Nursing Education in the Future

The future for nursing is looking bleak from many different perspectives. There is a significant shortage of nurses at the current time and the next 10 years could be even worse. There is a deficiency of baccalaureate trained nurses coming out of universities to fill leadership roles, and academic leaders can not agree on a standard for nursing education.

In the 1960’s most nurses came out of hospital based diploma programs where nursing students were both educated and used as a major component of the nursing workforce in the hospital. In 1965 the American Nurses’ Association (ANA), published a position statement advocating the minimum preparation for a nurse should be a baccalaureate degree. Due to great controversy and debate the position was never adopted. Additionally, it was defeated in 1978 and in 1982. The issue continues to be a hot topic, with organizations such as the American Association of Colleges of Nursing (AACN) and the Association of California Nurse Leaders (ACNL) coming on board to push for one standard of education for entry into nursing.

As we enter the 21st century most graduates of nursing schools have an associate degree and enter a healthcare world where they work side by side with colleagues educated as physicians, psychologists, social workers, physical therapists, audiologists and occupational therapists. Do they have the critical thinking skills to navigate these waters? Can these nurses feel comfortable attending policy making meetings/boards and representing the concerns of nurses?

Educat ing Nurses

How do we both rectify the problem of the nursing shortage and educate nurses to fill positions which require professionalism, critical thinking and technological savvy, while allowing for convenience and flexibility for students? Many programs look at the continuum of nursing. Educate nurses at the community college level with convenient and abundant programs to take them from RN to BSN and further if possible.

Another innovation is the development of on-line programs which allow 24 hour a day access to education. There are numerous on-line programs available for RN to BSN and BSN to MSN.

With the need to educate more nurses comes the need to educate more nurse educators. Many nursing school programs must turn down nursing students due to lack of adequate nursing instructors for the students. The current median age for nursing educators is 50-53, meaning most doctoral prepared professors will retire in the next 10 years.

Recruitment of Nurses

Johnson & Johnson and other private institutions have taken an interest in the recruitment of high school students into nursing and re-entry of nurses into the work force. Johnson & Johnson has partnered with Sigma Theta Tau International, the National League of nurses, the National Student Nurses Association and the Association of Nurse Executives to develop and administer a major nursing recruitment campaign. It includes a website which profiles a wide variety of nurses, gives the how’s and why’s to join nursing, information on nursing programs and funding opportunities. The site can be found at www.discovernursing.com.

Federal based scholarships and loan incentives will increase the number of educated nurses in hard hit areas. The currently non-funded Nurse Reinvestment Act would bring $250 million to the recruitment and education of Nurses with 800 nursing education loans, including the National Nurse Service Corps which will pay tuition, books and stipend to those who will commit to working in underserved areas for two years.

With innovation and creativity in nursing recruitment and education, nursing has an exciting, though tumultuous future. What can be done to help nursing? Let your senators and representatives know you want the Nurse Reinvestment Act funded as soon as possible, advocate for youth to go into nursing, and if you are a registered nurse with an advanced degree consider teaching nursing.


Submitted by: Kate Hutchison, Region 1
Quality of Care: Focusing on the Carrot - Implementing Regional Perinatal Education

Maintaining clinical competency in maternal and neonatal health care requires ongoing multidisciplinary education. Although there is a plethora of educational options available, one can not discount the benefits a regionalized perinatal education system involving outpatient and inpatient providers, varying disciplines (medical, nursing, social work, respiratory therapy), professionals who care for both low and high-risk patient conditions, lectures on both maternal and neonatal topics and experts from both the academic and public health sectors. This concept extends beyond the walls of any one facility and requires community-based assessment of need, outreach efforts and extending oneself to the community, while at the same time creating a cost-effective model of regionalized education.

Why should there be regionalized perinatal education? According to the American Academy of Pediatrics and the American College of Obstetrics and Gynecology’s Guidelines for Perinatal Care, it is the role of the subspecialty perinatal unit to provide education to other facilities. In the State of California, the California Children’s Services (CCS) Regional Cooperation Agreement standard requires the provision of education between facilities. Title 22 requires that all perinatal care units have written policies and procedures for transport and consultation between facilities.

For the community hospitals

- Required for CCS Community and Intermediate NICUs
- Acquire knowledge and skills leading to enhanced quality
- Low cost educational opportunities
- Give input into topics relevant to local facilities needs in terms of occurrences, sentinel events and/or risk management
- Establishment of relationship with receiving center which will promote ease of requesting consultation, referral and transfer of high-risk patients

For individuals

- Need for local continuing education on perinatal topics
- Ability for professional networking
- Establish relationships with multiple hospitals
- The benefits and opportunities are great. The education will be phenomenal. The quality of care will excel.

Submitted by: Ellen Silver, RNP, Region 6

Joint Commission Issues Sentinel Issues Alerts

The Joint Commission on Accreditation of Healthcare Organizations (JACHO) has issued one new sentinel event alert and revised another dealing with kernicterus. The issues discussed included infant death and injury during delivery and prevention of kernicterus.

Revised Sentinel Event Issue 18 (now 31) reviews kernicterus a highly preventable condition of newborns that leads to severe brain damage or death. The clinical guideline stressed the importance of universal systematic assessment while the newborn is hospitalized, close monitoring and follow-up upon discharge and prompt intervention once jaundice is diagnosed.

The essential elements of the recommendations provided by the American Academy of Pediatrics suggest that clinicians should promote and support successful breast feeding, establish nursery protocols for the identification and evaluation of hyperbilirubinemia, measure the total serum bilirubin (TSB) or transcutaneous bilirubin (TcB) level of infants jaundiced in the first 24 hours, recognize that infants <38 weeks gestation particularly those who are breastfed are at higher risk of developing hyperbilirubinemia and require closer monitoring, perform a systematic assessment for the risk of severe hyperbilirubinemia on all infants prior to discharge and the risk assessment, treat newborns when indicated with phototherapy or exchange transfusion.

In July, 2004 JACHO issued Sentinel Event Issue #30: Preventing Infant Death and Injury During Delivery, which describes reviewable cases under this standard as those where “any perinatal death or major permanent loss of function unrelated to a congenital condition in an infant having a birth weight of greater than 2,500 grams.” JACHO reported that 47 cases of perinatal death or permanent disability were reported since 1996. These cases represented a wide range of maternal age, mostly primigravida women at term. For more information on root causes, risk reduction strategies and recommendations please visit: http://www.jcaho.org/about/us/news+letters/sentinel+event+alert

Perinatal Profiles of California:

2001 and 5-Year Cohort Data

This fall hospitals and regions will receive the eighth annual issue of the Perinatal Profiles maternal and child data. The objective of Perinatal Profiles is to provide facilities information on their performance that may reveal where efforts in Quality Improvement (QI) are needed. The primary purpose of this analysis is to provide a way of comparing mortality rates in a hospital or within a region to the statewide mortality rates. The Perinatal Profiles provide risk-adjusted fetal, neonatal and post-neonatal mortality rates for all facilities. A secondary purpose is to assess additional sentinel indicators of the quality such as the percentage of very low birth weight infants born at hospitals without expanded neonatal care and the percentage of primary cesarean sections. This year the Perinatal Profiles will be available on the web at a secure site https://perinatalprofiles.berkeley.edu. For more information or to receive access to your facility’s data please contact your Regional Perinatal Program of California.
Black Infant Health Program (BIH)

The Black Infant Health Program (BIH) was created as a result of California Senate Bill 165 of the Budget Act of 1989. The bill was enacted to address the high rate of infant mortality for African American families. In that year, the infant mortality rate for African Americans in California was 19.2 deaths for every 1,000 live births.

Program Purpose
The purpose of BIH is to eliminate the disproportionate African-American infant mortality rate and to improve related health status indicators in the African-American communities of California. The BIH program is designed to identify “at risk” pregnant and parenting African-American women, to provide them assistance that will aide in their assessing and maintaining appropriate health care and receiving other family supportive services. Additionally, BIH assures that appropriate pediatric and preventative baby care, including immunizations are available and accessible to all children in the family and community through the first year of life.

The goals of the Black Infant Health Program are as follows:

- To reduce African-American infant mortality through a comprehensive community-based effort by assuring that at-risk pregnant, parenting woman and children up to age two have access to quality maternal and child services.
- To increase the number of African-American women obtaining prenatal care in the first trimester.
- To reduce the number of African-American infants born with birth weights below 2,500 grams.
- Reduce the number of pregnant African-American women who use tobacco, alcohol or nonprescription drugs.
- Reduce the number of African-American babies who die due to SIDS.
- To reduce African-American maternal mortality.

Jurisdictions and Populations Served
BIH services are available within 17 local health jurisdictions where 93% of African-American live births and deaths occur. The 17 jurisdictions are: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, the City of Berkeley, Cities of Long Beach and Pasadena. Health department personnel in conjunction with local community advisory boards and community/faith based-organizations provide services. As funds are not available to provide BIH services for all African American pregnant and parenting women, specific zip codes are targeted. Services are for women age 18 and over. Teen mothers under age 18 are not eligible for the BIH program, but do qualify for Adolescent Family Life Program (AFLP) services.

Funding
Funding sources are Federal Title V MCH Block Grant Funds and State General Funds.

Implementation Activities
Models of practice include prenatal care outreach, social support/empowerment, case management and the role of men. Specific implementation activities include, but not limited to:

- Providing and/or assuring culturally competent outreach in the African-American community targeting pregnant and parenting women at risk for poor birth outcomes.
- Promotion of better health care, pre-conception care, proper nutrition, putting babies on their backs to sleep, and smoking cessation programs in a community context.
- Educate and increase awareness in the community on the status of infant morbidity and mortality.
- Increase community awareness regarding the disparate African-American infant mortality rate through conducting at least two Celebrate Healthy Baby Events.
- Maintain a BIH Community Advisory Board for the purpose of developing/strengthening local community partnerships collaboration.
- Collaboration with relevant programs, service providers, community level resources such as Alcohol and Drug Programs for the purpose of service provision and networking.

Data Collection
As with most programs, documenting outcomes and program activities has become increasingly important. Documentation includes outreach to potential clients, meeting the needs of clients, and looking at fetal, infant, and maternal outcomes. Reducing the number of African-American infants born with birth weights below 2,500 grams, the number of African-American babies who die due to SIDS and African-American maternal mortality are important endpoints. An evaluation of the BIH program from 1994 to 1998 showed a reduction in the births of very premature and very low birth weight infants to high-risk women.

Summary
The program has collaborated with programs and agencies to meet the needs of BIH clients. Examples of collaborating agencies include the California State SIDS Program, and the State Epidemiology and Prevention and Injury Control Branch and the California Institute on Human Services at Sonoma State University. The Black Infant Health Program has served as a national model of focused interventions to a population at high risk for poor perinatal outcome.

Adapted from
- BIH Scope of Work (http://phps.dhs.co.la.ca.us/mch/BIH/BIH%20RFP%202004-1/RFP%20files/Attachment%201Scope%20of%20Work%2011-04%20.pdf)

Submitted by: Jennifer Baptiste-Smith / Fran Davis Snavely, Region 7
Legislative Update

California State Budget:
In July Governor Schwarzenegger signed SB1113, a $105 billion budget plan for FY2004-2005. Many core protections for healthcare coverage were maintained in the budget act, including no caps on enrollment, no waiting lists for services and no “tiering” of healthcare benefits. Premiums in the Healthy Families Program for families with incomes between 201-250% of the Federal Poverty Level were increased from $9 per child and $27 per family of three or more to $15 and $45 respectively. However, there are no increases in co-pays, nor will total out of pocket expenses exceed the 5% maximum allowed under the federal law.

California Performance Review
In August the California Performance Review (CPR) released its final report to the Governor. The report contains over 1000 recommendations. Chapter 2, pages 11-17, describe the recommendations. Proposed improvements include:
- To assure all Californians that the state’s public health systems will respond effectively and without delay in the event of any outbreak of disease or bioterrorism;
- To operate state facility and health professional licensing programs in a way that protects consumers and applies fair and rational licensing standards.
- To build an organization that better addresses the common linkages between mental health problems and substance abuse problems.
- To recognize the priority of providing both developmental and physical rehabilitation services to California’s disabled community.
- To provide effective assistance to any family that needs support from government on a temporary basis due to unforeseen circumstances, and
- To ensure that taxpayers get the best value for the health services purchased by the state. To implement these strategic goals, the CPRT recommends organizing the department into seven (7) entities: Office of the Secretary, the Center for Health Purchasing, the Center for Public Health, the Center for Behavioral Health, the Center for Services to the Disabled, the Center for Social Services and the Center for Finance and Supportive Services.

The Report, titled A Government for the People for a Change: form follows function is available at Website: http://cpr.ca.gov

Federal Fiscal Relief:
Congress recently introduced bi-partisan federal legislation to extend the temporary increase in federal Medicaid (MediCal in California) funding, generating approximately $500 to $600 million in relief for the State of California.

Legislation 2004-2005
AB 2331 (Mountjoy): Abortion: Fetal Pain
This bill would require the physician performing an abortion in the 3rd trimester to offer the pregnant woman information and counseling on fetal pain and offer anesthesia for the fetus.

AB 2049 (Nakanishi): Fetal Ultrasound (Chaptered)
A person or facility that offers fetal ultrasound, or a similar procedure, for keepsake/entertainment, without a physician's prescription, shall disclose to a client in writing, the following statement: "The federal Food and Drug Administration has determined that the use of medical ultrasound equipment for other than medical purposes, or without a physician's prescription, is an unapproved use.”

AB 3044 (Yee): Prenatal Ultrasound (Senate, third reading)
This bill would require any licensed health facility that provides prenatal ultrasound screening to detect congenital heart Defects, with the exception of a small and rural hospital, to require that the ultrasound be performed by a sonographer who is nationally certified in obstetrical ultrasound by the American Registry for Diagnostic Medical Sonography or the American Registry of Radiologic Technologists, or has a minimum of 5 years of work experience in this state as a sonographer. The bill would require ultrasounds be performed under the direct supervision of a qualified physician.

SB 1555 (Speier): Maternity Care (Assembly third reading)
Would require every individual or group policy of health insurance that covers hospital, medical, or surgical expenses issued, amended, renewed, or delivered on or before Jan 1, 2005, shall cover maternity services including prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care including labor and delivery and postpartum care.

SB 1590 (Dunn): Public records: personal information.
(Assembly third reading)
The bill would allow disclosure of personal information regarding patients age, ethnicity, etc. as long as there is no individually identifiable information.

AB 2963 (Pacheco): Health Facilities: nurse : patient ratio
Hearing cancelled at the request of the Author.

SB 1275 (Ortiz): Hospitals: maternity services-infant feeding. Failed passage.


AB2839 (Daucher): Nursing schools.
This bill would require the board to encourage and facilitate transfer agreements or enrollment models between associate degree and baccalaureate degree nursing programs.

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