,000...and that total job openings due to growth and net replacements will result in 1.1 million job openings for RNs by 2012.”¹⁵

Nationally in 2003, hospital vacancy rates for Registered Nurses were 13.5 percent, up from 13 percent in 2001; the comparable vacancy rate for Licensed Practical Nurses was 12.9 percent in 2001¹⁶. Additional federal projections indicate that by 2020, the U.S. nursing shortage will grow to more than 800,000 Registered Nurses¹⁷. National turnover rates for RNs were 15.5 percent in 2003; the overall cost of recruiting and orienting a hospital staff nurse is estimated to equal that nurse’s entire annual salary, a major expense to health care employers¹⁸. A recent (2005) national poll of health care recruiters found a vacancy rate of 16.1 percent and an RN turnover rate of 13.9 percent¹⁹. See Figure 1: National Supply & Demand Projections for FTE (Full-Time Equivalent) Registered Nurses: 2000 through 2020.

To educate more new nurses, we must have additional nursing faculty. Nationally, there is a nurse faculty vacancy rate of 8.6 percent. “Nurses who teach in academic settings are aging and are not being supplemented or replaced by younger instructors. The median age of nursing instructors is about 51.1 years, and many will be retiring within the next decade.”²⁰

Nursing Workforce Issues in Michigan

Michigan is in the early phase of a projected 30-year shortage of professional nurses, correlated with the aging of the Baby Boom generation, which simultaneously causes a decrease in the supply of healthcare professionals and an increase in the demand for healthcare. The U.S. Census estimates that in 2030 Michigan’s population will include 2,420,447 people age 65 and older, with 287,089 of those people age 85 and older²¹. Other

demand factors include population growth, the increasing intensity of care provided, and emergency preparedness needs. Supply factors include increased occupational opportunities for women, the shortage of nursing faculty to educate replacement nurses²², and the low-prestige, high-stress image of nursing²³. The shortage of RNs in Michigan is estimated by the Michigan Department of Labor and Economic Growth to be 7,000 nurses in 2010 and 18,000 nurses in 2015²⁴. Extrapolating the 2015 supply/demand estimates provides an RN shortage estimate of 30,000 in 2020. Both the federal projections and the Michigan projections of nursing shortages are intentionally conservative, since projections are informed approximations based on current knowledge²⁵. See Figure 2: Michigan Supply & Demand Projections for FTE Registered Nurses: 2000 through 2020.

Michigan nursing shortage supply factors are similar to those in the national situation, discussed above. Supply factors include problems with:

- aging of the nursing workforce – the average age of Michigan RNs is 46.1 years
- retention of the existing nursing workforce – almost 33% intend to continue practicing nursing for 10 years or less
- aging of the nursing faculty needed to educate replacement nurses -- 36% of full-time nursing faculty and 19% of adjunct faculty are age 55 or older
- retention/replacement of existing nursing faculty – 70% of institutions have difficulty filling faculty positions, with production of new faculty inhibited by the high cost (dollars, time, and energy) of graduate credentials, and salaries lower than those in clinical nursing
- enrollment of qualified students in all available admission slots in nursing educational programs – there were no admission slots for 2,097 qualified applicants in 2002/3
- retention, graduation and licensure of admitted nursing students – nursing graduates decreased from 4,260 in 1997/8 to 3,951 in 2002/3²⁶.

Subsidiary supply factors slow down the educational process, and delay entry of new nurses into the field. Subsidiary supply factors include shortages of:

- clinical faculty and clinical opportunities for nursing students – 45% of institutions lack enough clinical placement sites and/or clinical preceptors for students; and
- nursing education infrastructure, including classrooms, meeting rooms, learning laboratories, simulation technology, and other teaching tools.

Diversity of Nursing Workforce

An important supply factor that also relates to healthcare access and quality is the need to increase the ethnic, cultural, and gender diversity of the nursing workforce. The population of the country (and Michigan) has become more diverse, and “it is important to have healthcare delivered by nurses who are representative of the population and skilled in providing culturally competent care. African-Americans (14% of Michigan’s population, 5.5% of nurses) and Hispanics (3.6% of Michigan’s population, 1% of nurses) are under-represented in Michigan’s nursing workforce. Asians/Pacific Islanders (2.2% of Michigan’s population, 3.4% of nurses) and American Indians/Alaskan Natives (.5% of Michigan’s population, 1% of nurses) are slightly over-represented in Michigan’s nursing workforce²⁷. The most significant under-representation is of men, who comprise about 50% of the population, but only 8% of the nursing workforce in Michigan and the nation. Intensive, long-term recruitment and retention efforts are needed to increase workforce diversity.

Figure 1

Figure 2

Examples to Guide Action in Michigan

The short-range, mid-range, and long-range Nursing Agenda Recommended Actions cluster into four major groups: Work changes (workforce, work environment and work design); Education program changes; Healthcare system changes; and Regulatory & licensure changes (see Chapter 2 and Appendix B). All of the Nursing Agenda Recommended Actions require simultaneous attention, since all are linked in the development of a healthy population and a healthy nursing economy for Michigan.

Before we look at the Recommended Actions in detail, we must acknowledge the progress already made in improving the nursing workplace environment and organizational culture. The Magnet Hospital Recognition program (administered by the American Nurses Credentialing Center) has begun to make a difference nationally and in Michigan. Magnet hospitals provide examples and guidance that we can use in implementing the Nursing Agenda (see <http://www.nursingworld.org/ancc/magnet/facilities.html>).

Magnet hospitals have higher rates of nurse satisfaction, lower turnover rates, and lower nurse vacancy rates than other hospitals. Characteristics of Magnet hospitals include: excellent patient outcomes, culturally diverse staffing, culturally competent patient care, practice models characterized by a high degree of nurse autonomy and control over practice, good communications between nurses and physicians, and strong nursing leadership^{28,29}. Other categories of nurse employers -- clinics, home health services, public health nursing services -- also have used national models and best practices to improve the nursing workplace.

As we implement the Nursing Agenda Recommended Actions, we always must seek to use national models and best practices. The Michigan effort to avert a nursing workforce crisis should make use not only of national resources, but also of the work of the Michigan Center for Nursing, particularly in acquiring and reporting nursing data and promoting nursing excellence (see www.michigancenterfornursing.org).

Chapter 2: What Can We Do About This Nursing Crisis?

Short-range Recommendations: 1-2 years

[After each recommendation are numbers for the related segments of the Action Plans in Appendix B; for example, to find 3.2.2 look under Section 3, Issue 3.2.]

Work Changes:

- Promote safe working hours to improve both patient and nurse safety and nurse retention. (Section 3.1.1)
- Improve the organization and design of nursing tasks to make them more efficient and effective. (Sections 2.1.1; 3.2.1, & 3.2.3)
- Improve the ergonomics of nursing tasks to improve the health and safety of patients and nurses. (Section 3.2.2)
- Increase shared decision-making to improve nursing input to patient care and safety. (Sections 2.1.2 & 3.2.1)
- Create a more respectful and supportive nursing workplace to improve retention of the existing nursing workforce. (Sections 1.1.3, 1.1.4, 1.1.5, 1.2.1, 2.2.1, 2.2.2, & 2.2.3)

Nursing Education Changes:

- Add additional faculty by increasing slots in fast-track master's programs, and recruiting faculty from clinical nursing and from both clinical and faculty retirees. (Sections 4.1.1, 4.2.5, & 5.1.5)
- Tap into underutilized faculty capacity to increase the number of nursing student slots available each year. (Section 4.1.1)
- Add new nurses to the workforce by increasing the number of student slots available in second-degree accelerated nursing programs. (Sections 4.2.1 & 1.4.1)
- Maximize the use and availability of web-based instruction and other technologies in nursing education. (Section 4.1.2)

Healthcare System Changes:

- Improve nurse retention through improved work design and work environment changes. (Sections 1.2.1, 1.3.2, 2.1.1, 2.1.2, 3.1.1, 3.2.1, 3.2.2, & 5.1.5)
- Improve nursing retention through improved workplace and nursing career supports. (Sections 1.1.1, 1.1.3, & 3.2.1)
- Set up collaborative multidisciplinary teams to manage & deliver patient care and increase shared decision-making. (Sections 2.1.1, 2.1.3 & 3.2.1)

Regulatory and Licensure Changes:

- Increase the outreach and responsiveness of the regulatory apparatus, so that licensure is not delayed. (Sections 5.1.1 & 6.2.1)
- Increase mentoring, support, and oversight for all stages of nursing careers, from student to retirement, by recruiting and supporting qualified retired nurses in a multitude of roles. (Sections 5.1.5 & 6.2.1)
- Use an increased nursing licensure fee to assist the nursing workforce. (6.2.1)

Mid-range recommendations (2-3 years)

[After each recommendation are numbers for the related segments of the Action Plans in Appendix B; for example, to find 3.2.2 look under Section 3, Issue 3.2.]

Work Changes

- Create the Michigan Healthcare Institute to change workplace culture and increase shared decision-making. (Sections 2.1.1 & 2.1.2)
- Increase workplace mentoring and other supports to improve nurse retention. (Sections 1.1.1, 3.1.2, 3.2.1, & 5.1.5)
- Identify areas for nursing task expansion and nursing task delegation to improve nursing practice. (Sections 3.2.3 & 6.1.3)

Nursing Education Changes

- Increase financial and other supports required to educate, recruit & retain additional nursing faculty. (Section 4.1.1)
- Increase economic, academic, and living supports needed to recruit and retain qualified nursing students. (Section 1.1.1, 1.1.2, 1.3.2, 1.4.1, 4.2.1, 4.2.2, 4.2.3, 4.2.4, 4.2.5, 5.1.4, & 5.1.5)
- Create a common curriculum for Associate's Degree in Nursing (ADN) programs statewide to improve the ADN graduation/licensure rate and quality. (Section 4.1.2)
- Ensure seamless movement from ADN to Bachelor of Science in Nursing (BSN) programs statewide to improve the BSN graduation/licensure rate and quality. (Section 4.2.1)
- Increase staff development & career education programs to improve nurse retention and improve capacities. (Sections 1.1.3 & 4.1.1)
- Promote a succession of careers in nursing for each nurse to improve nurse retention and improve capacities. (Sections 1.1.3, 1.1.4, & 4.1.1)

Healthcare System Changes

- Change organizational culture to improve nurse retention and quality of care; use selected hospitals as laboratories for change. (Section 3.2.1)
- Use mentors, and support for career & role development to improve nurse retention. (Sections 1.1.4, 2.2.1, & 3.2.1)
- Invoice nursing services as billable hours to improve the organizational culture and the image & value of nursing. (Sections 1.3.2 & 5.1.4)

Regulatory and Licensure Changes

- Create Nursing Credentials & Terminology Commission to improve consistency & quality of terminology and credentials for nursing categories. (Section 6.1.1)
- Create Nursing Education & Practice Standards Commission to ensure quality of standards for nursing education programs and nursing practice. (Section 6.1.2)
- Review Public Health Code and recommend changes to modernize the nursing-aspects of the Code. (Sections 6.1.1 & 6.1.3)

Long-range Recommendations: >3 years

[After each recommendation are numbers for the related segments of the Action Plans in Appendix B; for example, to find 3.2.2 look under Section 3, Issue 3.2.]

Work Changes

- Innovate work design & ergonomic changes to improve nurse retention and the nursing economy. (Sections 3.1.1 & 3.2.2)
- Innovate work environment changes to improve nurse retention and the nursing economy. (Sections 2.1.1, 2.1.2, 3.1.1, & 3.2.1)
- Raise the image of nursing as a profession to improve nurse recruitment, retention, & quality. (Sections 1.3.1, 1.3.2, 2.1.2, 4.2.2, 5.1.1, & 5.1.3)
- Improve the status of nursing as a revenue center to improve nurse recruitment, retention, & organizational culture. (Sections 1.3.2 & 5.1.4)

Nursing Education Changes

- Innovate faculty preparation systems to improve Michigan's percentage of graduate-degree faculty. (Sections 3.1.2 & 4.1.2)
- Innovate student recruitment & retention approaches to improve graduation/licensure numbers and rates. (Sections 1.1.2, 1.3.1, 1.4.1, 3.1.2, 3.2.1, 3.2.2, 3.2.3, & 4.2.2)
- Set up Regional Education Centers (share cutting-edge teaching/clinical technology) to improve student retention/graduation/licensure numbers & rates. (Section 4.2.5)
- Use electronic (Virtual Reality, web-based) education systems to extend the reach of education programs and increase educational capacities. (Sections 4.2.5 & 4.3.2)

Healthcare System Changes

- Expand national-standard electronic information systems to improve efficiency, quality of care, and nurse retention. (Section 3.2.4)
- Innovate nursing life-career supports to improve nurse retention. (1.1.4 & 2.2.1)
- Institutionalize nursing as a revenue center to secure the status of nursing as a profession and improve nurse recruitment & retention. (Sections 1.3.2 & 5.1.4)

Regulatory & Licensure Changes

- Institute a continuous quality improvement process (CQIP) for nursing regulatory policies & procedures to improve the responsiveness of the system to the needs of nurses and nurse employers. (Sections 3.2.1 & 6.2.1)
- Expand data collection, analysis, and reporting to inform nursing & health policy. (Sections 1.3.1 & 6.2.1)
- Enact Public Health Code recommended changes for nursing to prepare Michigan for the challenge of the next thirty years in healthcare. (Sections 6.1.1, 6.1.2, & 6.2.1)
- Engage the nursing community for policy input on a continuing basis to ensure that nursing systems adjust to a changing environment. (Sections 1.3.1, 6.1.1, & 6.2.1)

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Chapter 3: What Will These Changes Accomplish?

Improve the Health of Michigan's People

Nurses are a critical component of the healthcare system, and provide the majority of patient care in virtually all health care settings. Nurses improve patient care and safety in hospitals, and provide direct care nursing, preventive care, health education, and public health, mental health, and occupational health care in a variety of settings. Nurses keep people well throughout the lifespan (immunizations, school nursing, diabetes education, etc.). This increases the number of healthy, productive people in the workforce overall.

Nurses improve the effectiveness and efficiency of the healthcare system by providing care/case management and disease management (to make sure that patients get the right care at the right time from the right provider). Nurses teach people what they need to know for self-care and self-care management (how to deal with the system). This approach to healthcare is becoming more common as health insurance covers less care, and our aging population requires more care.

Professional nurses will become even more important in the provision of healthcare as an aging population increases the demand for healthcare over the next thirty years, the wide range of healthcare services provided by nurses become more important, our country must deal with health threats from both socio-political and natural sources, and the funding of healthcare becomes even more problematic.

Implementation of the Michigan Nursing Agenda Recommended Actions will:

first, help us keep the nurses we already have by improving the work environment, the safety of the work itself, and the respect and support provided to nurses³⁰;
second, help us add new nurses to the workforce by increasing the number of nursing faculty and students, and improving the image of nursing;
third, help us understand both the healthcare and economic roles of nursing in Michigan;
fourth, strengthen the nursing profession and nursing standards of practice in Michigan, so that we can maintain high quality care, increase respect for nursing as a profession, and create an arena in which nursing can adapt to the needs of the population; and
fifth, help us increase the ethnic and cultural diversity of the Michigan nursing workforce, so that it reflects the ethnic and cultural diversity of the state population and thereby improves patient access to care and patient outcomes.

Improve the Health of Michigan's economy

The business case for nursing is made in the 2004 and 2005 *Economic Impact of Health Care in Michigan* reports from the Partnership for Michigan's Health³¹. Healthcare is Michigan's largest single employer, providing over 472,300 direct jobs, plus 254,340 indirect/induced jobs. The average healthcare employee earns \$34,300 per year and contributes \$55,000 to the local economy in direct and indirect/induced spending. Nurses are the largest licensed group of healthcare professionals, and have above average compensation. Therefore, each nursing position is worth a minimum of \$55,000 per year, and the 90,470 nurses working in direct patient care jobs in 2004 brought a minimum of \$5 billion into local and state economies.

Each unfilled nursing position constitutes a substantial economic loss to local and state economies. The number of unfilled nursing positions (vacancies) statewide in 2004 is estimated to range from almost 12,000 to over 14,000, based on the number of licensed nurses providing direct patient care and national vacancy rates³². This has a negative effect on patient care and safety, increases stress on the nurses caring for patients, and means that local and state economies have suffered a minimum estimated loss of \$660 million over the past year. The Nursing Agenda Recommended Actions will help to fill those nursing vacancies, improve patient and nurse safety, and increase the economic benefit of nursing to local and state economies.

As the Nursing Agenda for Michigan is implemented, innovations in nursing ergonomics, healthcare design, facilities design, and healthcare organization can be marketed widely. Michigan's innovations in nursing products and services can be leveraged to increase national and international sales. Organizational, educational, funding and regulatory changes will also ensure that Michigan's healthcare dollars are invested in Michigan for Michigan's future.

The nation and the State make a huge investment in healthcare every year. Shouldn't Michigan's healthcare investment be targeted within Michigan to improve Michigan's healthy economy and healthy future?

The complete Nursing Agenda for Michigan is available online at:
www.michigan.gov/mdch/ocne

End Notes

¹ Rothert, M., Wehrwein, T., & Andre, J. (2002). *Nursing Workforce Requirements for the Needs of Michigan Citizens* in "Informing the Debate: Health Policy Options for Michigan Policymakers", IPPSR, Michigan State University, East Lansing, Michigan.

² The practice of nursing is regulated by the Occupational Regulations of the Michigan Public Health Code. These regulations require that nursing care be provided under the supervision of a Registered Nurse. Without adequate numbers of professional registered nurses, healthcare systems cannot function. Other roles of professional nurses include: nursing leadership and management (nurses define standards of nursing care and practice, develop policies and procedures in health care settings); nurse-executives (chief executive nurses oversee the operations of nursing services, nurses serving as chief operating officers oversee the operation of clinical services delivered in healthcare settings); nurse educators (nurses provide patients and staff education, ensure that health care personnel receive orientation to new jobs, or updates in current health care practices). Advanced practice nurses (with a masters degree in nursing), Clinical Nurse Specialists, and Nurse Practitioners are all Limited independent Practitioners who specialize in an area of nursing practice. [Michigan Public Health Code and communication from Michigan Mental Health Nursing Directors.]

³ Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy*: p.26.

⁴ Michigan Center for Nursing (2005). *Survey of Nursing Education Programs: 2002-2003 School Year*.

⁵ It is interesting and significant that the US Department of Labor still lists nursing and teaching under the "Women's Bureau".

⁶ Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2004-5 Edition*, Registered Nurses, on the Internet at <http://www.bls.gov/oco/ocos083.htm>.

⁷ Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy*: p.47.

⁸ Kalisch, Bea. *The Image of Nursing: Evolution and Revolution*. Sigma Theta Tau International, Rho Chapter, University of Michigan New & Events, 2000.

⁹ *Crisis in Nursing has its roots in an image problem*, Seattle Post-Intelligencer, September 3, 2000.

¹⁰ Public health nurses and other community-based nurses express concern about low compensation and respect levels, but also express pride in their greater autonomy, and less difficulty in recruitment and retention for positions in their fields. [Communication from MALPH Public Health Nurse Administrators Forum.]

¹¹ U. S. Bureau of Labor Statistics (2005). *Women in the Labor Force: A Databook*.

¹² Heylin, M (2005). Evolving anatomy of the U.S. Labor Force, *Chemical & Engineering News*, June 13, 2005: 17-20.

¹³ Ibid.

¹⁴ Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2004-5 Edition*, Registered Nurses, on the Internet at <http://www.bls.gov/oco/ocos083.htm>

¹⁵ <http://www.dol.gov/wb/factsheets/Qf-nursing.htm>.

¹⁶ Michigan Department of Labor & Economic Growth, October 2004. *The Health Care Sector and Michigan's Economy*: pp 8-9

¹⁷ Health Resources and Services Administration, Bureau of Health Professions (2002). *Projected Supply, Demand and Shortages of Registered Nurses: 2000-2020*. Washington, DC: U.S. Department of Health & Human Services.

¹⁸ Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy*: p.10.

¹⁹ <http://www.aacn.nche.edu/Media> Fact Sheets/NursingShortage.

²⁰ Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy*: p.38.

²¹ United States Census: Population Projections by State. [See: <http://www.census.gov>.]

²² Rothert, M., Wehrwein, T., & Andre, J. (2002). *Nursing Workforce Requirements for the Needs of Michigan Citizens* in "Informing the Debate: Health Policy Options for Michigan Policymakers", IPPSR, Michigan State University, East Lansing, Michigan.

²³ Ibid, p13.

²⁴ Michigan Department of Labor & Economic Growth (2004). *The Health Care Sector and Michigan's Economy*: p. 26, plus projections drawn from federal sources (see above).

²⁵ All Michigan projections are rounded to the nearest thousand, since projections are necessarily approximations. The extrapolation of 2015 projections to 2020 takes into account a slight drop in nursing supply due to Baby Boomer Retirements (compare to federal projections), Michigan's generally low rate of population increase, and the effect on demand of the aging Baby Boomers (about half of whom will be retired by 2020). Keep in mind that all projections are approximate, and unpredictable factors (environmental, demographic, economic, technological, & socio-political) may render projections unreliable. Shortage projections should be updated as circumstances change.

²⁶ All data are taken from recent reports of the Michigan Center for Nursing. See

<http://www.michigancenterfornursing.org> and

http://www.mhc.org/mhc_images/surveyfinalreport.pdf.

²⁷ See Rothert, M., et al (2002). Ibid, p 9. The figures given in the Nursing Agenda text are for 2004; Michigan population figures are from the U.S. Census 2004 estimates, nursing estimates are from the Michigan Center for Nursing, *Survey of Nurses 2004*. Comparable 2004 figures on the national level are: African-Americans (12.1% general population, 4.9% Registered Nurses) and Hispanics (12.5% general population, 2% Registered Nurses). Results from the Michigan Center for Nursing *Survey of Nurses 2005* are for Michigan licensed nurses actively working in the field of nursing: For active Registered Nurses (6% African-American, 4% Asian/Pacific Islander, 1% American Indian/Alaskan Native, and 1% Hispanic); for active Licensed Practical Nurses (13% African-American, 2% Asian/Pacific Islander, 1% American Indian/Alaskan Native, and 1% Hispanic).

²⁸ American Nurses Credentialing Center website: <http://www.nursingworld.org/ancc/magnet>.

²⁹ Examples of Michigan hospitals and healthcare systems holding or seeking Magnet hospital status include: Henry Ford Health System, St John Health, Trinity System (Mercy General Health Partners), Ascension System, and others whose goals align with the Magnet program.

³⁰ *The Nursing Agenda for Michigan* should be used by nurses as a source of ideas for workplace and workforce improvement in their various work environments, and in strategic planning. *The Nursing Agenda for Michigan* also should be included in senior and graduate nursing courses at colleges/schools of nursing, to stimulate critical thinking, creativity, and interest in health policy and the Future of Nursing. [Communication from Ada Sue Hinshaw, PhD, RN, FAAN, Dean, University of Michigan School of Nursing.]

³¹ The Partnership for Michigan's Health includes the Michigan State Medical Society, the Michigan Health & Hospital Association, and the Michigan Osteopathic Association.

³² Michigan Department of Labor & Economic Growth (2004). *Health Care Workforce Development in Michigan*. and the Michigan Center for Nursing, *Survey of Nurses 2004* and *Survey of Nurses 2005*.