

**Michigan Department of Community Health
Task Force on Nursing Regulation**

Final Report

February 2008

MDCH - Task Force on Nursing Regulation

List of Members¹

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Linda Taft
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Organizations

Genesys Health System
 Michigan Board of Nursing
 Three Rivers Health System

Voting Members

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Organizations

Coalition of Michigan Organizations of Nursing
 Hospice of Michigan
 MALPH – Nurse Administrators Forum
 Michigan Association of Colleges of Nursing (MACN)
 Michigan Board of Nursing
 Education Committee Representative
 Michigan Board of Nursing
 Advanced Practice Nursing Representative
 Michigan Center for Nursing
 Michigan Chapter NADONA/LTC
 Michigan Council of Nursing Education Administrators
 (MCNEA)
 Michigan Health & Hospital Association
 Michigan Licensed Practical Nurses Association

 Michigan Nurses Association
 Michigan Organization of Nurse Executives
 Michigan Peer Review Organization
 Registered Nurses Association in Michigan (RN-AIM)
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The Honorable Kathy Angerer
The Honorable Tom George
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Organizations

Michigan Department of Community Health,
 Bureau of Health Professions
 Michigan Department of Community Health
 Health Policy, Regulation, and Professions
 Administration
 Michigan Department of Community Health
 Legislative Office
 Michigan Department of Community Health
 Office of the Chief Nurse Executive
 Michigan Department of Community Health
 Public Health Administration
 Michigan House of Representatives
 Michigan Senate
 Office of the Governor

¹ This list is arranged alphabetically by organization.

MDCH - Task Force on Nursing Regulation

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MDCH – Task Force on Nursing Regulation (TFNR)

Charge

Rationale

The health and safety of Michigan patients require that nursing standards and appropriate scope of nursing practice be strengthened and reflected in nursing education and regulation. *The Nursing Agenda for Michigan* includes action steps to strengthen the nursing profession through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. Michigan must maintain high quality care and increase respect for professional nurses while increasing the nursing workforce [See *The Nursing Agenda for Michigan*, 2006.]

Task Force on Nursing Regulation

- **Establish** a Task Force on Nursing Regulation (TFNR) composed of professional nurses, including representatives of Nursing education programs, professional nursing practice organizations, nurses with expertise in nurse credentialing, quality improvement, and regulation, plus representatives from the Michigan Board of Nursing and other stakeholders.
- **Charge** to the TFNR is to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education and nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan citizens.
- **Activities:** TFNR shall engage in appropriate information gathering; refer to national standards for nursing education, credentials, practice, and regulation; conduct deliberations; and promulgate recommendations to address the issues.
 1. Review and recommend improvements to nursing education programs and practice standards with emphasis on high-quality patient-centered care, evidence-based care, preventive care and national models, including national accreditation of nursing programs, unified curricula, and student/faculty ratios; recommend related changes in uniform nursing credentials.
 2. Identify changes needed in the Public Health Code and related rules and regulations, plus nursing standards, nursing education, and nursing credentials, to implement the recommendations made. Recommend these changes to appropriate entities in State Government; and support the realization and implementation of the recommended changes.
 3. Recommend the implementation mechanisms to ensure continuing five-year review of the recommendations made and the corresponding changes to the Public Health Code and related rules and regulations; and support the realization and implementation of such mechanisms.
 4. Recommend education of employers, nurses, other health professionals and the public on regulatory changes in nursing education, credentials, and standards.
 5. Recommend provision of appropriate education content on nursing education, credentials, practice, and standards for student nurses, faculty, practicing nurses, and nurse-executives.

TFNR History and Process

TFNR History

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TFNR was composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders (see list on page 2). TFNR members representing government entities provided expertise and background information to the task force, and participated in discussions.

The TFNR met from September 24 through December 7, 2007, and identified certain issues as high priority and amenable to solution. These issues have been developed into Nursing Regulatory Position Papers (NRPP) for this report; five NRPPs are recommended to the Director of MDCH for action. The six remaining NRPPs are recommended for referral to a future task force on nursing education, which TFNR recommends be convened by the Director of MDCH.

TFNR Process

The Task Force had five meetings between September 24, 2007 and December 7, 2007. The TFNR members adopted rules for interaction and decision-making (see Attachment A), and committed to meeting participation in person or by phone. The members of the Task Force (see list on page 2) were guided by Co-Chairs Matthew Chambers, Norma Hagenow, and Linda Taft in identifying and discussing issues. As nursing regulatory issue summaries were developed, each member kept their constituency informed as to progress.

Using the 80/20 rule for adoption, the TFNR members prioritized issues, moving some forward for development as Nursing Regulatory Position Papers (NRPP), and shifting others to "parking lot" status, since they were issues with merit, but not appropriate for consideration by the TFNR. The issues developed as NRPPs were further categorized as 1) recommended to the Director of MDCH for action (five NRPPs) or 2) recommended to the Director of MDCH for referral to a later task force (six NRPPs).

An approval form and the final versions of all eleven NRPPs were sent to each voting member of TFNR; members representing government entities did not vote. After the NRPPs were reviewed by constituents, the TFNR voting members signed off on each NRPP. Some constituents and TFNR members made comments about specific NRPPs. These comments will be made available to future nursing task forces. Using the 80/20 rule, all eleven NRPPs were approved for recommendation (five for action and six for referral to a future nursing education task force) by February 1, 2008.

This section of the Final Report is followed by a Summary of Recommendations, in which the statement of recommendation for NRPPs 1.2 through 5.1 is shown. The complete text of all approved NRPPs is next, followed by Acknowledgements and Attachment A.

MDCH - Task Force on Nursing Regulation

Summary of Recommendations to the Director of MDCH

[1.2] It is recommended that the Public Health Code be changed to meet the current and future priorities and needs of the profession of nursing through increased flexibility in the utilization of the Nurse Professional Fund (NPF) and increased funding of the NPF.

[2.2] It is recommended that retired nurses who wish to practice nursing as volunteers should be encouraged to do so through the same Public Health Code provisions that encourage retired physicians to practice as volunteers – the Special Volunteer License and liability exemption.

[3.1] It is recommended that the Michigan Department of Community Health support a change in the Public Health Code and in the Michigan Board of Nursing (MBON) Administrative Rules that adds definitions for certain Advanced Practice Nursing (APN) specialties. These include Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP). The inclusion of definitions for these APN specialties will a) educate the public, health care employers, and health policy-makers with respect to these practitioners, and b) clarify the content and maintain the integrity of these APN specialties.

[4.1] It is recommended that the Governor and MDCH Director exempt MDCH-Bureau of Health Professions regulatory staff positions that are approved and that are supported by restricted funds (such as the Health Professions Regulatory Fund) from current and future hiring freezes.

[5.1] It is recommended that the Director of MDCH work with the Director of MDE to charge the Interagency Healthcare Workforce Coordinating Council (MDCH, MDE, MDLEG, and MDHS) with the task of effectively resolving the inconsistencies among the Public Health Code, the School Code, and MIOSHA Statutes that affect the provision of in-school healthcare for children. The relevant codes and administrative rules should be reconciled with the goal of improving the safety and quality of healthcare for children in schools.

[5.2-7.1] It is recommended that the Director of MDCH convene a Task Force on Nursing Education (TFNE) to make recommendations to the Director on the issues discussed in Nursing Regulatory Position Papers 5.2 through 7.1, plus such other nursing education issues as TFNE members identify as high priority and amenable to solution. It also is recommended that the TFNE be followed by the convening of a Task Force on Nursing Practice (TFNP) to make recommendations to the Director on the issue discussed in Nursing Regulatory Position Paper 5.2, plus such other nursing practice issues as TFNP members identify as high priority and amenable to solution.

MDCH- Task Force on Nursing Regulation

Nursing Regulatory Position Papers

Nursing Regulatory Position Papers (NRPP) recommended to the Director of MDCH for action:

NRPP 1.2
NRPP 2.2
NRPP 3.1
NRPP 4.1
NRPP 5.1

Nursing Regulatory Position Papers (NRPP) recommended to the Director of MDCH for referral to the Task Force on Nursing Education and/or the Task Force on Nursing Practice:

NRPP 5.2
NRPP 6.1
NRPP 6.2
NRPP 6.3
NRPP 6.4
NRPP 7.1

NRPP 1.2: Nurse Professional Fund – Utilization and Fee

Recommendation

It is recommended that the Public Health Code be changed to meet the current and future priorities and needs of the profession of nursing through increased flexibility in the utilization of the Nurse Professional Fund (NPF) and increased funding of the NPF.

The Michigan Department of Community Health (MDCH) - Task Force on Nursing Regulation recommends support of *The Nursing Agenda for Michigan*, the nursing strategic plan to address current and future needs, particularly those related to the nursing shortage expected to continue through 2030. Innovative efforts must be made to retain our nursing workforce, improve the working environment for nurses, and educate increasing numbers of new nurses. The Nurse Professional Fund (NPF) is an appropriate source of funding for piloting, evaluating, and leveraging such efforts, but Section 16315(9) of the Public Health Code strongly constrains utilization of the NPF. Flexibility in NPF utilization must be increased and the amount allocated to this fund from the annual nursing licensure fee must be increased to support needs. Michigan's nursing licensure fee is among the lowest in the country at \$24 per year. The average nursing licensure fee for other Great Lakes states is \$52 per year; California's fee is \$85 per year, and New York's fee is \$65 per year. The NPF currently is allocated \$2 of the \$24 annual licensure fee. Raising the annual licensure fee to \$32 and increasing the NPF annual allocation to \$10 will support the new focus of the NPF: – meeting current and future needs to advance the profession of nursing and assure a continuous future supply of high quality nurses for Michigan. Since nurses are the only contributors to the NPF (through license fees and voluntary contributions) it is appropriate that the Michigan Board of Nursing -- in consultation with the Office of the Chief Nurse Executive, the Michigan Center for Nursing, and other nursing stakeholder groups – annually advise the MDCH Director on priorities for allocation of NPF funds.

Approved by the MDCH - Task Force on Nursing Regulation, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TFNR was composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of adequate funding and a more flexible spending plan for the Nurse Professional Fund (NPF) as high priority and amenable to a straightforward solution. The priorities and needs of nurses and the nursing profession have changed since the NPF was established in 1989, and more utilization flexibility and more funding are needed.

Nursing Regulatory Issue

The Nurse Professional Fund (NPF) was created by statute in 1989 at the suggestion and with the support of the Michigan nursing community. The purpose of the NPF was to provide support for nursing scholarships, nursing continuing education, and research and development to advance the nursing profession. The NPF is established in the state treasury as a restricted fund. Two dollars of each annual nursing licensure fee is placed in this fund (\$4 of the \$48 two-year licensure fee for each nurse renewing). The priorities and needs of nurses and the nursing profession have changed over the past seventeen years and more utilization flexibility and funding are needed. Michigan now has a Nursing Strategic Plan (*The Nursing Agenda for Michigan*) that addresses current and future needs, particularly those related to the nursing shortage expected to continue through 2030. For example, innovative efforts must be made to retain our nursing workforce and improve the working environment for nurses. The NPF is an appropriate source of funding for piloting, evaluating, and leveraging such efforts, but the current statute strongly constrains utilization and funding. Michigan's nursing licensure fee is among the lowest in the country at \$24 per year, and only \$2 of that licensure fee is allocated to the NPF. The average nursing licensure fee for other Great Lakes states is \$52 per year; California's fee is \$85 per year, and New York's fee is \$65 per year.

Recommended Solution and Rationale for the Solution

- A. It is recommended that the Public Health Code language regarding the purposes and utilization of the Nurse Professional Fund be revised to allow greater flexibility in line with current and emerging needs of the nursing profession. Section 16315(9) of the Public Health Code should be changed to read (changes underlined): “The department of community health shall use the nurse professional fund (NPF) each fiscal year to support projects and initiatives that advance the profession of nursing (for example, special projects and activities of the Michigan Board of Nursing) and assure a continuous supply of high quality nurses for Michigan (for example, nursing education and workforce projects, data collection and evaluation with respect to nursing education and workforce strategies, leveraging of NPF resources through foundation grants and partnerships, Office of the Chief Nurse Executive, Michigan Center for Nursing, and targeted nursing scholarships). The Michigan State Board of Nursing shall consult with the Office of the Chief Nurse Executive, the Michigan Center for Nursing, and other nursing stakeholder groups and then annually advise the department as to priorities for allocation of NPF resources.”
- B. It is further recommended that the amount of the nursing licensure fee be increased by \$8/year (from \$24/yr to \$32/yr) and that the increase plus the current \$2/yr be allocated to the Nurse Professional Fund. The two-year licensure fee is to be raised from \$48 (\$24x2) to \$64 (\$32x2); the current \$4 (\$2x2) amount earmarked for the NPF would be maintained and \$16 (\$8x2) would be added, for a total of \$20 [(\$2x2)+(\$8x2)] allocated to the NPF for each 2-year nursing license renewed (see p. 192 of *Occupational Regulation Sections of the Michigan Public Health Code*, MDCH Bureau of Health Professions, 2007). Section 16315(6) of the Public Health Code should be changed to read (changes underlined): “The nurse professional fund is established in the state treasury. Of the money that is attributable to per-year license fees collected under section 16327, the state treasurer shall credit \$10.00 of each individual annual license fee collected to the nurse professional fund. The money in the nurse professional fund shall be expended only as provided in subsection (9).”

- C. It is further recommended that the MDCH Bureau of Health Professions change the nursing licensure renewal form to include an explanation of the Nurse Professional Fund, and a check-off box and amount line for nurses' voluntary gifts to the NPF.

The NPF contributions of Michigan nurses should be utilized in ways that reflect current and future needs, addressing the most important nursing issues of the time. The *Nursing Agenda for Michigan* is a blueprint that can help guide the best use of NPF funds. For example, the most pressing needs today are related to the education of more nursing faculty (addressed in the Governor's proposal for the Michigan Nursing Corps) and strategies to retain our current nursing workforce as well as new nurses entering practice. More general language for the purpose and utilization of the NPF will provide flexibility to address high priority nursing issues as needs and circumstances change (example: nursing scholarships are not currently a major issue, but retention of nursing students is a problem requiring innovative solutions). The amount currently earmarked for the NPF is \$2 per year per nurse. Raising the nursing licensure fee and the amount allocated to the NPF will provide the funding needed to significantly impact the issues that are important to nurses and to the health and safety of Michigan's people; for these same reasons, some nurses may wish to make voluntary gifts to the NPF. Since nurses are the only contributors to the NPF (through license fees and voluntary contributions) it is appropriate that the Michigan State Board of Nursing consult with the Office of the Chief Nurse Executive, the Michigan Center for Nursing, and other nursing stakeholder groups and then advise the Director of MDCH annually as to NPF allocation priorities.

Supporting References

RWJF News Digest: Nursing, 9-7-2007: *Challenge of Retaining Newly Licensed RNs; ...*"the 13 percent who left their positions within the first year cited poor management and stressful working conditions as the top reasons for their departure." (newsdigest@rwjf.org)

The Nursing Agenda for Michigan, Issue 1.1.1: Retention of new nurses requires that upper & mid-level nursing managers receive education in leadership, mentorship, and modern management skills.

The Nursing Agenda for Michigan, Issue 1.1.2: Nursing retention requires that new graduates receive worksite education and mentoring.

List of Nursing Licensure Charges, MDCH Bureau of Health Professions. 2007.

List of State Centers for Nursing Funded/Not Funded by License Fees, MDCH Bureau of Health Professions, 2007.

Nurse Professional Fund Fee Change: Coalition of Michigan Organizations of Nursing, 2006.

HB 4591 of 2007. Education; teachers; teacher certification fees; revise, and implement fees for teacher college review. Amends sections 1538 & 1539 of 1976 PA 451 (MCL 380.1538 & 380.1539) & adds section 1538a.

NRPP 2.2: Special Volunteer Nurses License

Recommendation

It is recommended that retired nurses who wish to practice nursing as volunteers should be encouraged to do so through the same Public Health Code provisions that encourage retired physicians to practice as volunteers – the Special Volunteer License and liability exemption.

Michigan and the nation are facing a nursing shortage expected to continue through 2030. Many nurses of retirement age are interested in continuing to practice as a volunteer. Such volunteer nursing services could ease the nursing shortage in underserved areas, and provide nursing care to indigent populations. At present, there is no provision in the Public Health Code for a Special Volunteer License for nurses. Sections 333.16184 and 16185 should include language adding nurses and nursing to the provisions that encourage other health professions to practice as volunteers – these provisions include the Special Volunteer License and a limited exemption from liability during the practice of their profession under a Special Volunteer License.

Approved by the MDCH – Task Force on Nursing Regulation, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TRNR was composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of provision of a Special Volunteer License opportunity for retired nurses high priority and amenable to a straightforward solution. The nursing shortage means that the services of all nurses willing to practice nursing are needed, and that retired nurses should be encouraged to volunteer.

Nursing Regulatory Issue

Section 333.16184 of the Public Health Code deals with the definition of eligibility and requirements for the Special Volunteer License available to those retired from the active practice of medicine, osteopathic medicine and surgery, podiatric medicine and surgery, or dentistry. Nursing should be added to this list of health care professions.

Section 333.16185 of the PHC deals with liability for care provided under a Special Volunteer License, and the conditions under which liability exemption applies. Nurses and nursing should be added to the health care professions provided with a limited exemption from liability during the practice of their profession under a Special Volunteer License.

Recommended Solution and Rationale for the Solution

It is recommended that nursing be added to the list of health care professions in Section 333.16184 (1) (changes underlined):

“An individual who is retired from the active practice of medicine, osteopathic medicine and surgery, podiatric medicine and surgery, dentistry, or nursing and who wishes to donate his or her expertise for the medical, dental or nursing care and treatment of indigent and needy individuals in this state or for the medical, dental, or nursing care and treatment of individuals in medically underserved areas of this state may obtain a special volunteer license to engage in the practice of medicine, osteopathic medicine and surgery, podiatric medicine and surgery, dentistry, or nursing by submitting an application to the board pursuant to this section. An application for a special volunteer license shall be on a form provided by the department and shall include each of the following:”

Modifications consistent with those above should be made throughout Section 333.16184.

It is further recommended that nurse and nursing be added to the language of Section 333.16185 (1) of the Public Health Code (changes underlined):

“Subject to subsection (2), a physician who provides medical care or a nurse who provides nursing care under a special volunteer license granted under section 16184 is not liable in a civil action for personal injury or death proximately caused by the professional negligence or malpractice of the physician or nurse in providing the care if both of the following apply:”

Modifications consistent with those above should be made throughout Section 333.16185.

Retired nurses who wish to practice nursing as volunteers should be encouraged to do so through the same provisions that encourage retired physicians to practice as volunteers – the Special Volunteer License. The nursing shortage and the resulting increased salaries for actively practicing nurses are already making it difficult for free clinics and facilities that serve the uninsured and medically indigent to compete for nursing staff. Adding nurses and nursing to the language in Sections 16184 and 16185 would serve to encourage retired nurses to volunteer their services to these underserved populations and to the facilities that provide them with health care services. It is important to note that the benefits of the Special Volunteer License include only a zero licensure fee and a limited exemption from civil liability for malpractice. All other provisions of the regular active licensure statutes and administrative rules apply.

Supporting References

Texas Board of Nurse Examiners, *Volunteer Retired Nurse Authorization FAQ*, 2007.

Michigan Department of Community Health, Bureau of Health Professions, *Occupational Regulation Sections of the Michigan Public Health Code*, 2007.

Coalition of Michigan Organizations of Nursing and the Office of the Chief Nurse Executive, MDCH, *The Nursing Agenda for Michigan*, 2006.

NRPP 3.1: Advanced Practice Nursing Definitions

Recommendation

It is recommended that the Michigan Department of Community Health support a change in the Public Health Code and in the Michigan Board of Nursing (MBON) Administrative Rules that adds definitions for certain Advanced Practice Nursing (APN) specialties. These include Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP). The inclusion of definitions for these APN specialties will a) educate the public, health care employers, and health policy-makers with respect to these practitioners, and b) clarify the content and maintain the integrity of these APN specialties.

The Michigan Public Health Code 333.17210 Section 17210 states that the Michigan Board of Nursing may issue a specialty certification to a Nurse Midwife or Nurse Practitioner, but does not provide a definition for either of these specialties. The MBON Rules: Part 4, R 333.10404 defines who may be granted specialty certification based on meeting the standards set forth by professional certification organizations, but does not provide definitions for the specialties. Definitions are needed to educate the public and other stakeholders who wish to know what practitioners in these specialties do; and to clarify the content of the nurse midwifery specialty and the nurse practitioner specialty, since the lack of definition may cause insurers to question or deny reimbursement for services. The proposed Certified Nurse Midwife (CNM) definition is: *Certified Nurse-Midwives manage women's health care, focusing particularly on common primary care issues, family planning and gynecologic needs of women, pregnancy, childbirth, the postpartum period and the care of the newborn.* The proposed Certified Nurse Practitioner (CNP) definition is: *Certified Nurse Practitioners manage health care along the age continuum, focusing particularly on prevention of disease, health promotion and education, and diagnosis and management of acute and chronic diseases.* These definitions should be added to the Michigan Public Health Code and the MBON Administrative Rules to clarify and maintain the integrity of these nursing specialty certifications.

Approved by the MDCH – Task Force on Nursing Regulation, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TFNR is composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of Certified Nurse Midwife and Certified Nurse Practitioner definitions as a high priority and amenable to a straightforward solution.

Nursing Regulatory Issue

The Michigan Public Health Code 333.17210 Section 17210 states that the Michigan Board of Nursing (MBON) may issue a specialty certification to a Nurse Midwife or Nurse Practitioner, but it does not provide a definition for either of these specialties. The MBON Rules: Part 4, R 333.10404 defines who may be granted specialty certification based on meeting the standards set forth by professional certification organizations, but does not provide definitions for the specialties. Definitions are needed to educate the public and other stakeholders who wish to know what practitioners in these specialties do; and to clarify the content of the nurse midwifery specialty and the nurse practitioner specialty, since the lack of definition may cause insurers to question or deny reimbursement for services.

Recommended Solution and Rationale for the Solution

Add to the definitions section of the MPHC 333.17210 and to the MBON Rules R333.10404, the following definition for Certified Nurse Midwives: *Certified Nurse-Midwives manage women's health care, focusing particularly on common primary care issues, family planning and gynecologic needs of women, pregnancy, childbirth, the postpartum period and the care of the newborn.*

Add to the definitions section of the MPHC 333.17210 and to the MBON Rules R333.10404, the following definition for Certified Nurse Practitioners: *Certified Nurse Practitioners manage health care along the age continuum, focusing particularly on prevention of disease, health promotion and education, and diagnosis and management of acute and chronic diseases.*

The rationale for these changes is that in the absence of definitions, neither the public, health care employers, nor health policy-makers are sure about the content of practice for these specialties. The Bureau of Health Professions reports receiving inquiries about what Certified Nurse Midwives and Certified Nurse Practitioners do; without definitions in the PHC and Rules, there is no basis for answers. The specialty practitioners themselves – Certified Nurse Midwives and Certified Nurse Practitioners – are concerned that the content of their specialties be clear and that the integrity of their specialties be maintained. The addition of definitions to the PHC and MBON Rules will provide clarity and meet the information needs of the public, health care employers, and policy decision-makers.

Supporting References

American College of Nurse Midwives (ACNM), *Standards for the Practice of Midwifery*.
American College of Nurse Midwives (ACNM), *Definition of Midwifery Practice*.

NRPP 4.1: Efficient, Timely Licensure for Nurses

Recommendation

It is recommended that the Governor and MDCH Director exempt MDCH-Bureau of Health Professions regulatory staff positions that are approved and that are supported by restricted funds (such as the Health Professions Regulatory Fund) from current and future hiring freezes.

The Michigan Department of Community Health (MDCH) Task Force on Nursing Regulation recommends facilitating the entry into nursing practice of new nurses and nurses coming into Michigan by decreasing the time between application completion and licensure. For new nurses, this means decreasing the time between graduation and the required approval by the MDCH Bureau of Health Professions (BHP) permitting new nursing graduates to take the national licensure examination (NCLEX). Pass rates on the NCLEX decrease as this post-graduation period lengthens, and the entry of new nurses into the health care workforce is delayed. In the face of a nursing shortage, it is critical to move nursing graduates into the workforce rapidly; that process begins with clearance to take the licensure examination. The timeliness and efficiency of the nursing licensure process for all Michigan nurses will be improved by filling all Bureau of Health Professions regulatory staff positions that are included in the Bureau's approved spending plan and funded by the Health Professions Regulatory Fund (licensure fees); 22 such positions are currently vacant.

Approved by: Task Force on Nursing Regulation, October 22, 2007

Submitted to: Director of the Michigan Department of Community Health, November 20, 2007

Background

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TFNR is composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of timely, efficient licensure for nurses as a high priority and amenable to a straightforward solution. In 2007, the MDCH Bureau of Health Professions required an average of six to eight weeks to process the applications of new nursing graduates and an average of 12 weeks to process the completed applications of nurses moving to Michigan.

Nursing Regulatory Issue

Renewal of the licenses of practicing nurses and licensure of new nurses or nurses moving into Michigan may be delayed to the point that months and even years of nursing services are removed from Michigan's nursing workforce capacity. Michigan is losing new nurses and nurses considering a move to Michigan who cannot receive licensure in a timely manner. New nursing

graduates must be approved by the MDCH Bureau of Health Professions (BHP) before they may take the NCLEX; the more months that go by between graduation and examination, the lower the NCLEX pass rate and the more delayed the entry of new nurses into the field becomes. Insufficient staffing of the BHP also delays the investigation of complaints against health professionals, thereby increasing the risk to the public's health and safety. About 22 BHP staff positions – included in the Bureau's approved spending plan and funded by the restricted Health Professions Regulatory Fund (licensure fees) – remain unfilled due to a Governor's Executive Order stipulating a hiring freeze.

Proposed Solution and Rationale for the Solution

At present, all units of State government, including the MDCH Bureau of Health Professions, are subject to the Governor's Executive Order that stipulates a hiring freeze. It is recommended that the Governor and MDCH Director exempt MDCH staff positions included in the Bureau's approved spending plan and supported by restricted funds (such as the Health Professions Regulatory Fund) from current and future hiring freezes.

Retention of practicing nurses, and rapid entry into the field for new nurses and nurses moving into Michigan requires that the licensure and licensure renewal processes be efficient and quick (recognizing that licensure of nurses moving into Michigan is dependent upon responses from states in which previous licenses were held). There are 22 unfilled positions in the BHP, which provides regulatory services, including licensure, to over 30 health professions. These positions are already included in the Bureau's approved spending plan and funded by a restricted fund, the Health Professions Regulatory Fund. The monies in the Health Professions Regulatory Fund are derived from licensure fees, and it is reasonable that the health professionals paying those fees should be appropriately supported (rather than impeded) in the practice of their professions. Since nurses are the largest group (over 150,000) of Michigan health professionals, these unfilled positions have a considerable impact on timely nursing licensure, which negatively affects Michigan's nursing shortage and the state's economy. Each unfilled nursing position costs about \$75,000 (direct benefit) per year plus \$55,000 (indirect benefit) per year removed from local and state economies. Nurses educated in Michigan and living in Michigan should be filling these positions, rather than moving to states where licensure is quicker.

Appropriate hiring to fill 22 BHP positions that are already approved and funded will decrease the processing time for nursing licenses (both initial and renewal) and expedite the investigation of complaints. This change will remove a barrier to new nurses entering the field, increase the nursing workforce, and help protect the health, safety and economy of Michigan residents. With strong support from the TFNR, the Director of MDCH is urged to advocate for filling the 22 vacant BHP positions and to arrange that MDCH staff positions supported by restricted funds are not subject to current or future hiring freezes stipulated by an Executive Order of the Governor.

NRPP 5.1: Safe Care for Children in Schools

Recommendation

It is recommended that the Director of MDCH work with the Director of MDE to charge the Interagency Healthcare Workforce Coordinating Council (MDCH, MDE, MDLEG, and MDHS) with the task of effectively resolving the inconsistencies among the Public Health Code, the School Code, and MIOSHA Statutes that affect the provision of in-school healthcare for children. The relevant codes and administrative rules should be reconciled with the goal of improving the safety and quality of healthcare for children in schools.

More students with chronic and urgent health care needs are now attending school and placing increased demands on school districts. These demands are exacerbated by the growing numbers of children without health insurance, whose working parents cannot risk leaving their jobs to take their child to a health care provider. In school districts both with and without certified school nurses, school personnel not licensed as health professionals (principals, teachers, secretaries and building helpers) are designated to administer medication and perform complex health care procedures, often without adequate training and supervision. School employees are governed by the School Code, which is in direct conflict with the Public Health Code and MIOSHA Statutes on matters related to the performance of health care tasks. Currently, the sections of the PHC dealing with the supervision [PHC 333.16109(2)(c)] and delegation [PHC 333.16104 & Rule 333.16104] of health care tasks do not apply in schools. In schools, a principal or teacher may act as a health professional, teaching, directing, and supervising less skilled personnel in the performance of health care tasks, which, in most healthcare settings, would be considered tasks for a physician or a nurse. Use of unqualified school personnel to evaluate health problems and perform health care procedures increases the risk of harm to children, especially those with medical emergencies, and increases the liability risk to school personnel, school systems, and school nurses.

Changes in the School Code, the Public Health Code, MIOSHA Statutes and/or the administrative rules attached to all of these should be made to ensure that a) children receive in-school health care from health care professionals or staff to whom health care professionals have appropriately delegated health care tasks, and b) the liability risk assumed by school systems and school staff is reduced. The Directors of MDCH and MDE should work together to ensure that the Interagency Healthcare Workforce Coordinating Council (MDCH, MDE, MDLEG, and MDHS) identifies and implements long-term and short-term strategies to ameliorate the statutory conflicts that put Michigan's school children at risk.

Approved by the MDCH – Task Force on Nursing Regulation, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in

Michigan, thereby protecting the health and safety of Michigan residents. The TRNR is composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of safe care for children in schools as a high priority and amenable to a collaborative solution.

Nursing Regulatory Issue

Growing numbers of students with chronic and urgent health care needs are now attending school (mainstreaming) and placing new demands on school districts. These demands are exacerbated by the growing numbers of children without health insurance, whose working parents cannot risk leaving their jobs to take their child to a health care provider. Most school districts have consolidated schools over the past ten years, so that many school buildings and complexes now contain as many as 3,000 to 10,000 students. In school districts both with and without certified school nurses, school personnel not licensed as health professionals (principals, teachers, secretaries and building helpers) are designated to administer medication and perform complex health care procedures, often without adequate training and supervision.

School employees are governed by the School Code, which is in direct conflict with the Public Health Code and MIOSHA Statutes on matters related to the performance of health care tasks. Currently, the sections of the PHC dealing with the supervision [PHC 333.16109(2)(c)] and delegation [PHC 333.16104 & Rule 333.16104] of health care tasks do not apply in schools. In schools, a principal or teacher may act as a health professional, teaching, directing, and supervising less skilled personnel in the performance of health care tasks, which, in most healthcare settings, would be considered tasks for a physician or a nurse. Use of unqualified school personnel to evaluate health problems and perform health care procedures increases the risk of harm to children, especially those with medical emergencies, and increases the liability risk to school personnel, school systems, and school nurses. As the funding of both healthcare and schools becomes more difficult and fewer working families can afford health insurance, this in-school healthcare situation will engender unacceptable levels of risk to children.

Recommended Solution and Rationale for the Solution

Changes in the School Code, the Public Health Code, MIOSHA Statutes and/or the administrative rules attached to all of these should be made consistent to ensure that a) children receive in-school health care from health care professionals or staff to whom health care professionals have appropriately delegated health care tasks, and b) the liability risk assumed by school systems and school staff is reduced. In part, the relevant Codes and Rules include: Michigan Public Health Code 1978 PA 368 as amended, Part 161 General Provisions, 333.16104 “Delegation”; MCLA 333.16109 (2) (c) Public Health Code regarding “supervision” and R.338.10104 Delegation Rule 104; MCL 333.17201, Qualifications and appropriate tasks of School Nurses; MCLA 380.1252, Employment of staff needed if there are students present with health conditions that require services as described in Administrative Rule R340.1163, and School Code, 1976 PA 451, 380.1178.

The Directors of MDCH and MDE should work together to ensure that the Interagency Healthcare Workforce Coordinating Council (MDCH, MDE, MDLEG, and MDHS) identifies and implements long-term and short-term strategies to effectively resolve the inconsistencies among the Public Health Code, the School Code, and MIOSHA Statutes that affect the provision

of in-school healthcare for children; these statutory conflicts put Michigan's school children at risk.

Supporting References

Grand Rapids Public Schools, *Policy #5141, Delegation of Health Services*. A potential model for provision of safe in-school healthcare in a practical manner.

Kansas Nurse Practice Act. <http://www.ksbn.org/npa/npa.pdf>.

Tony Pugh, Miami Herald, November 18, 2007. *Schools Scrambling to Help Uninsured Kids*, <http://www.miamiherald.com/news/nation/v-print/story/312188.html>.

M.C.L.A. 333.17201 Practice of Nursing, M.C.L.A. 333.16104 delegation, M.C.L.A. 333.16215 delegation of acts, tasks, and functions, M.C.L.A. 333.16109 supervision.

Minnesota Statutes sec. 148.171-148.285, Minnesota Rules Chapter 6301-6330.

NASN Delegation Position Statement <http://www.nasn.org/Default.aspx?tabid=349>.

NASSNC Position Statement: Delegation of School Health Services

http://www.tjcats.net/nassnc/040817/nassnc/NASSNC_del-unlic.html#DELEGATION.

National Education Associations. *Guidelines for the Delineation of Roles and Responsibilities for Safe Delivery of Specialized Health Care in the Educational Setting*. May 1, 1990.

Nevada State Board of Nursing: *School Nurse Regulation*.

<http://www.nursingboard.state.nv.us/pinfo/school%20nurse%20regulation%20advisory%20opinion>.

School Code, 1976 PA 451, 380.1178.

Recommendation to the Director of MDCH with Respect to Nursing Regulatory Position Papers 5.2 through 7.1:

It is recommended that the Director of MDCH convene a Task Force on Nursing Education (TFNE) to make recommendations to the Director on the issues discussed in Nursing Regulatory Position Papers 5.2 through 7.1, plus such other nursing education issues as TFNE members identify as high priority and amenable to solution. It also is recommended that the TFNE be followed by the convening of a Task Force on Nursing Practice (TFNP) to make recommendations to the Director on the issue discussed in Nursing Regulatory Position Paper 5.2, plus such other nursing practice issues as TFNP members identify as high priority and amenable to solution.

Nursing Regulatory Position Papers 5.2 through 7.1 are presented here for referral to the recommended Task Force on Nursing Education. Nursing Regulatory Position Paper 5.2 is presented here also for referral to the recommended Task Force on Nursing Practice.

NRPP 5.2: Delegation of Nursing Tasks

Recommendation

It is recommended that the Director of MDCH charge the 2008 Task Force on Nursing Education and Task Force on Nursing Practice with a substantive review of the content and implementation of Michigan statutes and rules governing the delegation of nursing tasks. The PHC and MBON Rules define nursing delegation and supervision and provide guidelines; however, *de facto* administration and practice may place nurses, their licenses, and their patients in jeopardy. Specific issues related to Long Term Care (LTC) include workplace conflicts and stresses that will worsen as the nursing shortage increases. Knowledge and understanding of delegation as a continuum of nursing processes is needed, as is the will to put patient safety before economic expediency. Education on delegation for nursing students (as part of curriculum), nurses (as a component of license renewal), nursing home administrators (as a component of license renewal), and nursing home regulators should be included in recommended solutions, in addition to potential statute and rules revisions.

The Task Force on Nursing Regulation tabled the delegation of nursing tasks issue and referred it to the anticipated Task Force on Nursing Education and the Task Force on Nursing Practice, since both education and practice are strongly engaged in this issue and its remediation. TFNR-NRPP 5.1 *Safe Care for Children in Schools* deals with delegation issues that threaten the health and safety of school children, due to conflicts between the Public Health Code and the School Code, plus the increasing difficulty of funding children's health care in school settings. The general *delegation of nursing tasks* issue centers around the conflict between statutes and rules covering delegation/supervision and the real-world pressures to decrease health care costs by shifting responsibility for nursing tasks to individuals with lower certifications and wages.

The delegation situation is notable in Long Term Care (LTC) settings, where the alignment between statutes, rules, and practice is increasingly fragile. This disconnect between regulation and practice is of great concern, since LTC facilities over the past 15 years have become the caregiver for patients of all ages with acute health problems, rather than just housing the elderly with chronic conditions. Just as, over the past 10 years, patient acuity has increased in hospitals, it has soared in LTC facilities. Other nursing practice environments are struggling with the same dilemma: how can patient care be made high-quality and safety be maintained, while, at the same time, health care costs are held constant or decreased? The nursing shortage expected to continue through 2030 can only make worse the nursing delegation issues that are already clear.

Other states and many nursing organizations have produced position papers and guidelines on nursing delegation and its relationship to patient care and safety. The Michigan Public Health Code and the MBON Rules may need amending, but the question will be whether to adjust the regulations to fit current practice, or to adjust practice to comply with current regulations. Education about delegation is needed for nursing students, nurses, their employers, and regulators; this will require a collaborative effort by nursing educators, licensing entities, and the healthcare industry.

This is a complex issue with many components; the Task Force on Nursing Regulation encourages an in-depth review, substantive discussions, and careful framing of recommendations to the Director of the Michigan Department of Community Health.

Approved by the MDCH – Task Force on Nursing Regulation for referral to the MDCH Task Force on Nursing Education, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan’s strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TRNR is composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of delegation of nursing tasks as a high priority that requires further work before recommendations are made.

References

M.C.L.A. 333.17201 Practice of Nursing, M.C.L.A. 333.16104 delegation, M.C.L.A 333.16215 delegation of acts, tasks, and functions, M.C.L.A. 333.16109 supervision.

Minnesota Statutes sec. 148.171-148.285, Minnesota Rules Chapter 6301-6330.

Texas Board of Nurse Examiners for the State of Texas & Texas Board of Vocational Nurse Examiners, September 2002. *Differentiated Entry Level Competencies of Graduates of Texas Nursing Programs*.

NASN Delegation Position Statement <http://www.nasn.org/Default.aspx?tabid=349>.

NASSNC Position Statement: Delegation of School Health Services

http://www.tjcats.net/nassnc/040817/nassnc/NASSNC_del-unlic.html#DELEGATION

NRPP 6.1: Change in Educational Requirements for Practical Nursing Students

Recommendation

It is recommended that the Director of MDCH charge the 2008 Task Force on Nursing Education with a substantive review of the content and implementation of Michigan rules and guidelines governing the educational requirements for practical nursing students. The MDCH Bureau of Health Professions and the Michigan Board of Nursing should change the MBON Administrative Rules and/or Nursing Education Program Review Guidelines to effectively eliminate the educational requirement for clinical experience in pediatrics and obstetrics for practical nursing students, and effectively add an educational emphasis on pharmacology and coordination of care. The existing requirement for classroom education in pediatrics and obstetrics must be maintained. This recommendation supports and reinforces the work already begun by the MBON Education Committee, Program Review Subcommittee, which should review the Guidelines for Program Review for clarity on this issue.

Practical Nursing students currently receive clinical experience in the specialty care areas of pediatrics and obstetrics. This places additional stress on already limited clinical sites for student nursing experiences, particularly in acute care sites. Few Michigan hospitals hire Licensed Practical Nurses (LPNs) to practice on pediatric or obstetrical units; thus clinical experience in these specialty areas is not essential. The majority of LPNs work in Long Term Care (LTC) facilities, assisting in the coordination of human and material resources in the provision of nursing care, and implementing plans of care under the supervision of a Registered Nurse. In the LTC practice environment, classroom and clinical learning in pharmacology, medical surgical nursing, geriatrics, and care coordination are the most appropriate preparation for LPNs. The MDCH - Michigan Board of Nursing Education Committee, Program Review Subcommittee has begun work to change its Program Review Guidelines and the interpretation of those Guidelines to: maintain the requirement for classroom education in pediatrics and obstetrics for practical nursing students; effectively eliminate the requirement for clinical experience in pediatrics and obstetrics for practical nursing students, and effectively add an emphasis on pharmacology and coordination of care for practical nursing students. This work should be supported, expedited, and implemented to better align LPN practice and preparation and decrease stress on clinical sites for nursing education.

Approved by the MDCH – Task Force on Nursing Regulation for referral to the MDCH Task Force on Nursing Education, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in

Michigan, thereby protecting the health and safety of Michigan residents. The TRNR is composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of clinical education requirements for practical nursing students as a high priority and amenable to a collaborative solution.

Nursing Regulatory Issue

Practical Nursing students currently receive both classroom education and clinical education experience in the specialty care areas of pediatrics and obstetrics. This places additional stress on already limited clinical sites for student nursing experiences, particularly in acute care sites. Few Michigan hospitals hire Licensed Practical Nurses (LPNs) to practice on pediatric or obstetrical units; thus clinical experience in these specialty areas is not essential. Classroom education in pediatrics and obstetrics must be maintained for practical nursing students, since practical nursing education graduates must pass the national examination (PN-NCLEX), which continues to include pediatric and obstetric content. The majority of LPNs work in Long Term Care (LTC) facilities, assisting in the coordination of human and material resources in the provision of nursing care, and implementing plans of care under the supervision of a Registered Nurse. In the LTC practice environment, classroom and clinical learning in pharmacology, medical surgical nursing, geriatrics, and care coordination are more appropriate preparation for LPNs. The current nursing education program requirements in the Administrative Rules create misalignment between LPN practice and preparation, while further stressing an already scarce resource – specialty clinical sites for nursing education.

Recommended Solution and Rationale for the Solution

Administrative Rules 10301, 10308, and 10309 should be modified and/or the Program Review Guidelines for implementation/interpretation of those rules should be changed to better align LPN practice and preparation, while removing stress from specialty clinical sites for nursing education. The MBON Education Committee, Program Review Subcommittee has begun work to change its Program Review Guidelines and the interpretation of those Guidelines to: maintain the requirement for classroom education in pediatrics and obstetrics for practical nursing students; effectively eliminate the educational requirement for clinical experience in pediatrics and obstetrics for practical nursing students; and effectively emphasize education in pharmacology and coordination of care for practical nursing students. The Guidelines should be reviewed for clarity on this issue. This recommendation supports the work of the Program Review Subcommittee; which should be expedited and implemented.

Nursing education for Registered Nurses (RNs) requires a range of specialty area clinical experiences, since RNs are hired to practice nursing in all of those specialty areas, particularly in acute care hospitals. Acute care settings for such clinical experiences are a scarce resource. Practical nursing education, particularly required clinical experiences in pediatrics and obstetrics, does not align well with real-world practical nursing practice, which is focused in Long Term Care requiring knowledge of and clinical experience in medical-surgical nursing, pharmacology, geriatrics, and care coordination. Classroom education in pediatrics and obstetrics must be maintained for practical nursing students, since practical nursing education graduates must pass the national examination (PN-NCLEX), which continues to include pediatric and obstetric content. Some LPN practice venues may shift LPNs from one specialty unit to another as the

workload changes; the entity administering the practice venue is then responsible for assuring LPN essential skills for the workplace.

It is possible that future development of pre-clinical and clinical experience resources -- such as simulation laboratories or virtual reality centers -- will expand availability of clinical experience sites to the extent that the recommended change should be reconsidered. Given the nursing shortage, such reconsideration is unlikely for the next twenty years.

Changing the practical nursing education requirements by eliminating clinical experiences in pediatrics and obstetrics (while maintaining classroom education in these nursing areas) would better align practical nursing education with LPN practice. It also would reduce competition for scarce clinical experience sites in pediatrics and obstetrics, particularly in smaller obstetrics and pediatric clinical specialty units. The MBON Education Committee, Program Review Subcommittee has begun work to change its Program Review Guidelines and the interpretation of those Guidelines to effectively eliminate the requirement for clinical experience in pediatrics and obstetrics for practical nursing students (but maintain classroom education in these nursing areas), and effectively add an emphasis on pharmacology and care coordination. This work should be supported, expedited, and implemented. In general, the MBON Administrative Rules and Education Program Review Guidelines would be more supportive of alignment between nursing practice and education if more open language were included to reflect the requirement for theoretical and experiential learning that supports program outcomes at all levels.

References:

Report from MCNEA/MACN/MONE Task Force on a *New Clinical Model for Education of Nursing Students, 2007.*

NRPP 6.2: Unified Nursing Education Curriculum

Recommendation

It is recommended that the Director of MDCH charge the 2008 Task Force on Nursing Education with a substantive review of the content and implementation of Michigan rules governing the curriculum for practical nursing (PN) and associate degree nursing (ADN) education programs. It is recommended that nursing education be made more efficient for students, faculty, and institutions by encouraging a Unified Nursing Education Curriculum in PN and ADN nursing education programs. The Michigan Board of Nursing (MBON) should make Administrative Rules and Education Program Review Guidelines changes that assign credits to courses in practical nurse (PN), registered nurse (RN) and PN to RN “ladder” education programs. This position paper is intended to support and reinforce the first steps toward a unified curriculum taken by the MBON Education Committee, Program Review Subcommittee and to encourage the allocation of resources in support of unified nursing education curriculum development.

Michigan and the nation are facing a nursing shortage expected to continue through 2030. If we are to graduate more new nurses, the efficiency and timely completion of undergraduate nursing education programs must be improved. At present, practical nursing (PN) and associate degree nursing (ADN) students find that credits and requirements vary widely from one education institution to another and that credits often are not transferable; students seeking a PN to RN “ladder” program find little consistency in courses and credits accepted. Faculty teaching in multiple nursing education programs find little consistency in course content among institutions; and institutions expend time and money on a) evaluation of course credits for transfer; and b) development and revision of unique courses and curricula. A Unified Nursing Curriculum will mitigate many of these problems.

A Unified Nursing Curriculum begins with the assignment of consistent credits to consistent course content. This change to the Administrative Rules and/or Education Program Review Guidelines of the MBON will benefit:

1. Students, who will gain predictability of courses, credits, and costs, transferability of their nursing education credits; and more efficient, timely completion of their PN or RN program.
2. Faculty, who will have greater consistency and comparability of courses among educational institutions.
3. Administrators, who will have a simpler, quicker, and less costly credit-transfer process.
4. Educational institutions, which will be able to share best practices for nursing education curricula.

Ultimately, this change will lead to improved NCLEX pass rates, and efficient, less costly national accreditation of Michigan nursing education programs, since the accrediting agency would review a sample of programs for a lower fee. Students and their parents will be assured of quality nursing education programs that may be completed in a timely manner.

Approved by the MDCH – Task Force on Nursing Regulation for referral to the MDCH Task Force on Nursing Education, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TRNR was composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of encouraging a Unified Nursing Curriculum to be high priority and amenable to a collaborative solution.

Nursing Regulatory Issue

The 36 Associate Degree in Nursing (ADN) programs in Michigan have a wide range of graduation credit requirements. The Michigan Board of Nursing (MBON) approves these programs and has Administrative Rules that set general program requirements. However, these approved programs vary in college academic credit from 60 to 105 credits. This disparity among programs creates barriers for transfer students or students seeking readmission at another school of nursing. Currently there are 28 MBON-approved practical nursing (PN) programs and 36 MBON-approved ADN programs, 10 of which are “laddered”. This is a very confusing academic environment for students and their families, faculty, administrators, and for anyone attempting to assess the quality or efficiency of nursing programs.

The Administrative Rules of the MBON (see R 338.10305) provide general guidelines for curriculum development, but do not specify the amount of clinical, laboratory, or theory content for any given course; neither do the Rules specify the credit hours per course. As a result, new courses are added, old courses are maintained, and “credit creep” often occurs, giving Michigan ADN education programs a minimum of 60 academic credits and a maximum of 105 academic credits; NCLEX pass rates vary, but not with the number of academic credits required. National standards do not support such a wide discrepancy in the number of academic credits required for graduation. Schools/Colleges of Nursing within institutions of higher education must follow institutional policies for curriculum requirements. Associate degree nursing programs are defined by the North Central Commission on Higher Learning to be a course of study ranging from 60 to 72 credits, inclusive of college required core courses.

Recommended Solution and Rationale for the Solution

It is recommended that the MBON change the Administrative Rules [R 338.10301 & 10305-10309] and the Program Review Guidelines to assign specific numbers of academic credits to courses with specific (theory, laboratory, clinical) content within PN and RN educational programs, plus language to address and align “ladder” nursing programs (PN to RN). The MBON should encourage ADN programs to set the number of academic credits required for graduation within the 60-72 credit range.

This shift toward a unified nursing curriculum will benefit:

- Students, who will gain predictability of courses, credits, and costs, transferability of their nursing education credits; and more efficient, timely completion of their PN or RN program.

- Faculty, who will have greater consistency and comparability of courses among educational institutions.
- Administrators, who will have a simpler, quicker, and less costly credit-transfer process.
- Educational institutions, which will be able to share best practices for nursing education curricula.

Ultimately, this change will lead to improved NCLEX pass rates, and efficient, less costly national accreditation of Michigan nursing education programs, since the accrediting agency would review a sample of programs for a lower fee. Students and their parents will be assured of quality nursing education programs that may be completed in a timely manner at consistent cost.

This position paper is intended to support and reinforce the first steps toward a unified curriculum taken by the MBON Education Committee, Program Review Subcommittee and to encourage the allocation of resources in support of unified curriculum development. The process of developing and implementing a unified curriculum will be demanding and resource-intensive. In Wisconsin, nursing education institutions are operating with a unified curriculum that required multiple years and approximately \$900,000 to develop and implement. Realistic resources should be allocated to this task in Michigan.

The nursing shortage requires that nursing students receive consistent, high-quality education with timely completion at predictable cost, that nursing faculty teach consistent, high-quality courses that are transferable from one education institution to another, and that education institutions keep students' time investment consistent and continuously improve the quality of the nursing curriculum they offer. In return, the educational institutions reap the benefits of students and faculty who return for further nursing courses, a more efficient and less costly approach to course credit transfers, shared best practices for nursing education, and national accreditation at a reduced price.

Supporting References

States with a unified curriculum:

- California http://cncc.org/featured_stories/ca_students_win.html
- Connecticut <http://www.nvcc.comnet.edu/newsevents/news070711.shtml>
- Oregon <http://www.ocne.org/update.php>
- Wisconsin
http://www.wids.org/index.php?option=com_content&task=view&id=72&Itemid=72

States discussing a unified curriculum:

- Alabama
- Kansas
- Michigan
- Montana
- New Mexico
- New York
- North Carolina
- North Dakota

NRPP 6.3: Student-to-Faculty Ratios in Clinical Nursing Education

Recommendation

It is recommended that the Director of MDCH charge the 2008 Task Force on Nursing Education with a substantive review of the content and implementation of Michigan rules governing Student-to-Faculty ratios in clinical nursing education. Revise MBON Administrative Rule 305(4) with input from the nursing education community and clinical experience sites to create and promote a collaborative, flexible process for setting safe, evidence-based, learning-appropriate student-to-faculty ratios in all types of clinical learning situations. Student-to Faculty ratios must consider patient safety, patient acuity, and level of care required. The Rules must provide examples and guidance for institutions both seeking and providing nursing student clinical experiences, with the *proviso* that all ratios shall be lower than the current maximum of 10 to 1. Student-to-Faculty ratios should never be considered on a “one size fits all” basis. This recommendation supports and reinforces the work already begun by the MBON Education Committee, Program Review Subcommittee.

A critical aspect of nursing education is clinical experience for nursing students. Clinical nursing faculty members are responsible for the patient care experiences of a group of nursing students in a specific clinical environment – typically a hospital. Clinical nursing faculty are responsible for checking the academic preparation and security paperwork of their students, and for keeping those students and their assigned patients safe during student clinical experiences. Hospital patients are much sicker than they were ten years ago. As patient acuity rises, so does the complexity of care and the ever-changing high technology required for care. As patient acuity has risen, some health care facilities have included student-to-faculty ratios in their clinical experience contracts, to assure care quality and safety. Depending upon the policies of the hospital, all or part of the regular nursing staff of the hospital unit may continue to provide patient care during the period of student nursing experience, or the regular staff may be reassigned to other units.

All of these factors add to the difficulty of assuring safe, high-quality care for patients (goal a), while also providing safe, high-quality, patient care experiences for nursing students (goal b). The number of nursing students per clinical faculty member and the number of patients per student are important factors in achieving both of these goals. The student-to-faculty ratio must be appropriate for the clinical setting, and should be set through negotiation between the institution providing nursing education and the institution providing venues for nursing students' clinical experiences. Nursing Administrative Rule 305(4) should be changed to enable such negotiation of venue-appropriate, safe student-to-faculty ratios, with the *proviso* that all ratios shall be lower than the current maximum of 10 to 1. Student-to-faculty ratios should never be considered on a “one size fits all” basis. Guidelines (using examples) should be provided to the educational and health care institutions negotiating appropriate, safe, evidence-based student-to-faculty ratios for specific clinical environments.

Approved by the MDCH – Task Force on Nursing Regulation for referral to the MDCH Task Force on Nursing Education, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TRNR was composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of facilitating flexible, safe, venue-appropriate student-to-faculty ratios to be high priority and amenable to a collaborative solution.

Nursing Regulatory Issue

R 338.10305 Program requirements generally.

- Rule 305(4) nursing faculty shall be sufficient in number to prepare students to achieve the objectives of the program. The maximum ratio of students to faculty in clinical areas involving direct care of patients shall be not more than 10 students to 1 faculty member.

MBON Administrative Rule R 338.10305(4) sets a maximum of 10 students to 1 faculty “in clinical areas involving direct care of patients.” With increased patient acuity, this student-to-faculty maximum ratio is now too high to facilitate a) safe, high-quality patient care in “clinical areas involving direct care of patients” or b) high-quality nursing student clinical experiences. Since the stated maximum ratio comes to be accepted as standard practice, it creates situations in which patient safety may be compromised, clinical faculty are heavily stressed, and students feel they have not received sufficient clinical experiences to prepare them for professional practice. The current student-to-faculty maximum ratio meets neither the need for real-world clinical experiences to prepare nursing students for real-world professional practice, nor the safety, care, and learning needs of the patients, nursing students, faculty, and institutions that engage in those experiences.

Recommended Solution and Rationale for the Solution

Revise Rule 305(4) with input from the nursing education community and clinical experience sites to create and promote a collaborative, flexible, evidence-based process for setting safe, learning-appropriate student to faculty ratios in all types of clinical learning situations. Student-to-faculty ratios must consider patient safety, patient acuity, and level of care required. The Rules must provide examples and guidance for education and health care institutions as they negotiate student-to-faculty ratios, with the *proviso* that all ratios shall be lower than the current maximum of 10 to 1. Research from the National Council of State Boards of Nursing (NCSBN) and the Institute of Medicine should inform decision-making and the negotiation process.

Rule 305(4) also states “nursing faculty shall be sufficient in number to prepare students to achieve the objectives of the program.” There are clinical learning situations where a very low student-to-faculty ratio is needed “to achieve the objectives of the program.” There are other clinical learning situations where a higher ratio might be adequate “to achieve the objectives of the program” – with the *proviso* that all ratios shall be lower than the current maximum of 10 to 1. Input from the nursing education community and clinical experience sites is needed to develop

a process for negotiating (and periodically updating) safe, evidence-based student-to-faculty ratios in all types of clinical learning situations, with examples and guidance provided for both the institutions seeking and the institutions providing nursing student clinical experiences. Student-to-faculty ratios should never be considered on a “one size fits all” basis.

Student-to-faculty ratios must be flexible, evidence-based, and customized to optimize the student nursing clinical learning experience while also providing safe, high-quality patient care at all levels of patient acuity. Less clinical experience is available to nursing students if the clinical faculty is “spread too thin” with high ratios. With increasing patient acuity, faculty must be shoulder-to-shoulder with students for medication administration, invasive procedures, sterile dressing changes, intravenous interventions, etc. Thus, the number of students in a clinical group directly impacts the number of experiences each student can have. The number of students in a clinical group also impacts the stress placed on nursing faculty; with high student-to-faculty ratios, faculty may succumb to “burn-out” and further decrease the group providing this vital nursing education component.

Information technology methods for providing clinical and pre-clinical experiences – such as laboratories offering simulations and virtual reality experiences -- should be fostered to decrease stress on clinical experience sites and clinical nursing faculty. Such laboratory experiences are not a substitute for clinical learning, but can be used to make on-site clinical experience more efficient and effective, and to decrease the stress on clinical experience sites and faculty.

A process for setting and periodically updating safe, evidence-based student-to-faculty ratios in all types of clinical learning situations must be developed and implemented so that the institutions providing nursing student clinical experiences (both nursing educators and clinical experience sites) are assured that the objectives of the nursing education program are met and safe, high-quality patient care is provided. Appropriate resources and time should be allocated to the process of developing, implementing, and promulgating this new approach to negotiating student-to-faculty ratios.

Supporting References

National Council of State Boards of Nursing resources on nursing student clinical experience guidelines and requirements.

Institute of Medicine recommendations on nursing clinical education.

Reports on surveys of new nursing graduates six months into their first employment position.

NRPP 6.4: Consistent Definitions in Nursing Education

Recommendation

It is recommended that the Director of MDCH charge the 2008 Task Force on Nursing Education and Task Force on Nursing Practice with a substantive review of the content and implementation of Michigan rules governing the consistency of definitions in nursing education. The MBON Education Committee, Program Review Subcommittee and the Office of the Chief Nurse Executive should work with the nursing education community to create and implement consistent definitions and nomenclature in nursing education; the agreed-upon definitions and nomenclature must be included in the MBON Rules and periodically updated. Consistent definitions and nomenclature must be specific as to licensure and certification, as well as experience in the education of nursing students.

As the nursing shortage intensifies, there has been and will be increasing stress on nursing education resources. There will be increasing pressure to utilize individuals in teaching roles for which they are under-prepared or unprepared. Standards will be compromised and variances will become common; the MBON Education Committee recently has had a substantial increase in the number of requests for exceptions with respect to faculty qualifications. Unclear, confused terminology – often used without definitions – can only increase the stress on the professional integrity of nursing and nursing education. Faculty members in all of the roles required to appropriately educate nursing students must have clear definitions of their roles and nomenclature that distinguishes one role from another. This is critical with respect to clinical faculty roles, since multiple terms currently are used for the same role in clinical education, just as a single term may be used to name several different roles. For example, the terms “clinical faculty”, “clinical instructor”, and “preceptor” are often used interchangeably for the same role or to denote a range of teaching roles; however, depending upon the situation and/or the facility, the terms may be defined quite differently. Such variation may occur from program-to-program or facility-by-facility, and it impedes both the maintenance of nursing education quality and the negotiation of agreements to facilitate clinical education.

The MBON Education Committee, Program Review Subcommittee and the Office of the Chief Nurse Executive shall work with the nursing education community to create and implement consistent definitions and nomenclature in nursing education; the agreed-upon definitions and nomenclature must be included in the MBON Rules and periodically updated. Consistent definitions and nomenclature must be specific as to licensure and certification, as well as experience in the education of nursing students. This “naming and defining” work is basic to the maintenance of quality nursing education and the health and safety of the people of Michigan.

Approved by the MDCH – Task Force on Nursing Regulation for referral to the MDCH Task Force on Nursing Education, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan’s strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate

regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TFNR was composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of consistent definitions and nomenclature in nursing education to be high priority and amenable to a collaborative solution.

Nursing Regulatory Issue

In most sections of the Michigan Public Health Code and the MBON Rules, the items at the top of the section are terms and definitions; it is very difficult to regulate or even to discuss a process unless all parties use the same terms and definitions. Historically, nursing education roles and the terms and definitions describing those roles have been relatively flexible and likely to change as faculty and research leaders introduce new ideas and processes into education. Such flexibility is valuable, but must be counterbalanced by professional standards. The maintenance of standards has not suffered appreciably in the past, since:

- Colleges/schools of nursing within universities are subject to national accreditation requirements and the nomenclature and definitions of their university.
- Community College nursing education programs are annually reviewed by the MBON Program Review Subcommittee, which has translated local usage into reasonably consistent terminology as reviews occur.

This translation process has become more difficult within the past few years as the nursing shortage places more stress on nursing education resources. Nursing faculty are scarce; the average age of faculty members is over 51 years, and retiring faculty are more and more difficult to replace. This leads to pressure on Deans and Directors to fill positions with persons who are under-prepared or unprepared for the teaching roles they assume. Clinical faculty members (just as clinical education sites) have become increasingly scarce over the past twenty years, a situation that has reached crisis proportions. There currently are many different terms used to describe the clinical faculty role, and varying “beliefs” about the preparation required (credentials and experience) to occupy the role. For example, the terms “clinical faculty”, “clinical instructor”, and “preceptor” are often used interchangeably for the same role or to denote a range of clinical teaching roles; however, depending upon the situation and/or the facility, the terms may be defined quite differently. This makes it difficult to know the quality of clinical education received by students, the quality of care received by patients at the clinical education site, or the degree of risk to the safety of patients, students, and institutions. This situation increases the risk to patients, nursing students, and clinical faculty themselves; it also threatens the integrity of professional nursing in Michigan.

Recommended Solution and Rationale for the Solution

The MBON Education Committee, Program Review Subcommittee and the Office of the Chief Nurse Executive shall work with the nursing education community to create and implement consistent definitions and nomenclature in nursing education; the agreed-upon definitions and nomenclature must be included in the MBON Rules and periodically updated. Consistent definitions and nomenclature must be specific as to licensure and certification, as well as experience in the education of nursing students.

The nomenclature and definitions should be implemented through education and promotion campaigns targeted at both education institutions and health care provider institutions. Positive review by the MBON Program Review Subcommittee should be made conditional on appropriate use of the agreed-upon terms and definitions, and agreements negotiated with health care provider institutions should use only the codified terms and definitions. The codified terms and definitions will clarify the needs and expectations of all parties, and help preserve the integrity of professional nursing in Michigan. Periodic review and revision will assure that the terms and definitions do not become outdated. This “naming and defining” work is basic to the maintenance of quality nursing education and the health and safety of the people of Michigan.

Supporting References

Nomenclature and definitions from national Nursing Education organizations.

Nomenclature and definitions as used in the nursing statutes and rules of other states.

NRPP 7.1: Public Health Nursing Shortage

Recommendation

It is recommended that the Director of MDCH charge the 2008 Task Force on Nursing Education and Task Force on Nursing Practice with a substantive review of the content and implementation of Michigan statutes, rules, and policies governing the employment, role, and education of public health nurses. The Michigan Department of Community Health should advocate for funding for public health nursing positions in local health departments. The goal of such funding is to enable local health departments (LHDs) to assure that qualified public health nurses and nurse administrator positions are maintained in LHDs to perform specific programmatic functions that protect the health and safety of populations. MDCH advocacy for such funding is part of its mission to protect the health of the people of Michigan. The Michigan Department of Community Health also should advocate for restoration of funding for training in the Public Health portion of the MDCH budget, enabling local health departments to support educational and clinical experience opportunities for nursing students.

The systemic factors that have led to a major nursing shortage expected to last through 2030 have led also to a critical shortage of Public Health Nurses. This nursing specialty uses knowledge from nursing, social science, and public health science to impact the health of populations. Many nursing education programs no longer include a public health nursing specialization, and fewer nursing students are enrolling in the public health nursing programs that are available. Local health departments are often unable to offer nursing salaries competitive with those offered in acute care settings. The role of Nurse Administrator in local health departments often has been filled by a public health nurse, who brought a population-based, community-based, public health approach to health promotion planning, disease-prevention planning, health system partnerships, and nursing leadership. Economic difficulties and declining or stagnant county/city budgets make it even more likely that public health nursing and Nurse Administrator positions will go unfilled, be filled inappropriately, or be deleted. In addition, the current public health nursing workforce is aging and insufficient new public health nurses are joining the workforce. Public health nursing education programs cannot produce new, high-quality public health nurses without additional public health clinical education sites and innovative approaches to provision of clinical experiences. Ultimately, the lack of qualified public health nurses at the local level means that the health of individuals, families, and local populations will decline.

The Michigan Department of Community Health (MDCH), as part of its mission to protect the health of the people of Michigan, should advocate for funding that will enable local public health departments to maintain Public Health Nurse and Nurse Administrator positions within their organizations. Public Health Nurses and Nurse Administrators promote population health and reduce morbidity and mortality rates. To increase the supply of new public health nurses, partnerships between local health departments and schools of nursing, public health training centers, and schools of public health should be established so that nursing students have access to public health clinical education sites. Multiple parties (see recommendation above) should work towards restoring training funding so that local health departments can engage in such partnerships, include local public health clinics in web-based clinical placement systems for

nursing students, and explore alternative models for appropriate public health nursing clinical experiences.

The presence of public health nurses and Nurse Administrators in local health departments is a cost-effective strategy for maintaining and improving the health of underserved populations. Funding for Public Health Nurse and Nurse Administrator positions in LHDs could be aligned with an amendment to the PHC mandating such positions, or could be aligned with LHD contract requirements.

Approved by the MDCH – Task Force on Nursing Regulation for referral to the MDCH Task Force on Nursing Education, February 1, 2008

Submitted to the Director of the Michigan Department of Community Health, February 13, 2008

Background

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The MDCH convened the Task Force on Nursing Regulation (TFNR) in September 2007 to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to improve the education of nurses and the practice of nursing in Michigan, thereby protecting the health and safety of Michigan residents. The TRNR is composed of professional nurses, including representatives of the Michigan State Board of Nursing, nursing education programs, professional nursing practice organizations, experts in nurse credentialing and regulation, plus other stakeholders. The TFNR met from September through December 2007, and identified the issue of the Public Health Nursing Shortage as a high priority and amenable to a collaborative solution.

Nursing Regulatory Issue

The systemic factors that have led to a major nursing shortage expected to last through 2030 have led also to a critical shortage of Public Health Nurses. This nursing specialty uses knowledge from nursing, social science, and public health science to impact the health of populations. Many nursing education programs no longer include a public health nursing specialization, and fewer nursing students are enrolling in the public health nursing programs that are available. Nursing students are aware that the highest nursing salaries are found in nursing clinical practice in an acute care setting (hospitals). Local health departments are often unable to offer nursing salaries competitive with those offered in acute care settings.

Nursing education programs that include public health nursing courses have difficulty finding appropriate public health clinical education sites for their students. The DHHS Health Resources and Services Administration (HRSA) national agenda for public health nursing proposes a partnership between academia and public health clinical experience sites. The University of Michigan -- Michigan Public Health Training Center has designed a Community Health Nursing Education Curriculum as a model for partnership between the university and public health agencies at the graduate education level. This type of partnership also is needed statewide at the undergraduate level to educate and provide experience to additional public health nurses.

The role of Nurse Administrator in local health departments often has been filled by a public health nurse, who brought a population-based, community-based, public health approach to

health promotion planning, disease-prevention planning, health system partnerships, and nursing leadership. Economic difficulties and declining or stagnant county/city budgets make it even more likely that public health nursing and Nurse Administrator positions will go unfilled, be filled inappropriately, or be deleted. Ultimately, the lack of qualified public health nurses at the local level means that the health of individuals, families, and local populations will decline. (See Quad Council of Public Health Nursing Organizations, *The Public Health Nursing Shortage: A Threat to the Public's Health* (February, 2007).)

Proposed Solution and Rationale for the Solution

There is currently no statutory mandate for local health departments to have a qualified public health nurse on staff. The Headlee Amendment to the State Constitution prevents “unfunded mandates” that affect local government. Thus, a change to PHC Section 333.2235 to mandate the maintenance of Public Health Nurse and Nurse Administrator positions in local health departments could be enacted only if funding for the mandated public health nursing positions was provided by the State. It is recommended that the MDCH Director should advocate for funding for LHD Public Nurse and Nurse Administrator positions through the MDCH budget. Funding for Public Health Nurse and Nurse Administrator positions in LHDs could be aligned with an amendment to the PHC mandating such positions, or could be aligned with MDCH-LHD contract requirements.

Public Health Nursing is in the midst of a critical shortage, one that threatens the health of the nation. While nursing shortages have existed before, the magnitude of the current shortage is far worse than any the U.S. has ever experienced. In this time of increasing demands on public health to respond to issues such as emergency preparedness, new emerging infections, and significant increases in chronic illnesses, the public health nursing shortage must be addressed.

Public health nurses focus on the health of populations, working with communities, and the individuals and families who live in them. With an emphasis on prevention, their practice is multifaceted, and has resulted in positive health outcomes including enhanced surveillance; higher rates of breastfeeding; reductions in pre-term births and low birth weight rates; and improved behavior, education, and employment.

The current public health nursing workforce is aging and insufficient new public health nurses are joining the workforce. Public health nursing education programs cannot produce new, high-quality public health nurses without additional public health clinical education sites and innovative approaches to provision of clinical experiences. The Michigan Department of Community Health should advocate for restoration of funding for training in the Public Health portion of the MDCH budget, enabling local health departments to educational and clinical experience opportunities for nursing students. The Michigan Center for Nursing and others should include local public health clinics in the development of web-based clinical placement systems for nursing students. The Office of the Chief Nurse Executive and the Michigan Board of Nursing should explore alternative models for appropriate public health nursing education clinical experience (simulation laboratories, virtual-reality training, etc.)

Public health nurses and Nurse Administrators promote population health and reduce morbidity and mortality rates. The presence of public health nurses and Nurse Administrators in local health departments is a cost-effective strategy for maintaining and improving the health of underserved populations. The State of Michigan should invest in this cost-effective strategy.

Supporting References

1. Quad Council of Public Health Nursing Organizations, *The Public Health Nursing Shortage: A Threat to the Public's Health*. American Public Health Association, Feb. 2007. Online at: <http://www.apha.org/membersgroups/sections/aphasections/phn/Article:http://www.apha.org/NR/rdonlyres/BF0C85E1-85FD-4246-B321-81E93930D989/0/AThreattothePublicHealthFULLFeb2007.pdf>
2. www.astdn.org
3. www.apha.org
4. <http://archive.rockefeller.edu/publications/conferences/rosskerr.pdf>
5. MPHTC Curriculum Committee (attached). This model could be revised for undergraduate nursing education use.
6. *The Public Health Workforce Shortage: Left unchecked, will we be protected?* American Public Health Association, 2006.
7. *Public Health Workforce Shortage: Public Health Nurses*. Association of State and Territorial Health Officials, 2004.
8. *Public Health Workforce Study*, Health Resources and Services Administration, Bureau of Health Professions, 2005.
9. Institute of Medicine, *Who Will Keep the Public's Health? Educating Public Health Professionals for the 21st Century*. Washington, DC: National Academy Press, 2003.

MDCH- Task Force on Nursing Regulation

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Linda Fox

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G. Elaine Beane
Tarah Collins

Attachment A

Task Force on Nursing Regulation Rules of the Road

Ground Rules for Effective and Respectful Communication

Members of TFNR agree to the following ground rules to facilitate effective and respectful communication:

- Make every effort to attend (in person or by phone) all meetings.
- Make every effort to be on time for meetings.
- All members are expected to participate and to contribute their perspective.
- Keep the focus on agenda items.
- Keep the discussion focused.
- Raise your hand to speak; a facilitator will keep a list of the order in which hands were raised.
- Wait to be recognized before you speak.
- Only one person may speak at a time.
- Do not interrupt others or monopolize the communication.
- When speaking, be brief and to the point; try to give examples.
- When speaking, explain the reasons behind your statements and ask for feedback from the group.
 - Ask questions to understand the rationale and data behind the positions of others.
- Speak to be understood, not to win.
- Be sensitive to differences in perspectives.
- Discuss issues, rather than debating them; do not assign blame.
 - Avoid personal attacks, cheap shots or loaded questions.
 - Don't assume motives behind the statement of others. Assume positive intent.
 - Test your assumptions and inferences by asking questions.
 - Define important words and agree on what they mean.
- Resist defending positions; rather, look for common ground and areas of agreement.

Ground Rules for Decision Making

Members of TFNR agree to the following ground rules to facilitate decision making:

The Task Force on Nursing Regulation will use the *Consensus with Qualification* procedure to make decisions. *Consensus with Qualification* does not mean 100 percent agreement on everything by all members. The following three conditions must be met to reach *Consensus with Qualification*:

1. All members agree that the information in the proposed document is factually correct.
2. Each member is at least 80% comfortable with the proposed document and the member's organization will not oppose it.
3. With regard to the final product (not individual proposals or components, but rather the final recommendations), 80% of members are satisfied.

The process to reach *Consensus with Qualification* will assure that all concerns have been heard, understood, and addressed to the fullest degree possible and to the satisfaction of the group.

For decision items, the following steps will occur:

- a. Proposals are presented and clarified to the group. Whenever possible, proposals will be distributed in advance of the meeting.
- b. Members grade the proposal as:
 - 1) Totally agree
 - 2) Can live with it (see #2 above)
 - 3) Have legitimate concerns (for example, consequences of the proposal that are contrary to the goals of the group)
- c. Concerns are listed and addressed by the group. Changes can be made to the proposal if the group agrees.

If the group fails to reach *Consensus with Qualification*, members will clarify their objections and the TFNR Co-Chairs will make a decision with the input from the group.