



Regional Nursing Summits

BRIDGING THE GAPS IN PRE-LICENSURE RN CLINICAL
EDUCATION CAPACITY

SUMMARY REPORT | JANUARY 2, 2019

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SUMMIT INTRODUCTION

Through an innovative series of regional summits, California developed a collaborative process of addressing some of the most challenging issues facing nursing education today: lack of standardization of educational programs and difficulty in securing clinical placement/immersion experiences for pre-licensure students. Multiple stakeholders from academia, healthcare providers, labor groups, and government identified opportunities for change as well as some of the challenges faced in preparing nurses for a rapidly changing practice environment. In coming together, summit participants learned from each other, developed new ideas, and strengthened the professional nursing communities' commitment to working together to find new approaches to old problems. Priorities for action were identified that will further progress toward the shared goal of a well-prepared nursing workforce.

Priorities for action to create greater efficiency and effectiveness in educating the nursing workforce will be the focus of future efforts stemming from the regional summits. Priorities have been identified in the general areas of nursing curricula, systems of distribution and onboarding of students, program approval processes, student nurses' exposure to the full continuum of care, and use of simulation. Underpinning all the priorities for action is the importance of multi-stakeholder involvement in implementation activities, reflective of the shared goal of well-prepared nurses.

SUMMIT BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

SUMMIT FORMAT

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

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

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

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

SUMMIT RESULTS

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

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

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

SUMMARY TABLE OF “PRIORITIES FOR ACTION”

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

Table 1. “Priorities for Action” Across Regions: Listed in this order below:

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

REGIONAL NURSING SUMMITS SUMMARY REPORT
Bridging the Gaps in Pre-Licensure RN Clinical Education Capacity

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

REGIONAL NURSING SUMMITS SUMMARY REPORT
Bridging the Gaps in Pre-Licensure RN Clinical Education Capacity

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

REGIONAL NURSING SUMMITS SUMMARY REPORT
Bridging the Gaps in Pre-Licensure RN Clinical Education Capacity

Adopt “BSN in Ten” strategy in California		X			X		
Discontinue the use of letters of impact as evidence justification for program approvals and or expansion requests			X	X			

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

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

- ✓ Pursue greater standardization of pre-licensure nursing education curricula, including credit load and clinical hour across programs and by type of program – ADN, BSN, ELM. Summit participants expressed the need to reduce the noted degree of variation existing within regions and across regions throughout the state. Discussion actions ranged from voluntary school reduction/alignment of credit loads and clinical hours, to mandates from the BRN or other sources. The California State University nursing programs were recognized by some Summit participants for the standardization accomplished in recent years.
- ✓ Pursue regular consistent participation by all nursing education programs and clinical partners in the use of clinical placement systems/tools/consortiums within regions and statewide. There was acknowledgement that multiple consortium systems/tools exist – sometimes multiple types even in the same region. It was also noted there has been a lack of consistent participation by both clinical partners and programs in any given system and or region/area with a region. There was also support for the value of a standardized, statewide approach to clinical placements. Cost, confidentiality, favoritism, and general lack of interest were all stated as reasons for not participating in a consortium or utilizing a scheduling system/tool. It was also noted existing consortiums and clinical placement systems are mainly used by nursing programs and acute care clinical agency partners rather than all clinical agencies providing placements in a region. Participation by all nursing education programs and clinical partners across all levels of care needs to occur to do a better job in successfully managing clinical capacity. Implementation of the suggested actions above is viewed as a better way to improve standardization and promote consistent and increased communication and cooperation.
- ✓ Standardize clinical site requirements for education program placements arising from regulatory, licensing, and accreditation requirements for orienting/onboarding students and faculty. Some regions have attempted to do this, but there remains much variability in clinical site requirements within a region and across the seven regions. Summit participants identified the lack of standardization and variation as creating administrative burdens for programs, students, and health care organizations.
- ✓ Increase and facilitate use of non-acute clinical practice settings statewide. This might include use of clinical practice settings such as correction facilities, telehealth, clinics, K-12 schools, etc., as well as expanded utilization of other non-acute care settings with capacity to provide a range of learning experiences along the continuum of care. Summit participants acknowledged RNs work in multiple settings and re-affirmed the significant value of developing and maintaining clinical learning experiences and placements across all levels of care. Participants emphasized that the focus moving forward should be on providing adequate student learning opportunities to develop safe competent clinical reasoning across different practice settings and levels of patient care delivery as opposed to skill building only for acute care practice settings.
- ✓ Pursue ways for schools to have flexibility in the use simulation/virtual reality experiences for up to 50% of pre-licensure clinical time to meet program learning outcomes when a program can demonstrate sufficient evidence to prepare a safe competent RN that meets regulatory requirements. Summit participants acknowledged this proposal would require regulatory changes and establishing and adopting a uniform set of simulation standards across California. There was also a clear recognition by participants that faculty should be prepared and certified to teach in simulation-based learning environments using national standards for teaching in simulation-based learning environments.

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

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

- ✓ Review and consider revision of some of the BRN’s faculty and clinical site approval processes. Summit discussions identified aspects of the faculty and clinical site approval processes that are burdensome for some programs in some instances. Two specific suggested modifications were put forth: 1) Allow RNs with Nurse Practitioner certification/preparation to serve as faculty without additional remediation in acute direct care; and 2) Eliminate the need for BRN approval of faculty and clinical sites for nationally-accredited nursing programs.
- ✓ Eliminate inconsistencies in interpretation/application of standards, regulations, and approval processes within regions and across regions. For example, variation in clinical site approvals was frequently cited.
- ✓ Create a group of key stakeholders to work with the BRN and legislative bodies for regulatory reform related to the nursing education program approval processes. The goal would be to simplify and streamline the approval processes. Summit participants recognize this will most likely involve opening the Nursing Practice Act and will need to be carefully considered and analyzed before pursuing this option as a viable action moving forward.
- ✓ Increase and sustain the opportunities/enrollment options for ADN students to be co-enrolled in AD to BSN or AD to MSN programs to promote increased academic progression faster. The goal should be to encourage all ADN students to be co-enrolled in a university program, and to facilitate enrollment and completion processes with forgivable loans, employer scheduling flexibility, and reasonable credit loads when students are co-enrolled in courses.
- ✓ Standardize and streamline RN post-licensure residency experiences to onboard newly licensed RNs in all initial practice settings. Consider adopting statewide standards and processes that would be foundational to all residency programs in California.
- ✓ Support school and clinical practice setting partnerships for the creation and sustained use of simulation spaces that can be used by all parties. A suggested variation on this recommendation was to develop mobile simulation spaces that can be brought to nursing programs or practice settings within a region/area. Participants suggested mobile simulation labs might be developed together by several school partners, employers, and/or the Chancellor’s Office, for example.
- ✓ Achieve greater standardization of the ratio of non-direct care/simulation/virtual labs/skills labs practice hours to direct care practice hours in the future. There is some evidence to support the theory that well

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

- ✓ Increased funding and provision of more opportunities for faculty to obtain the requisite formal preparation to teach in simulation-based learning environments.
- ✓ Develop a regional approach to nursing program advisory committees. In urban areas, practice leaders find it challenging to attend multiple nursing program advisory committees if they host students from multiple nursing programs. Summit participants suggested regular participation/attendance at advisory meetings could more than likely be improved if individuals could attend one meeting that involved all the programs and clinical partners across all practice settings in the region. Moreover, participants suggested action in this area would have the added benefit of programs and practice settings sharing best practices with each other and provide continuing opportunities to standardize and further align curriculum and clinical practice needs and processes.
- ✓ Adopt a “BSN in Ten” strategy in California. This would require all future graduates of ADN nursing programs to obtain a BSN degree within ten years of graduation to qualify for continued RN licensure.
- ✓ Identify valid and reliable processes/practices that provide sufficient evidence of clinical capacity/clinical placement impact that will enable the BRN to replace the existing approval processes now requiring clinical sites and neighboring nursing programs to write letters of impact as part of the BRN’s approval processes for nursing education program expansion or new program approvals should be discontinued.
- ✓ Develop processes that support joint faculty appointments.

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

- ✓ Support BRN action to limit program growth in impacted areas of the state (LA region). Discussion encompassed both new programs coming into the region as well as existing programs expanding their pre-licensure enrollment capacity.
- ✓ Address faculty recruitment and retention. This is a major issue for nursing education (Fresno region) not just for the one region mentioned in the one Summit session listed here. Summit participants suggested several ideas such as increasing compensation, developing joint academic/practice appointments, creating faculty pipelines, and building different structures to recognize faculty expertise and tenure as solutions that could favorable impact faculty recruitment and retention.
- ✓ Eliminate pre-licensure nursing student preceptorships. This was a priority in one region (Riverside region). This action would free up preceptors to work with newly licensed nurses, and also allow them to be more available to higher numbers of pre-licensure students.
- ✓ Develop necessary algorithms to determine/predict the numbers and skill mix of nurses required year to year in a specific region (Bay Area region) and across all regions. The developed algorithms would also take clinical practice setting (across the continuum of care) capacity into consideration in setting future targets. These

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

- ✓ Consider eliminating all nursing program curricula in the state and start over with a goal of building a statewide (or regional) shared curriculum (Bay Area region).
- ✓ Combine the BRN and Board of Vocational Nursing and Psychiatric Technician (BVNPT) into one board (Riverside region) was suggested. Having one board was suggested as a way to further streamline program approval processes and leverage regulatory learning and oversight responsibilities. California, West Virginia, and Louisiana are currently the only states in which these boards function as separate entities.
- ✓ Establish more refined/detailed BRN guidelines for clinical placements in non-acute care clinical settings (Sacramento). This would further support standardization of clinical placements in non-acute care, ambulatory care and other community-based clinical settings.
- ✓ Allow and facilitate use of clinical placements in non-acute care settings across all levels of care without faculty or RN presence when an RN role focus can be demonstrated to meet program/course objectives (San Diego region) and regulatory requirements. Provide necessary level of supervision/oversight via greater use of technology and or through an RN manager or provider role.

CONCLUSION

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

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

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

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

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

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

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

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

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

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

SUGGESTED NEXT STEPS

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

- I. **Sustain the Summit momentum to make needed changes that ensure sufficient clinical capacity and a well-educated, sufficient RN workforce now and in the future.**
 - Summit participants clearly acknowledged that the degree of variability in clinical capacity/clinical placements processes within regions and across the state needs careful and continued examination so workable/practical solutions can be more fully developed, implemented and evaluated. An example is to

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

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

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

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

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

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

REFERENCES AND RESOURCES

Board of Registered Nursing

Nursing Practice Act <https://www.rn.ca.gov/practice/npa.shtml>

Business & Professions Codes [Article 4. Nursing Schools - 2785-2789](#)

California Code of Regulations [Article 3. Prelicensure Nursing Programs](#)

Board of Registered Nursing approved programs **[Pre-Licensure RN Programs \(ADN, BSN, and ELM Programs\)](#)**

National Council Licensure Examination for Registered Nurses (NCLEX-RN®) Pass Rates for California graduates
<https://www.rn.ca.gov/education/passrates.shtml>

HealthImpact <https://healthimpact.org/>

Regional Nursing Summits: Bridging the Gaps in Clinical Capacity CA BRN Regional Summit Report

<https://healthimpact.org/publication/regional-nursing-summits-bridging-the-gaps-in-clinical-capacity/>

<https://healthimpact.org/publication/ca-brn-regional-summit-report/>

Supply & Demand of RNs – Central Valley & Sierra region <https://healthimpact.org/publication/supply-demand-of-rns-central-valley-sierra-region/>

Supply & Demand of RNs – Inland Empire <https://healthimpact.org/publication/supply-demand-of-rns-inland-empire/>

Supply & Demand of RNs – LA/Orange/Ventura region <https://healthimpact.org/publication/supply-demand-of-rns-la-orange-ventura-region/>

Supply & Demand of RNs – Sacramento & Northern regions <https://healthimpact.org/publication/supply-demand-of-rns-sacramento-northern-regions/>

Supply & Demand of RNs – San Diego region <https://healthimpact.org/publication/supply-demand-of-rns-san-diego-region/>

Supply & Demand of RNs – SF Bay Area region <https://healthimpact.org/publication/supply-demand-of-rns-sf-bay-area-region/>

National Council of State Boards of Nursing (NCSBN) <https://www.ncsbn.org/index.htm>

National Simulation Guidelines for Prelicensure Nursing Programs <https://www.ncsbn.org/9535.htm>

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

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Attachment A

Regional Nursing Summits Agenda

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



Regional Nursing Summits

Bridging the Gaps in Clinical Capacity

AGENDA

10:00 AM – 2:30 PM

- | | |
|-------------------|---|
| 9:30-10:00 am | Registration |
| 10:00-10:30 am | Welcome (<i>Judee Berg</i>) |
| | History – “What Got Us Here?” (<i>Judee Berg</i>) |
| | <ul style="list-style-type: none">• Quad Council letter (<i>Quad Council Representative</i>) |
| | Summit Purpose: Identify Priorities for Action (<i>Dr. Joseph Morris</i>) |
| | <ul style="list-style-type: none">• Immediately actionable• Long term |
| 10:30-11:00 am | Regional Supply & Demand Forecast Reports (<i>Dr. Joanne Spetz</i>) |
| 11:00-11:30 am | BRN Nursing Program & Hospital Capacity Survey Results (<i>Dr. Joseph Morris</i>) |
| 11:30 am-12:00 pm | Box Lunch & Small Group Instructions (<i>Judee Berg</i>) |
| 12:00-1:00 pm | Small Group Discussion – Educating Nurses for the Future (<i>All</i>) |
| | <ol style="list-style-type: none">1. Identify unique issues, challenges, and best practices for region
(15 minutes)2. Identify strategies for innovative, collaborative solutions, including the role of placement systems/consortiums
(20 minutes)3. How can simulation/virtual learning be effectively leveraged for clinical experience?
(10 minutes) |

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

1:00-2:00 pm	Large Group De-brief/Innovative Ideas Discussion (All)
2:00-2:15 pm	Innovative Ideas Ranking (All)
2:15-2:30 pm	Next Steps (Dr. Joseph Morris)

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



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





Attachment B

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

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



Regional Nursing Summits

Bridging the Gaps in Clinical Capacity

Issue

The demand for pre-licensure Registered Nurse (RN) clinical education capacity/clinical placements is outpacing current acute care capacity for pre-licensure Associate Degree Nursing (ADN) Baccalaureate Science Nursing (BSN), and Entry Level Masters (ELM) nursing programs and students. Increasing numbers of clinical training slot requirements, resulting from both increased enrollments in existing pre-licensure RN programs in some areas of the state coupled with simultaneous decreases in acute care training capacity due to a number of factors is causing flow disruption and concern among academia and healthcare organizations. The degree of operational disruption has been slowly surfacing over the past several years as both academia and healthcare settings strive to meet the needs of a dynamic transforming health care system while achieving effective organizational efficiencies and targeted quality outcomes and improvements. This year several issues and concerns arose that highlighted the need for re-examination of all aspects of academic and industry educational clinical placement coordination and programming. Left unresolved these issues can impact and potentially compromise effective RN student learning and strain organizational efficiencies. Most importantly, if not addressed, these issues/concerns may threaten the significant progress California has made in maintaining a viable professional workforce in the future. The complex systemic challenges in academia, healthcare and the regulatory environment today all influence the depth and breadth of pre-licensure RN education. It is crucial that all stakeholders continue to work together so these complex multilayered issues, concerns and challenges are discussed and solutions identified. As many stakeholder groups and Summit participants already recognize, the clinical capacity/clinical displacement issues are part of a much larger complex set of nursing education and nursing practice issues partners deal with regularly. These encompasses, but are not limited to, how best to prepare new RNs for the ever-changing practice

environments, how to achieve the best patient care outcomes, how to maximize use of available resources while achieving operational efficiencies and effectiveness, how to manage changes in clinical capacity and availability of clinical placements in inpatient, outpatient/ambulatory and community based settings, how to maintain continued support for implementation of nursing education redesign initiatives, how to ensure seamless academic progression, how to effectively select and implement a variety of direct and indirect instructional methods that will most effectively prepare the RN graduate for clinical practice (direct patient care, indirect care skills/simulation labs), how to best to accomplish review and revision of nursing curriculum and how to effect regulatory changes to keep pace with the changing health care environment, how to address preceptor requirements, labor requirements, sufficiency of resources, and how to move forward so all pre-licensure RN nursing education programs in California have the necessary resources to support program implementation, compliance with Board of Registered Nursing Regulations and attainment of voluntary national nursing accreditation.

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

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

Summit Goals

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

Summit Outcomes

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

Summit Planning Group Beliefs/Assumptions

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

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

(HealthImpact, August 2016). Also relevant to Summit discussions is California's White Paper Recommendation II: "Promote academic progression for all registered nurses to obtain a BSN or higher degree by 2030."

California recognizes the crucial importance of providing education opportunities to California's very diverse population. Stakeholders recognize and support the educational opportunities and inclusive teaching and learning environments all three types of degree programs (AD, BSN, ELM) provide to meet the diverse educational, cultural, and economic needs of the communities the programs serve. All three types of programs support the value of lifelong learning and afford all Californians, irrespective of economic means, the opportunity to achieve their educational goals. These programs consistently provide rigorous, high quality nursing degree preparation. Collectively these programs provide graduates with excellent RN educational preparation for safe competent entry in to registered nursing practice. All Board approved pre-licensure nursing programs provide clinical learning experiences in a variety of clinical practice settings that ensure graduates are prepared to function safely and competently in the current and emerging practice environments.

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

California's Education White Paper recommendations are consistent with the Future of Nursing Report (IOM, 2010) recommendation that established a goal of 80% of nurses in the workforce having a BSN or higher degree by 2020. Recommendation V in California's Education Plan White Paper states, "Provide transformative learning opportunities that prepare nurses for evolving roles in rapidly changing interprofessional practice environments."

The Summit Planning Group also believes and supports attainment of voluntary national nursing accreditation by all pre-licensure RN nursing education programs in California. Presently, all BSN and ELM nursing programs are accredited by a national nursing accreditation body (CCNE or ACEN). About 30% of Associate Degree nursing programs hold national nursing accreditation. In California, Board of Nursing approval is required and national nursing accreditation decisions are made by each nursing program. State Board of Nursing approval and national nursing accreditation processes have the same goals to provide society with a safe competent RN workforce. Both bodies review and evaluation processes use appropriate evidenced based outcome metrics to determine program success in meeting compliance and established standards of quality and improvement.

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

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

Lastly, the Summit Planning group supports program curriculum change initiatives to achieve less variability in the total degree units and required clinical units/hours beyond the BRN minimum requirements (18 semester units or 27 quarter units). It is believed that curriculum changes would help to even out the need for clinical space. While the BRN regulations set the overall minimum clinical unit and hours requirements for nursing education programs, it is each college/nursing program that determines the total number of units required to earn the nursing degree. If all nursing education programs adopted the BRN clinical minimums required, this action alone may “open up” a number of additional clinical slots and hours for other nursing programs needing placements. For example, in the California State University system nursing education programs consistently require 120 units for the bachelor’s degree, but that may not be the case for all other California BSN degree programs. For the Associate Degree Nursing programs, total degree units across this degree type programs may vary and range from 70 units to 90 or more units. The Summit Group suggests now is an opportune time for nursing programs and faculty to make the curriculum revisions necessary. The recommendation is ... *To create efficient educational pathways that minimize student burden (including debt), maximum credit units should be 70 units for ADN and 120 units for BSN programs to avoid programmatic variability and even out need for clinical space.*

In summary, the academic and healthcare agencies/service partners and the BRN have agreed to host regional summits to collectively identify practical solutions to the pre-licensure nursing clinical placement capacity dilemma. The regional summit planning group has identified the aforementioned beliefs and assumptions as guiding principles for Summit discussions. Moreover, the Summit Planning group recognizes the value, nature and importance of present regional planning consortiums and related infrastructures where they exist and the invaluable role regional clinical planning groups play managing the complex clinical placement scheduling,

programming, and coordination activities associated with securing needed clinical placements in the various regions throughout California. These groups have been pivotal to the many successes achieved in matching regional clinical placement requests by large numbers of nursing education programs with available clinical sites in an efficient and effective manner. Action steps specific to each region will specifically address local needs, using the identified assumptions to guide conversation and solutions.

Stakeholder Information

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

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

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

BRN regulations require pre-licensure nursing education programs obtain BRN approval of all clinical sites prior to use. The program submits required forms/paperwork and sufficient evidence showing compliance with the regulations. For decades, the Board has supported and approved clinical placements in a wide variety of clinical settings across all levels of care including inpatient, outpatient/ambulatory care, and community-based healthcare agencies. There is no Board regulation that requires all of an approved program's clinical learning experiences be completed in an acute care clinical agency. In the past, some programs may have depended on available acute care agencies to achieve a significant portion of program objectives and student learning outcomes. Board approved nursing program faculty select, plan, implement, and evaluate the appropriateness and suitability of the clinical placements to meet clinical objectives and student learning outcomes. The selected and approved clinical placements are expected to provide a sufficient number and type of learning experiences and an adequate patient census to support the number of students placed in the clinical rotation. Selected approved clinical sites/placements need to provide the appropriate level of complexity to meet learning objectives, and enable student mastery of the knowledge, skills, abilities and clinical judgment that facilitates student progression in providing safe competent care at the level of required complexity in each nursing course.

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

The BRN is working closely with the BRN Nursing Education and Workforce Advisory Committee (NEWAC) and its simulation workgroup to facilitate quality driven simulation to the allowable amount. Currently the NEWAC simulation workgroup has developed a set of uniform simulation standards and is working on nursing program adoption of a uniform set of simulation moving forward. Adoption of a uniform set of simulation use standards is an important next step in relation to simulation and ensuring the delivery of quality simulation learning experiences across all nursing programs. Simulation is also a regular agenda item for the NEWAC BRN advisory committee.

The BRN annual school surveys provide a significant amount of data regarding pre-licensure nursing education programs. Annually, the NEWAC committee reviews the annual school survey tool and makes needed revisions. The NEWAC group has done a fine job of revising the surveys year to year. Recently the BRN received a comment

suggesting it may be valuable to capture more information via the annual school survey processes in relation to Associate Degree to BSN Degree Program affiliations that support academic progression and information regarding co-enrolled students (AD-BSN). This may be an opportunity for consideration at the BRN's upcoming Fall 2018 NEWAC committee meeting.

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

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

Board Curriculum Regulations

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

§ 1426. Required Curriculum

- (a) The curriculum of a nursing program shall be that set forth in this section, and shall be approved by the board. Any revised curriculum shall be approved by the board prior to its implementation.
- (b) The curriculum shall reflect a unifying theme, which includes the nursing process as defined by the faculty, and shall be designed so that a student who completes the program will have the knowledge, skills, and abilities necessary to function in accordance with the registered nurse scope of practice as defined in code section 2725, and to meet minimum competency standards of a registered nurse.
- (c) The curriculum shall consist of not less than fifty-eight (58) semester units, or eighty-seven (87) quarter units, which shall include at least the following number of units in the specified course areas:
 - (1) Art and science of nursing, thirty-six (36) semester units or fifty-four (54) quarter units, of which eighteen (18) semester or twenty-seven (27) quarter units will be in theory and eighteen (18) semester or twenty-seven (27) quarter units will be in clinical practice.
 - (2) Communication skills, six (6) semester or nine (9) quarter units. Communication skills shall include principles of oral, written, and group communication.

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- (3) Related natural sciences (anatomy, physiology, and microbiology courses with labs), behavioral and social sciences, sixteen (16) semester or twenty-four (24) quarter units.
 - (d) Theory and clinical practice shall be concurrent in the following nursing areas: geriatrics, medical-surgical, mental health/psychiatric nursing, obstetrics, and pediatrics. Instructional outcomes will focus on delivering safe, therapeutic, effective, patient-centered care; practicing evidence-based practice; working as part of interdisciplinary teams; focusing on quality improvement; and using information technology. Instructional content shall include, but is not limited to, the following: critical thinking, personal hygiene, patient protection and safety, pain management, human sexuality, client abuse, cultural diversity, nutrition (including therapeutic aspects), pharmacology, patient advocacy, legal, social and ethical aspects of nursing, and nursing leadership and management.
 - (e) The following shall be integrated throughout the entire nursing curriculum:
 - (1) The nursing process;
 - (2) Basic intervention skills in preventive, remedial, supportive, and rehabilitative nursing;
 - (3) Physical, behavioral, and social aspects of human development from birth through all age levels;
 - (4) Knowledge and skills required to develop collegial relationships with health care providers from other disciplines;
 - (5) Communication skills including principles of oral, written, and group communications;
 - (6) Natural science, including human anatomy, physiology, and microbiology; and
 - (7) Related behavioral and social sciences with emphasis on societal and cultural patterns, human development, and behavior relevant to health-illness.
 - (e) The program shall have tools to evaluate a student's academic progress, performance, and clinical learning experiences that are directly related to course objectives.
 - (f) The course of instruction shall be presented in semester or quarter units or the equivalent under the following formula:
 - (1) One (1) hour of instruction in theory each week throughout a semester or quarter equals one (1) unit.
 - (2) Three (3) hours of clinical practice each week throughout a semester or quarter equals one (1) unit. With the exception of an initial nursing course that teaches basic nursing skills in a skills lab, 75% of clinical hours in a course must be in direct patient care in an area specified in section 1426(d) in a board-approved clinical setting.
- Note:* Authority cited: Sections 2715 and 2786.6, Business and Professions Cod. Reference: Sections 2785-2788, Business and Professions Code

Healthcare/Clinical Agencies/Industry Partners

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

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

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

Universities & Community Colleges

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

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

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

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

placement approval processes, and or may have misinformation, misperceptions, or misunderstandings about BRN regulations regarding clinical facility placements and clinical site approvals.

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

California Nursing Programs & Student Census by Region

School Years	# of Nursing Programs			Student Census		
	ADN	BSN + ELM	Total	ADN	BSN + ELM	Total
Bay Area						
2012-2013	18	12	30	1872	3393	5265
2013-2014	18	12	30	1826	3156	4982
2014-2015	18	12	30	1789	3233	5022
2015-2016	18	12	30	1718	3216	4934
2016-2017	18	12	30	1795	3211	5006
Central Coast						
2012-2013	5	0	5	354	37	393
2013-2014	5	0	5	361	44	405
2014-2015	5	0	5	385	0	385
2015-2016	5	0	5	403	0	403
2016-2017	5	0	5	393	0	393
Central Sierra (Zero Programs in Region)						
2012-2013	0	0	0	0	0	0
2013-2014	0	0	0	0	0	0
2014-2015	0	0	0	0	0	0
2015-2016	0	0	0	0	0	0
2016-2017	0	0	0	0	0	0
Greater Sacramento						
2012-2013	6	1	7	604	539	1143
2013-2014	6	1	7	582	467	1049
2014-2015	7	1	8	541	314	855
2015-2016	6	3	9	534	393	927
2016-2017	6	3	9	532	509	1041
Northern California						
2012-2013	3	1	4	165		165
2013-2014	3	0	3	158	0	158
2014-2015	3	0	3	170	0	170
2015-2016	3	0	3	175	0	175
2016-2017	No Data	No Data	No Data	No Data	No Data	No Data
Northern Sacramento Valley						
2012-2013	2	2	4	286	259	545
2013-2014	2	2	4	264	261	525
2014-2015	2	2	4	279	258	537
2015-2016	2	2	4	280	265	545
2016-2017	No Data	No Data	No Data	No Data	No Data	No Data
San Joaquin Valley						
2012-2013	10	5	15	1681	982	2663
2013-2014	10	5	15	1479	1129	2608
2014-2015	10	5	15	1799	969	2768
2015-2016	10	4	14	1574	1033	2607
2016-2017	No Data	No Data	No Data	No Data	No Data	No Data

California Nursing Programs & Student Census by Region

Southern Border						
2012-2013	7	6	13	949	1480	2429
2013-2014	7	6	13	962	1396	2378
2014-2015	7	6	13	964	1851	2815
2015-2016	7	6	13	823	1652	2475
2016-2017	7	5	12	994	1955	2949
Los Angeles Area						
2012-2013	24	17	41	4089	3841	7930
2013-2014	24	16	40	3754	3436	7190
2014-2015	25	17	42	3972	5270	9242
2015-2016	25	16	41	4019	5623	9642
2016-2017	27	15	42	3963	5119	9082
Inland Empire						
2012-2013	13	11	24	2068	3730	5798
2013-2014	14	10	24	2096	3592	5688
2014-2015	13	9	22	2128	1892	4020
2015-2016	13	9	22	1982	1981	3963
2016-2017	13	9	22	2205	2048	4253
Total						
2012-2013	88	55	143	12070	14261	26331
2013-2014	89	52	141	11502	13481	24983
2014-2015	90	52	142	12027	13787	25814
2015-2016	89	52	141	11508	14163	25671
2016-2017	91	50	141	11965	14116	26081

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

Students

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

Regional Nursing Summits

Bridging the Gaps in Clinical Capacity

Issue Statement in Brief

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

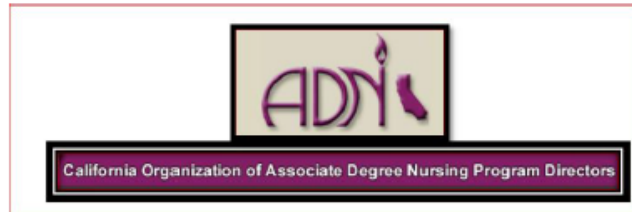
Interrelated Clinical Capacity Issues

- Multiple complex issues comprise successful RN education, such as educational goals, accreditation, regulations, practice sites, faculty and preceptor requirements, etc.
- An increasing body of evidence recommends that the BSN-or-higher prepared RN increases the quality and safety of care and is best prepared to work across the care continuum.
- The Nursing Education Plan White Paper and Recommendations for California, (HealthImpact, 2016), recommends: 1) providing transformative learning opportunities that prepare nurses for evolving roles in rapidly changing interprofessional practice environments, including non-acute settings; and 2) providing academic progression for all RNs to obtain a BSN or higher degree by 2030.
- External review for accreditation is valuable and it is recommended that nursing programs be nationally accredited.
- To create efficient educational pathways that minimize student burden (including debt), maximum credit units should be 70 units for ADN and 120 units for BSN programs to avoid programmatic variability and even out need for clinical space.
- Existing best practices, including clinical placement systems/consortiums, will be used as templates for future planning if appropriate to local and regional settings.
- The ongoing tension about clinical placements has had a negative impact on clinical practice and academic work settings to include nursing students.
- New approaches to clinical immersion experiences for pre-licensure nursing students are needed.



Attachment C

Quad Council Letter



April 2, 2018

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

Dear Dr. Morris,

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

Support for collaboration between nursing programs and clinical agencies.

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

Consider findings from the Academic Progression in Nursing Program (APIN) work and successful models from other states in fostering innovative educational pathways.

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

Incentivize national accreditation for all nursing programs.

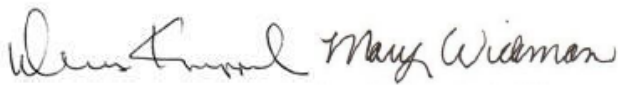
We recognize the need for a professional nursing workforce that can coordinate and lead healthcare teams across the continuum of care. To achieve this outcome, we encourage the BRN to consider ways to “incentivize” ADN programs to becoming nationally accredited. Accreditation is a nationally recognized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

Support nursing program enrollment management.

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

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

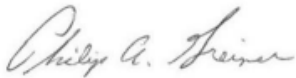
Respectfully submitted,



Association of California Nurse Leaders (ACNL)



American Nurses Association of California (ANA\C)



California Association of Colleges of Nursing (CACN)



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



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



Attachment D

Supply & Demand of RNs

Sacramento & Northern Regions

LA -Orange-Ventura Regions

Central Valley & Sierra Regions

Inland Empire

Southern Border Region

San Francisco Bay Area

UCSF
University of California
San Francisco

Supply & Demand of RNs in the Sacramento & Northern regions

Joanne Spetz, PhD, FAAN
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COLUMNISTS | 77,973 SHARES | [Facebook] [Twitter] [LinkedIn] [Reddit]

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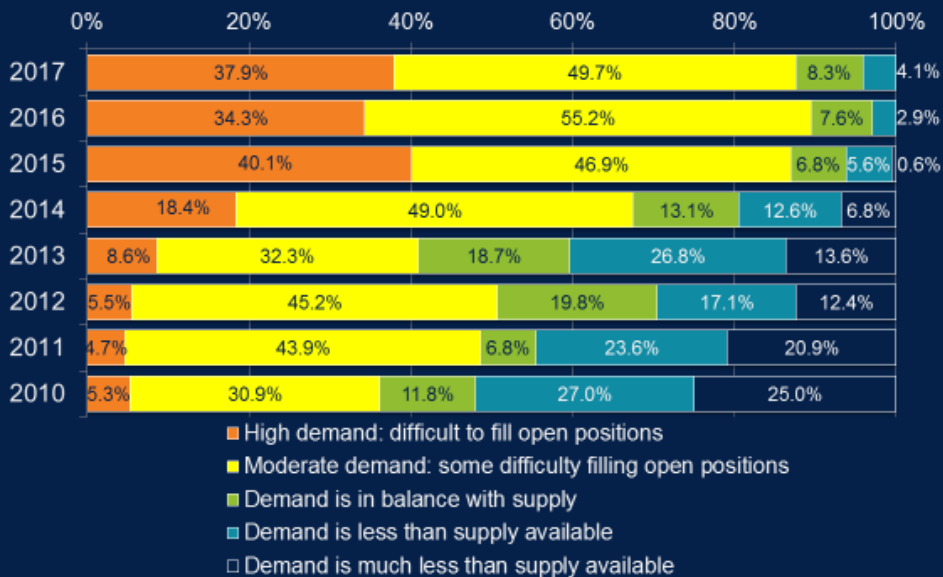
2

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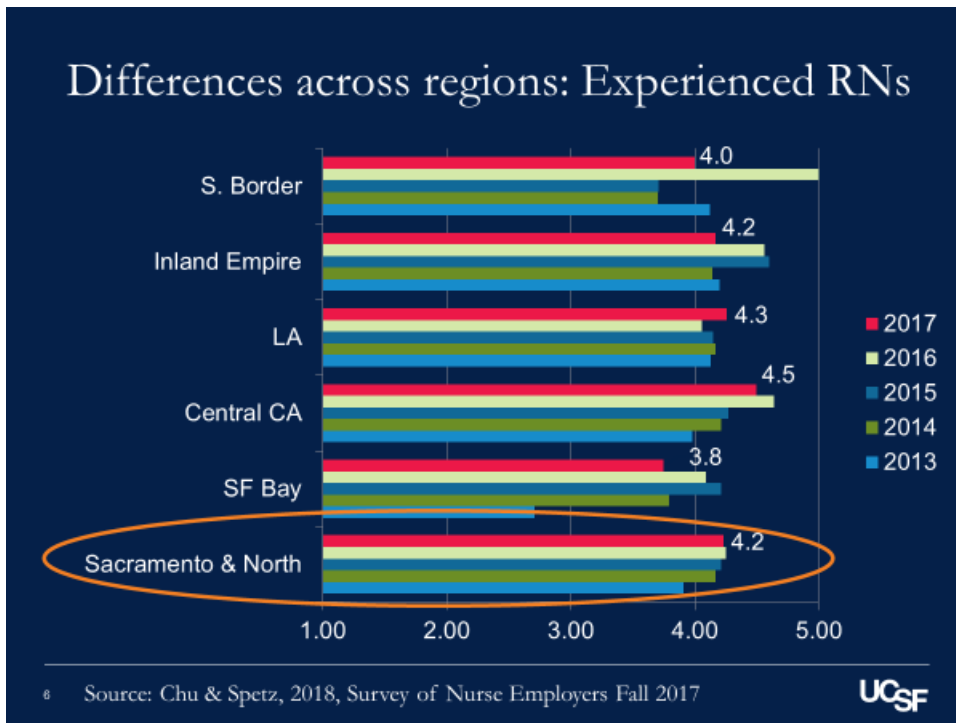
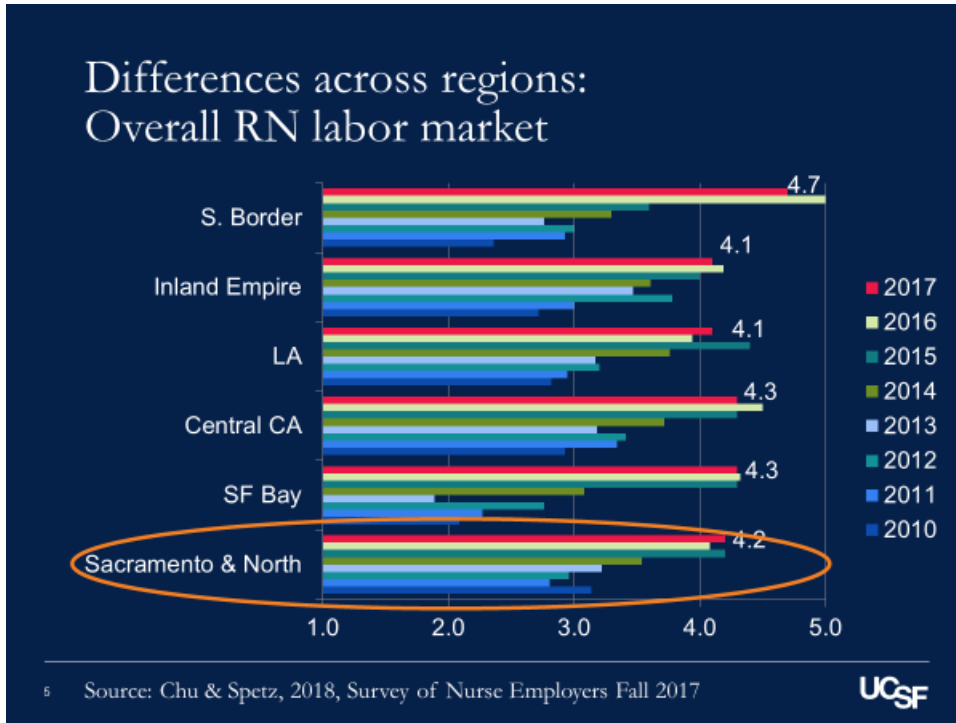


Perceptions of employers: Overall labor market

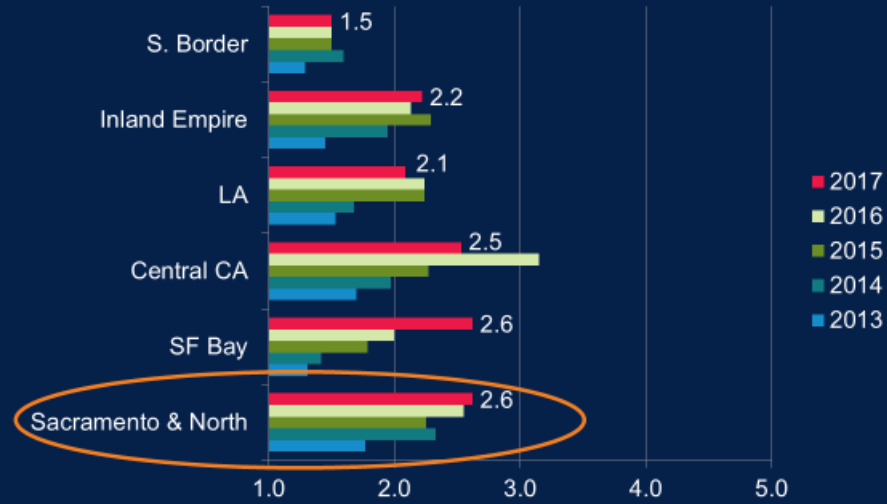


4 Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017





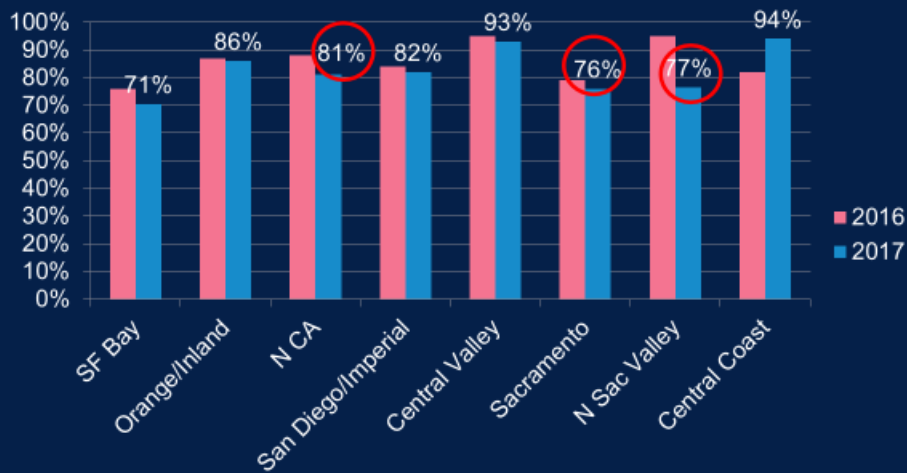
Differences across regions: New Grad RNs



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

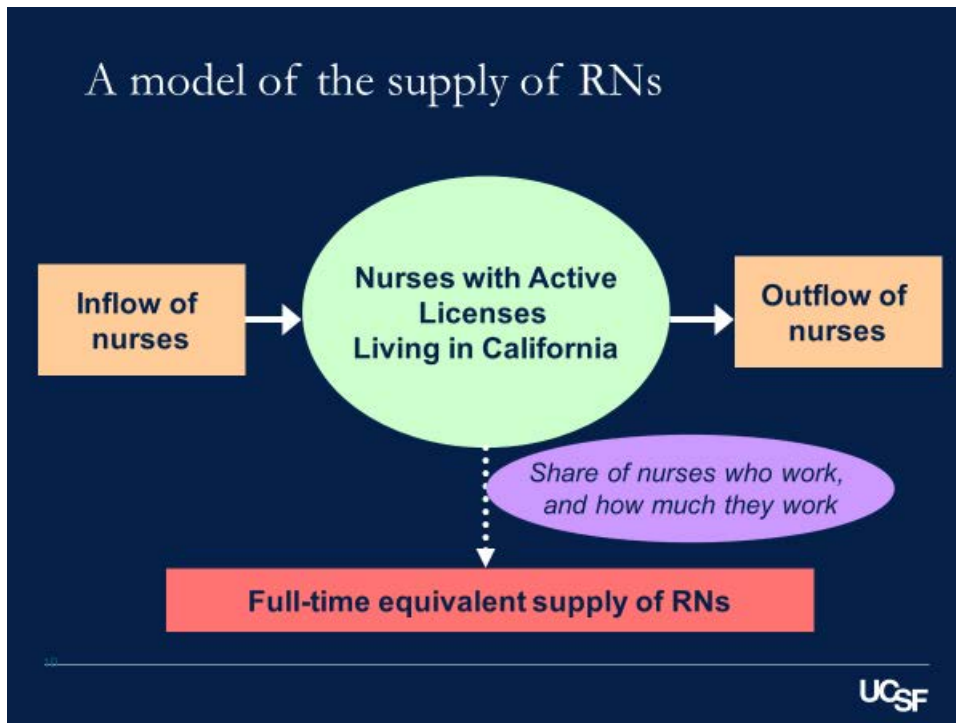
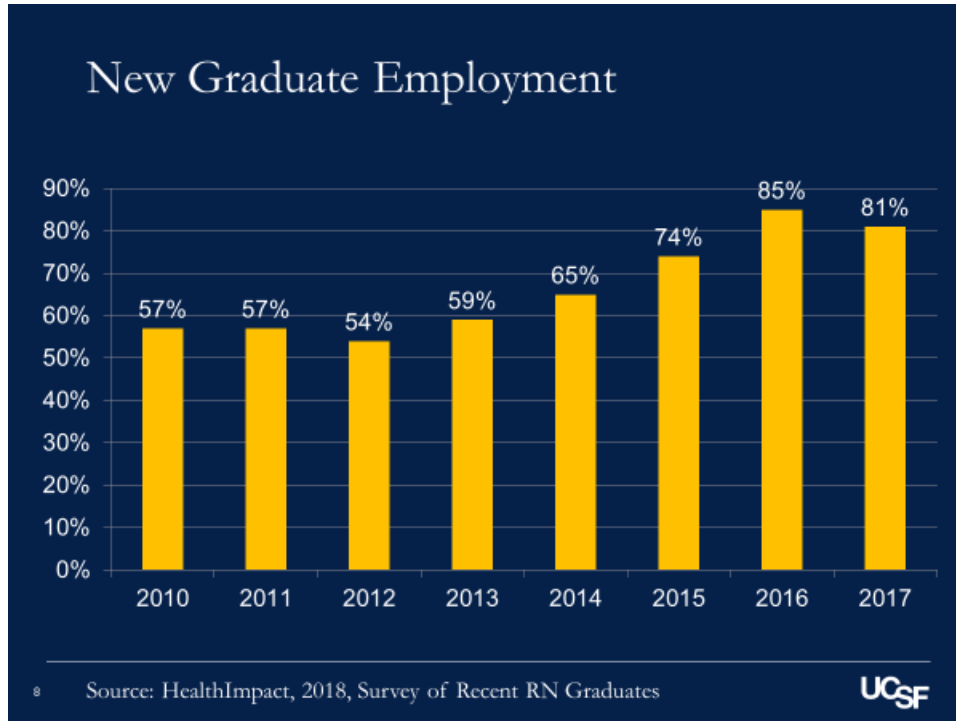


Regional Differences in New Grad Employment



9 Source: HealthImpact, 2018, Survey of Recent RN Graduates



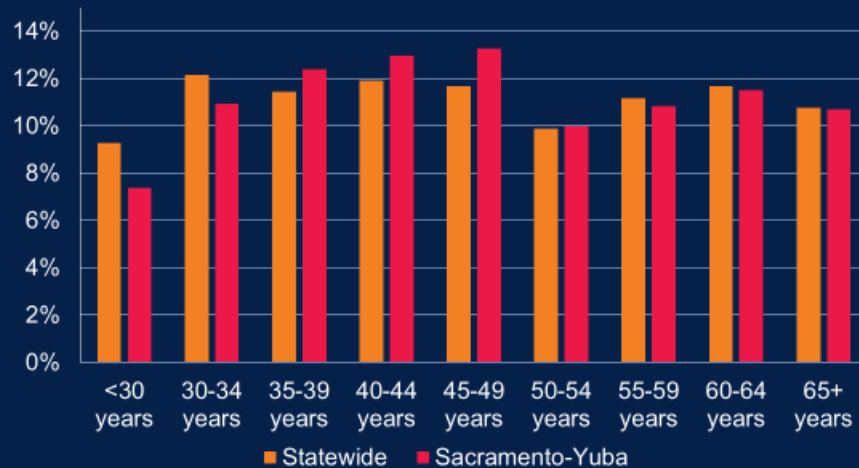


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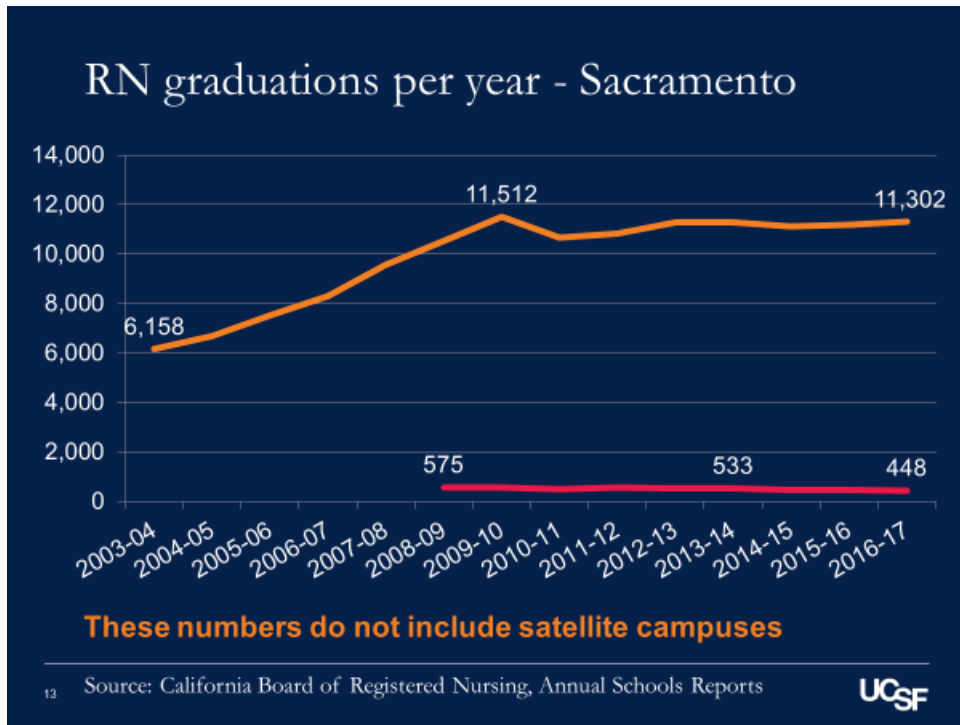
UCSF

Age distribution of licensed RNs - Sacramento



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

UCSF



Statewide graduations are expected to hold steady

	New enrollment	Projected enrollment from 1 yr	Projected enrollment from 2 yrs	Graduations
2014-2015	13,318	12,162	13,347	11,119
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Source: California Board of Registered Nursing Annual Schools Report, 2016-2017

UCSF

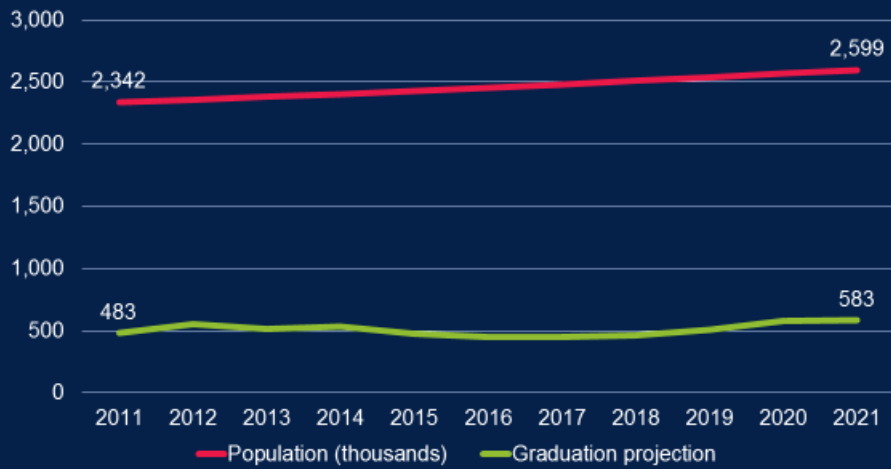
Sacramento-Yuba graduations are projected to grow

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

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

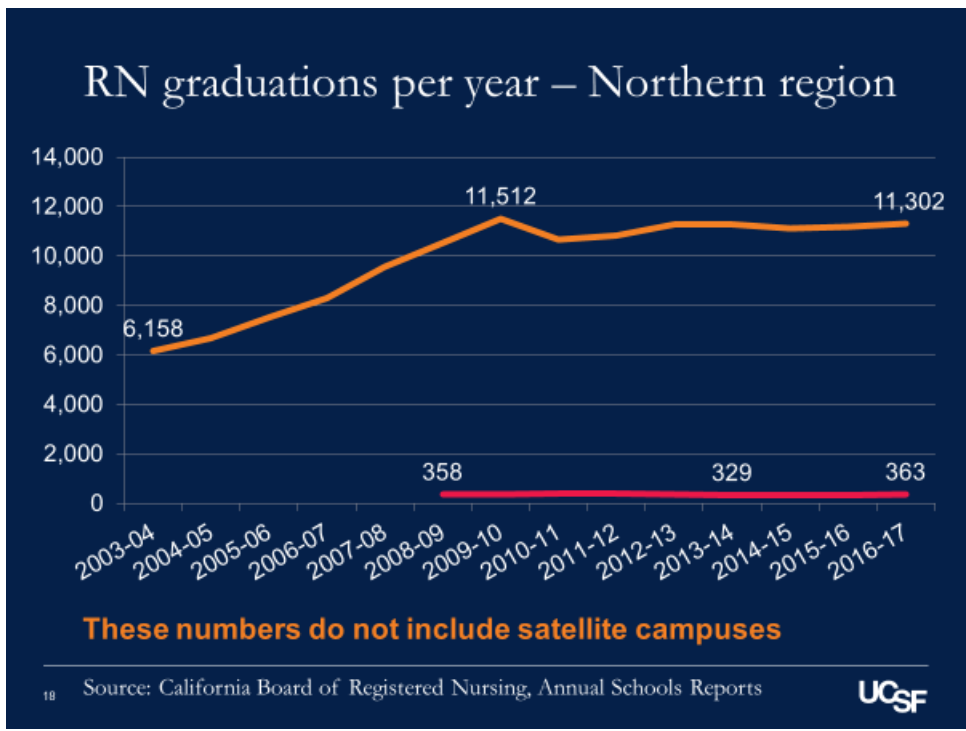
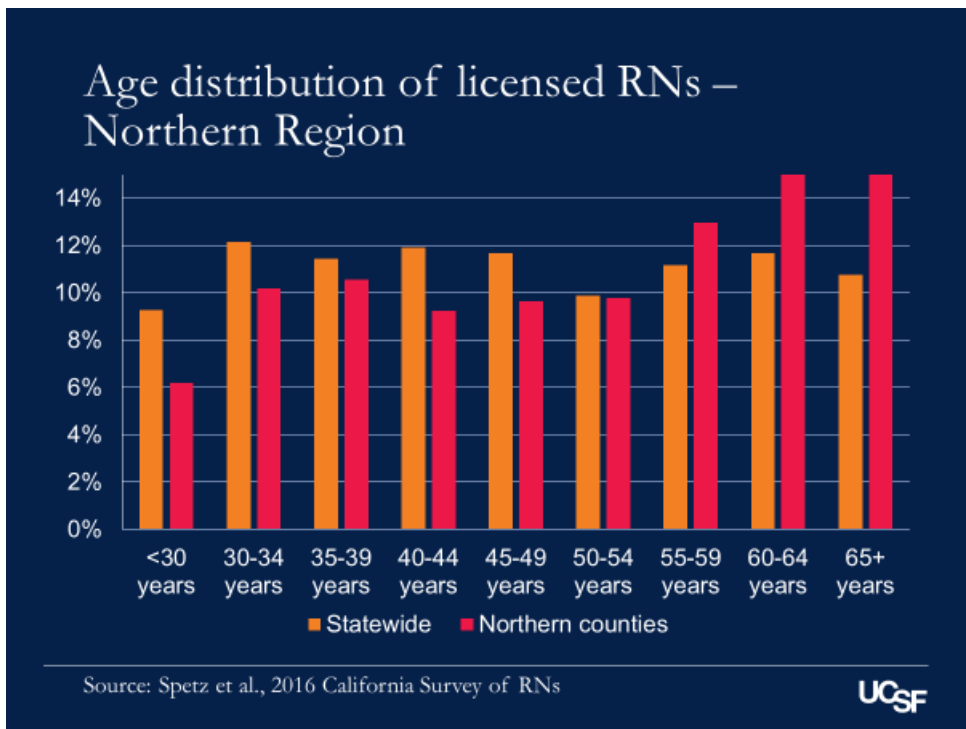


What is projected population growth in the Sacramento region?



18





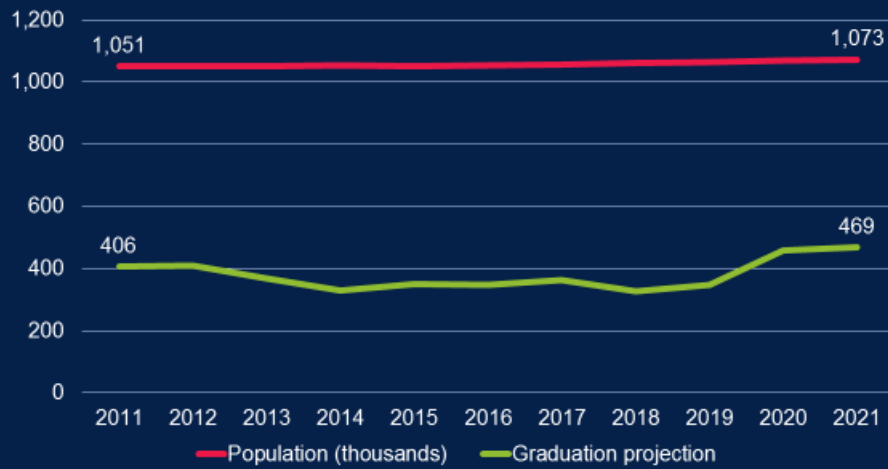
Northern region graduations are projected to grow

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

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

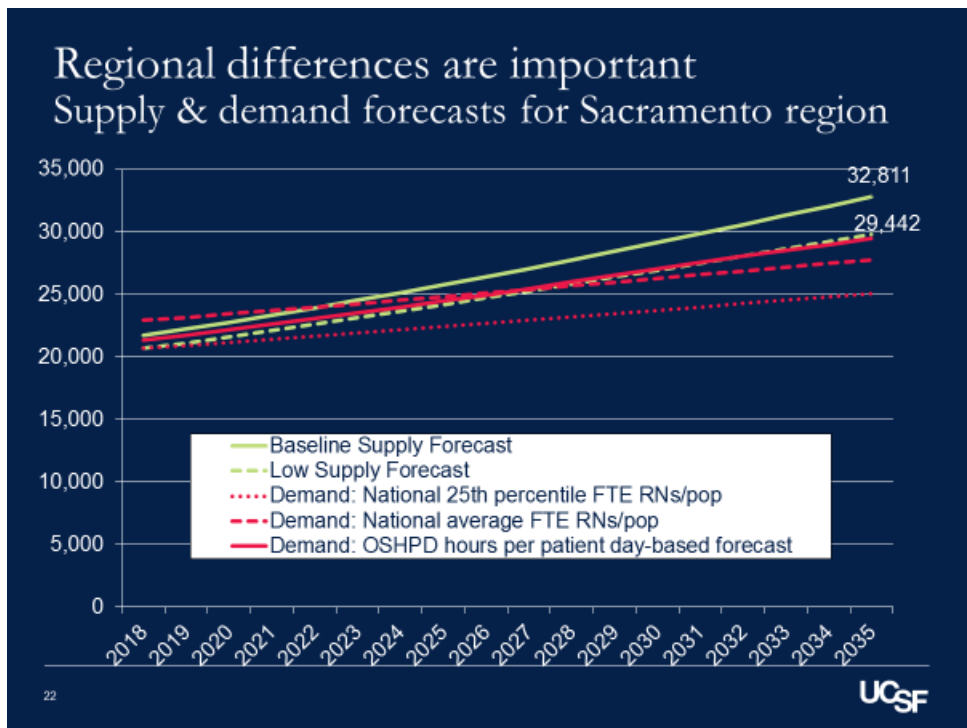
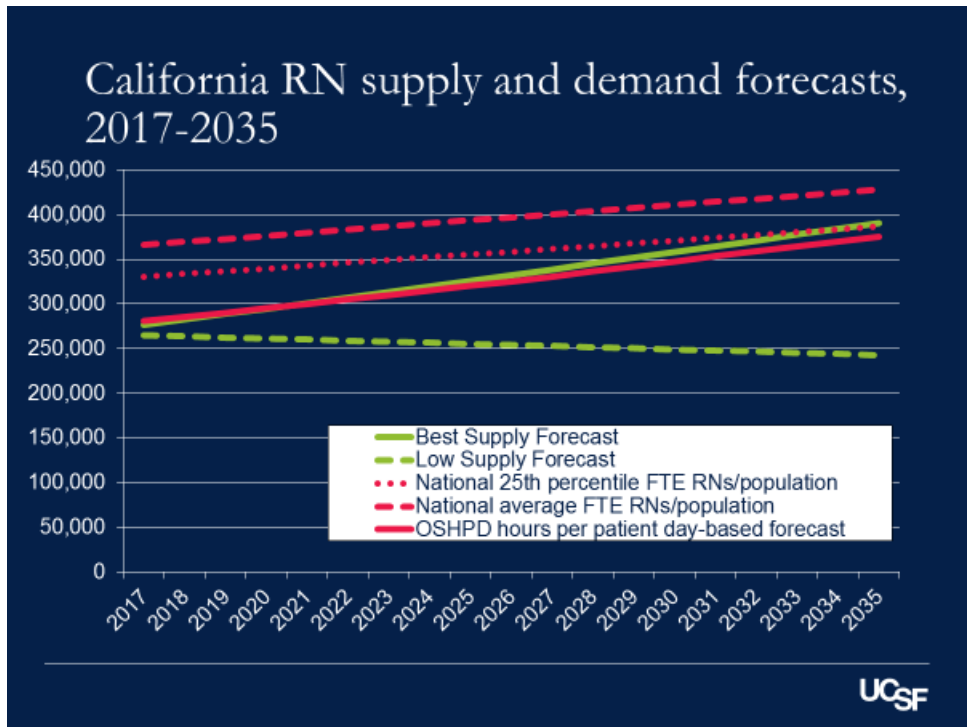


What is projected population growth in the Northern region?

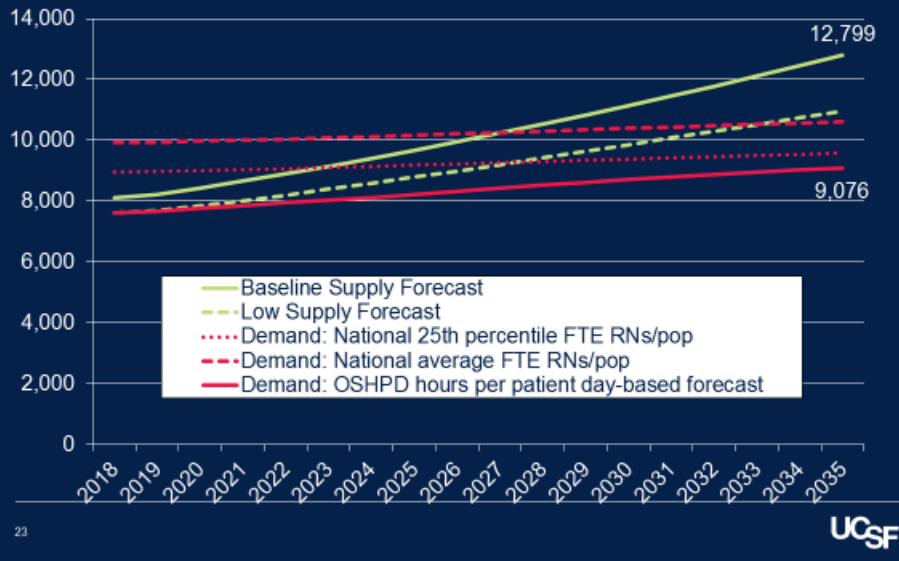


20





Regional differences are important Supply & demand forecasts for Northern Counties



23

UCSF

Inflows and outflows for the Sac region

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

24

UCSF

Inflows and outflows for the Northern region

- Inflows = 669 now, 812 by 2021
 - Graduations: 326 in 2016-17 469 in 2020-21
 - Migration into the region: 239 per year 2016-2018
 - Endorsements from other states: 104 in 2017
- Outflows = 772 now
 - Migration out of the region: 288 per year 2016-2018
 - Lapsed licenses: 484 per year 2016-2018

- Older nurses keep their licenses longer than average
- New graduates tend to be younger than average – 53% <30 years

25

UCSF

Balanced labor markets!

- No need for program growth – models assume 1.5% per year

- Anticipated growth of graduations in northern counties might be more than needed, but not something to worry about

- Will these new RNs move to other regions or states?
 - >50% of recent RN grads work within 40 miles of high school

UCSF

How do we address the challenge?

Labor market overall is fairly well balanced

Younger graduates will support the workforce for many years in the future

Long working lives of nurses in Northern Counties will be important



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

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

September 2018

Tales of a nursing shortage...

The screenshot shows a webpage with a dark header for NURSE.com. The main content area features a photograph of three nurses in a clinical setting. Overlaid on the image are several headlines and text boxes:

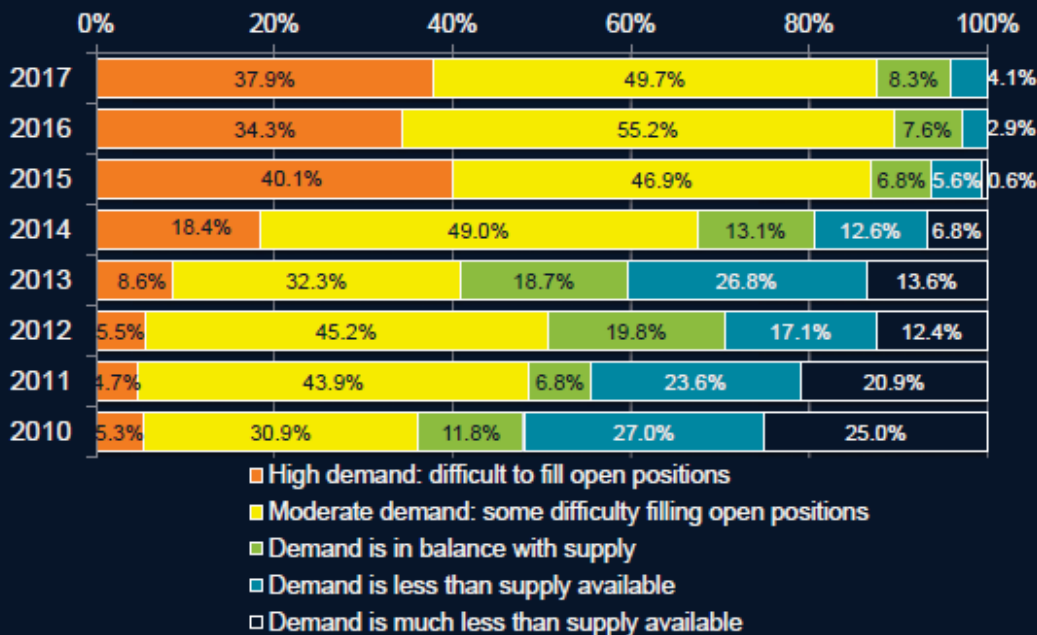
- Top left: **NURSE.com** OnCourse Learning | jobs education news events awards | 1-800-856-091
- Top right: HEALTH NEWS | OCTOBER 19, 2017 / 10:12 PM / 5 MONTHS AGO
- Center left: **U.S. still headed for nurse shortage**
- Center right (green border): **Short on staff: Nursing crisis strains U.S. hospitals**
- Bottom left (white box): **The U.S. Is Running Out of Nurses**
The country has experienced nursing shortages for decades, but an aging population means the problem is about to get worse.
REBECCA GRANT | FEB 3, 2016 | HEALTH
- Bottom center (blue border): **Is US headed for worst nursing shortage?**
COLUMNISTS 77,973 SHARES | By: Howard Gerber-@inquirerdotnet | INQUIRER.net US Bureau / 01:51 AM November 30, 2017

Forecasting future RN supply & demand

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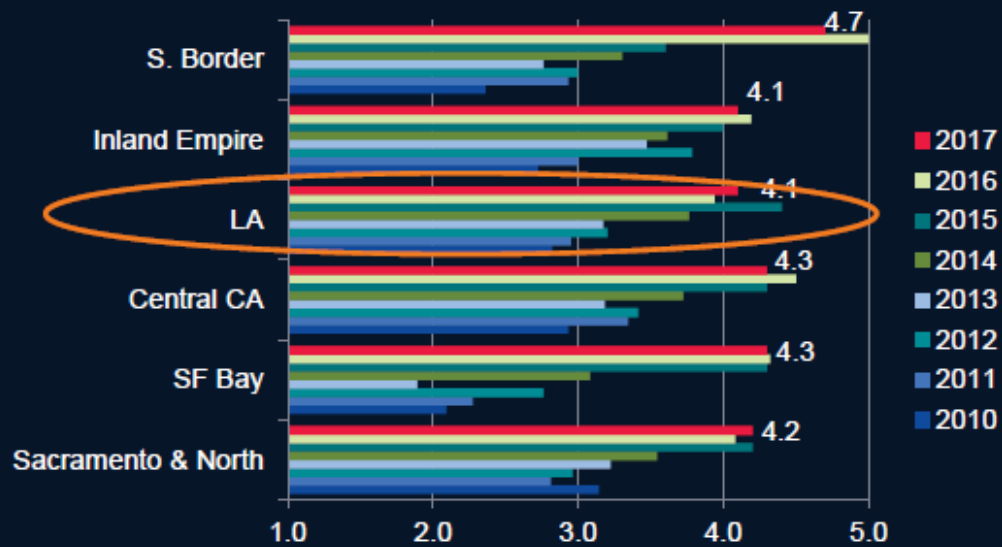
Perceptions of employers: Overall labor market



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



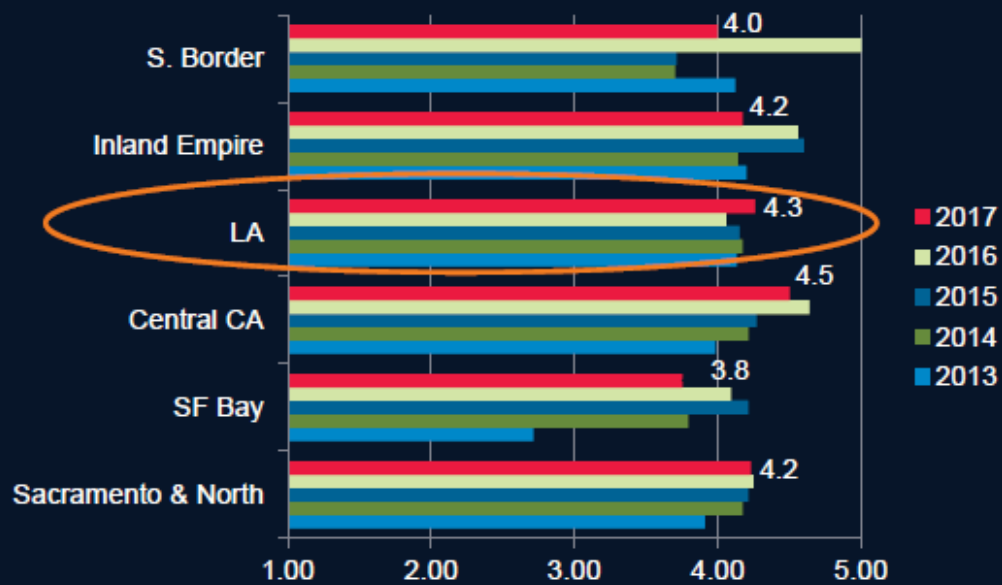
Differences across regions: Overall RN labor market



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

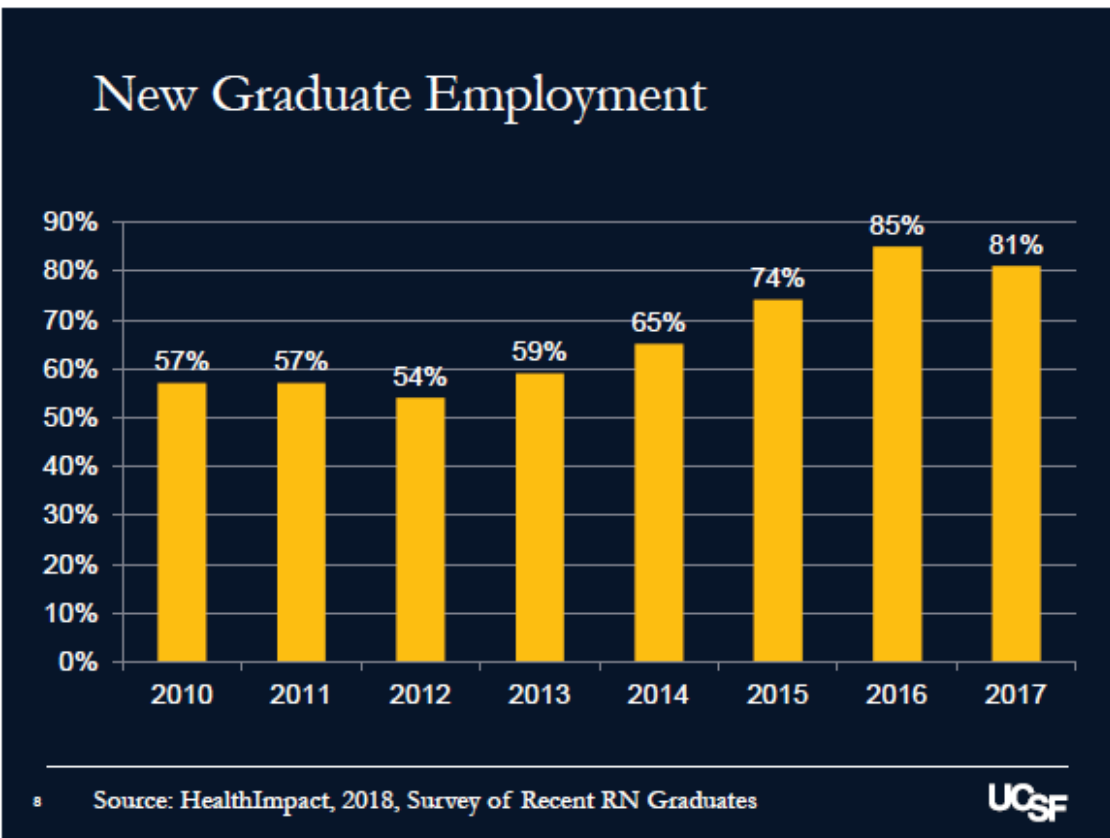
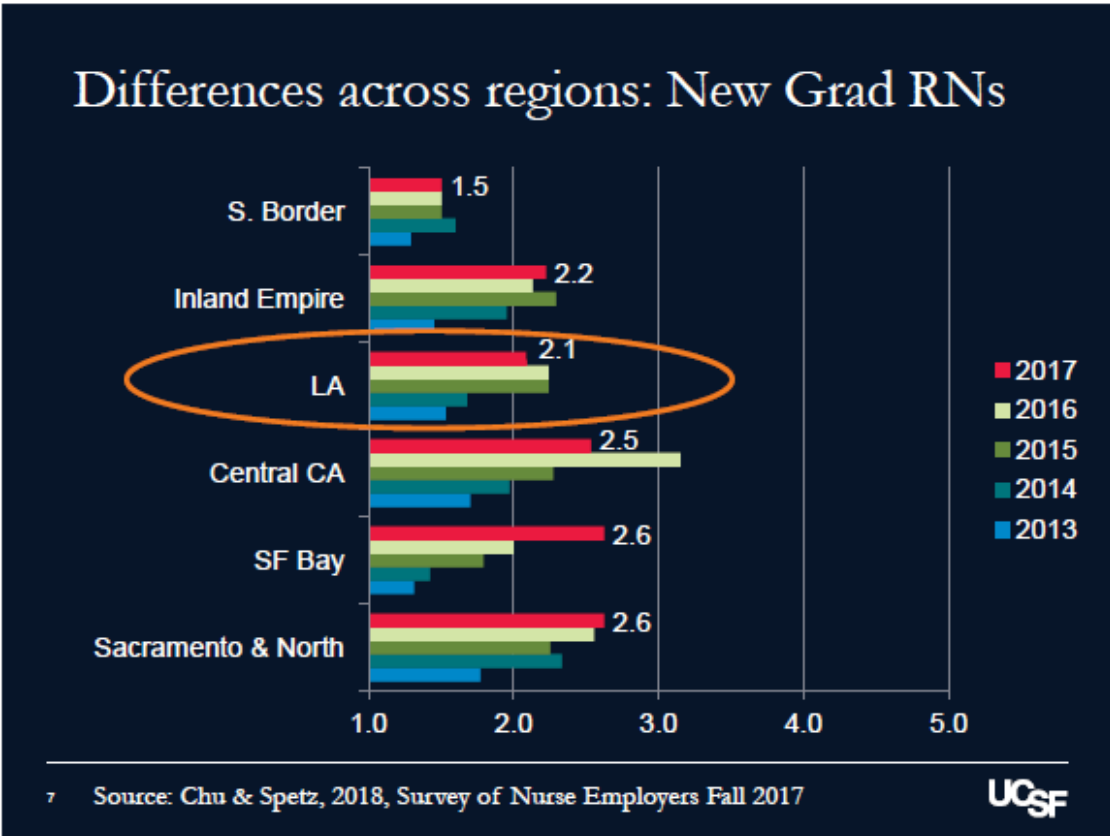


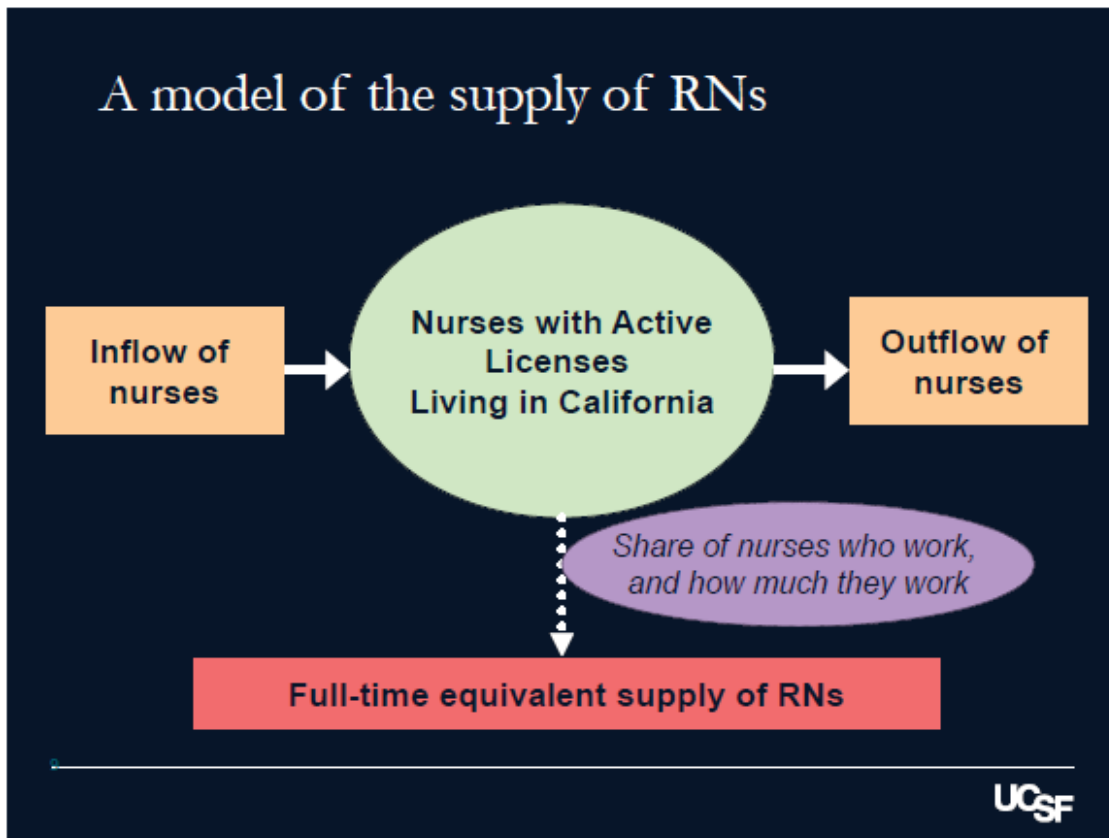
Differences across regions: Experienced RNs



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



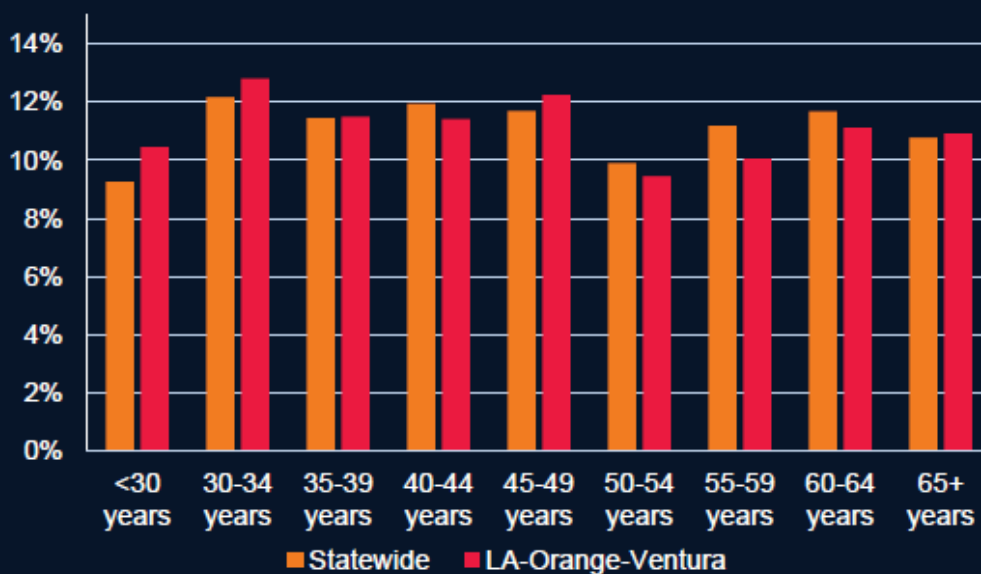




Forecasting demand is harder

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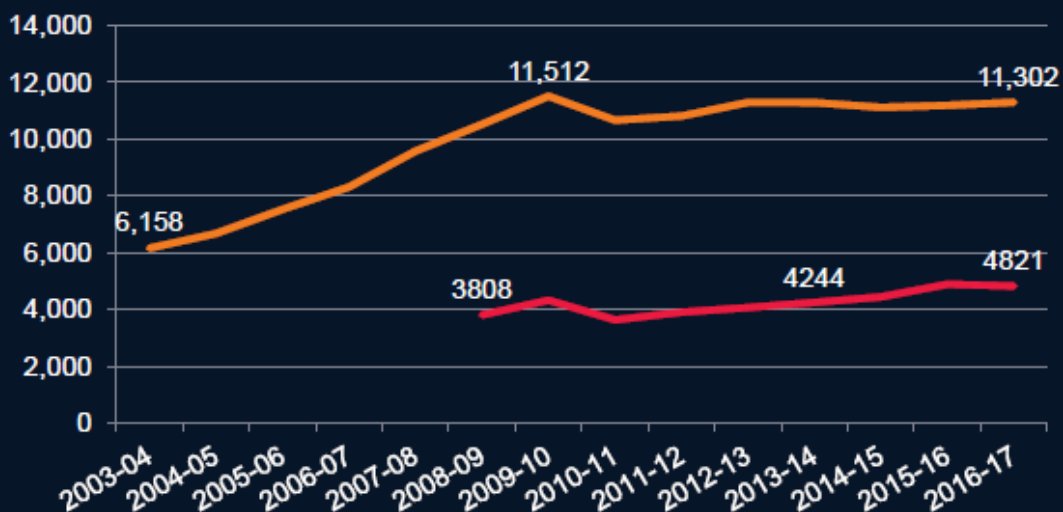
Age distribution of licensed RNs



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



RN graduations per year



These numbers do not include satellite campuses


12

Source: California Board of Registered Nursing, Annual Schools Reports




Statewide graduations are expected to hold steady

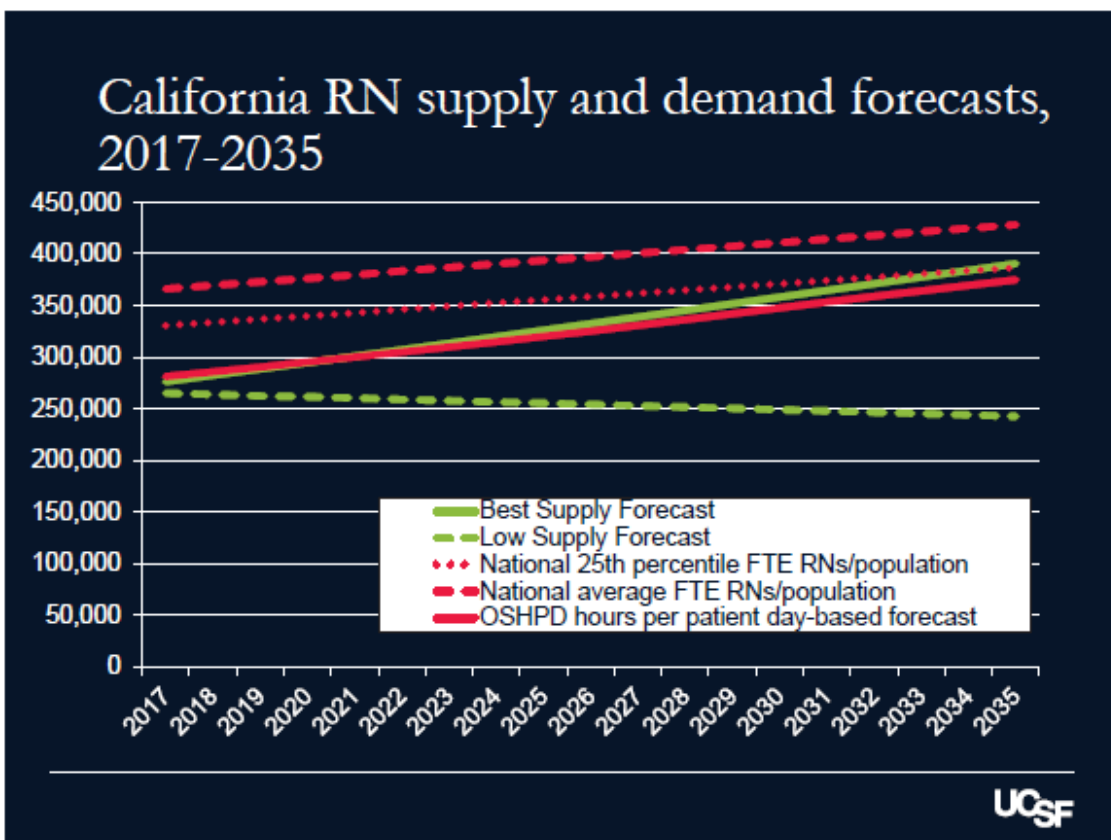
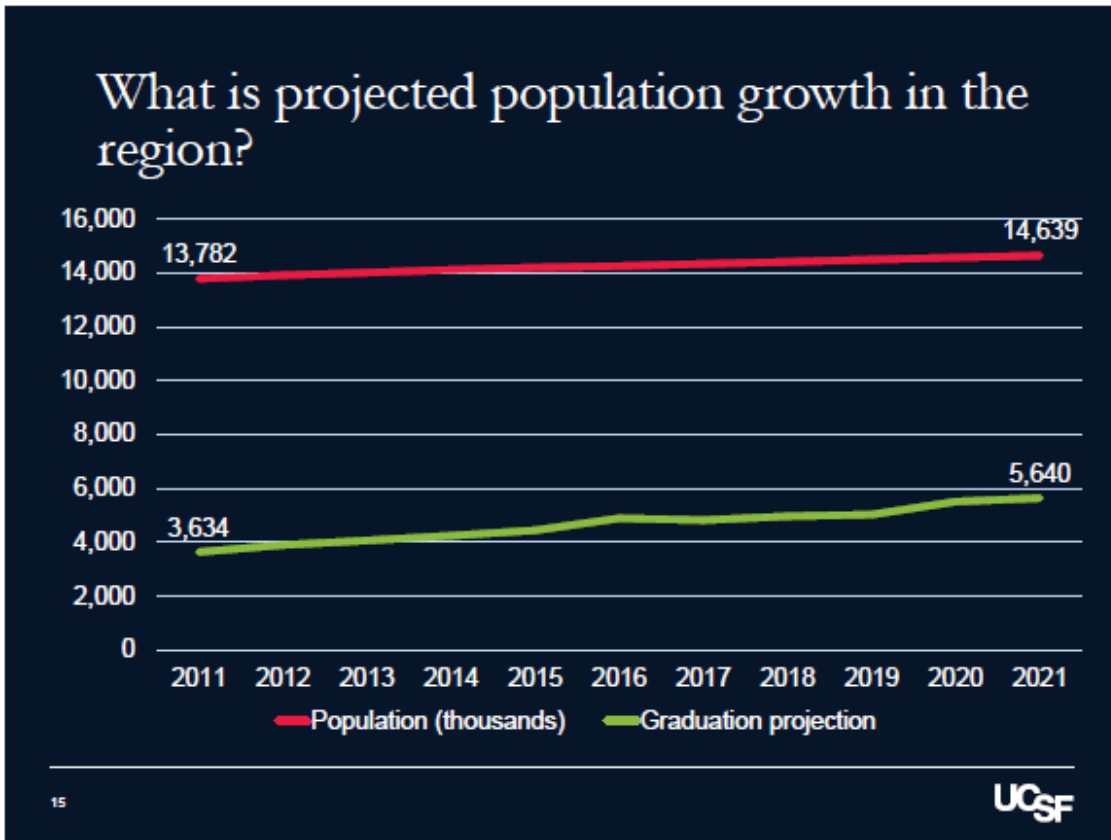
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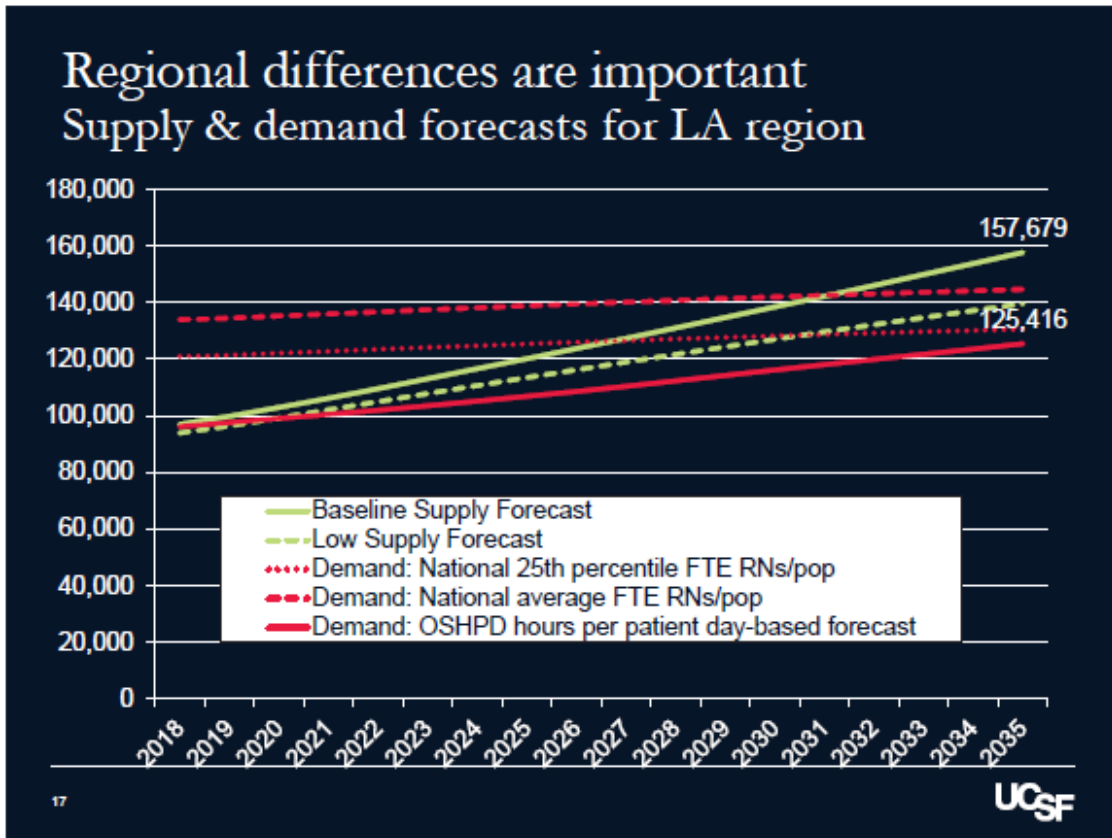
Source: California Board of Registered Nursing Annual Schools Report, 2016-2017 

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

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

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





- ### Inflows and outflows for the LA region
- Inflows = 6,438 now 7,257 by 2021
 - Graduations: 4,821 in 2016-17 5,640 in 2020-21
 - Migration into the region: 896 per year 2016-2018
 - Endorsements from other states: 721 in 2017

 - Outflows = 5,334 now
 - Migration out of the region/state: 2,101 per year 2016-2018
 - Lapsed licenses: 3,233 per year 2016-2018

 - Conclusion: Inflows exceed outflows >2000 in a few years
 - Even with low growth the region will overshoot demand
- 18 UCSF

Impact of oversupply

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

UCSF

How do we address the challenge?

LA-Orange-Ventura region faces a large surplus

Projected new graduate growth is much higher than needed

Competition for clinical space

Need to encourage graduates to move elsewhere

20

UCSF



University of California
San Francisco

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

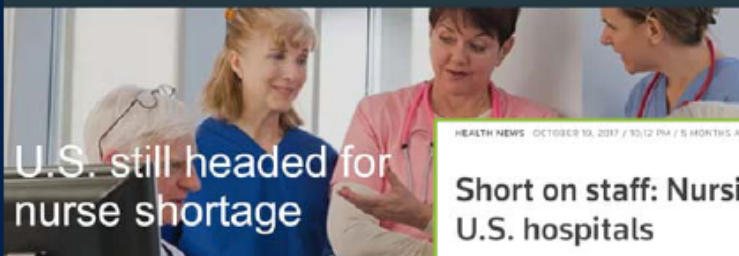
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REBECCA CRANK FEB 3, 2016 HEALTH

COLUMNISTS 77973SHARES



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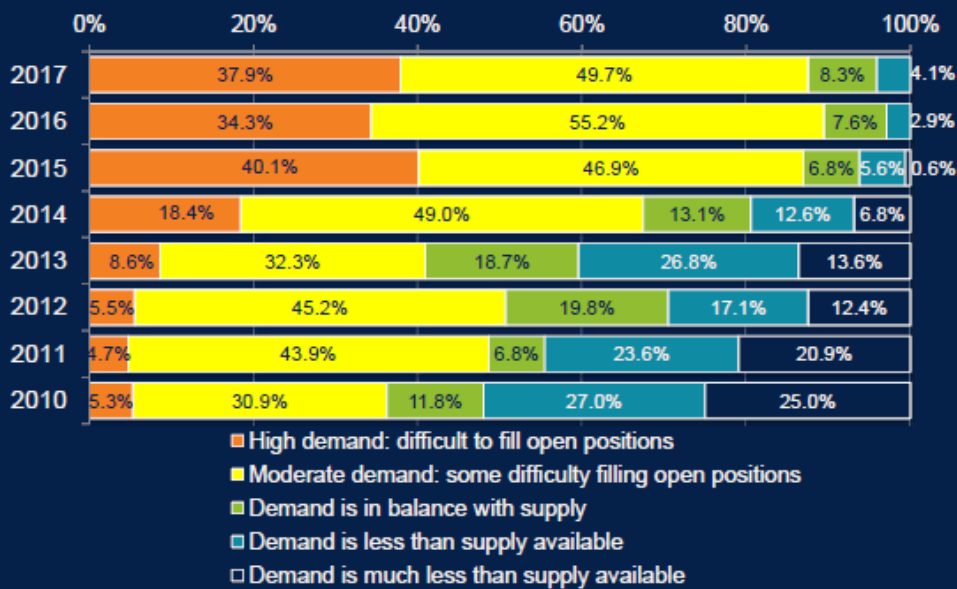
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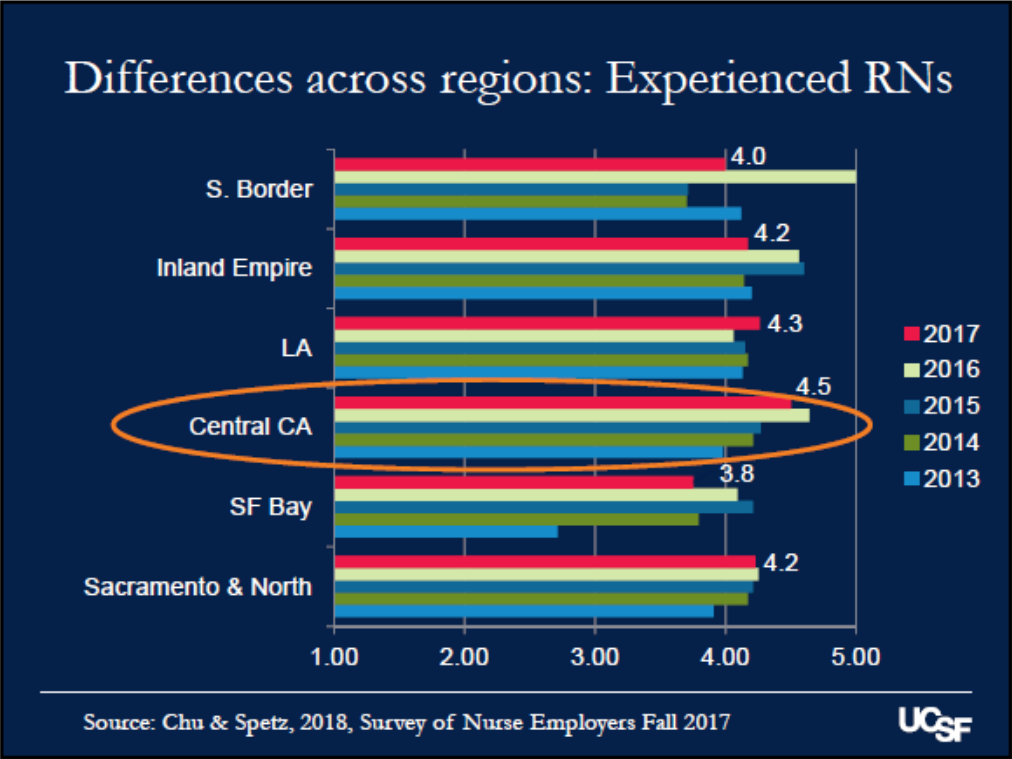
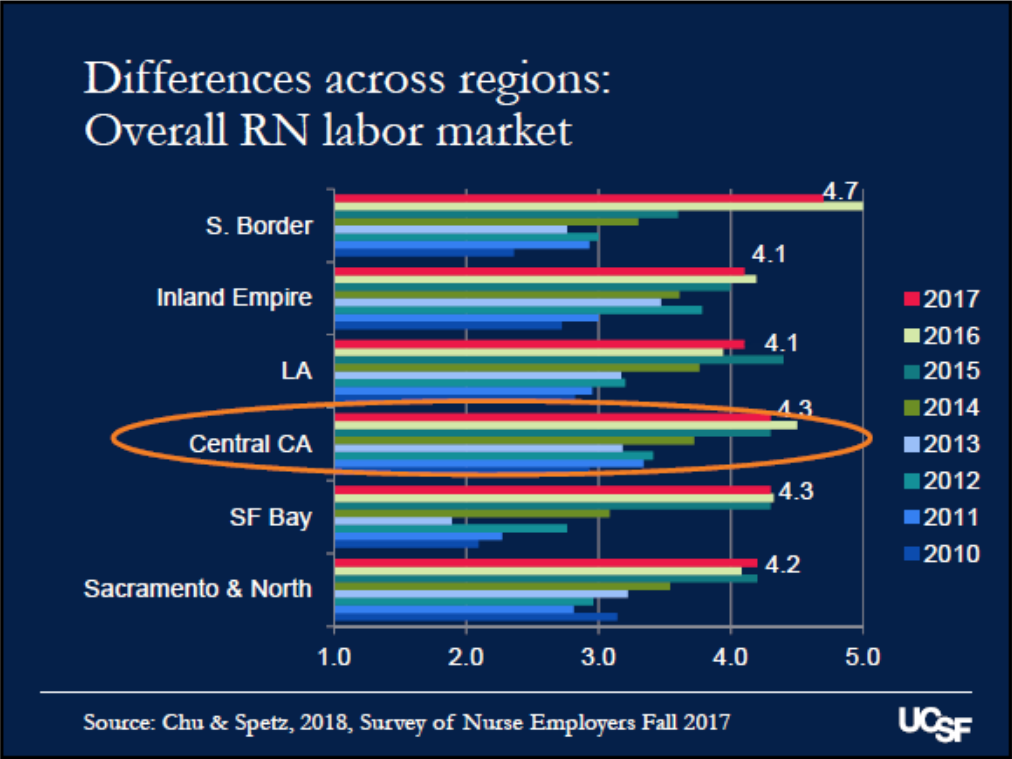


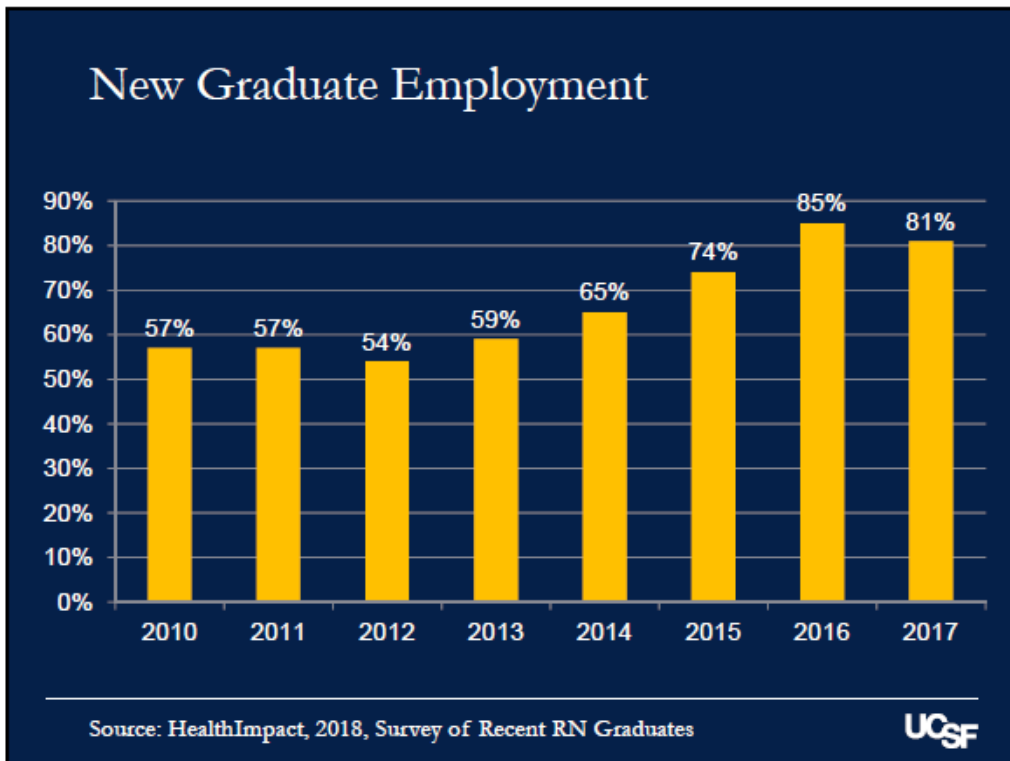
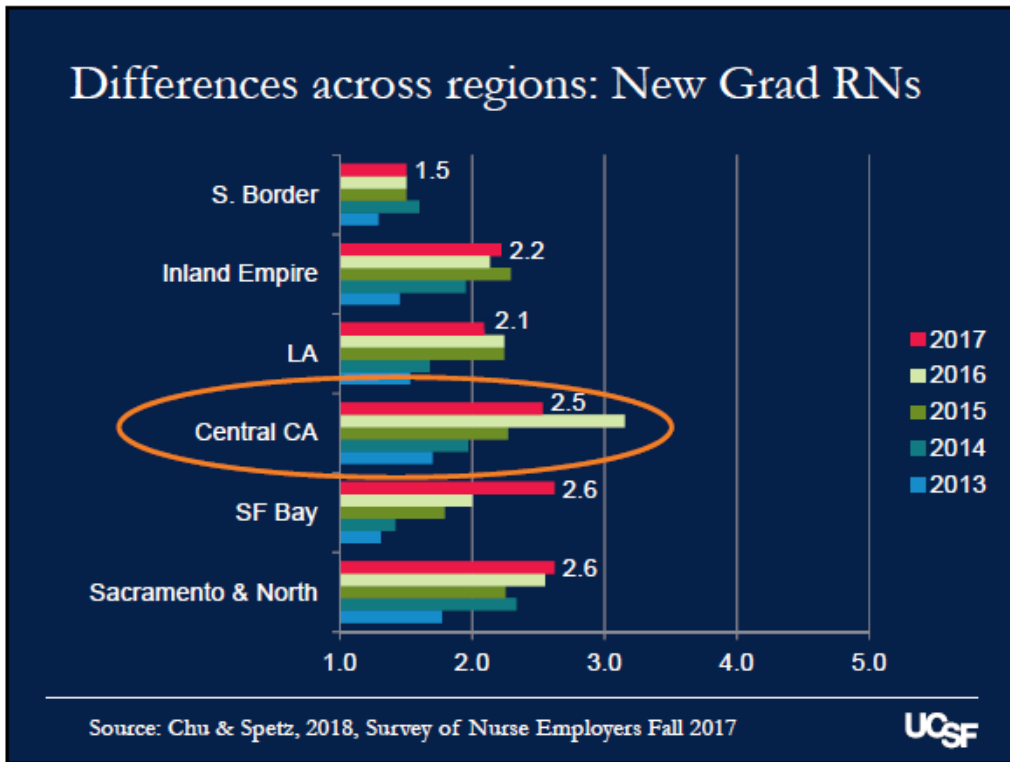
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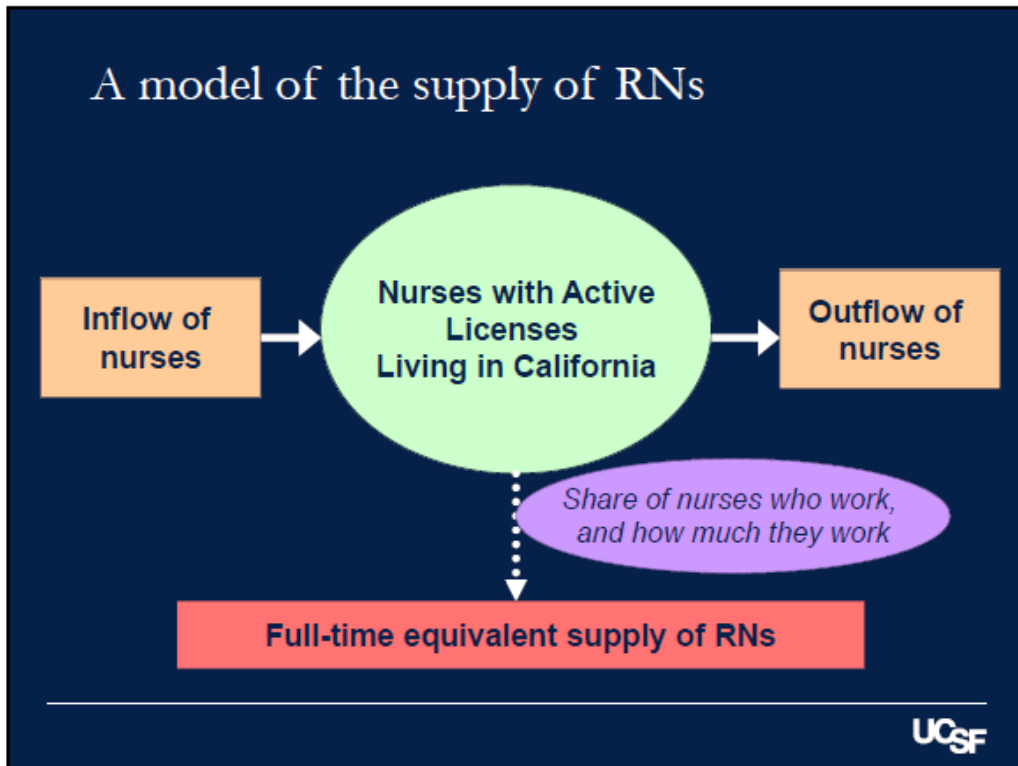
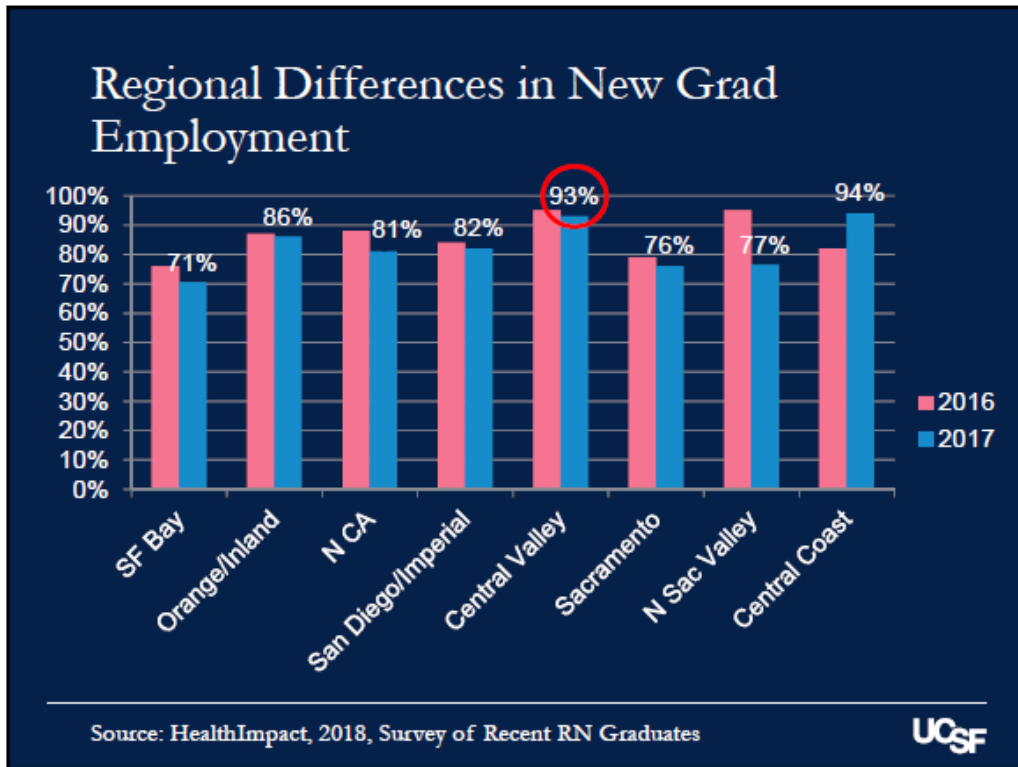


Source: Chu & Spetz, 2018, Survey of Nurse Employers Fall 2017







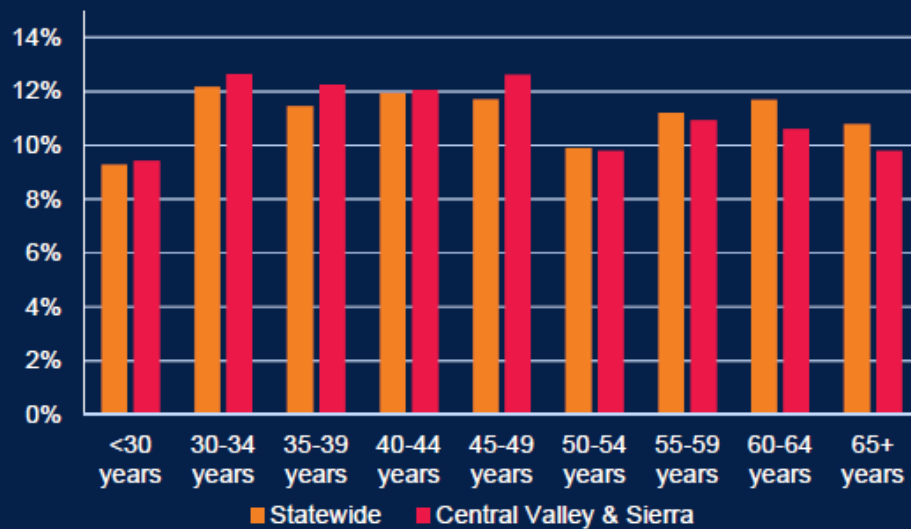


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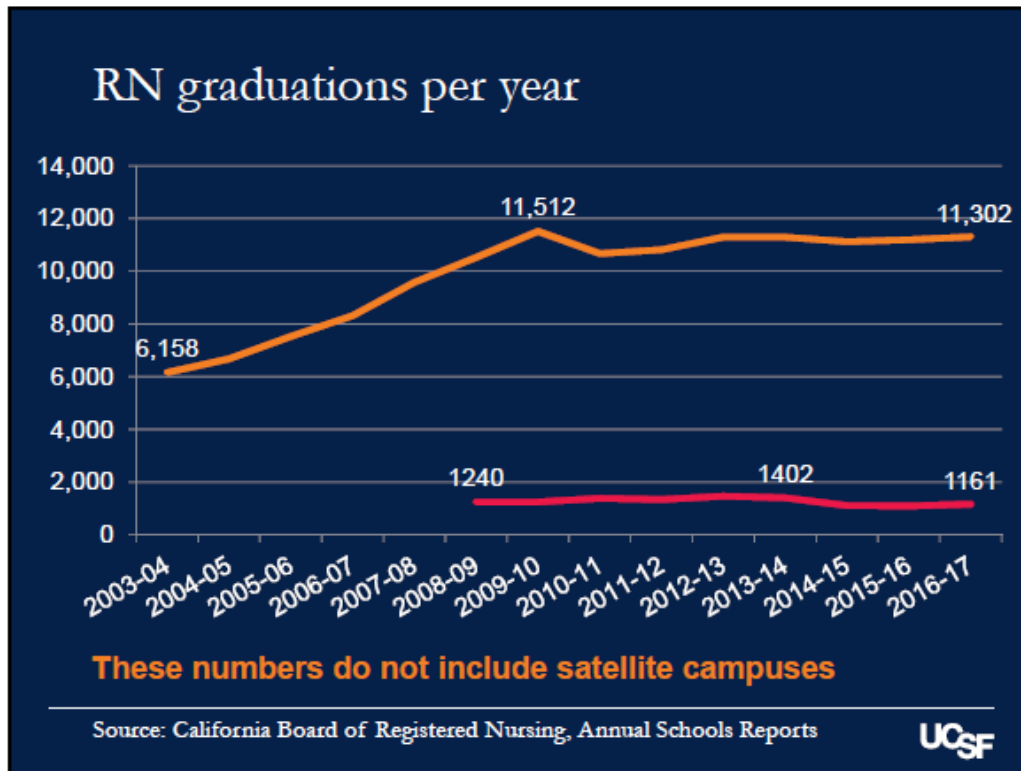
UCSF

Age distribution of licensed RNs



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

UCSF



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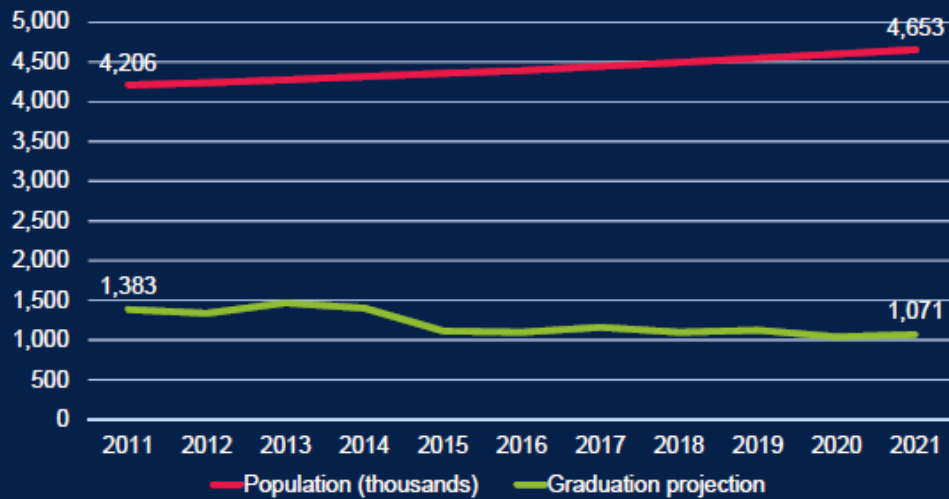
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Central Valley & Sierra graduations are projected to remain steady

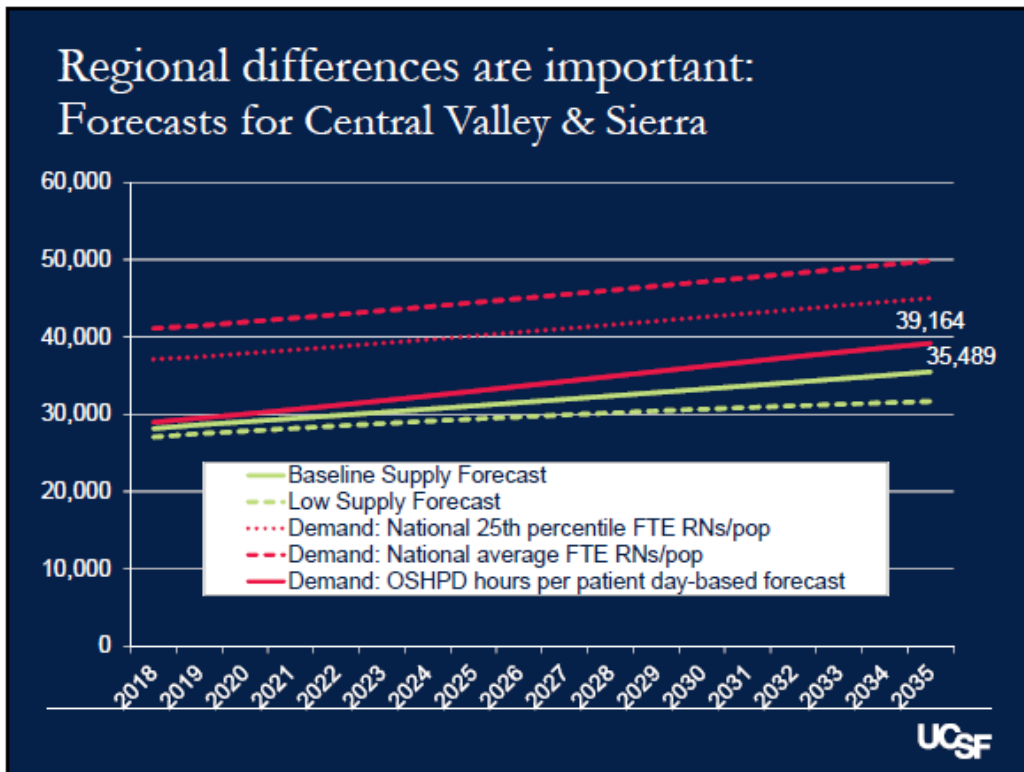
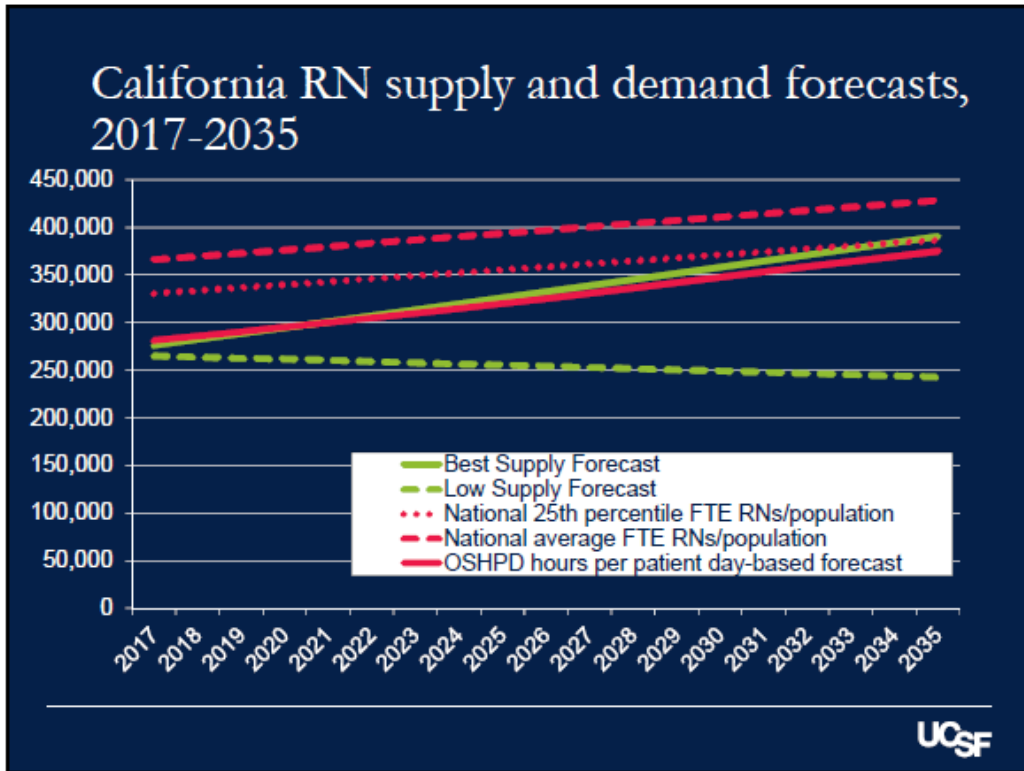
	New enrollment	Projected enrollment from 1 yr	Projected enrollment from 2 yrs	Graduations
2015-2016	1,276	1,101	1,094	1,097
2016-2017	1,305	1,099	1,101	1,161
2017-2018		1,208	1,122	1,099
2018-2019			1,244	1,124
2019-2020				1,040
2020-2021				1,071

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

What is projected population growth in the region?



UCSF



Inflows and outflows for the Central region

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



Costs of shortages and turnover

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

Source: Cheryl Jones, Nursing Outlook, 2004



How do we address the challenge?

Central Valley & Sierra faces a shortage of about 10% by 2035

Rapid population growth projected → workforce needs to keep up

Younger RN workforce, but not enough new graduates

Relatively small changes in graduations can fill the gap



Supply & Demand of Registered Nurses in the Inland Empire

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

September 2018

Tales of a nursing shortage...

The screenshot shows a webpage with several headlines related to nursing shortages. At the top left is the **NURSE.com** logo with the tagline "OnCourse Learning". Navigation links for "jobs", "education", "news", "events", and "awards" are visible, along with a phone number "1-800-869-091". A main image shows three nurses in a clinical setting. Below the image are three highlighted headlines:

- U.S. still headed for nurse shortage**
- Short on staff: Nursing crisis strains U.S. hospitals** (with subtext: HEALTH NEWS | OCTOBER 19, 2017 / 10:12 PM / 5 MONTHS AGO)
- The U.S. Is Running Out of Nurses** (with subtext: The country has experienced nursing shortages for decades, but an aging population means the problem is about to get worse. | REBECCA BRANT | FEB 3, 2016 | HEALTH)

At the bottom, there is a social media share bar for "COLUMNISTS" with 77,973 shares and icons for Facebook, Twitter, and Email. Below this is another headline:

- Is US headed for worst nursing shortage?** (with subtext: By: Howard Gerber - @inquirexdotnet | INQUIRE.net US Bureau / 01:51 AM November 30, 2017)

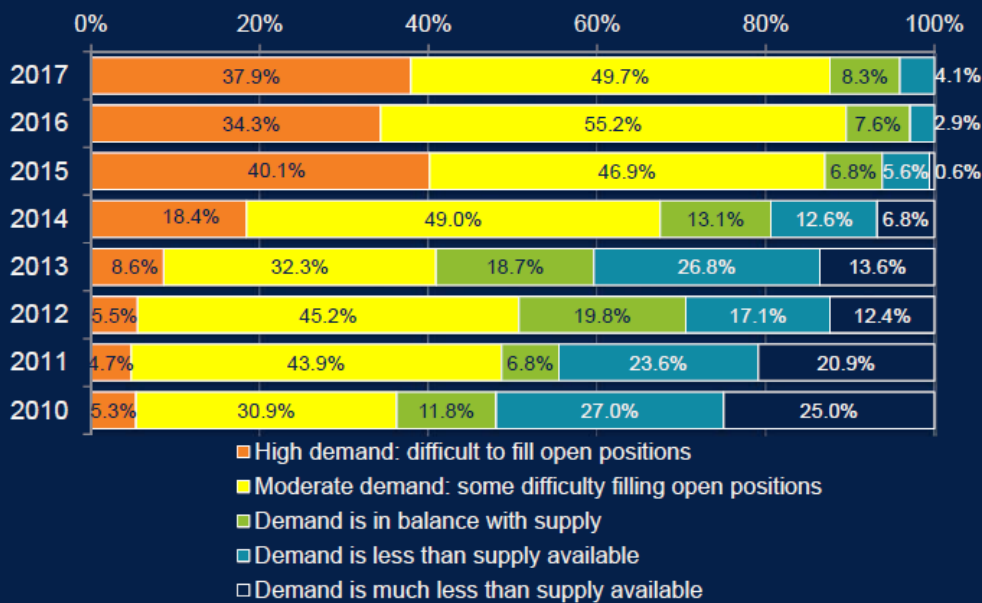
A small number "2" is visible in the bottom left corner of the screenshot.

Forecasting future RN supply & demand

- **National forecasts:** market is balanced
 - National Center for Health Workforce Analysis, 2017
 - National surplus of 293,800 RNs by 2030 (8.2%)
 - Assumes supply = demand in 2014
 - Auerbach et al. 2015 – 128,000 RN shortage by 2025 (4%)
- **California**
 - NCHWA 2017 – 44,500 short (11.5%)
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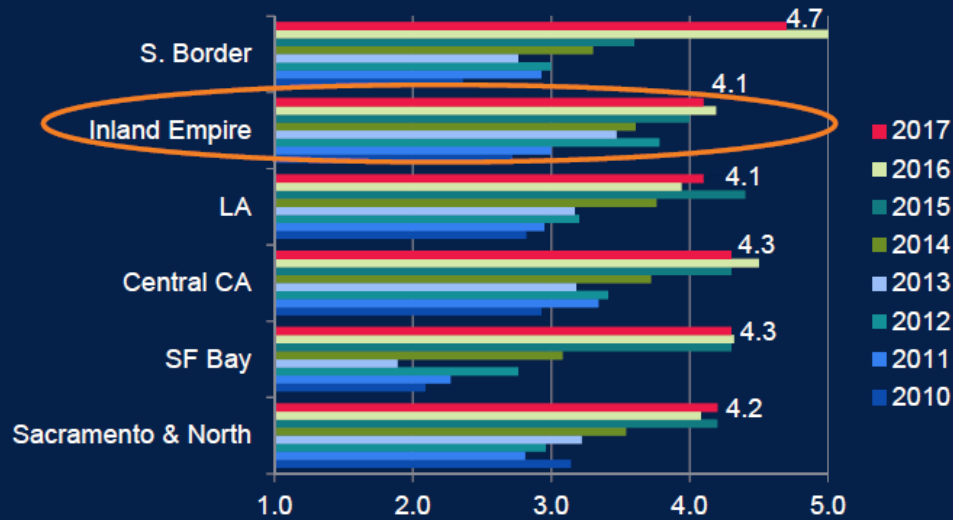
Perceptions of employers: Overall labor market



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



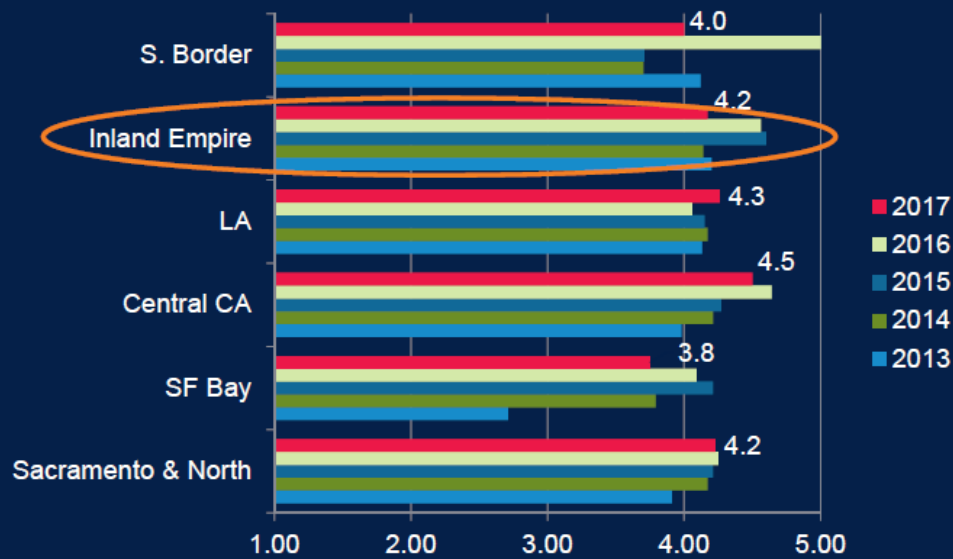
Differences across regions: Overall RN labor market



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



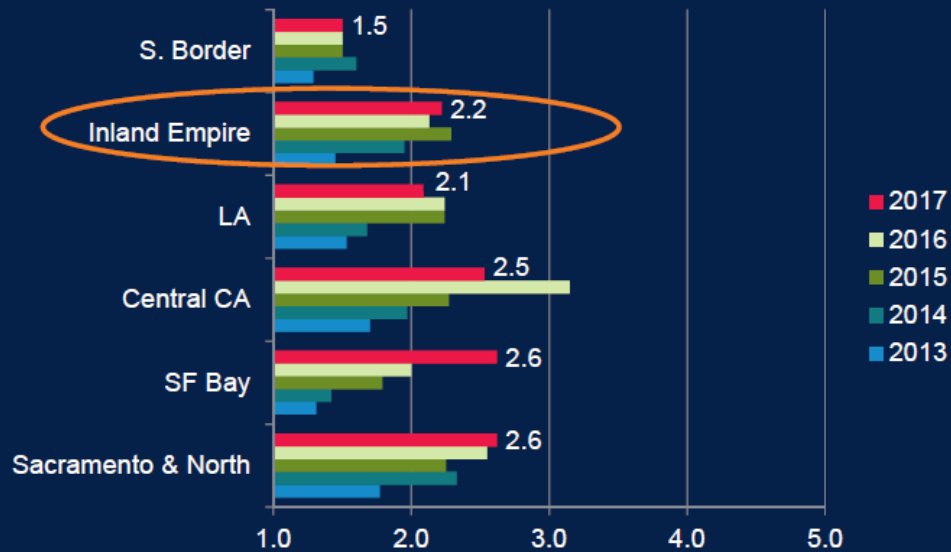
Differences across regions: Experienced RNs



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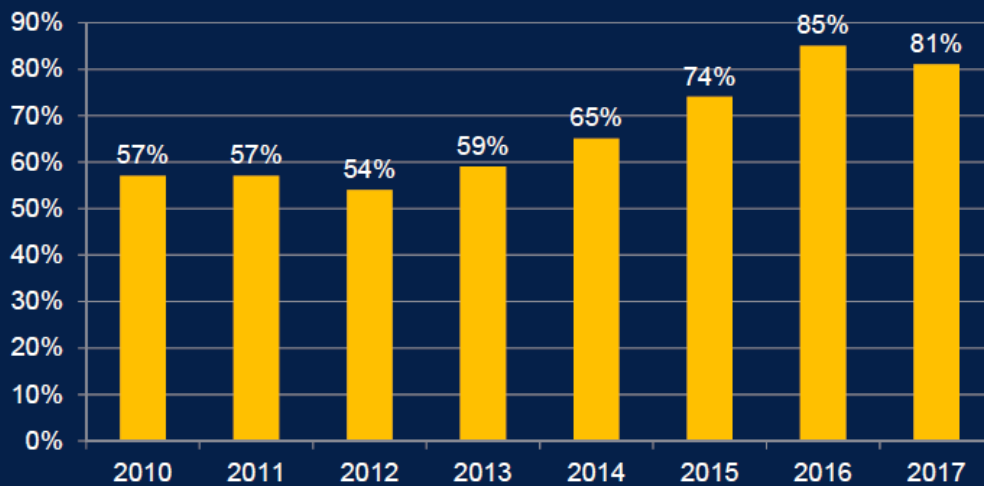
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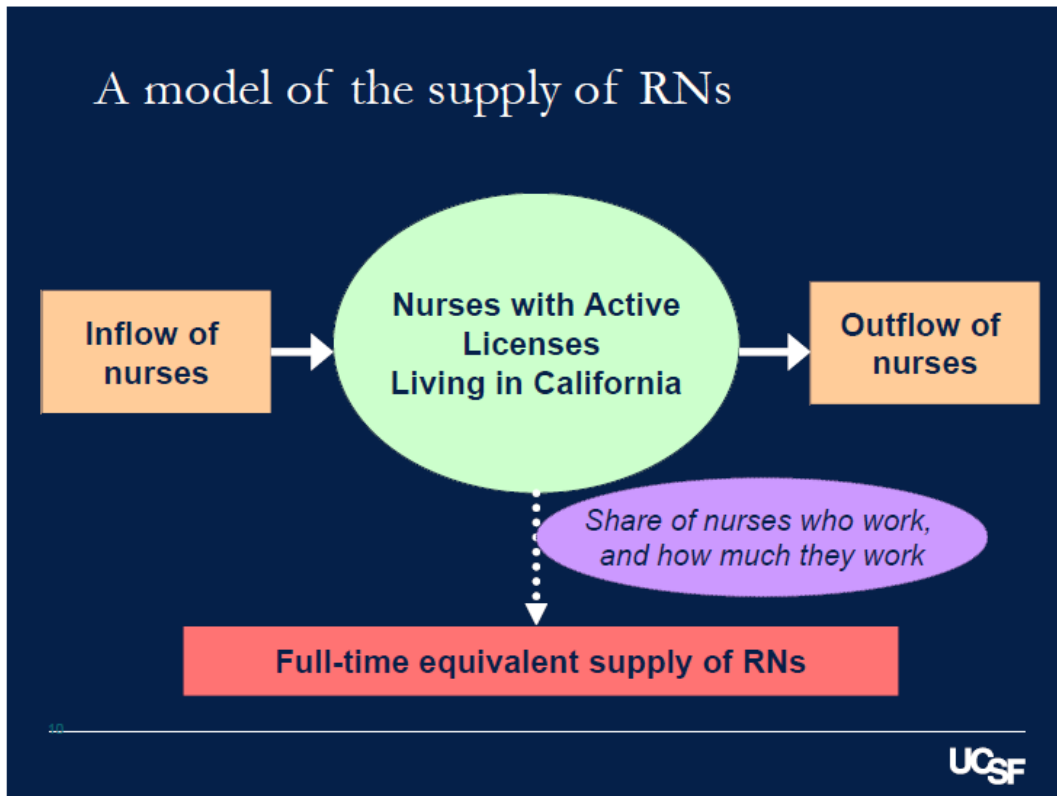
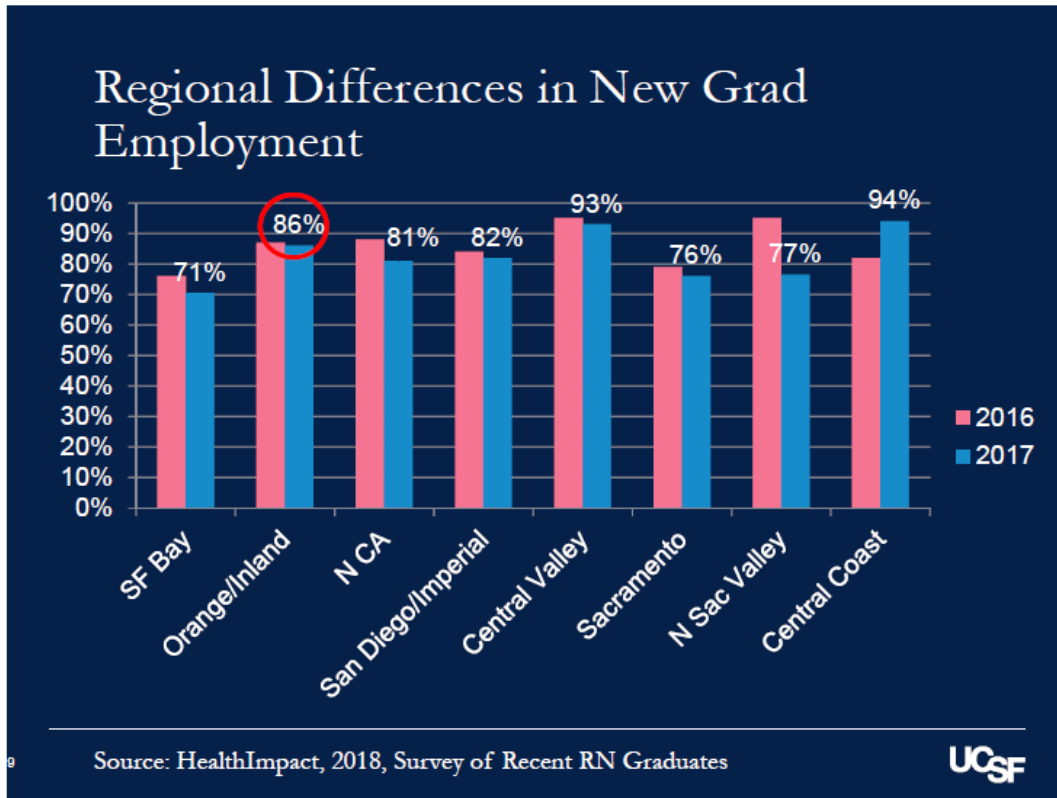


New Graduate Employment



8 Source: HealthImpact, 2018, Survey of Recent RN Graduates



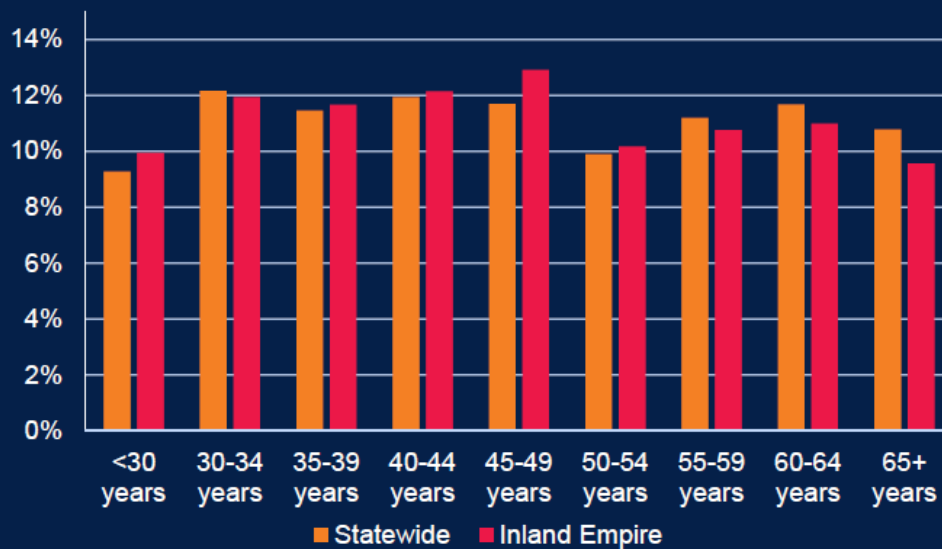


Forecasting demand is harder

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

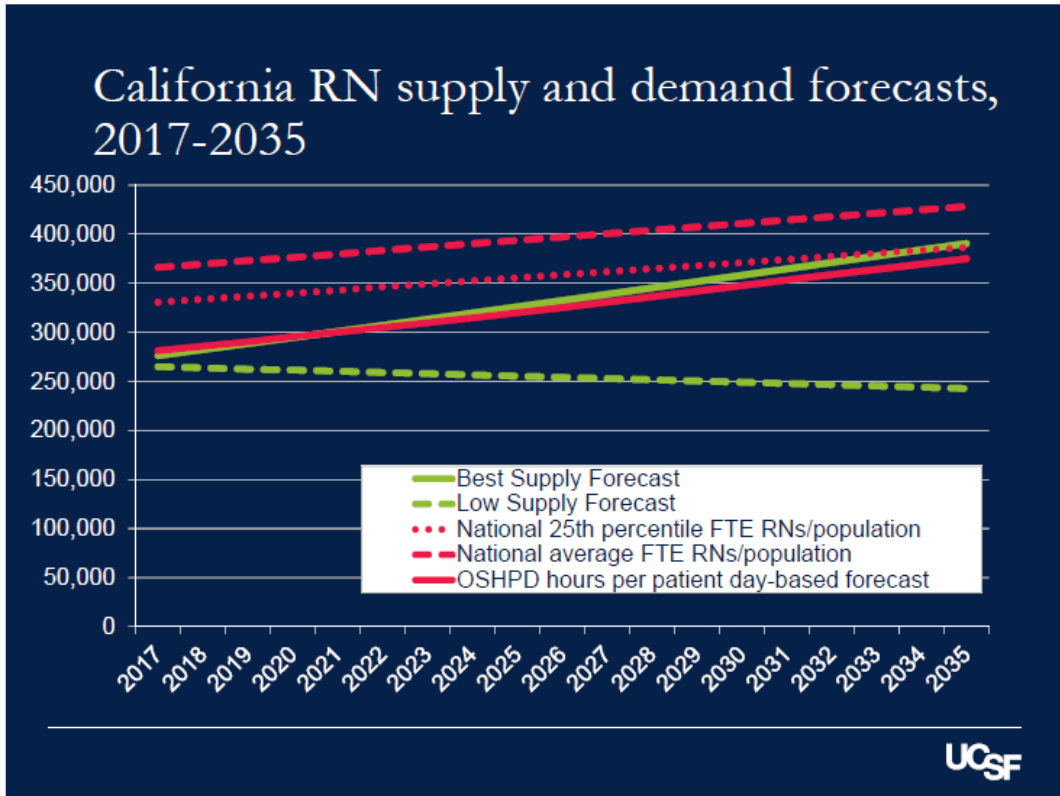
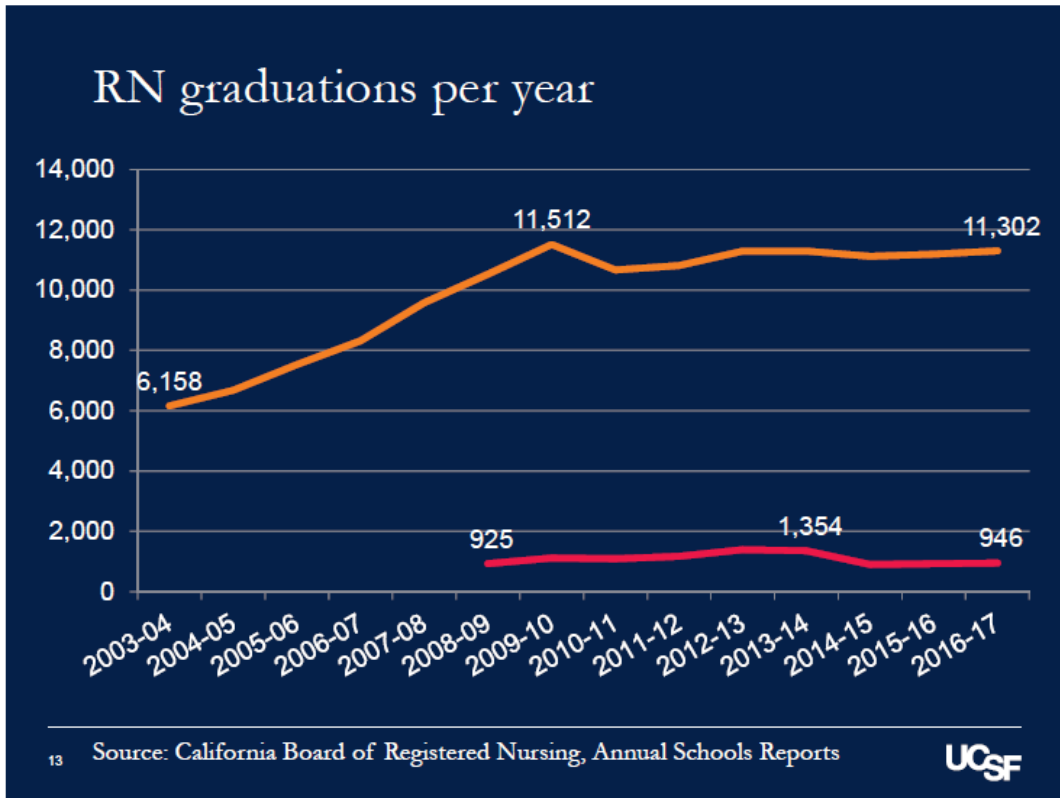
UCSF

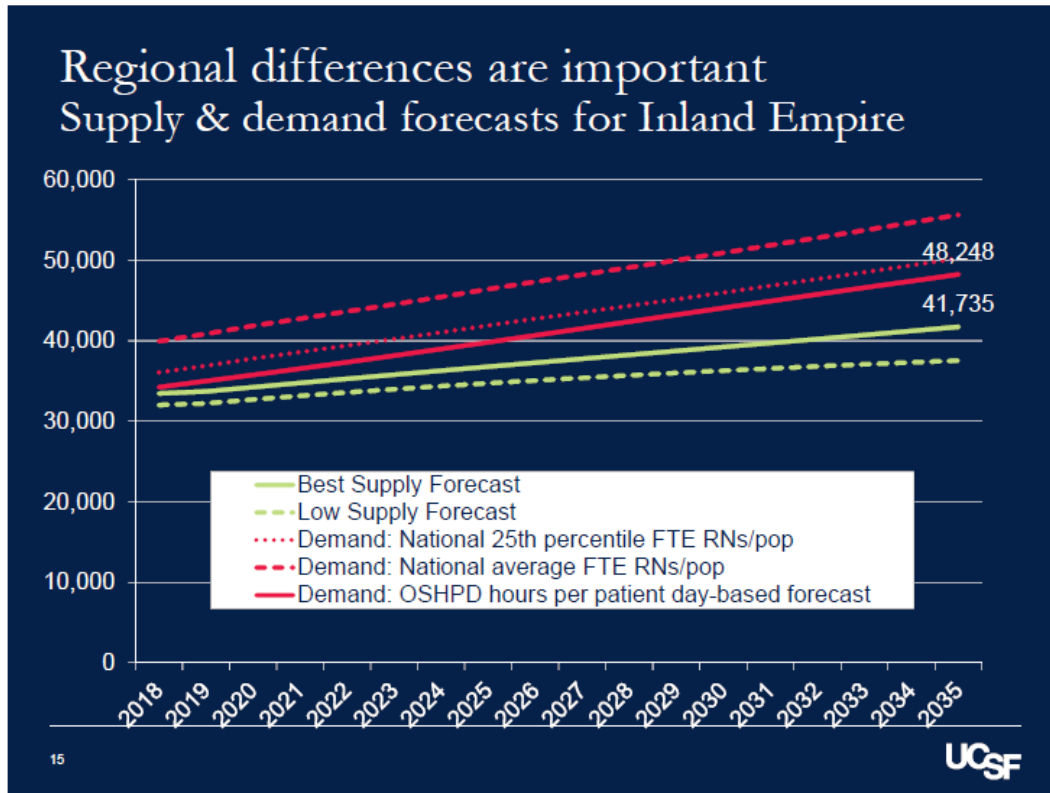
Age distribution of licensed RNs



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

UCSF





Statewide graduations are expected to hold steady

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

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

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

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

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



Other sources of RNs to the Inland Empire

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



Costs of shortages and turnover

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

Source: Cheryl Jones, Nursing Outlook, 2004



How do we address the challenge?

Inland Empire faces a shortage of ~15%

Rapid population growth projected → workforce needs to keep up

Younger RN workforce, but not enough new graduates





University of California
San Francisco

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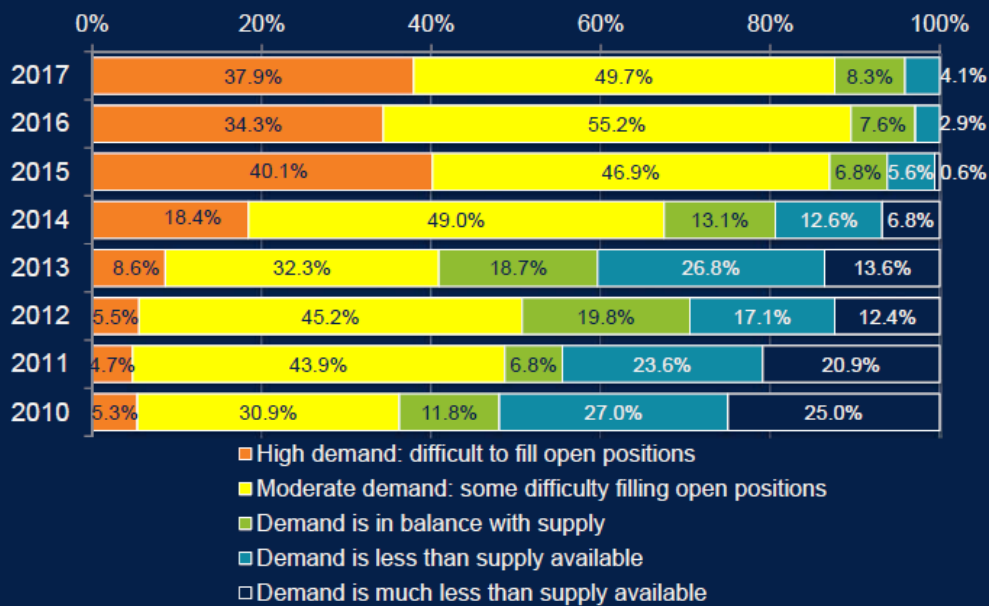
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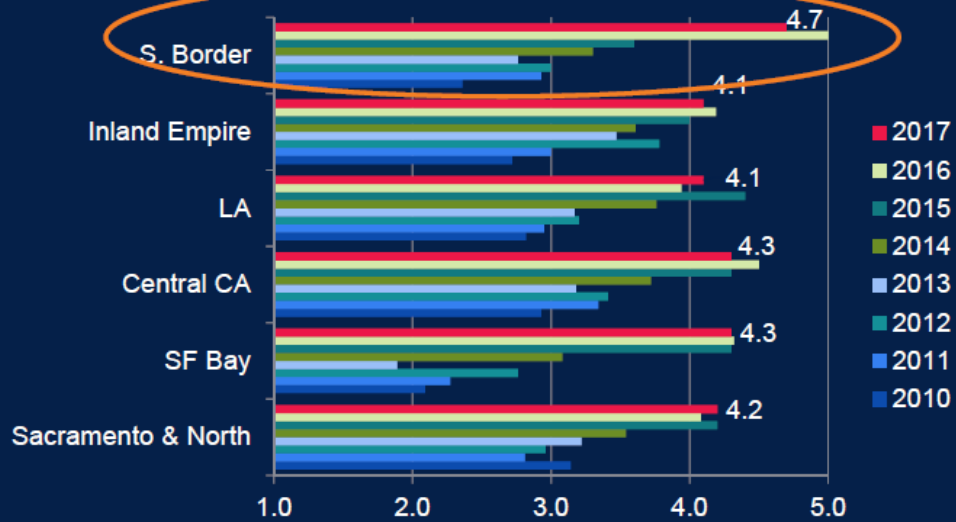
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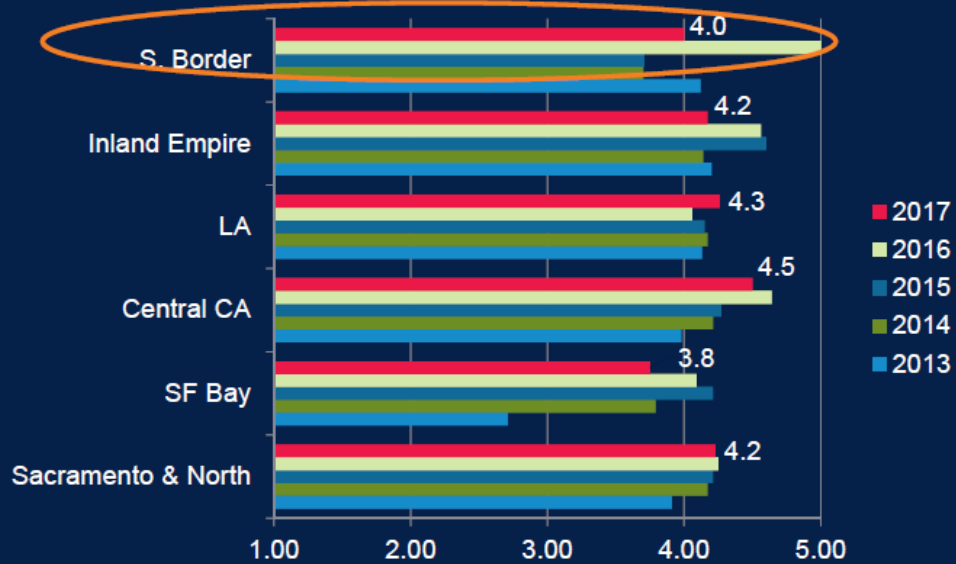
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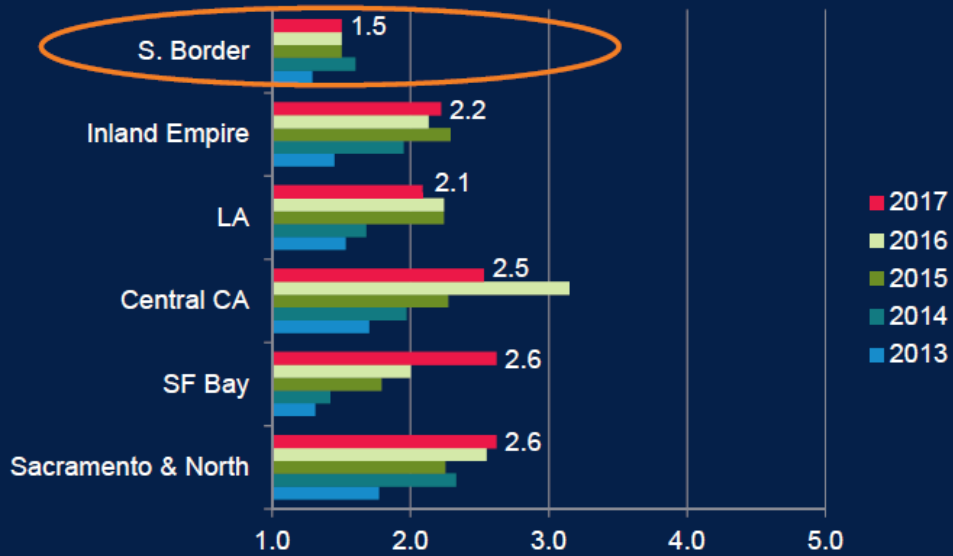
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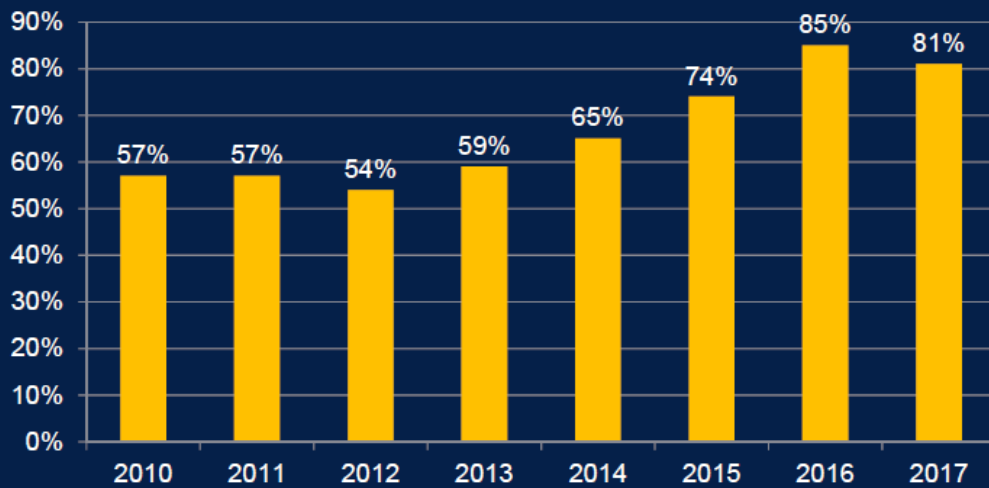
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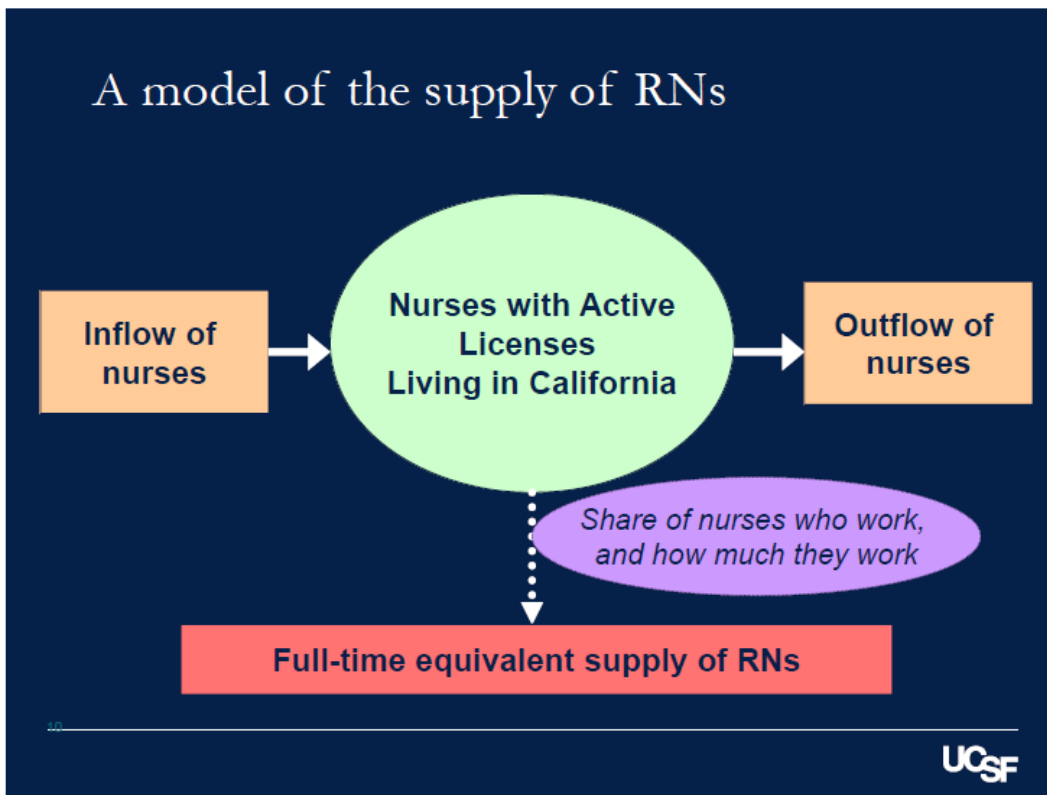
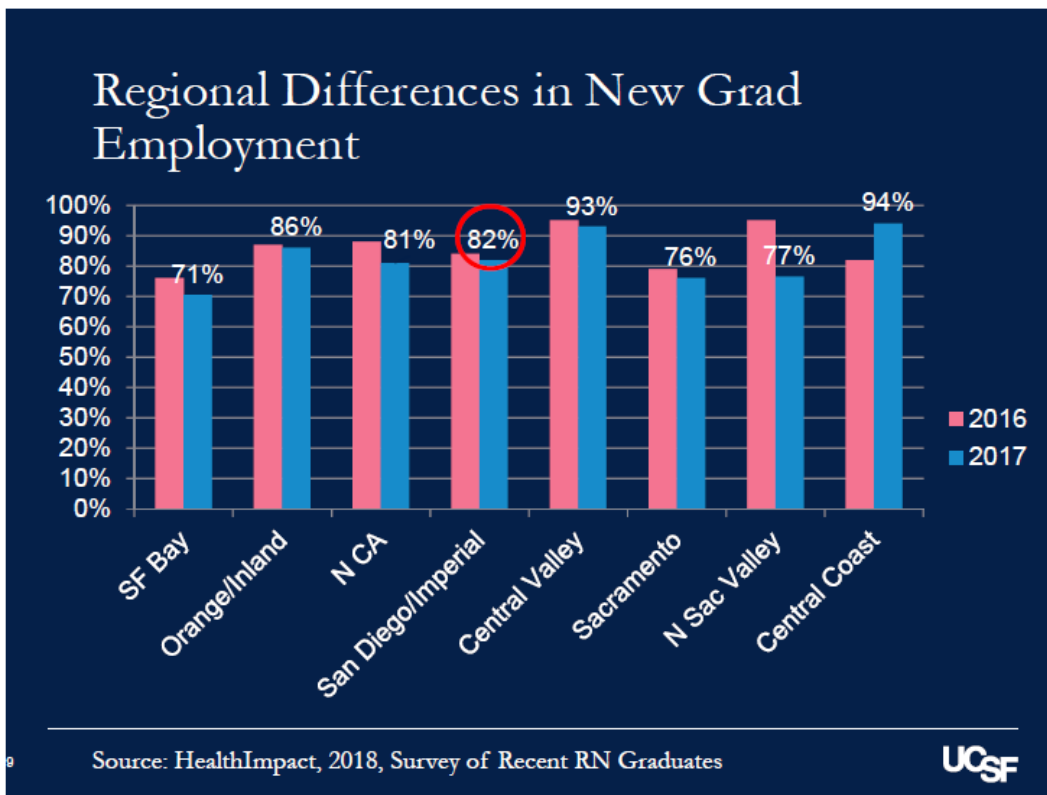


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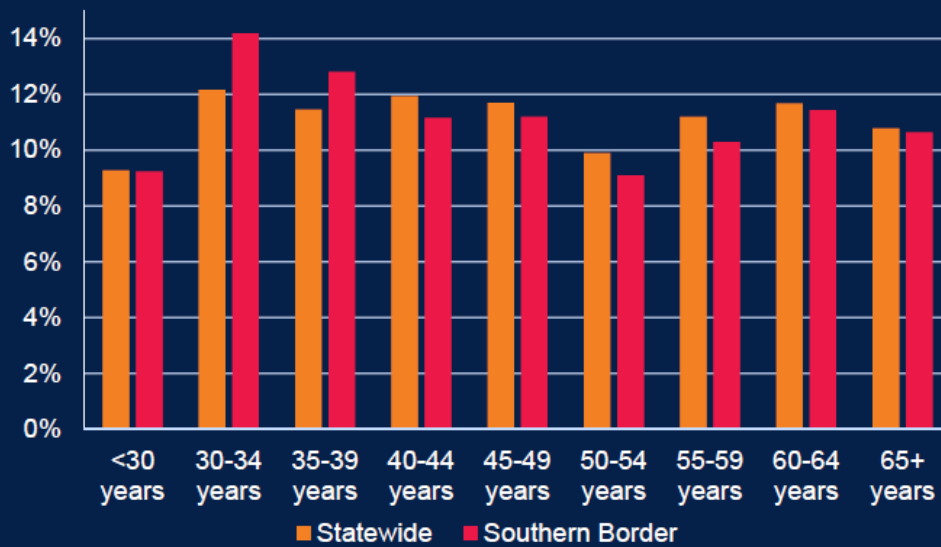


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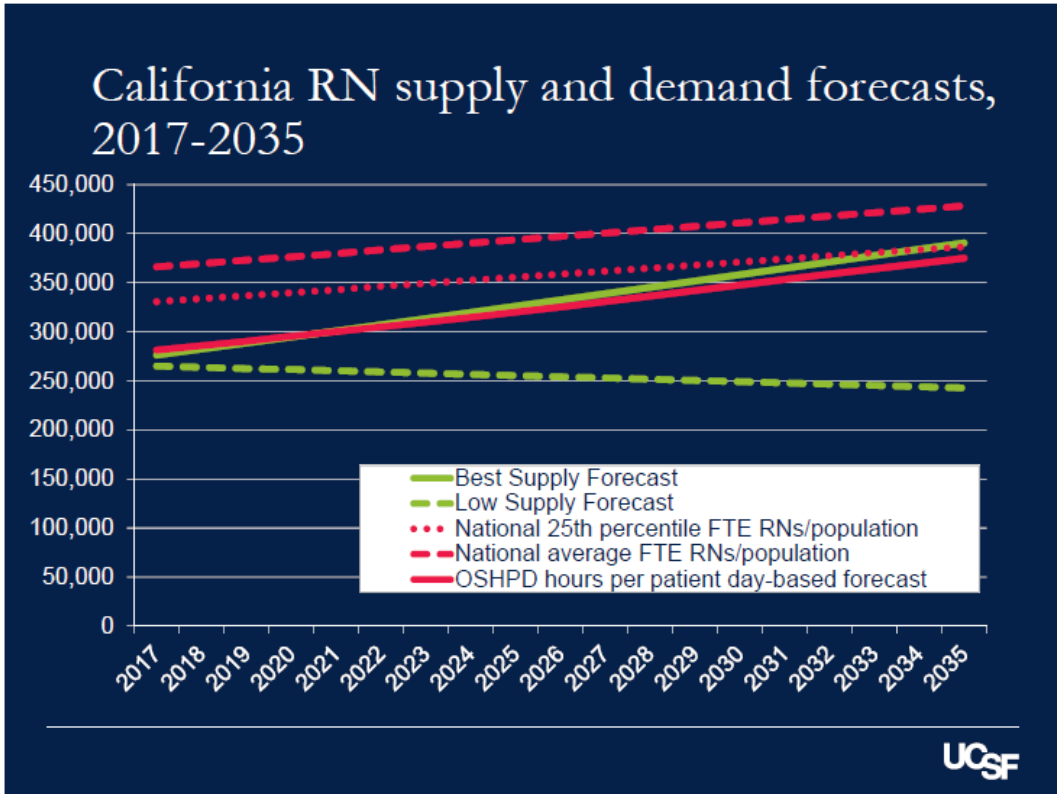
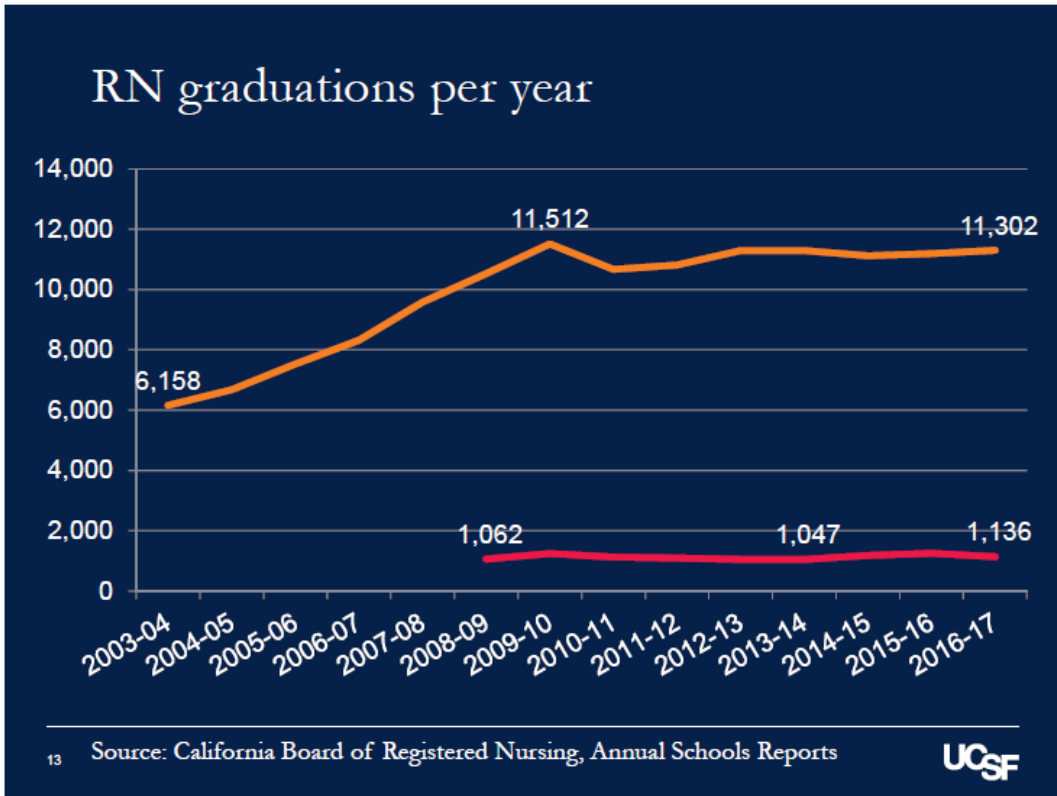
UCSF

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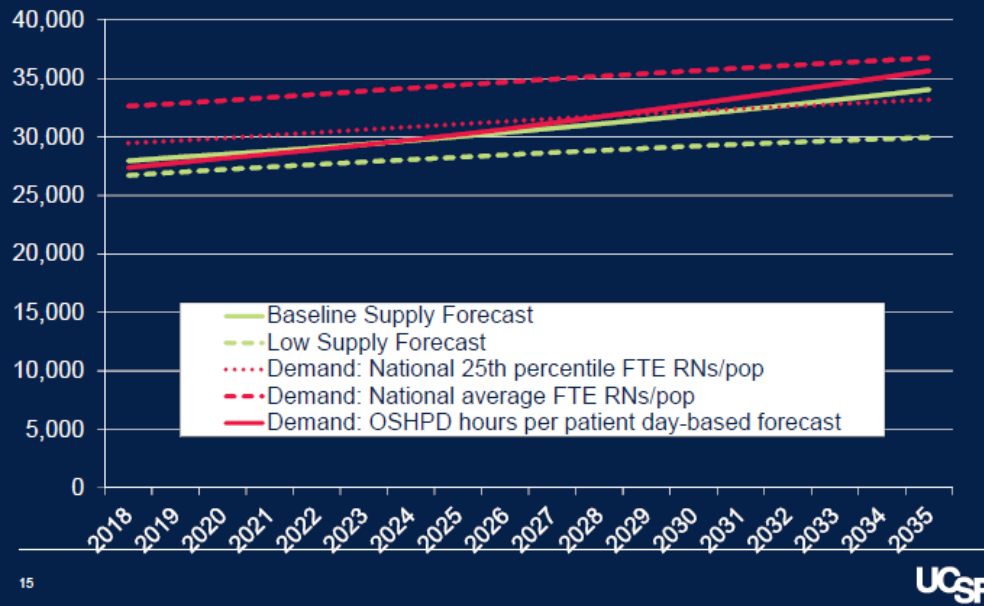


Source: Spetz et al., 2016 California Survey of RNs

UCSF



Regional differences are important Supply & demand forecasts for Southern Border



Statewide graduations are expected to hold steady

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

Border region graduations are steady

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

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



Inflows and outflows for the Border region

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



How do we move forward?

San Diego has a very well-balanced labor market

Population growth projected & education is keeping up

Employers indicate there are too many new graduates – but the region needs them & they want to stay



Supply & Demand of Registered Nurses in the San Francisco Bay Area

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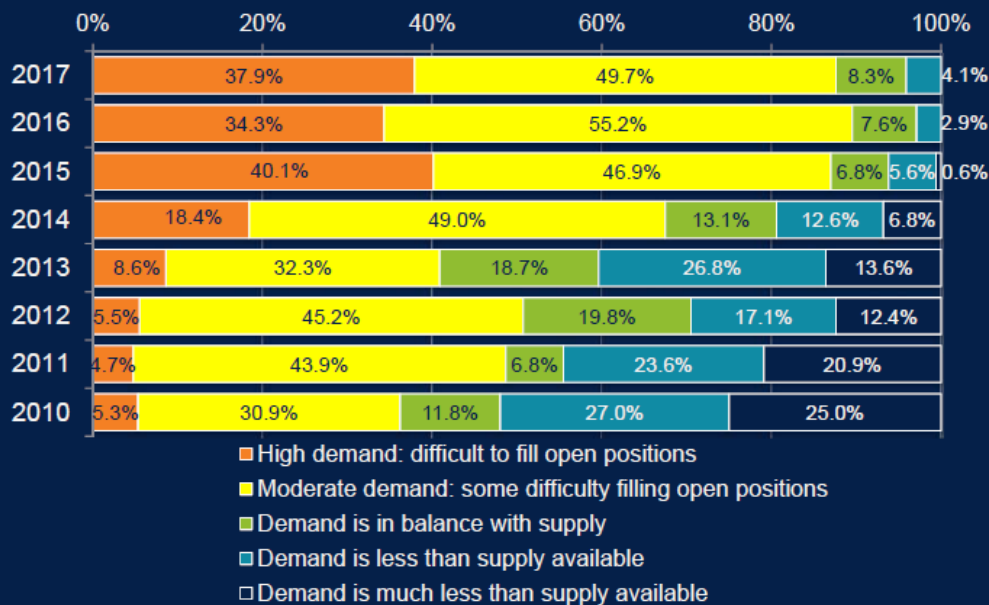
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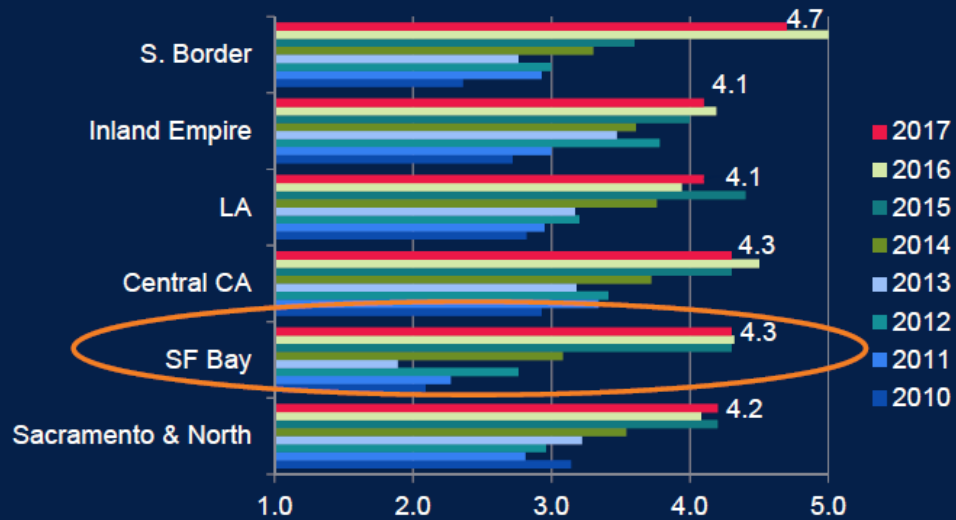
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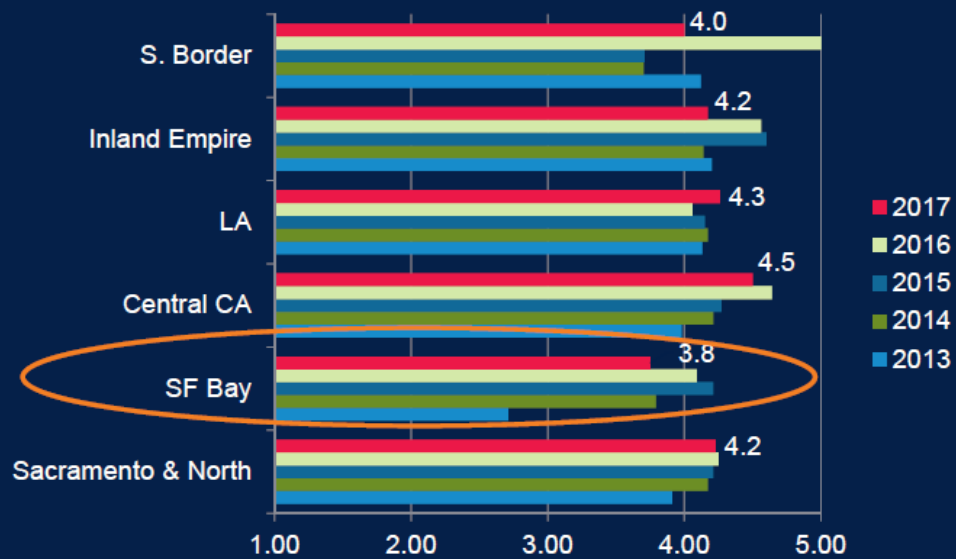
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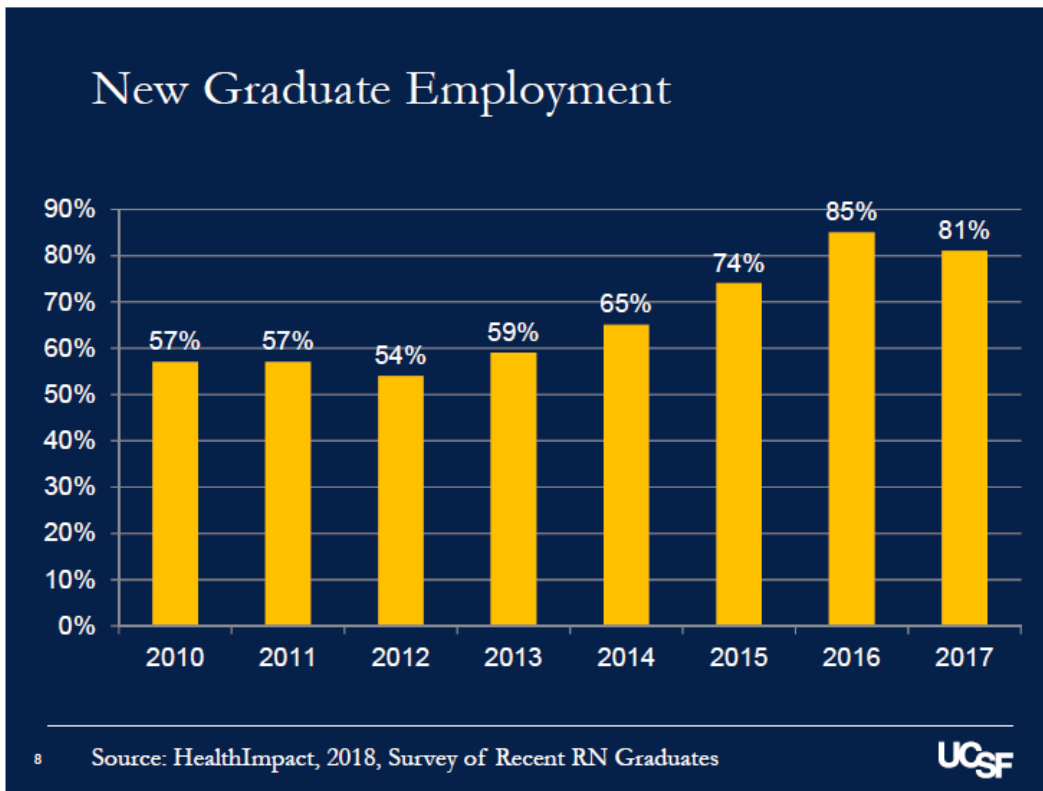
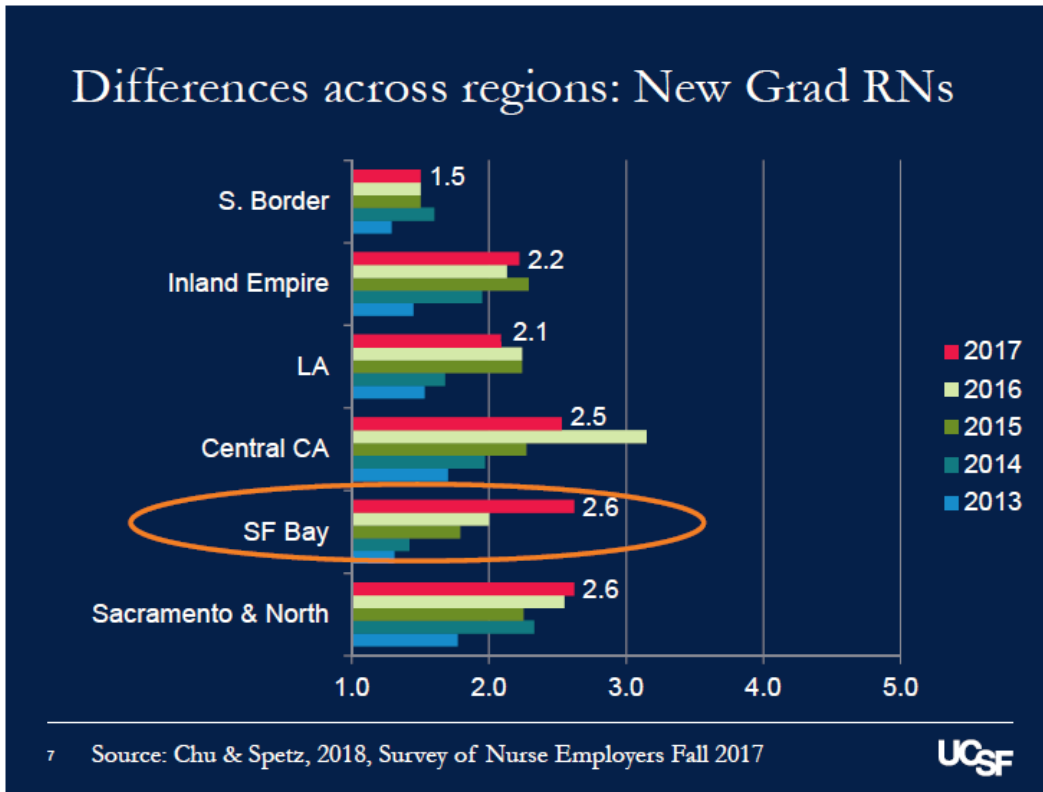


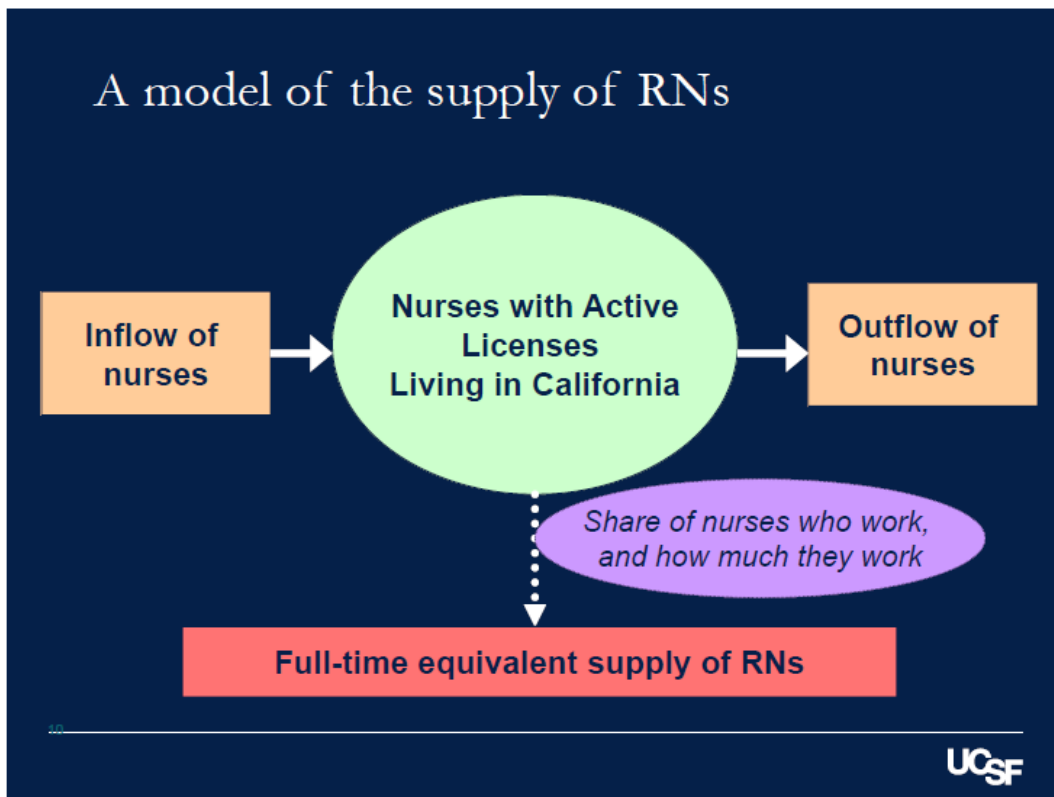
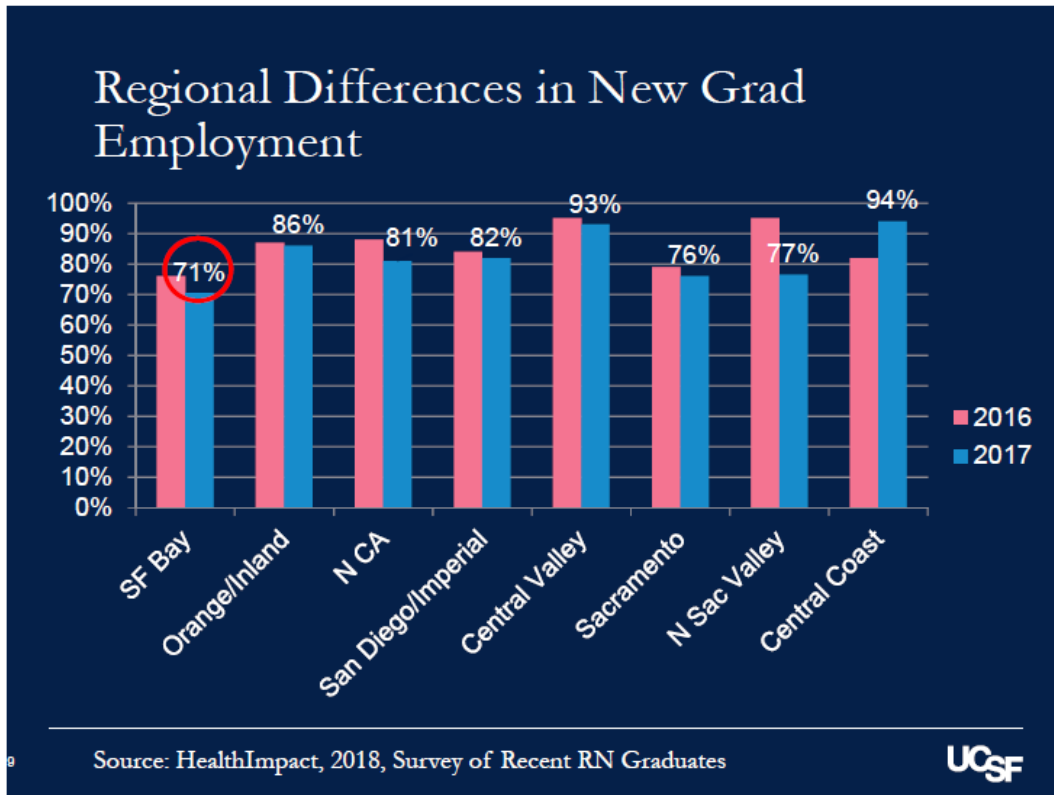
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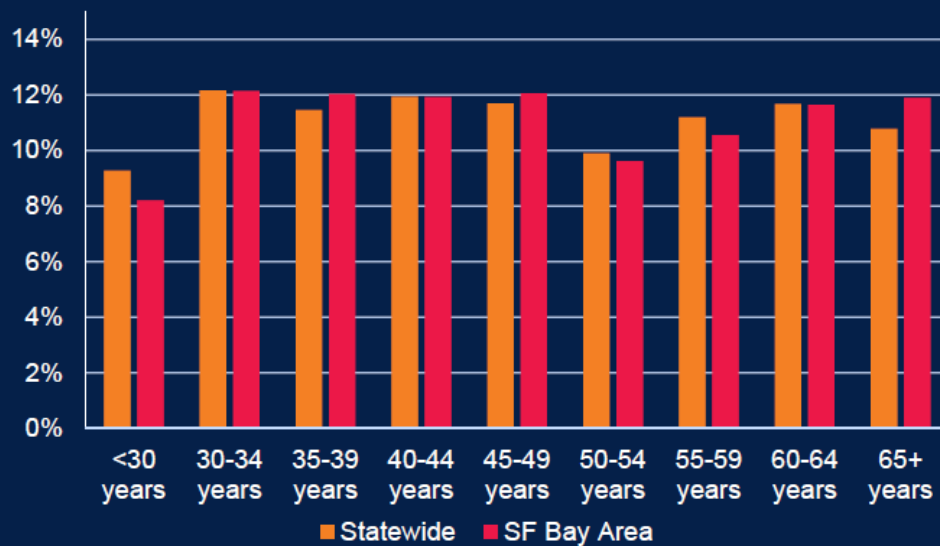


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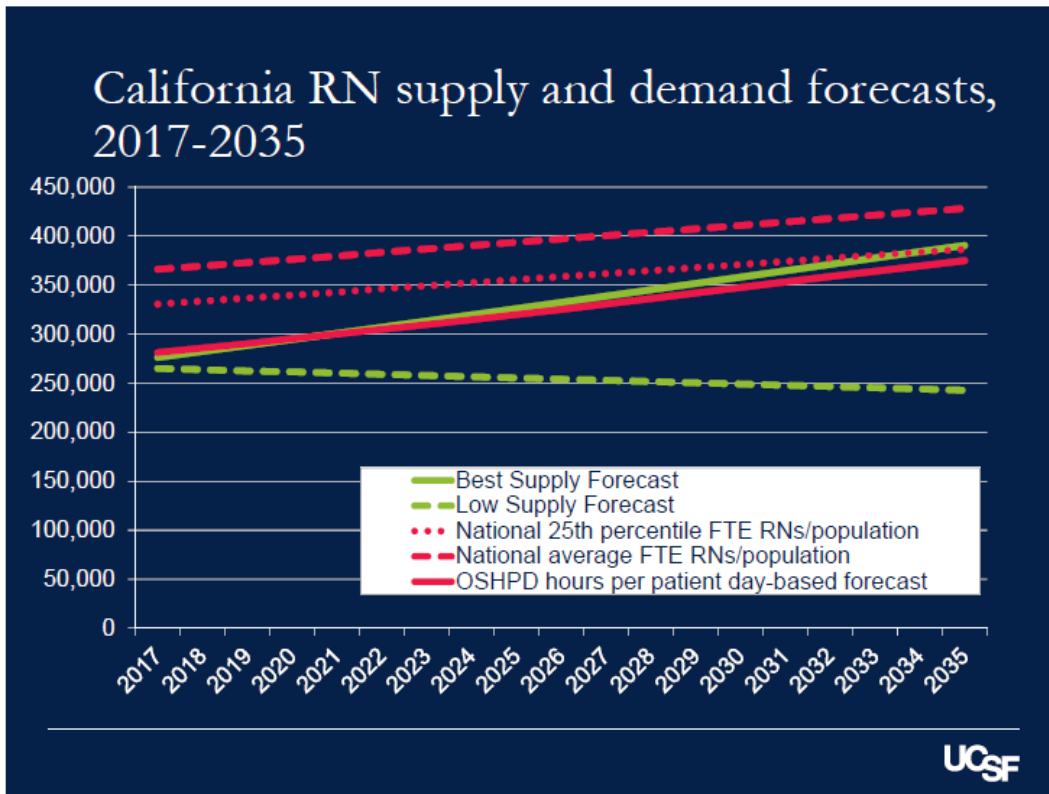
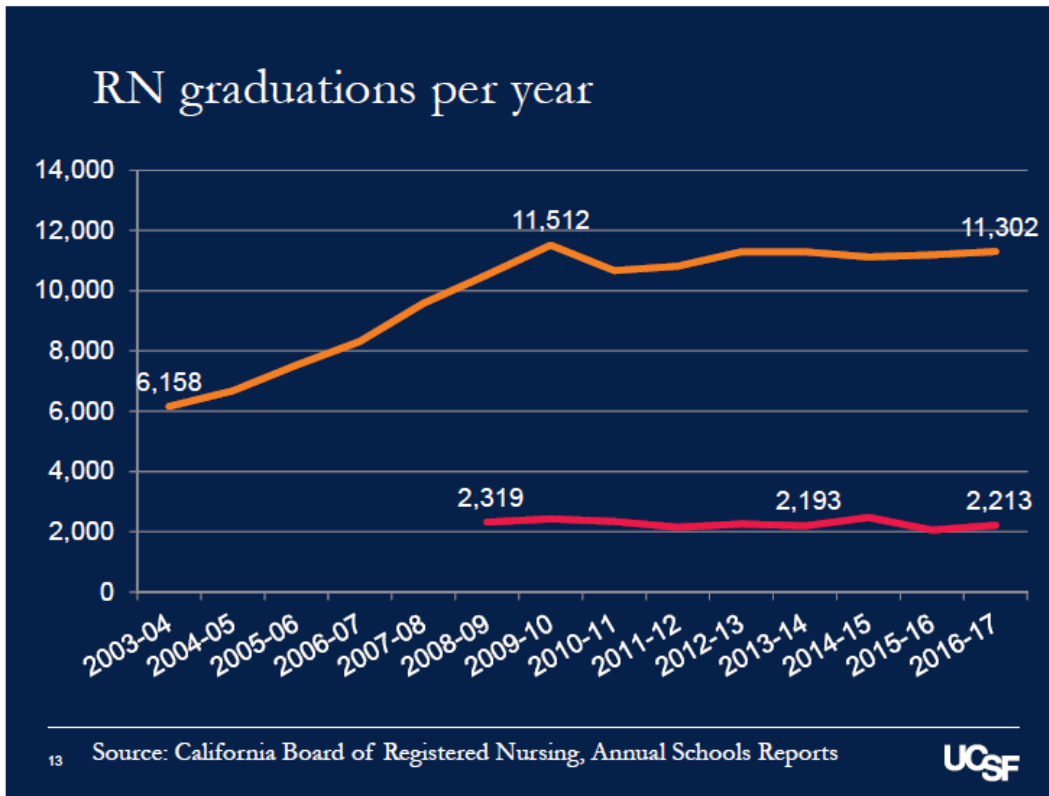
UCSF

Age distribution of licensed RNs

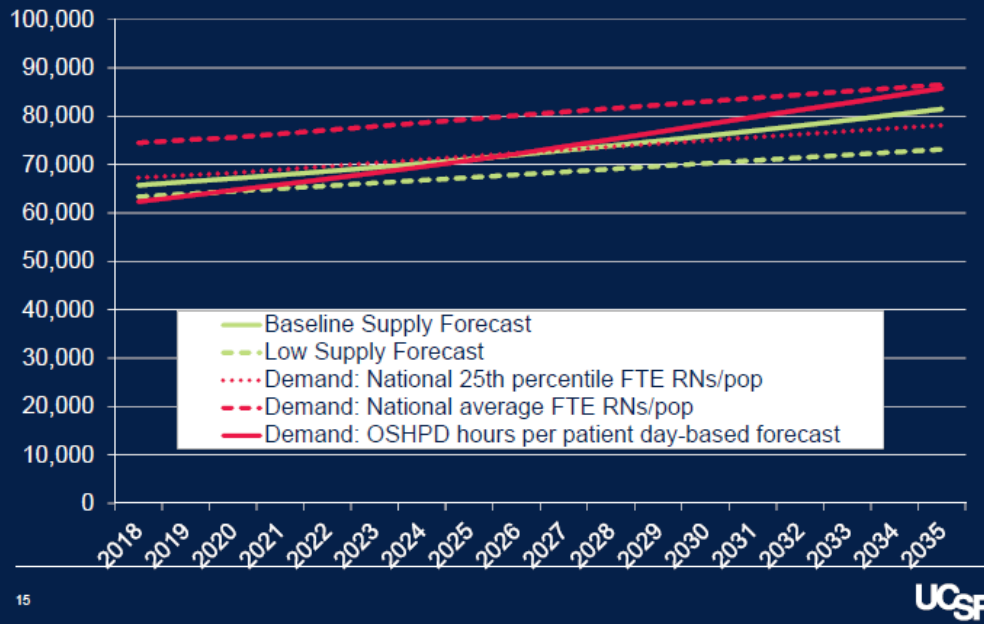


Source: Spetz et al., 2016 California Survey of RNs

UCSF



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



Statewide graduations are expected to hold steady

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

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

SF Bay area graduations are growing a bit

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

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



Inflows and outflows for the SFBA region

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



How do we move forward?

San Francisco Bay Area is moving toward a balanced labor market

Population growth projected & education is keeping up

Employers are more interested in new graduates than in many other regions of the state – this is good strategy



Attachment E

BRN Pre-Licensure RN Clinical Education Capacity Survey Report



Objectives:

1. Report the May 2018 survey results of Clinical Capacity/Clinical Displacement Survey as reported by California Pre-licensure Nursing Education Programs and Clinical Agencies
2. Share the reported Impact of clinical capacity issues/clinical displacement on Nursing Education Programs and Clinical Agencies
3. Highlight the proposed solutions/comments provided by Nursing Education Programs and Clinical Agencies responding to the May 2018 surveys





Pre-licensure Nursing Programs Report

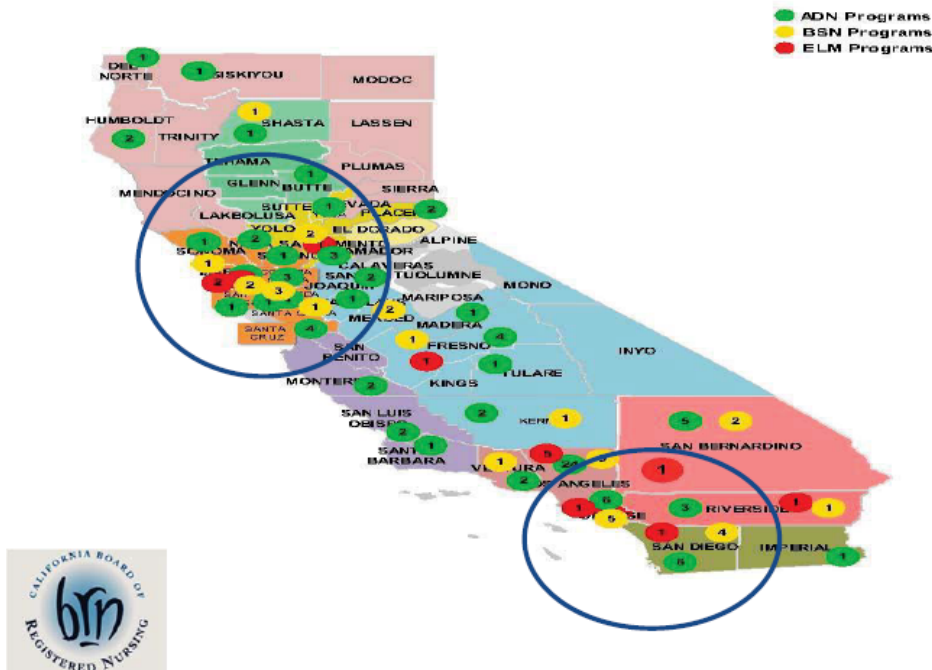
Scope: Total Number of Pre-licensure Nursing Education Programs in California

Type of Nursing Program:

Associate Degree Nursing Programs	= 91
Baccalaureate Degree Nursing Programs	= 37
Entry Level Master's Degree Programs	<u>= 13</u>
Total	= 141



Scope: Location of Nursing Education Program by Region



Scope: Pre-licensure Nursing Education Programs Annual School Survey

Trends:

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

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



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

Trends:

Reporting period July 1, 2017-June 30, 2018

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



Scope: BRN Nursing Education Programs Pertinent Statutes & Regulations

Nurse Practice Act:

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

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

Quarter or Semester	Degree type	Weeks	Theory	Clinical	Clinical Hours	Total Units	Communication	Science	Total for licensure	Total for graduation	2017-2018 NCLEX
Quarter	ADN	10	34	28	840	62	9	24	95	99	74.63%
Semester	ADN	16.4	21	26	1279.2	47	6	24	77	87	94.03%
Quarter	ADN	10	31.5	30.2	906	62	10	25	97	108	71.93%
Semester	ADN	17	21	20	1020	51	6	23	80	88	94.68%
Quarter	ADN	10	2	29	870	61	10	30	101	116	98.04%
Semester	ADN	17.5	10	23	1207.5	43	7	18	68	80	96.10%
Quarter	ADN	12	28.5	30.5	1098	59	13	37	109	125	91.67%
Semester	ADN	18	21.75	22.75	1228.5	44.5	6	22	72.5	77.5	100%
Quarter	ADN	10	4	30	900	70	9	30	107	118	91.92%
Quarter	ADN	10	49.5	28.5	855	78	9	28.5	116	119.5	100%
Semester	ADN	16	21	21	1008	42	7	24	73	80	100%
Semester	ADN	18	27	21.5	1161	48.5	6	30	84.5	89.5	96.88%

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

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

Quarter or Semester	Degree type	Weeks	Theory	Clinical	Clinical Hours	Total Units	Communication	Science	Total for licensure	Total for graduation	2017-2018 NCLEX
Quarter	BSN	10	50	39	1170	89	15	40	144	189	94.64%
Semester	BSN	15	28	22	990	6	50	25	81	120	86.92%
Semester	BSN	15	27	24.5	1102.5	41.5	9	22	82.5	132.5	91.49%
Semester	BSN	15	38	22	990	70	12	31	103	129	90.14%
Semester	BSN	15	30	21	945	61	6	27	84	120	92.00%
Semester	BSN	16	20	25	1200	55	9	32	86	130	93.77%
Semester	BSN	15	38	23	1035	61	9	20	90	120	87.18%
Quarter	BSN	10	38	30	900	68	12	35	115	185	94.00%
Semester	BSN	15	39	20	900	59	6	21	86	120	97.22%
Semester	ELM	15	35	22	990	57	9	28	94	131	83.78%
Quarter	ELM	10	66	28	840	94	11	27	131	180	97.73%

Scope: Clinical Capacity vs. Clinical Displacement

Definition:

- **Clinical Displacement:** A student or a cohort of students enrolled in a nursing education program and placed in a site to gain clinical experience who are **replaced** by a **student and/or cohort of students** from another nursing education program for a shift, unit, entire placement or fewer preceptorships
- **Clinical Capacity:** Sufficient **supply and demand** of safe competent RN nursing education program graduates to meet California's **workforce needs** now and in the future



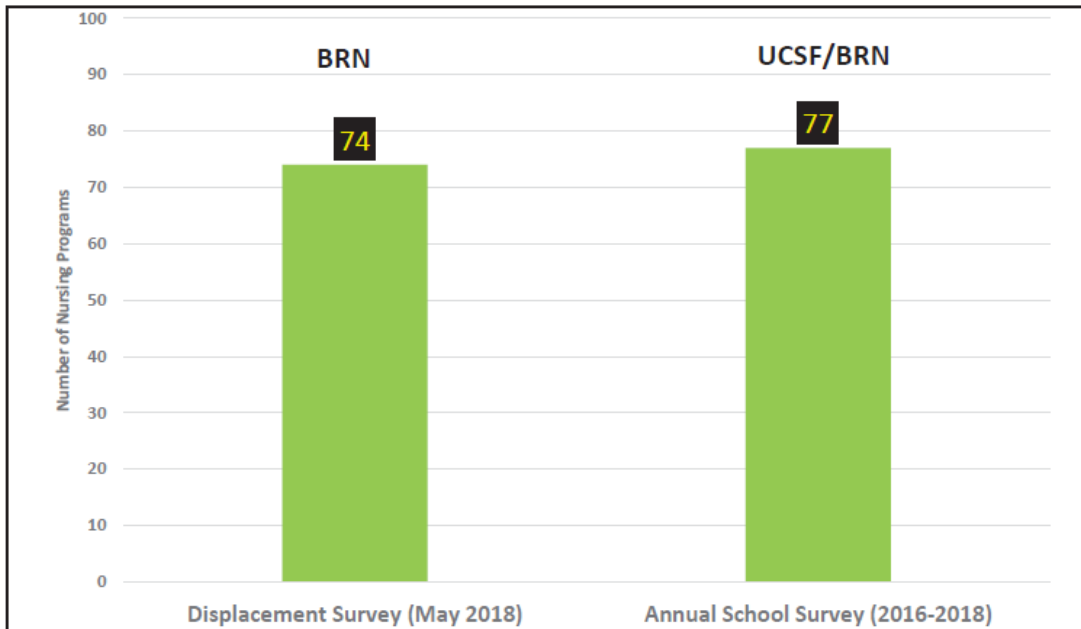
Scope: May 2018 Survey Results from Nursing Education Programs

Survey:

- A 27-item
- Online link was sent to **141** Pre-licensure RN education programs
- A total of **134** programs responded:
 - **91** ADN
 - **30** BSN
 - **13** ELM programs
- *Note: some survey respondents included schools/programs that offer more than one degree option*



Scope: Comparison of Annual School Survey and Displacement Survey




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

Ranking of Counties:





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



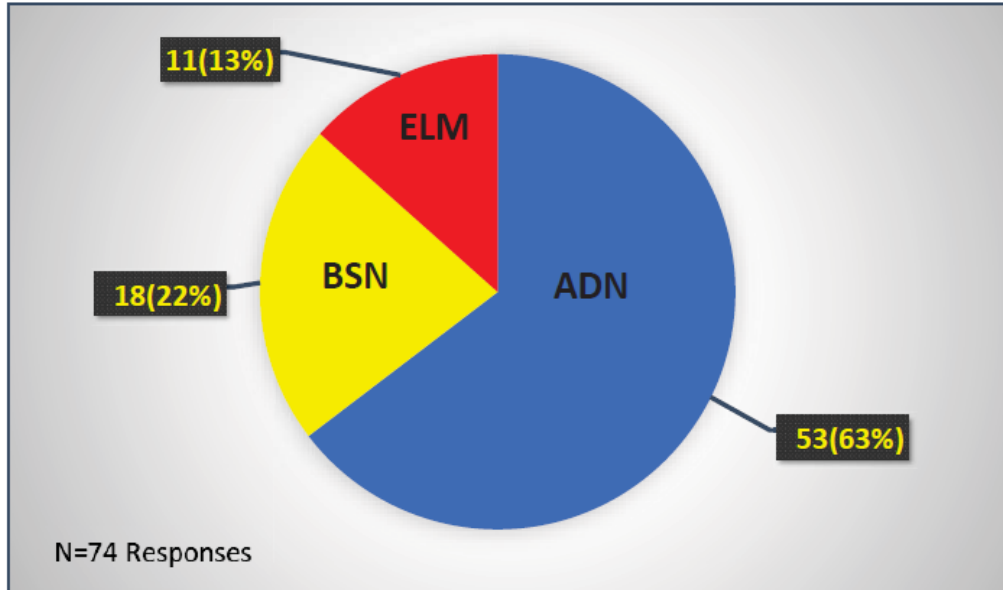
Scope: Total Number of Reported Clinical Displacements by Counties

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

N = 99 responses

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

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



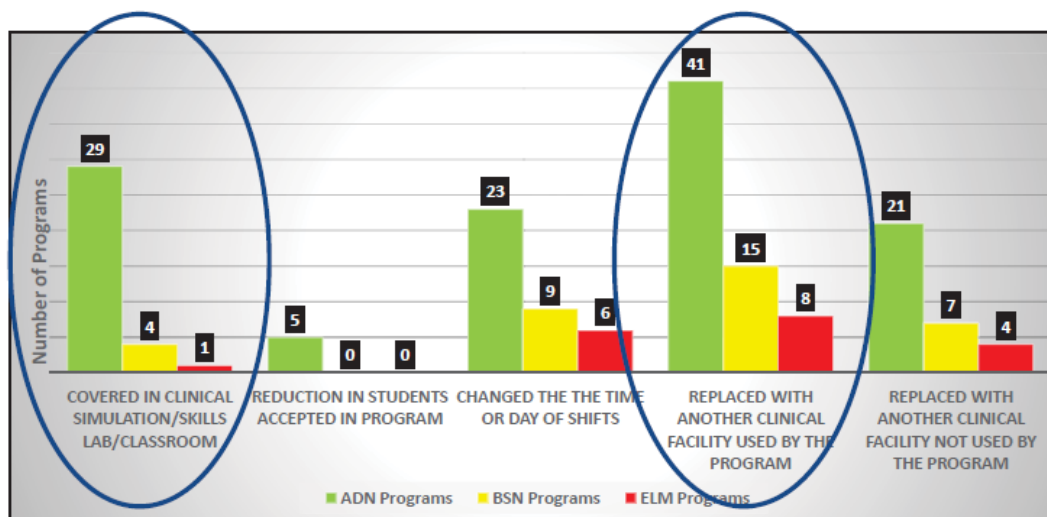
Scope: Top 3 Ranked Clinical Areas Nursing Education Programs Reported Displacement

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

Scope: Programs Most Common Perceived Reasons for Clinical Displacement

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

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



N = 173 Responses

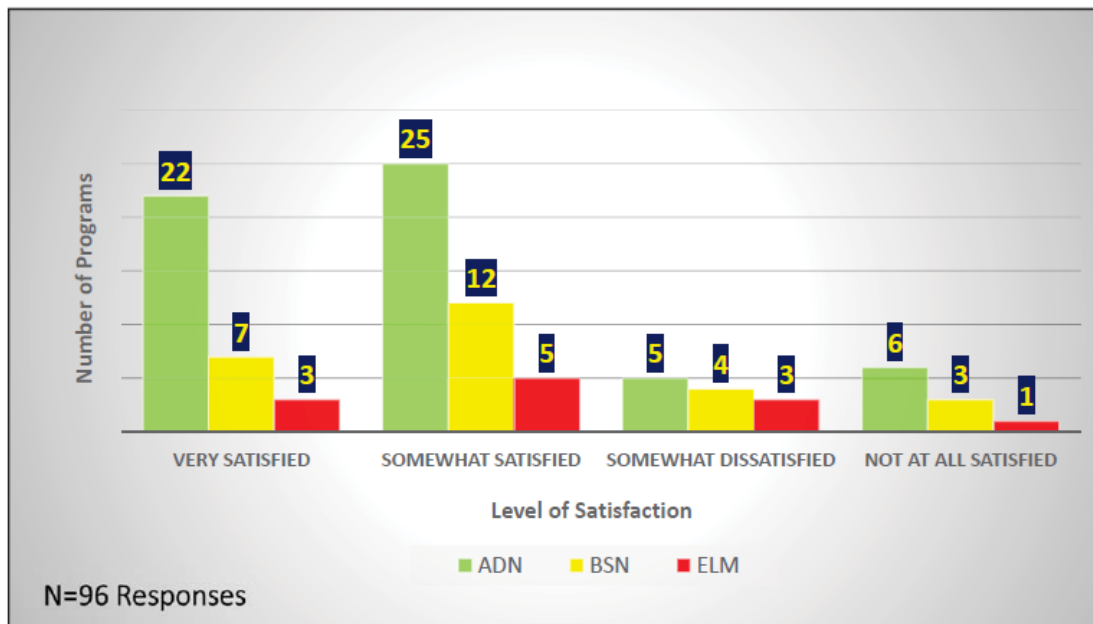
ADN reported use of simulation/skills lab significantly more than BSN & ELM

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

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

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

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



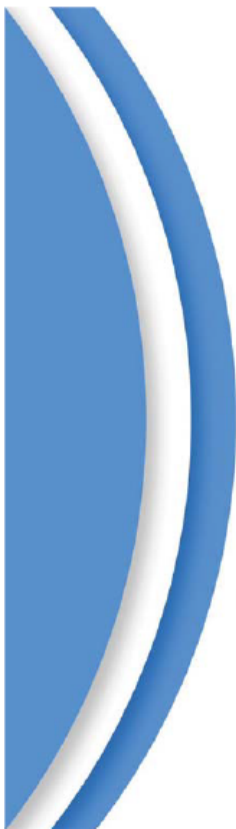
Solutions: Nursing Education Programs Reasons for Not Participating in Consortium(s)/Clinical Planning Systems

Qualitative Responses:

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



Clinical Agencies Report



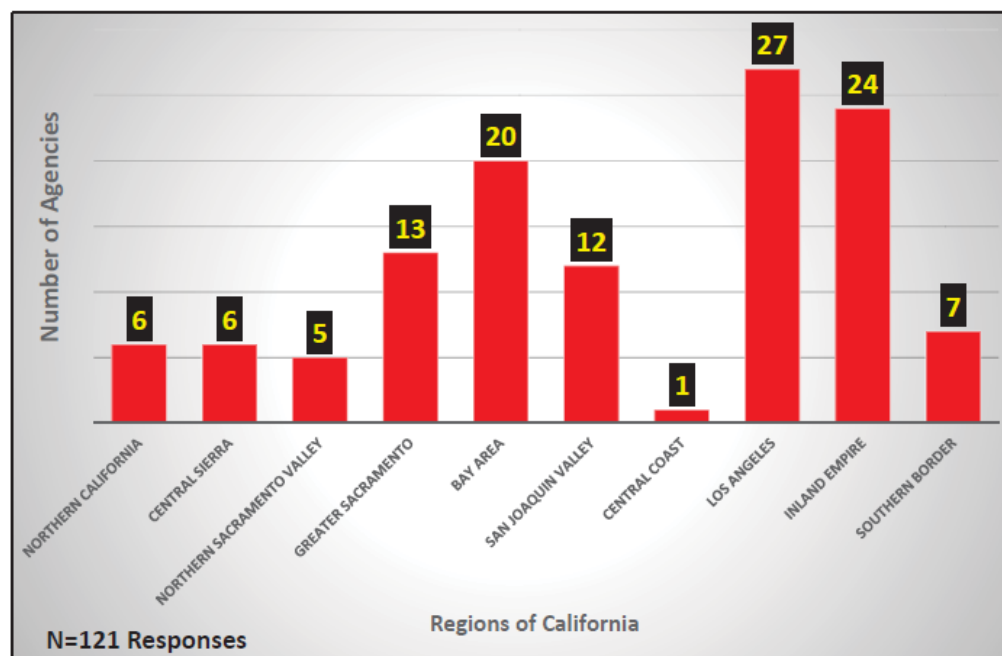
Scope: Clinical Agencies Report

Background

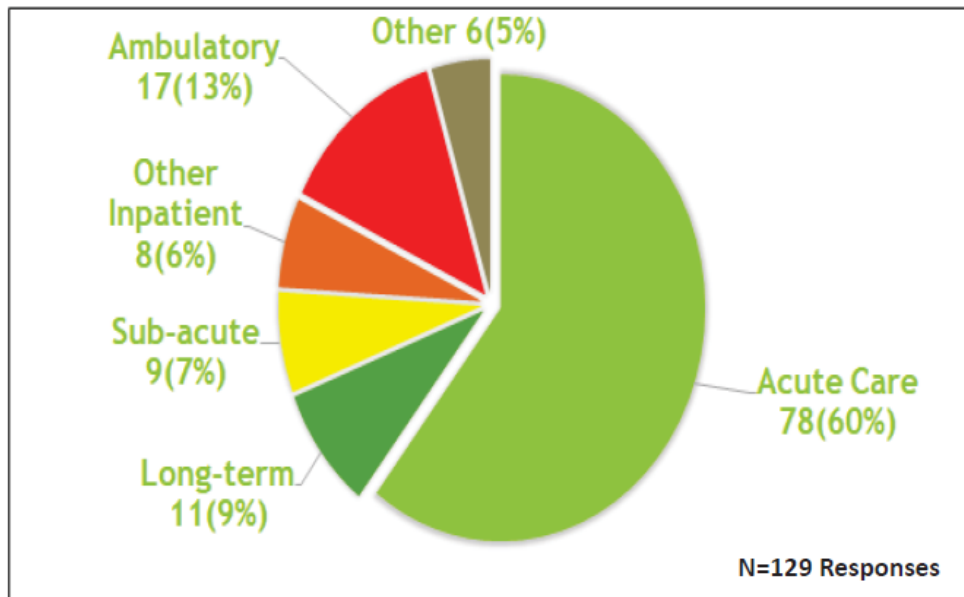
- About 400 clinical agencies were invited to participate in the online survey
- 91 responded to the 30-items survey
- Majority (78) of clinical agencies were identified as an acute care facility
- Note:
 - Not all agencies responded to all the questions
 - Some agencies had multiple responses to the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



Scope: Clinical Agencies that Responded to Survey By Region

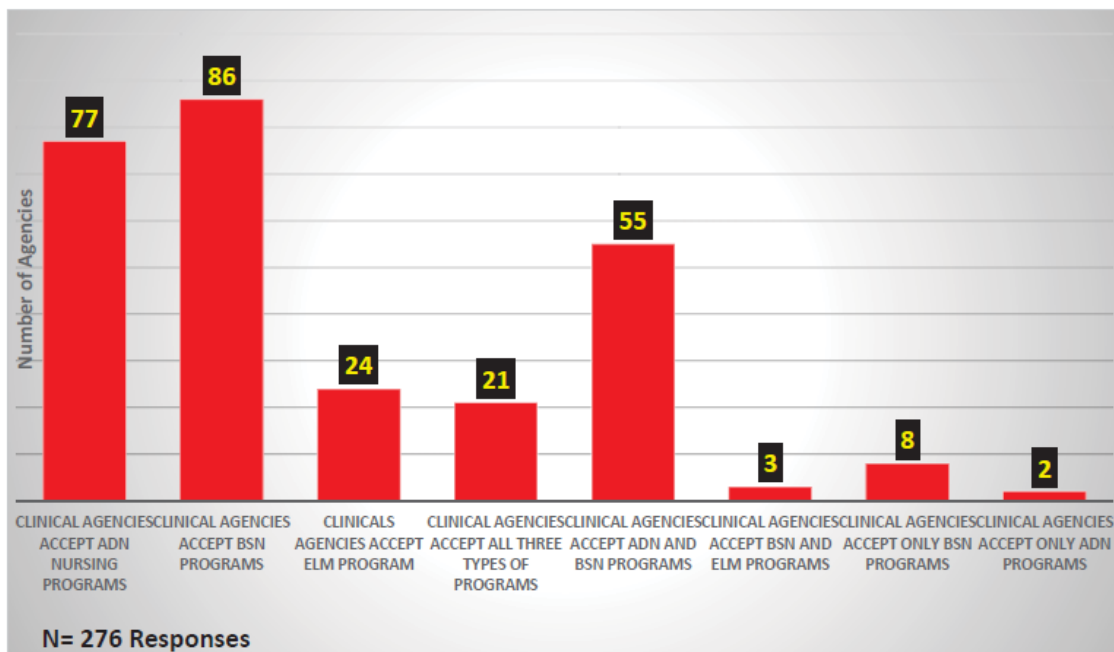


Scope: Types of Services Clinical Agencies Provide

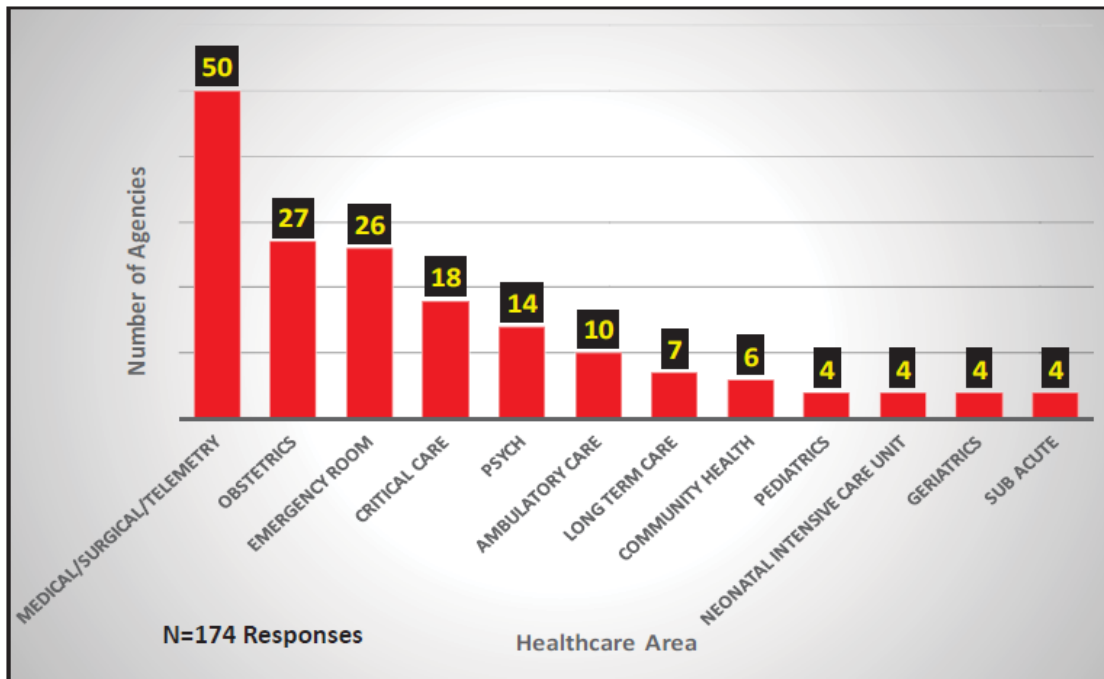


*This slide illustrates the variety of clinical placement opportunities available to students

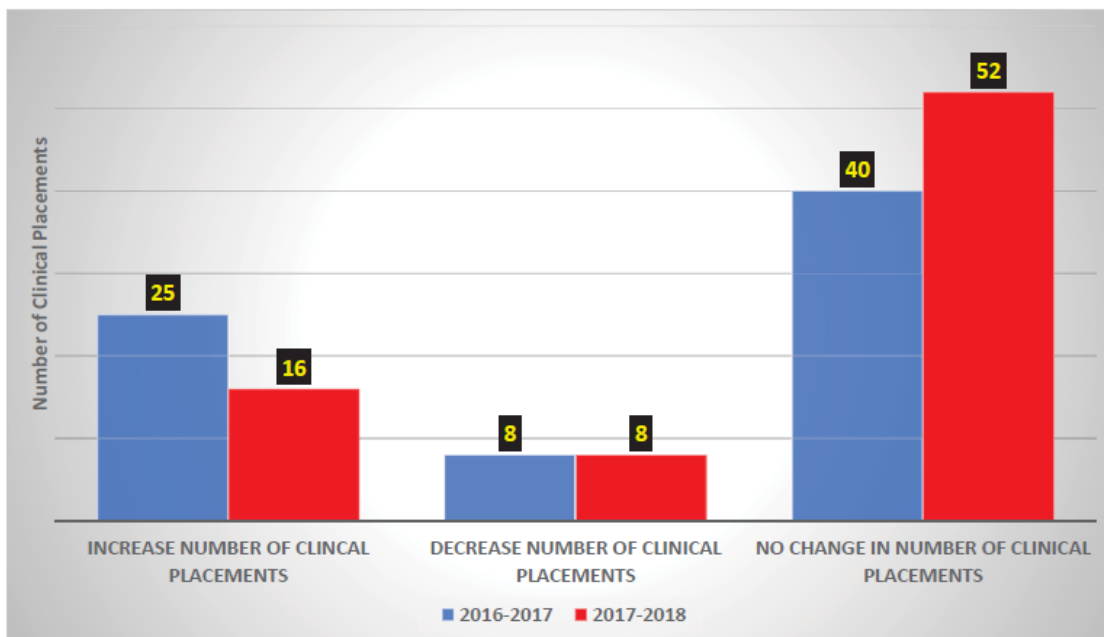
Scope: Types of Nursing Education Programs Accepted by Clinical Agencies



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



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

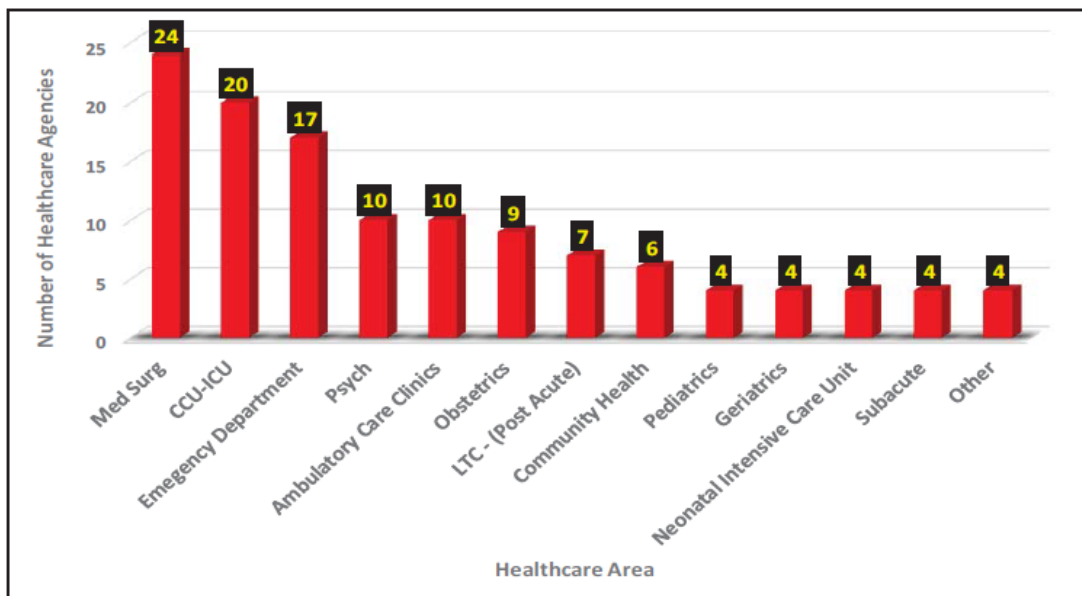


Impact: Factors Contributing to Decreased or Planned Decreases in the Number of Clinical Placements

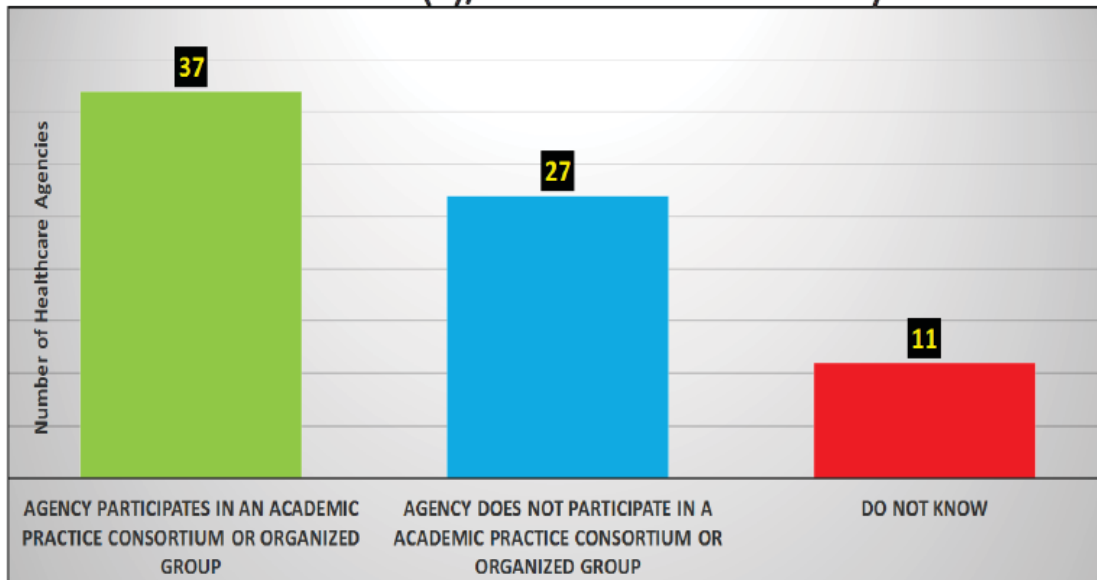
Qualitative Responses:

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

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



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



N=75 Responses

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

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



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

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



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

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

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

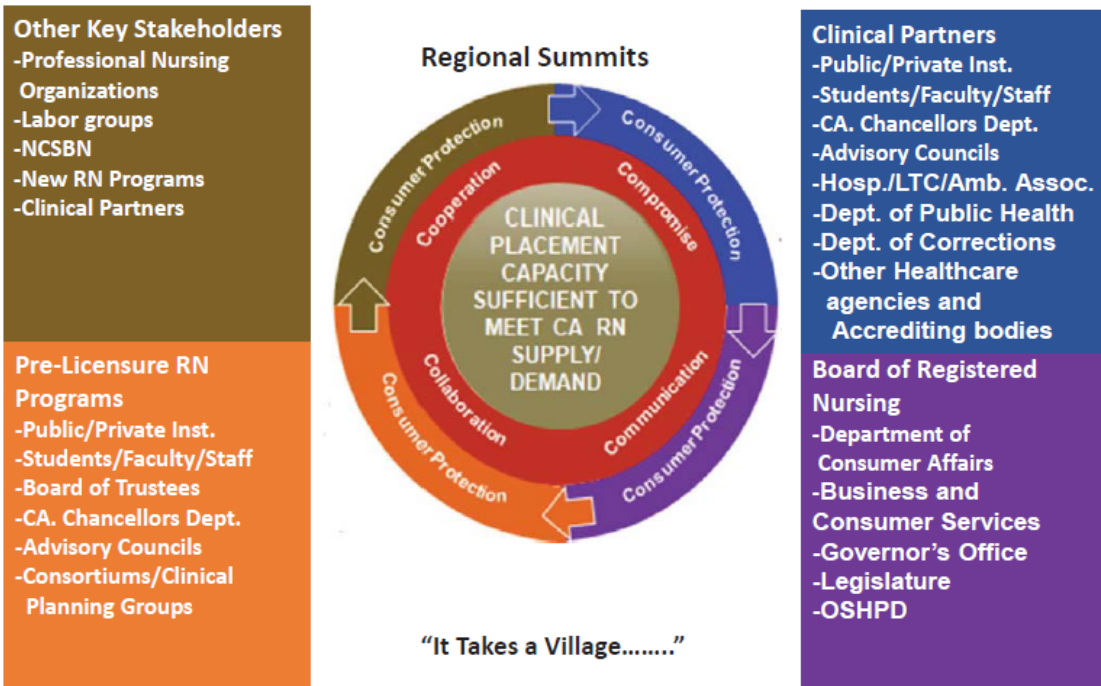
- **Standardize/streamline consortiums and clinical placement planning systems and processes**
- **Continue to carefully monitor, manage, and regulate the impact that increased student enrollments and new program approvals**



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

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

Influences that Potentially Impact Clinical Placement Capacity for Nursing Programs



Thank You.....Questions?

