April 20, 2017 RN Labor Market Webinar Questions and Answers

Q: Thinking that RNs are members of middle-class families which may have suffered reduced GENERAL employment opportunities due to globalization and automation and RN work isn't vulnerable to globalization/automation, might this be a factor that increases the likelihood that experienced RNs will remain in the labor market (which of course would be a barrier for new graduates). This sort of is an updated version of the usual pattern that in recessions RNs either don't retire or reenter the labor market to help keep their families afloat. Please comment.

> A: During the recession period, incumbent RNs definitely delayed retirements and some increased their working hours to compensate for lost retirement savings and spouse/partner job losses. This definitely contributed to new graduate RNs having a hard time finding work. There also has been a 20-year trend toward older retirement ages among RNs (https://www.ncbi.nlm.nih.gov/pubmed/25031246), which is likely to continue. Data suggest that near-retirement RNs often move to non-acute settings, which may open up acute jobs for new graduates, but as the older RNs retire then non-acute settings will also have a great need for RNs.

Q: What about the Obamacare repeal? Do you know if this will negatively affect demand for nurses. (Pence has indicated he wants to bring the AHCA to the forefront).

> A: As mentioned during the webinar, two studies have found the potential for significant health care job losses. These studies didn't separate out RN jobs, but since we know RN jobs grew in part due to the ACA, we know they also would decline.
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> The Berkeley Labor Center report: http://laborcenter.berkeley.edu/californias-projected-economic-losses-under-aca-repeal/
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> Commonwealth Fund / George Washington University report: http://www.commonwealthfund.org/publications/issue-briefs/2017/jan/repealing-federal-health-reform

Q: Given the large number of BSN graduates from foreign schools, do many of these participants research education equivalency?

> A: I'm not aware of the degree to which employers or RNs research education equivalency for graduates of foreign schools of nursing. There is an organization in the United States that was established in 1975 specifically to address issues associated with foreign educated nurses, COGFNS International. Their website is www.cgfns.org. One of the services they provide is education equivalency verification.

Q: One of the first slides indicated 104 facilities were represented, but I thought the first speaker said 114 facilities were represented. Please clarify.

A: It is 104 facilities.

Q: Where do RNs returning to the workforce fit into this discussion? Nurses that are not new graduates and who often come with years of experience but have been out of the profession for 5+ years? Are they employable by completing nurse refresher programs?

A: Most employers will require a refresher program prior to employing a nurse who has been out of the workforce for a period of time. In some cases, if the employer offers a transition to practice/residency program, they will use that program as a refresher opportunity for returning nurses. Once the programs are completed, these nurses are employable and their experience is seen as valuable.

Q: Does your data indicate the difference between percentage of employers who prefer versus require a BSN? There could be a big difference between preferring and requiring. Does your data indicate if preference/requirement for BSN vary by care delivery.

A: In the Fall 2016 CNO survey, 53.8% said a BSN is preferred, and only 3.8% said it is required.

Q: Are there programs to share RNs nearing retirement with academic programs (exit transition) to provide mentoring both of students and entry transition residencies?

A: I'm not aware of formal programs, but this is a great idea.

Q: Is there any movement in formalizing and defining what is meant by a "residency"? That's a huge difference between 1 month in length compared to 1 year.

A: Yes – The California Action Coalition has had a group working on establishing a common set of definitions for use in California residencies, and those definitions will be posted on the HealthImpact website very soon. Check back in a month on www.healthimpact.org.

Q: What information do you have on surrounding states? Is California training new grads and then losing them or experiences nurses to surrounding states?

A: We will have more information about this when we release the report on the 2016 Survey of RNs.

Q: Has anyone suggested making RN preparation an apprenticeable occupation a-la the German "dual" model where hands-on learning and academic learning are systematically coordinated and provided simultaneously while apprentices work in paid jobs?

A: RN preparation was primarily in hospital-based diploma programs, which had some characteristics of apprenticeships. Nearly all of these programs transitioned to Associate Degree programs due to the increasingly technical/academic nature of RN work. The history of nursing education transitioning from hospitals to colleges is an interesting one, and goes back to some important reports in the first part of the last century. The Goldmark Report (1923) emphasized that the training needs of students and service needs of hospitals were incongruent. She wrote that when "the needs of the sick must predominate; the needs of education must yield." Similarly, May Ayres Burgess published a report in 1928 (Burgess Report) that argued that within the apprenticeship model, students' patient assignments were based on the hospital's needs rather than on the educational needs of students. There have been numerous reports over the years since regarding nursing education, and most reflect the current view that nursing education is best accomplished through an academic vehicle coupled with strong collaborative partnerships with clinical practice settings.

Q: Do you foresee the BSN becoming the minimum requirement for the RN?

A: The Institute of Medicine Committee on the Future of Nursing recommended that 80% of RNs have a bachelor's degree, but that this does not necessarily need to be the starting point for RN education. Many aspiring RNs cannot access BSN education without relocating, and have only an AD program available nearby. AD programs provide excellent education. The philosophy recommended by the Future of Nursing report is that all RNs should consider education a lifelong endeavor, and that AD nurses should view that initial education as a stepping stone toward continuing their education. The expansion of high-quality RN-to-BSN programs have supported such education, particularly in communities that do not have physical BSN programs nearby.

Q: My experience is that new grads can be progressed faster if the residency program is structured appropriately. Is there a way to ensure the structure of the best residency programs are shared and used?

A: There have been several articles published regarding transition to practice programs. Some of these articles can be accessed through HealthImpact's 2015 Annual Report, which can be found on the website, www.healthimpact.org. In addition, the California Action Coalition has compiled standards and guidelines associated with transition to practice/residency programs, that will soon be available on the HealthImpact website.

Q: While BSN programs have streamlined the RN - BSN tracks, the extended time-to-graduation in AD programs uses up financial aid and produces students with 100+ credit units as they enter the RN-BSN programs. What can be done to address this on-going problem?

A: AD programs typically take 3 years to complete, if one includes the prerequisite courses before a student can be admitted to the 2-year RN program. If a student needs to strengthen their basic education level in science, math, and English, a semester or two of community college education prior to taking prerequisites might also be needed. Indeed, pursuit of the AD can be quite an endeavor. Each student is in a unique position with respect to their skills upon starting post-secondary education, and thus there is not likely a one-size-fits-all solution to the challenge you describe. HealthImpact is the sponsor of a model referred to as the California Collaborative Model of Nursing Education (CCMNE). This model is increasingly becoming available to AD students in CA, and significantly reduces the time/cost of attaining a BSN. Features of this model include co-enrollment in AD and BSN programs, shared faculty, a deliberate way of sustaining the program, and attainment of the BSN within one year of AD graduation. In 2016, there were 1,000 newly enrolled students in these programs across the state in 20 universities working in partnership with 66 community colleges.

Q: The RN salary is not the biggest cost in healthcare; in other countries, administrative costs are MUCH lower (as well as MD costs).

A: Administrative costs are much lower in other countries, indeed. The Commonwealth Fund published an excellent report comparison health systems and the US does not fare well in terms of administrative costs (as well as many other factors). Page 23 of their report has the administrative costs at 7.1% in the US: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

The Institute of Medicine has estimated that administration costs amount to $361 billion (about 11-12%). They obtained a higher percentage than Commonwealth Fund because they tried to measure the administrative time that physicians and other health professionals spend, in addition to the other obvious administration categories such as coding and billing. http://www.nejm.org/doi/full/10.1056/NEJMp1209711#t=article

Let's compare this to spending on physicians and nurses.

There are about 810,000 physicians providing patient care in the US. (https://www.statista.com/topics/1244/physicians/) Average physician salaries were $196,520 in 2015 (http://money.usnews.com/careers/best-jobs/physician/salary). This totals about $160 billion. Spending on physicians is definitely a lot lower than spending on administration. In other countries, physician salaries are lower than in the US. This is in part because a larger share of physicians in the US are specialists, while a larger share are in primary care in most other countries. In addition, medical education is free or

heavily subsidized in other countries, so physicians do not graduate with much debt, while medical school in the U.S. is extremely expensive and physicians graduate with much debt. These types of differences make it hard to compare salaries directly, since when taxpayers subsidize the education, salaries can be lower and offer the same overall standard of living/wealth with smaller loans to repay.

There are about 3.1 million RN jobs in the US (http://www.truthaboutnursing.org/faq/rn_facts.html). Average RN salaries were $67,490 in 2015 (http://money.usnews.com/careers/best-jobs/registered-nurse/salary). This totals about $210 billion. Spending on RNs is larger than spending on physicians, but still lower than spending on administration.

National Health Expenditures in 2015 were $3.2 trillion (https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html).

Thus, RNs account for about 6.6% of national health care spending. Physicians are about 5%, and administration is somewhere between 7.1% and 12%.

Q: Any statistics of RN Case Mgrs shortage for Managed Care industry companies such as: Health Net, Molina Health Net, United Group, Anthem, etc?

A: No, this survey is completed by hospital CNOs only.

Q: Are there any surveys or studies related to retention?

A: In the future, HASC will be adding survey questions about retention rates. For more research on the factors that support retention, we suggest you look at http://scholar.google.com and search "registered nurse retention".

Q: Can we use this data to present to the BRN if we are requesting program expansion?

A: Yes.

Q: In the future will you have NP info?

A: Yes. We are finishing a survey of NPs for the Board of Registered Nursing now. The report will be published later in 2017. In addition, UCSF colleague Janet Coffman is leading a study on the primary care workforce in California. We will publish a report forecasting future supply of NPs, PAs, and primary care physicians within 1-2 months.

Q: Is there one or two major trends that stand out for this year as compared to last year's survey results? As compared to last year's results, there doesn't seem to be big changes.

A: We agree. The big change happened between 2014-2015. The fall 2016 data are very similar to 2015.

Q: Where does the funding come from for interships for new grads that are not being hired by that facility.

A: Most of the funding to date has come from grants. In a small number of instances, program participants have paid tuition themselves to participate in the program.

Q: Any BRN changes in Simulation allowances to help increase educational capacity?

A: The BRN is interested in exploring the potential to adjust their requirements to best leverage simulation and ensure high-quality education.

Q: Do any of the participants track the success rate of their TTPs after 1, 2, or 5 years?

A: We currently do not have these data.