Past Event: 2023 NCSBN Symposium: Solutions Addressing Nursing Workforce Crisis - Introduction & Staffing Panel Video Transcript

Event
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Presenters
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Karen C. Lyon, PhD, ANCC, MBA, APRN-CNS, NEA, Chief Executive Officer, Louisiana State Board of Nursing
Beverly Malone, PhD, RN, FAAN, President and CEO, National League for Nursing
Lavonia Thomas, DNP, RN, NEA-BC, Nursing Informatics Officer, MD Anderson

- [Moderator] Good morning, everyone, and thank you for all that are attending here live in Chicago and viewing digitally. We're here today to provide solutions to the greatest healthcare challenges we are facing today. For any media or interested parties that are seeking to collaborate or report on the solutions provided today, please contact ncsbn@reputationpartners.com.

Without further ado, I'll pass the baton to Maryann Alexander, chief officer of Nursing Regulation for NCSBN.

- [Maryann] Thank you, and let me begin by extending a warm welcome to all of you, to our panelists, and to those who are watching digitally. Today is an important day. We are addressing an important topic that is going to affect the future of health care.

In April of 2023, NCSBN released the results of our National Nursing Workforce Study. NCSBN is a world leader in nursing regulation, exam development, and nursing research. The result of that study was alarming, and I'm going to recap some of the results to you that we want you to pay close attention to.

And it shows the impact of COVID-19 on the nursing workforce. So, as a result of the pandemic, 100,000 nurses left the workforce, and this is in addition to nurses that left due to normal reasons, such as retirement or going back to school.

During that time, the nurses showed that they had an extraordinary increase in their workload. They changed practice settings. Many retired because of COVID-19. More, even more alarming are the fact that 45% to 56% of the nurses in our study said they are emotionally drained, used up, fatigued, or burned out.

29% say they are at the end of their rope. What we want to call your attention to is that, by 2027, over 800,000 RNs and almost 200,000 LPNs, that is, 1 million nurses say they have an intent to leave the nursing profession.

This is equivalent to 20% of the total licensed nursing workforce. And what is even more alarming is we are seeing something that we have never seen before, 24% of those nurses that want to leave nursing have less than 10 years of experience.

The reasons for leaving are burnout, understaffing, concern for patient safety, a lack of educational preparation for entering the workforce, and violence in the workplace, and bullying.

And I want to call to your attention that these are basic needs. These are not things that are extraordinary requests. Thus, all of this adds up to the fact that the U.S.

will experience a national healthcare crisis within the next five years if we don't see this as a call to action. So, in the wake of COVID-19, the nursing workforce has lost hundreds of thousands of nurses, potentially up to 1 million in the next 5 years.

We are asking healthcare leaders to take heed. We need to think differently. We need to build new models of care and make enhancements so that our profession is stronger, better, and even more rewarding for generations to come.

Today is a day about solutions. We are going to have three panel discussions that address these basic needs of nursing, staffing and entry to practice, violence in the workplace, and mental health issues. And we have brought thought leaders from around the world together to bring us their innovations from their institutions, their ideas, and their inspiring thoughts as to how we can lead nursing into the future.

And so, without further ado, I'd like to have our panelists come up and introduce them. We'll begin with you and have you introduce yourself, and then let's go around our panel so everyone can meet you.

- [Lavonia] Good morning. My name is Lavonia Thomas. I am the Nursing Informatics Officer at MD Anderson Cancer Center in Houston, Texas. I do have responsibility for all things in the electronic health record and health IT, but in addition, I am the operational lead that has introduced and is moving virtual nursing forward at the organization.

- [Beverly] My name is Beverly Malone. I'm the President and CEO for the National League for Nursing. And our organization is 130 years old right now. And I'm happy to say, that's not my age. Good morning.

- [Karen] I'm Karen Lyon. I'm the Chief Executive Officer of the Louisiana State Board of Nursing. I have regulatory authority for 70,000 RNs, 9,000 of whom are advanced practice RNs, 31 pre-licensure undergraduate programs, and I believe, now, it's 15 graduate MSN and DNP programs that provide APRN licensure.

- [Eileen] Good morning. My name is Eileen Fry-Bowers. I am the Dean of the School of Nursing and Health Professions at the University of San Francisco in California. And at our school, we educate pre-licensure and post-licensure advanced practice nurses.

- Well, thank you all very much for being here. Lavonia, I'd like to begin with you. I'm going to quote you some of the data that I just talked about. One hundred thousand RNs have left the workforce due to COVID-19. Potentially, another 800,000 RNs plan on leaving the workforce in the next 5 years.

A large percentage of them say this is due to understaffing and, in fact, unsafe staffing, where not only they are overworked, they feel their patients are at risk. Does this retention issue concern you and the administrators at MD Anderson?

- As a nurse for more than 35 years, what impacts my profession and my sisters and brothers in this profession certainly touched my soul. At MD Anderson, we have put forth opportunities that we have harnessed from our monitoring of national and local trends, as well as the work we have done to establish contact ongoing through formal structures to tap into what our nurses are telling us they want us to do.

As a result, we have launched nursing transformation efforts with at least eight different work streams to address the issues that our MD Anderson nurses are telling us that they want us to address. Largely, the message we are getting is they want holistic addressing of them as a whole person, not just when they come to work but their needs above and beyond in this profession.

And that's what we're doing.

- Karen, I talked a lot about patient safety. Tell me why this is a regulatory issue and regulators should be worried about it.

- Well, I don't think there's a bigger safety issue in terms of taking care of patients than nurse staffing who provide the majority of care both in our hospitals and in our healthcare organizations. So a nursing shortage like this, either because nurses are dropping out or young people aren't coming into the profession, is a very dangerous trend for us because we have patients in our hospitals and in our healthcare organizations and even in community care where we're moving patients that are older, sicker, and have many comorbid conditions that make their care more complicated.

So we need sufficient staffing to take care of those people. And having had family members at MD Anderson and in institutions at Ochsner in Louisiana, I know when care suffers, when there's not enough staff there to take care of the patients.

And I know that our newly licensed nurses are very, very concerned. And our survey that preceded the one we did showed some very concerning trends in the narrative data that our newly licensed, less than two-year licensed nurses told us about how they were treated during COVID, what they were faced with during COVID, and that they wanted out, and they were only in the profession for two years.

It's very concerning.

- Absolutely. Bev and Eileen, I know this is probably impacting education as well. Tell me about it. Bev?

- Well, when everyone does the analysis of the workforce issues, they come up with two basic reasons for it. One is not enough nurse educators, and the second is not enough clinical placements. And so that, if we go to the root of the problem, I think that's where we'll find it in terms of, in my area, nurse education and having access to clinical placements is a huge issue.

And I know that, digitally, you're working on it, and virtually. And so I'm really happy about that. I'm thinking that we've got to make sure health equity is in there too, and diversity and inclusion are also part of that calculation. It's usually not printed out that way, but it's embedded in it, that we know, unless we make that inclusion, it won't help.

So, are we to the solutions yet? Should I mention a possible solution, or should we hold off on that?

- Hold off. I want to give everybody the grand scope of the problem.

- Okay.

- But we'll get to it.

- So the only other thing that I...I'm sorry. The only other thing that I would say is that it's not just our problem. It's not just a nursing problem. When you talk about that it's going to affect health care, it becomes a nationwide, global issue that will require all of us working together on this.

- Absolutely. Eileen?

- Yes. I would like to dive in a little bit more on this issue of clinical placements just so that everybody understands. In nursing education, our students have, of course, the classroom kind of education, but a huge percent of the education really takes place in the clinical setting. And in order to do that, we need to be able to come into hospitals or healthcare agencies or community agencies, and we need to have our students work with the nurses that are working in those spaces.

When those nurses are fatigued or burned out, the ability of them to be able to work with our students is reduced. And oftentimes, many of our clinical agencies then say, in an effort to alleviate some of the stress that the staff are having that we're not going to take, you know, more students or we're going to have our nurses take a break.

And while this is really important, what it does is it backs up the students who can then be educated and continue to move forward. So it really clogs up the pipeline. And so we really need to focus on ways that we can support the nurses who are functioning in these settings as preceptors, but also, you know, we need to partner with our clinical agencies to be able to bring in our students in larger numbers so that we can, again, move them through the educational process so that they're successfully entering into the workforce.

- Great, thank you. And now I want to turn to solutions. Lavonia, please tell us what's happening at MD Anderson.

- Well, at MD Anderson, some time ago, we engaged in nursing transformation efforts based on our feedback from our staff nurses, such activities as focusing on leadership training, first off, focusing on those that were hired in the last three years, because they were hired during the pandemic and needing to focus some of their skills, and then moving forward to those with more experience to build their skills, and then to all nurses, because nurses are leaders in whatever job that they hold.

In addition, we've introduced the virtual nursing platform to layer on a registered nurse with experience to the care team to support those that are delivering hands-on patient care. Our nurses spoke about the need to ensure that when we place resources in place like technicians that we make sure that we have those people with some level of dependability, because the work falls back to the nurse when those people are not available and also that they are trained to do that which we need to delegate to them.

In addition, I am proud to say today, MD Anderson is announcing, through a generous $25 million gift, the launching of the Meyers Institute for Oncology Nurses, and it is designed... It's wonderful. Philanthropic efforts toward nursing are wonderful. This institute is designed to look at the nurse as a whole person, both professional development as well as providing wellness resources.

We want nurses to come to MD Anderson and retire from MD Anderson, and to do that, we need to support all of their needs, not just what they come to work to do but also their wellness.

- Absolutely. Could you tell us a little bit more about virtual nursing?

- Absolutely. After a career of over 35 years, this is really something I'm excited about, almost like when I first went to the ICU many years ago. It has enabled us to hire...we have now hired 10 virtual nurses for the organization, and we are using a sprint methodology to introduce, right now, admission and discharge support for our frontline nurses.

Again, this was based on their feedback of things that they felt someone could assist them with but it needed to be a nurse. We have been able to hire nurses that have got a great deal of longevity at MD Anderson, and an oncology nurse is a valuable member of the MD Anderson family because of the work they do with patients.

So we have now come across four units, and we are going to slowly implement admission and discharge work utilizing this virtual platform. But that's just the beginning. There's so much potential, and we are listening to the voice of our nurses both through in-person forms plus surveys that we're sending out for them to tell us, as a nurse, what can we partner with and create a virtual member of this team to assist with?

We've received some excellent feedback. I can't say enough. The feedback the nurses have said, one actually said, "I don't know how we'd get through some of my busiest days without my virtual nurse, and it has enabled me," and this is directly from nurses, "It has enabled me to spend time with my patient and do a more thorough assessment with having this individual on board."

- Have you had any assessment yet of retention and the impact of any of these interventions?

- MD Anderson has seen a stabilization of our turnover, and we are pleased with that. But we are continuing our efforts to continue to listen to our nurses and provide the resources that they need.

- And we'll be looking forward to the results.

- Absolutely.

- Bev, you began talking about diversity. We know we need that. We have better outcomes when we have a diverse workforce. Share your thoughts on that.

- Yeah. Well, you know, I've got so much in my mind and my heart about this that I will get to diversity, but I want to start with some topic that people cringe at, especially nurses, pay in terms of nurse educators, an acknowledgment that in the university systems and college programs, community colleges, other places, nursing is not valued the same way that other departments are, and yet, frequently, they're bringing in more money into those programs, into those universities than any other program.

And if not the most, they're right up there with the top in terms of the number of students, and they take biology, they take chemistry. I mean, they are like the material of the university and yet not acknowledged in the same way our physician colleagues or even the legal colleagues that we have, professional programs are.

So that's one issue that we've got to face. And I say cringe because nurses, we're so good. We're so angelic. We don't need money. But the truth is money makes a difference in terms of this whole thing. Secondly, there just aren't enough nurse educators of color. The diversity is not there.

I always say that some people are praying that that educator of color will turn up the next day because if that person doesn't, there's no one there. It's like I got one or I got two. We've got to work on that pipeline, and I don't know if people have some aversion to pipeline, but I still see it as something that runs through, that's prepared, that's leveled, that you don't wait till the last minute to say, "Do we have enough?"

And so we've got...and I think one of the things that we did...I used to be Dean of Nursing at North Carolina A&T State University. For 10 years, I suffered. And I was told that we can't go into the community and talk to the high schools because the principals will not let us in.

And so, of course, anytime I get a challenge like that, I went to the principal. They'll say, "Oh, sure, come on in." We need to investigate and get into our communities. We got into the schools, into the high schools, we talked to the students. We found that the key person in terms of getting that diversity issue there, it was the counselors. They are the ones who take those bright students who are taking biology and chemistry, and they say, "Oh, darling, no, you're too bright. You don't want to go into nursing. You need to go this way and that way."

We have got to feed those people and help them to understand that nursing is the program they need to go in. It is the go card to your profession and a lifetime of learning and opportunity. So we went in and crashed those courses. Those wonderful counselors, we got them breakfast every morning. They started bringing students to us.

We have got to understand...I said, it's not just a nursing problem. We've got to involve our communities in solving this. And they're ready to. They know the difference when I take my family member to the hospital and there's just not enough. Nobody comes in because the nurses that do come in look like you want to say, "Please, go get some rest." So we've got to make sure that we are joining together, nurse to nurse, all the different groups, practice, education, and regulation, to face this issue and to make sure that we bring in more nurses of color but more nurses also and more nurse educators to prepare those nurses for practice.

- Thank you very much for that. And one thing I want to talk about is our data from NCSBN's workforce does show that the LPN workforce is far more diverse and far more mimics the overall population of the U.S.

as opposed to the RN workforce. So that seems to me that we need more of a pipeline to get those nurses that are LPNs into the RN workforce and keep advancing careers of nurses.

- I just want to mention that we had a program called LPN to BSN 20 years ago, and it was about getting LPNs to the baccalaureate. And we were funded for that program at A&T, $6 million to do that. It was a nine-year program.

We got a lot of nurses that way. That's not an outdated idea.

- Thank you. Well, I want to turn to some other statistics. We have not only issues with experienced nurses, as I said, but 24% of RNs say they plan on leaving the profession in the next 5 years. They have less than 10 years of experience.

They're our future. In that study, one of the main reasons younger nurses are stressed is because they feel ill-prepared to enter the workforce. Clearly, we need to address the needs of this group. So, Eileen, I'm going to begin with you. Talk about how educators...

And, Karen, I want you also to talk about the need for transition to practice. But, Eileen.

- Yes, thank you so much, Maryann. I think one of the things that we're really focusing on at the education level is really ensuring that we're graduating practice-ready nurses. So, at the University of San Francisco right now, we're revising our nursing curriculum, and we're doing this in conjunction with our clinical agencies in our region to really make sure that what we're teaching in the classroom reflects the needs of health systems today.

You know, health care and the work of health systems evolves so quickly, and academia doesn't quite move that fast. And so we're really trying to make sure that what we're teaching in the classroom really prepares the students. And that goes back to that clinical placement issue, really working with our clinical agencies to find innovative ways to involve their staff nurses in the education of our students, again, making sure that what the students are learning is preparing them for their work when they do graduate.

I think one of the other things that we're also incorporating at USF is really thinking about the whole person. So it's not just about making sure that they're studying and memorizing what it means to take care of a patient, but they're also learning ways to take care of themselves.

So we're trying to integrate from day one things that they can do to ensure that they're going to be able to sustain their own mental health, their own physical health, to prioritize themselves. Because if they don't prioritize themselves, they are not going to be able to have a long career in nursing, and they're not going to be able to give their best to the patients.

So those are just a few of the areas that we're working on, recognizing that we need to ensure that we can get nurses over that hump, you know, sort of that transition, and that they can realize that nursing can be a very, you know, great career for them. There's many options.

You don't just have to work in one area. You can change throughout your career to be able to find, you know, something, a new challenge, or if you're sort of burned out in one area, you move on to a new area. And so we want to make sure that we keep them long enough so that they can learn that those are options.

- Karen?

- You know, having spent 20 years in academia, I always say that it's not so much that I don't believe our graduates are prepared for practice. It's the transition. I've always said that they have had a safety net their entire time in nursing school. They have faculty members.

They have nursing preceptors in the hospitals and in the clinical areas where they are. They have experts all throughout the hospital that can be there for them. When they transition and if they don't have a transition to practice program at the institutions, and our larger institutions have those, although they lost them during COVID, I mean, you just couldn't support all of that, they're coming back.

But our smaller hospitals, our rural hospitals, do not have that. And it's our nurses or new nurses that are going to those areas that feel like they don't have that safety net. They don't have people to call on. They're working the 7p to 7a shift. There's not as many experts around. There's not as many people to call on.

And so, I think, it's not that I don't think that they're academically prepared well, and I will just say that, having looked at the second and third quarters of the next generation NCLEX that was launched April 1st, we had eight schools on probation for not meeting our 80% mark. We now have nine schools for the third quarter, all of which were in those eight that had 100% pass rate on the next generation NCLEX, and 29 of our 31 schools all met the 80% benchmark and they're doing really well on that test.

And that's just one test. I don't believe in teaching to test. I just believe that we've got to have a better way to try to transition them and match them up with experienced nurses. And we've got some of those programs going on. Ochsner has a wonderful program for students. And you know, one of the questions you asked me was about, do I think some of our rules are antiquated?

Well, absolutely, I do. Too rigid, outdated, and one of those was we were treating student nurses who have demonstrated competencies the same way we treat every other unlicensed assistant personnel in Louisiana. And I said, you know, there's no reason why these people can't work as nurse techs using the competencies that they have already demonstrated, that, you know, at every semester, they have validated competencies from their faculty, and we can use them to create dyads with experienced nurses to be able to take care of more patients and do a better job in terms of staffing hospitals.

Not only does it help them to get more experience, they get to be paid for that during those processes. And so, you know, Ochsner has it. Our Lady of the Lake has it. We have many programs now starting those kind of paid programs, including LPN to RN programs that want to pay our LPNs while they're doing their student clinicals as LPNs in their institutions where they work as nurses.

- That's great. Eileen?

- Yes. I was just going to mention, I think, again, this is another area that we need to look at the well-being of the existing workforce. Because, again, when students move into the practice setting, again, they're going to be working with colleagues and preceptors, and if those individuals are not at their best health mentally and physically, they are not going to have the ability to support the newer nurse.

And so that's where you start to hear stories of bullying and accelerated burnout among our new nurses, is because they're not coming into a supportive environment because the current situation doesn't support the current workforce.

- And it shows how each of these issues are all interconnected.

- They are. Lavonia, what's going on at MD Anderson with your new graduates?

- So we are, and we've heard the feedback as far as entry and taking care of our existing workforce. We do have year-long residencies but also, then, looking at how long do we go beyond that. To be honest with you, we all need a form of safety net as we move through our careers, because we make transitions, we take new jobs, and we all need that backup and safety net.

So why not build that in for experienced nurses as well? Because if I, as an experienced nurse, feel that safety net, I'm going to generously share that with you. And so we do, we are looking to expand our residency. How do we support beyond that year? One of our work streams around nursing transformation is dealing with encouraging the heart. And what does that mean?

It means allowing people to feel like they belong, they have a place here, they're welcome to this team. They do come out of school practice-ready. Absolutely, they do. However, we need to then create that safety net where they feel welcomed onto the team so that they can then continue to grow in practice. And that's some of the work streams that we are working on not just training and education, not just through professional development, but looking at nurses across their career and what they need.

- Karen.

- I just want to build on that for just a second, because we were talking about technology and the use of technology and virtual nursing and how that can help. And again, Ochsner, really, in our state, has taken the lead because they are the biggest employer of nurses. And they now are using that. They have a thing called iPad on a stick. But I'm thinking that all of those new nurses, as they transition, if they had a virtual nurse that they could always call on, take their little iPad into the room, answer the questions, help them assess, just be there, a real experienced nurse that's been in the trenches for a while, has all of those good skills, and that's with them all the time that they can call on 24/7.

And I just think that's a use of technology and, you know, coming AI, I don't know if anybody wants to talk about AI. But virtual nursing, you know, when I first heard about it, I thought, "Oh, this is not a good idea." But now I think it's a really good idea.

- And it's for the nurse that wants to work from home that has to work.

- That's what I think I'm going to do when I retire.

- And I couldn't agree with you more. And one of the things that we are building in and we're working toward with our virtual nurse program is exactly that, where we can have that experienced nurse. And I'm telling you, the experienced nurses on the other side of that camera are so excited to be a part of the onboarding and the ongoing support. One thing we have found is, with the busy workday, nurses feel very rushed in everything that they do.

And so having that person to back them up, that they, in their mind, is like, "Okay, I'm not taking you away from another patient," has really been well received. We're actually starting it at MD Anderson with the admission process because, since the virtual nurses are doing everything with the hands-on assessment, for admission, you know, the new nurses that are onboarding aren't learning that.

So we're going to be partnering so that we teach them across that screen and they can participate with us for that piece of it. So we're hoping to grow that expert advice piece, but virtual nursing absolutely does have a place in our future to maintain the health and wellness of our existing workforce, create new career paths for nurses, create opportunities for nurses who need to work modified work schedules.

There's lots of opportunities around it.

- Bev, did you?

- Yeah. Listening to my colleagues, a thought came to me that it's really operationalizing Pat Benner's "Novice to Expert," that the virtual nursing can do that. So you have your expert there with your novice in a different way. And I think that taking existing theories and applying, that's the kind of problem-solving we're going to need to do.

The other thought that came to my mind is that there's concentrated effort on the clinical setting about making sure that the culture there is supportive of growth not just for new nurses but for those who are already there. I'm not sure there's that concentration of effort on university faculties and community college faculties, that there's that effort to make sure that it is a welcoming, warm, cuddly environment there for faculty.

There's the assumption that these are grownups and they should know how to behave. And that just doesn't prove to be true all the time. There is a need to focus on, and I know our dean at UCSF is thinking about this, to focus on, how does that faculty work together?

How does the faculty treat students? Does the faculty actually have biases? Oh, my goodness, they're a human. That's right, they do. So it's that concentration about the problem-solving can't be done just at one part of the system. It's going to take multiple fingers into all aspects of the system for us to get to where we need to go, to retain our nurses, to improve how faculty and educators are teaching, and that you cannot just be a great clinician and become a great teacher.

There are some that are unusual and like that, but usually, you have to learn how to teach. It's just helpful. And there is a science to nursing education, and our students deserve that science. They deserve educators who are prepared to teach and to care.

- Absolutely. I do have to ask this question about staffing ratios. This is a huge controversial subject right now. Patients hospitalized in California, the only state that has enacted safe staffing legislation, say they get two to three more hours of RN care per day than patients in other states.

Is this a solution for our workforce? Lavonia, do you have staffing ratios at MD Anderson?

- We do have staffing ratios at MD Anderson. However, we also have leaders who are empowered to make decisions about staffing based on their patient need. Our patient population is complex. We are the largest research facility. We do a great deal of phase I trials, and no two patients are the same.

So, in addition to have the ratios that you have to build to develop a budget, which we all have to do, we also, at MD Anderson, afford our leaders and our frontline teams the ability to staff based on what the patients need.

- Eileen, you're from California. What do you see?

- You know, I think staffing ratios do make a difference, obviously, and the data shows that. But I do agree with Lavonia that it really does need to be in the hands of the nurse leaders, you know, that can assess the patients on a minute-by-minute basis to be able to ensure that staffing is meeting the needs at that particular time.

I think the challenge with staffing ratios is that, you know, it's a double-edged sword. You can say that we're going to provide you with this ratio, but is that all that we're going to provide instead of allowing that flex that needs to be considered throughout a shift? So I think, as long as it still remains in the hands of those who are caring for the patients, that final decision needs to rest there.

- Karen or Bev, any thoughts?

- Yeah. Staffing ratios, I think there needs to be some level of assurance that patients are getting care, right, the numbers that are needed. But I, and like my colleagues here, believe that leadership should be providing that guidance. And the thing that I heard Lavonia saying was that it's at MD Anderson that they have their staffing ratios. It's not some state legislature that has made a decision about, boom, "For all of you, this is going to be it, colleagues."

And that's pretty far away from the clinical area to be making that decision. So I'm thinking that there's a place for them, but it's not just the only thing, that it has to be within the context of the system you're working in, and it has to be with the leadership of those who are providing and saying on a day-to-day basis, "Hey, this is an emergency. We need more than anything you can tell."

But, no, the state or the federal system says, "We only need this much. So you're only going to get this much." To me, that endangers the patient, and it is all about quality patient care, that we start there. And I know that those who are proponents of staff ratios are saying it's about quality patient care. But I'm thinking that we still need the leadership of on-site people who are making decisions on a day-to-day basis about, what is the situation here?

So if you're going to put them in, have your escape clause in there somewhere that says that it really is up to those who are monitoring the day-to-day situation that goes on.

- Well, what I would add is, spending a lot of my time in front of legislative committees, giving testimony to legislators, the last people on earth I want doing staffing ratios for nurses is legislators. So I absolutely agree with my colleagues, and I just go back to what I said, you know, the patients we see in hospitals are not the patients I saw in hospitals 49 years ago when I graduated.

These are sicker, older patients with so many comorbid conditions. And you could have five patients, all with the same diagnoses and maybe the same comorbidities, and they're all different. And you've got to be able to do that staffing and develop that based on the needs of your patient population in your hospital and your setting, and I want nursing in control of that.

- And if I could add to that, it's not just the patients. The patients are number one, but we also have to...we talk about our new workforce. When you have a complexion of a shift that has newer nurses, you may need more. You may need more for a whole lot of reasons, but when we speak about supporting our newer workforce, that is one thing we need to take into consideration.

The numbers are just the numbers. Nursing is a profession. It's not about numbers, and that's where we need to get ourselves to.

- Great, thank you. Well, I want to open now the questions up to the audience to see if you all have any questions for our panelists.

- [Brendan] Good morning. First of all, I'd just like to preface this all with this is a wonderful conversation.

I've taken a lot away from this, and so I think I love being here. My name is Brendan Martin. I'm in the research department at NCSBN. And one of the things, when you were discussing transition to practice and residency programs, one of the things that you mentioned about MD Anderson, in particular, is that you had a focus on new graduates who were perhaps trained in kind of a pre-licensure setting during the COVID-19 pandemic.

And it seemed as though you kind of set that apart as kind of an extra set of training or an extra set of attention. And I was hoping maybe any of the panelists but maybe beginning with MD Anderson, if you could extrapolate on that a little bit as to what was maybe lost or what maybe wasn't on par with kind of pre-pandemic training for those graduates, in particular, you know, when some of those clinical site restrictions were in place, when programs were often relying on things like virtual clinical simulation at higher rates or higher rates of simulation-based education.

- So let me clarify. I must have created some confusion. Our residency program was in place before the pandemic, and we have continued it, albeit making some changes based on what our nurses that were hired during the pandemic and post-pandemic have given us as what we need to do.

What we focused on with our leadership training is we launched our Leadership Institute, and we focused first on those new leaders that are within three years of being hired, because they were hired during the pandemic, during a time when we didn't have some of the same things in place for obvious reasons. And so now we want to ensure that we give them the skills they need in order to lead, manage. And then we moved to some of them more experienced who may need to improve their skillsets.

So hopefully, I clarified.

- Anyone else with a question?

- Yeah. Let me just say, Brendan, we did have issues. You know, I'm always really glad that my post-doc was an MBA, because when they started talking about supply chain issues, I actually knew what they were talking about. And you know, we had our students literally not allowed to come into clinical at the beginning of the pandemic, and so, all of a sudden, we transitioned didactic onto computers, and that was okay.

We could do the theory, but in terms of clinical, relying on simulation, they weren't allowed in clinical. I mean, the hospitals didn't know. It was a pandemic, and we were flying by the seat of our pants at the beginning. And so we did have people graduate that didn't have as many of the clinical skills, so they did need more help. And so that's one of the reasons why that happened early on in the pandemic.

- I think one of the things that was most missing is that, you know, nursing education is the theory and is the practice, but more importantly, the two of them have to be learned concurrently and practiced concurrently. And the learner needs to be able to respond and react to changes.

While we can use simulation, we can't simulate every single kind of interaction that they might have had throughout their nursing education that really helps prepare them to be competent practitioners when they graduate. And so, you know, you could think of it as time or a volume, but that's really those experiences were missing for those students.

And that's what we're seeing, you know, in terms of them coming out and needing that extra support.

- Yeah. Just wanted to mention that there is going to have to be an exploration and determination of new clinical placements, new places that we have not considered sending our students or only a few people consider, a few schools consider sending their students. So there's a whole prison health system that has not been used to any great degree.

There are some schools that are starting to do that, but we're going to have to think out of the box about clinical placements. Even if everybody opened their door to us, we still don't have enough, with competition from other provider groups that are needed. So it's going to be a revolutionary kind of thing that nursing is going to have to give some strong consideration too about innovative new places of clinical learning.

And I do want to put a plug-in for clinical nurse specialists who were, in my day, they were the expert on the units who provided assistance to the staff in figuring out the culture of the area and the expert nature of it. I'm a psych nurse, so mine was just to go around and knock on people's heads and say, "Are you all there today?"

But there are other types that are just incredibly helpful and useful. Wound care, I mean, amazing. Everybody gets bed sores if you stay in bed long enough. But just different types of experts, as clinical nurse specialists, to assist the units, to assist the staff, so...

- I was just going to say, I think, to Bev's point about finding other opportunities, we also need to recognize that education and clinical practice does not just occur in the hospital setting. I think we often default to that, but so much is happening out in the community now. And so, at the University of San Francisco, we're really partnering with other agencies to put our learners out in places like with the farm workers up in the Central Valley and in, you know, other types of community settings, because that's really where health is being developed and where care is being delivered.

- Thank you. Any more questions?

- [Amy] Hello. I'm Amy Lippert. I'm also at NCSBN as an education outreach associate with ICRS or Center for Regulatory Scholarship. I wanted to echo my colleague Brendan's comments to thank all of you for a really illuminating morning. And I guess I just wanted to follow up on the second half of the core issues that you identified, Bev. We've talked about clinical placement now, and I wanted to follow up on the nurse educator aspect of this, with all of you really.

So I'm wondering, you know, if insufficient pay or valuation, in a larger sense, is a central issue in attracting and retaining quality nurse educators, then who and how might we effectively lobby in order to rectify that problem?

It sounds like you're pointing towards university administrators, for instance, who seem to value colleagues in the medical school or the law school differently than the school of nursing. So that might be a good place to start. I'm just thinking in terms of the nursing profession as a whole, regulators,

nurses themselves. If an educator or a potential educator can get better pay in clinical practice, then are we falling on an appeal to their good graces to do this anyway?

Or how can we go about rectifying that?

- Well, you know, there are educator colleagues that say that their students graduate, and in three years, they're making more than they do, or in two years, and they know they're novices still, you know. And it's very discouraging for those faculty to be turning out students in that way. Many educators have just this gift for teaching and love for it.

I mean, there's passion and commitment involved, but you still have to put food on the table. You still have to make things happen. So pay is something okay to talk about, and I have to help...sometimes I have to help nurses help with that because we're very not self-serving on that. It's the physicians that are money grabbers, nurses are just angels. And so we have to work on that because we deserve to be rewarded and awarded for what we do as nurse educators.

So I'm thinking of things like joint positions help a lot between universities and schools of nursing, and that goes back to my colleagues mentioning about clinical and academe working together. I think things can be figured out like that.

I believe there should be partnerships between corporations in your community and schools of nursing about faculty and pay that they need to bring the kind of staff they need, and they need a good healthcare system. And without enough nurses, they're not going to have a good health. So you have to take it to your...sit down and have some conversations with some of those CEOs about the healthcare of their employees and how they could even feel better about some of the things they do, that is called business, but they need a clean mental state about it.

So help them spend their money wisely on nurse educators. But we need to look at a number of ways. First, we have to acknowledge that this is an issue. And like I said, we have a hard time saying it out loud, "I charge." Work your mouth, "I charge." So nurses have to get over that.

We have to start standing up for ourselves and standing up for each other and saying, "I deserve this." Educators are far behind even our nurses in doing that. And deans are just trying to make everything survive and get to the next level, and they got the provost and the president and colleagues in other areas who are being treated very differently than the nursing programs. So we have to provide some support from the outside for our deans of nursing too.

It's not always just deans supporting staff. It's staff supporting deans, supporting the leadership also. It goes both ways.

- So let me just say really quick before Eileen finishes off. One of the benefits of working for a women's university led by a chancellor, a provost, and provosts that were fantastically strong women at Texas Woman's University was differential. We solved the problem for faculty pay through differential tuition. Now, I'm told in Louisiana that that's never going to happen.

You know, every time I bring it up at the legislature, they just look at me and say, "Yeah, that's not going to happen." Yeah, I said, "Well, yeah, since you told me about the compact, you know, we got that done in six months." So I don't believe anything they... They're men, I'm a woman. I just get things done.

- Go on, girl.

- But differential tuition, $25 for every NURS course at Texas Woman's University allowed us to meet and exceed the median for CCNE, you know, when they put out their salary booklet for all the different types of nursing programs. And in a university that, again, and that's what... It's a big issue, is that we're not paid as much as they can make in practice.

But we solved that and made it much easier to attract younger faculty and to keep them in. So I just wish everybody had introduced differential tuition.

- That sounds great.

- It's a very complex issue. You know, higher ed is under a lot of strain these days. And nursing education, sort of, if you have a Venn diagram, and you've got health care and you've got higher education, nursing education sits right smack in the middle there. So I absolutely agree with my colleagues. But I do think we need to recognize that nursing is a bit of an outlier on an academic environment.

The kinds of faculty that I have are faculty that need to be in the classroom and out in the clinical setting, maintaining their skills. In fact, it's a requirement in California. And so it's very different than what might be expected of an English professor or a chemistry professor, but those are very challenging arguments to make within the hierarchy of an academic environment because, you know, we're one school among many.

And so, you know, there's competing pressures. So while we should absolutely continue to move in that direction, I think we can't just wait around for that. We have to be exploring, like Bev said, academic practice partnerships, thinking about other ways to provide opportunities for faculty to have time dedicated during the week that allow them to go ahead and work clinically if they so choose and, you know, not have that be penalized against them in terms of some of their other workload within the university setting.

There's also opportunities to work with clinical agencies, and this actually has benefits of giving individuals who are burned out other opportunities where they can take a break from the clinical setting, be an instructor for a while or maybe one day a week. So there's a couple of different ideas that we should be working at while we're working on the pay equity issue as well.

- So I want to end with each of you giving one final thought. If there is one thing you want our audience to remember, what would you like it to be? Lavonia?

- I want us all to remember that the nurse comes to work as a whole person and that whatever we put in place needs to address her or him as a whole professional person.

- Bev?

- The goal in nursing is to make a difference in the world. It has a lot to do with healing and caring, and caring, the definition is promoting excellence. That's excellence, itself, in nursing education and building a strong and diverse nursing workforce.

Caring is about that, and it's about making sure that we respond to the human condition in an appropriate way. So I'm so passionate about nursing and so honored to be a nurse.

- Thank you. Karen?

- You know, the one thing that I love about my profession is that it has given me the opportunity to do so many different things and an almost 50-year career. And I love being in academia. I love being in practice. I love being an APRN-CNS. Thank you so much for that. And I came to regulation at the end.

I guess what I want people to know is we're not just about licensure and discipline. We're about working with our colleagues in practice and academia to make health care and the health care that we provide in this country and around the world good and to make the world a better place.

- That's right.

- Eileen?

- I would say it takes a village to raise a new nurse. It takes practice, education, regulation, our clinical partners, you know, all working together, our communities, to invest in their education so that they can go out and serve the public in a safe and competent manner while not sacrificing their own well-being.

- Well, I want to extend my heartfelt thanks to all of you for this enlightening and inspiring discussion. We certainly hope that all of you that have been listening have been taking to heart the many suggestions and ideas that have been addressed here and that a lot of it will become practice in institutions around the country.

Thank you.