

But Who Will Teach Them?

**A report on the faculty shortage in publicly funded
nursing education programs in Massachusetts**

**Prepared for the Nursing Career Ladder Initiative (NUCLI),
an industry/labor/education/workforce development partnership**

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Nursing Career Ladder Initiative (NUCLI)

NUCLI was funded in May 2002 by the U.S. Department of Labor to address the critical nursing shortage in Massachusetts. NUCLI aims to help rebuild and reinvigorate the nursing development pipeline in Massachusetts, and in so doing to:

- Increase the number of nurses available to work in the healthcare industry,
- Increase the enrollment capacity of Massachusetts nurse education programs,
- Decrease the attrition rates of Massachusetts nurse education programs, and
- Improve the retention rate of practicing nurses.

NUCLI State Advisory Committee

Industry Partners

Home Health Care Association of Massachusetts
Massachusetts Association of Health Plans
Massachusetts Council for Home Care Aide Services
Massachusetts Extended Care Federation
Massachusetts Healthcare Human Resources Association
Massachusetts Hospital Association
Massachusetts Medical Society
Metrowest Community Health Care Foundation

Unions and Professional Associations

Institute for Nursing Healthcare Leadership
Massachusetts AFL-CIO
Massachusetts Association of Registered Nurses
Massachusetts Center for Nursing
Massachusetts Organization of Nurse Executives
State Healthcare and Research Employees
SEIU, Local 285
SEIU, Local 767, Hospital Workers

Education and Workforce Development

College of Nursing, University of Massachusetts, Amherst
College of Nursing, University of Massachusetts, Boston
Massachusetts Community Colleges Executive Office
Massachusetts Workforce Board Association

State Partners

Commonwealth Corporation
Department of Labor and Workforce Development
Department of Public Health
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Senator Richard T. Moore, Massachusetts Senate, Chair,
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Technical Assistance Partners

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Metro South/West Regional Employment Board
Regional Employment Board of Hampden County

Executive Summary

The Nursing Shortage

The United States is in the midst of a dramatic nursing shortage. While the need for additional nurses continues to grow, the healthcare industry cannot fill the positions that are currently vacant. The American Hospital Association reports that 126,000 nursing positions are currently vacant.¹ The US Bureau of Labor Statistics projects that “one million new and replacement nurses will be needed by the year 2010.”² In Massachusetts, according to a recent study by the Massachusetts Hospital Association and the Massachusetts Organization of Nurse Executives, the state is experiencing a 10 percent vacancy rate in acute care facilities, the highest in almost 14 years. In long term care, the shortage is closer to 22%.³ The overall shortage is projected to reach 29 percent by 2020.⁴ In hard numbers, there are estimated to be about 7000 nurse vacancies in the state at the present time. The Massachusetts Department of Employment and Training (DET) projects an expansion of 12,000 new nursing positions by 2010.

Nursing and the Healthcare Economy

The nursing shortage impacts all levels of health care in every region of the state, from the major teaching hospitals in Boston to the rural, community hospitals in the Berkshires, and from hospital nursing to home care. In addition to contributing to the quality of life for the state’s citizens, healthcare also plays a tremendous role in the Massachusetts economy. Nursing and the ability of the industry to hire qualified nurses is a critical component on both fronts.

As an economic sector, health care is the state’s second largest employer, accounting for over 400,000 jobs, or 14% of employment. That number is projected to continue to climb. Registered nurses account for more than eighteen percent (18.25%) of all health care workers, 61,920 at the bedside and 12040 in other positions. According to the Massachusetts DET, the number of jobs for registered nurses is expected to climb to 84,410 by 2008. This increase, mostly in bedside positions, translates to an annual number of

1 For more information, see www.hospitalconnect.com/ahapolicyforum/trendwatch/twjune2001.html

2 United States, Bureau of Labor Statistics at www.bls.gov/

3 MECF Annual Employment Survey, 2002.

4 As cited in “Massachusetts Health Care Organizations Team with Johnson & Johnson To Address State Nursing Shortfall,” at www.jnj.com/news/jnj_news/20030127_131049.htm

new openings of 2,270 from 2002 to 2008. Approximately half of this number will replace retiring nurses and half will meet increased demand for healthcare services, created by the aging population and increased life expectancy.

The Nursing Pipeline

In the past, nursing was one of the primary career choices for women. Currently, young people, particularly young women, are not choosing to become nurses because they see many more career options open to them than were open to young women in the past—and because the nursing profession seems less appealing. This is reflected in the fact that from 1998 and 2001, enrollments in registered nursing programs in Massachusetts decreased by 21% and the total number of graduates decreased by 39%.⁵ In addition, the well-publicized push for managed care in the 1990s resulted in reorganization within many healthcare facilities and, at times, nurses being laid off. This perceived lack of job security and the image of nursing as a demanding role may be keeping qualified new recruits away.

In response to the current nursing shortage, the Massachusetts Nursing Career Ladder Initiative (NUCLI) was created through a grant from the US Department of Labor, and by a multi-stakeholder consortium representing the healthcare industry, nursing education, workforce development, state policy-makers, unions, and nurse professional organizations. NUCLI aims to rebuild and reinvigorate the nursing development pipeline within the Commonwealth. Specific objectives include increasing the number of nurses available to work in Massachusetts, expanding the capacity of the publicly funded nursing education programs in the state, decreasing the attrition rate of these nurse education programs and improving the retention rate of practicing nurses.

Other efforts to address the shortage include employer-based solutions such as increased salaries, sign-on bonuses, referral bonuses and flexible scheduling options. In addition, recruitment strategies, which include marketing campaigns such as Johnson & Johnson's Campaign for Nursing's Future, aim to change the image of nursing and attract new people to the profession. Legislative efforts at the federal and state levels are raising public awareness of the shortage and aim to provide funding to individuals interested in pursuing nursing education.

5 See Massachusetts Board of Registration in Nursing: Licensed Nursing Statistics at www.state.ma.us/reg/boards/rn/nedu/02rnstat/02cont.htm

The Nursing Faculty Shortage

Unfortunately, encouraging workers to enter the profession can only go so far towards solving the nursing shortage. Without adequate capacity in nursing education programs to educate greater numbers of nursing students, the system can, at best, replace exiting or retiring nurses, but never impact the overall growing need for additional nurses throughout the industry.

In Massachusetts, there are currently 41 Approved Registered Nurse Education Programs: 20 at the BSN level and higher, 20 at the ADN level, and 1 Hospital Based Diploma ADN Program. These programs range in size from approximately 25 to 450 enrolled students. At the BSN level and higher, seven of the twenty institutions that offer RN programs are public, including three state colleges and four of the five UMass campuses.⁶ At the ADN level, the majority of the programs are within public institutions of higher education, specifically, the fifteen Massachusetts community colleges. Informal survey data indicates that the majority of these programs are operating at full capacity and most have substantial waiting lists. Similar information is reported for the Licensed Practical Nurse (LPN) programs across the state. Nursing program administrators report that faculty shortages, limited sites for clinical rotations and inadequate lab facilities on campus contribute to their programs inability to expand capacity and enroll more qualified applicants.

This mirrors national data. Responses to a national survey during the 2000-2001 academic year, indicate that nursing schools turned away 5,823 qualified applicants across the U.S. due to insufficient numbers of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. More than a third (38.8%) of schools who responded to the survey pointed to faculty shortages as the major reason for not accepting all qualified applicants into entry-level baccalaureate programs.⁷

The Aging Workforce and the Nursing Faculty Pipeline

Across the nation, the median age of nursing faculty is 51 years.⁸ This holds for Massachusetts as well. At the time that the NUCLI proposal was submitted, all partners were aware that the nursing faculty corps in Massachusetts was aging and the shortage of nursing faculty would become a major obstacle

6 Framingham State College offers a bachelor of science with a major in Nursing for registered nurses who already have an associate degree or a diploma in Nursing.

7 American Association of Colleges of Nursing. (2001) Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing.

8 American Association of Colleges of Nursing, 2002a.

in sustaining initiative results. Mass retirements were expected to begin in 5 to 10 years. What was expected to be a problem in near future, though, became an immediate concern when the state implemented its Early Retirement Incentive Program and many of the state's nursing program faculty retired early from their positions. In fact, at one of the community colleges, the nursing program lost four out of seven faculty members as a direct result of the early retirement program.

The current faculty vacancy rate in Massachusetts averages approximately 17% at ADN programs and 6% at BSN programs. The vacancy rate is expected to remain at this level or increase over the next several years. The problem is that there are minimal numbers of individuals in the nurse educator pipeline to replace those who do retire. Nurses are not choosing to further their education. In fact many report that there are inherent disincentives in salary and advancement opportunities if they leave their positions in order to acquire an advanced degree.

In Massachusetts, only 10% of nurses have an MSN (the minimum degree required to teach in a nursing program) and 35.9% have their BSN (MACICC, 2002). Although these figures are slightly higher than the national averages, most of the registered nurses in Massachusetts (78.2%) do not plan to seek additional nursing education during the next two years (MACICC, 2002). Furthermore, in light of current trends, it is clear that the vast majority of students who are pursuing an MSN degree are not seeking the advanced degree in order to become nurse educators, but instead are choosing clinical practice or nurse practitioner degrees. These positions are attractive because they typically involve a relatively high salary level and higher level of autonomy than other roles.

The causes of the faculty shortage are complex. As with the nursing shortage in general, the faculty ranks within nursing education programs are aging and faculty are beginning to retire in large numbers. Other contributing factors include historic downsizing of nurse education programs in response to enrollment fluctuations, lower salary levels compared to clinical roles, the challenges of working in an academic environment, the length of time it takes to obtain graduate degrees, the lack of graduate programs with educator tracks, and the fiscal crisis in Massachusetts.

Recommendations

Partnerships

Like the nursing shortage itself, there is no one answer to the problem. And the complexities involved suggest that no one group of individuals or even organizations will be able to furnish the solutions, the resources to enact the solutions, and make the lasting changes required to prevent the situation from occurring again. Solving the faculty shortage will require collaboration among a range of stakeholders, invested in improving the situation for the long-term. RN programs, graduate schools of nursing, healthcare employers and workers—including nurses, state and federal policy-makers, third party payers, private foundations, consumers, and others must come together to create and implement a solution-focused strategy.

Strategies must address both recruitment and retention of faculty and include ways to address the many barriers described above. There are currently efforts under way that are focusing on the immediate need for clinical instructors. Schools of nursing are partnering with healthcare employers in their regions to find qualified clinical instructors. In many cases, the employers are paying the full salary for those instructors, who remain on the employer payroll. In other cases, employers and colleges are supporting joint appointments, in which the nurse educator has duties at both the college and the employer facility. These partnerships are effective in meeting an immediate need, and may be a step towards a longer-term solution if partners are willing to codify and institutionalize their relationships and commitments.

There is much more room for creative partnership development between employers, colleges, and other community and state partners. In other states, there are examples of partnerships creating joint research opportunities for both practicing nurses and nurse educators, enabling nurses to become more involved with bettering the practice of nursing and healthcare, which is an incentive for both groups to continue and advance their employment. Centers for Nursing Excellence have been established by multiple stakeholders, which has helped to institutionalize partner relationships and support by giving a name and face to their concepts. The mutual benefit for all partners is the most telling aspect of these models, and a critical factor in whether any partnership survives or not.

Altering Structural Barriers

Additional strategies, and those that make a longer-term impact, will need to address the structural issues affecting recruitment and retention of full time

academic faculty. Hiring practices, compensation structures, collective bargaining procedures and contracts should be examined by all stakeholders to determine where real and perceived barriers exist, and then work to remove those barriers. An effort should be undertaken to market the role of nurse faculty among both practicing nurses and student nurses.

The academic discipline of nursing must also be examined. Across the country, new faculty are older than their counterparts in other disciplines. They also advance to higher degrees at a slower pace than their non-nursing colleagues. Perhaps the two issues are linked. That is, older nursing faculty, often with family obligations, lack the time and energy to include advanced degree work in their already overburdened schedules. This situation should be explored by the profession itself, initially by a working group of nursing faculty, new entrants and long-timers, who can identify the issues affecting faculty retention, where changes can be made, and what types of supports are needed to encourage faculty to advance. It may be of value to consult with colleagues in other disciplines.

There appears to be limited capacity in nursing graduate programs to support nursing education courses. While most of the schools did have such courses on the books, few were offering those courses on a regular basis, largely, it seems, because students were not choosing these courses. If efforts are made to encourage individuals to become nurse faculty, this particular capacity issue will have to be addressed. Shared courses across schools may be an option, or even on-line programs would be cost effective mechanisms for distributing learning across multiple campuses.

Partnering with Policy-Makers: Building a Consensus Agenda

Because many of the parameters affecting nursing education and healthcare generally are established or influenced by government entities, local partners will not be able to make effective and lasting change on their own. State and federal policy-makers must be viewed as partners in this effort. If multiple stakeholders, who may not always be in agreement politically, can come together with legislators and other policy-makers, they will be a force to be reckoned with. Educators and employers should come together with policy-makers to establish a consensus agenda, that all can agree to support.

Table of Contents

Introduction	1
The Nursing Shortage in Massachusetts	4
The Nursing Faculty Shortage in Massachusetts	7
The current faculty	8
Anticipated faculty vacancies	10
The current faculty pipeline	12
The Complexities of the Nursing Faculty Shortage	14
Historic downsizing	14
Aging faculty	14
Salary issues	15
Alternatives for MSNs: Advanced Practice Nursing	17
Teaching environment	17
Length of time to obtain doctoral degrees	18
Lack of educator preparation programs	18
The fiscal crisis in Massachusetts	20
Budget cuts	20
The early retirement incentive program	20
Strategies to Address the Faculty Shortage	22
Short-term strategies	22
Resources	22
Increasing the pool of clinical instructors	22
Partnerships between schools and employers	23
Dual appointments	24
Long-term strategies	25
Salary	25
Support for faculty	25
Marketing the educator role	26
Compress the time to PhD	27
Keep the educator track within graduate programs	27
Policy implications	27
Conclusion	29
Sources	30

Introduction

The United States is in the midst of a nursing shortage. The American Hospital Association reports that 126,000 nursing positions are currently vacant.¹ The US Bureau of Labor Statistics recently projected that “one million new and replacement nurses will be needed by the year 2010.”² In Massachusetts, “according to a recent study by the Massachusetts Hospital Association and the Massachusetts Organization of Nurse Executives, the state is experiencing a 10 percent vacancy rate in acute care facilities, the highest in almost 14 years. In long term care, the shortage is closer to 22%.³ The overall shortage is projected to reach 29 percent by 2020.”⁴ In hard numbers, there are estimated to be about 7000 nurse vacancies in the state at the present time. The Massachusetts Department of Employment and Training (DET) projects an expansion of 12,000 new nursing positions by 2010.⁵

Research suggests that the demand for nurses will continue to grow due, for the most part, to the aging population and increased life expectancy. Between 2010 and 2030, “the proportion of the population aged 65 or older will increase from approximately 13 percent to 20 percent. This represents an increase of approximately 30 million people aged 65 and older.”⁶ For Massachusetts, this is of particular concern. According to the US Census Bureau, Massachusetts’ population is older than the majority of the country. In the “Population and Ranking Tables of the Older Population for the United States, States, and Puerto Rico,” Massachusetts is ranked 12th.⁷ Other factors which will drive the need for nurses include an increase in public health problems, increases in patient acuity, and market pressures demanding quality care (Brendtro & Hegge, 2000).

Healthcare plays a tremendous role in the Massachusetts economy, as well in the quality of life for the state’s citizens. Nursing is a critical component on both fronts. As an economic sector, health care is the state’s second largest non-government employer, accounting for 341,320 jobs, or 10% of employ-

The Massachusetts Department of Employment and Training (DET) projects an expansion of 12,000 new nursing positions by 2010.

1 For more information, see www.hospitalconnect.com/ahapolicyforum/trendwatch/twjune2001.html

2 United States, Bureau of Labor Statistics at www.bls.gov/

3 MECF Annual Employment Survey, 2002.

4 As cited in “Massachusetts Health Care Organizations Team with Johnson & Johnson to Address State Nursing Shortfall,” at www.jnj.com/news/jnj_news/20030127_131049.htm

5 Massachusetts Division of Employment and Training at www.detma.org

6 “Who will Care for Each of Us?” May 2001, University of Illinois at Chicago, College of Nursing, Nursing Institute, page 7.

7 See United States Census at www.census.gov/population/www/cen2000/phc-t13.html

ment. By 2008, that number is projected to climb to 404,190. Registered nurses account for eighteen percent of these health care workers, 61,920 at the bedside and 12040 in other positions. According to the Massachusetts DET, the number of jobs for registered nurses is expected to climb to 84,410 by 2008.⁸ This increase, mostly in bedside positions, translates to an annual number of new openings of 2,270 from 2002 to 2008. Approximately half of this number will replace retiring nurses and half to meet increased demand for healthcare services, created by the aging population and increased life expectancy.

In response to the nursing shortage, the Massachusetts Nursing Career Ladder Initiative (NUCLI) was created through a grant from the US Department of Labor. One of the key objectives of the initiative is to expand the capacity of the publicly funded nursing education programs in the state in order to increase the number of individuals in the nursing pipeline. Other

Strategies to address the faculty shortage will need to go hand in hand with strategies to recruit more individuals into the nursing profession.

objectives include enabling 400 individuals to attain a license to practice as a nurse and lowering the attrition rate in nurse education by 50%. At the time that the proposal was submitted, we were aware that the shortage of nursing faculty would become a major obstacle in sustaining initiative results. Across the nation, the median age of nursing faculty is 51 years⁹ and there are minimal numbers of individuals in the faculty pipeline. This mirrors the situation in Massachusetts. At all of the public institutions offering registered nursing programs, many faculty are rapidly approaching retirement age. The situation in Massachusetts was exacerbated and accelerated, however, when the state implemented the Early Retirement Incentive Program for state workers. In fact, at one of the community colleges, the nursing program lost four out of seven faculty members as a direct result of the early retirement program. The current faculty vacancy rate averages approximately 17% at ADN programs and 6% at BSN programs. The vacancy rate is not expected to decrease significantly over the next several years. In terms of the pipeline for faculty, currently, 35.9% of the RNs in Massachusetts have their BSN (MACICC, 2002). These are the nurses who must be encouraged and supported to become faculty.

Strategies to address the faculty shortage will need to go hand in hand with strategies to recruit more individuals into the nursing profession. Through this initiative, efforts are currently underway at state-wide and regional levels to do both. Reaching the objectives will require effective, ongoing collaboration between schools of nursing, healthcare employers, workforce develop-

8 Massachusetts Division on Employment and Training at www.detma.org

9 American Association of Colleges of Nursing, 2002a.

ment organizations, legislators and other key stakeholders. The NUCLI Initiative is being directed at the state level by the State Partnership composed of representatives from Commonwealth Corporation, the Workforce Board Association and the Massachusetts Community Colleges Executive Office. At the regional level, key workforce investment boards are taking the lead within the four designated regions of the state.

The Nursing Shortage in Massachusetts

According to data compiled by the Massachusetts Hospital Association, the vacancy rate for RNs in 2002 for both acute care and specialty hospitals is 9.9% (MHA/MONE, 2002). The Mass. Extended Care Federation reports that the average vacancy rates for RNs in the long term care industry across the state is 21.5%.¹⁰ This currently translates to approximately 6,000 to 7,000 positions, with an additional 2000 new vacancies per year until at least 2010.¹¹ Within the hospital setting, the areas with the highest vacancy rates are oncology, telemetry, critical care (NICU), critical care (PICU) and Medical/Surgical. The nursing shortage impacts all levels of health care in every region of the state, from the major teaching hospitals in Boston to the rural, community hospitals in the Berkshires, and from hospital nursing to home care.

This shortage is different from past nursing shortages. Two distinguishing factors are the aging of the nursing workforce and the overall shrinking workforce. The most recent National Sample Survey of Registered Nurses reports that the average age of the working registered nurse population was 43.3 in March 2000, up from 42.3 in 1996. In Massachusetts, the average age is even higher at 45.7 years (MACICC, 2002). The RN population under the age of 30 dropped from 25.1% of the nursing population in 1980 to 9.1% in 2000.¹²

The nursing shortage impacts all levels of health care in every region of the state.

In the past, nursing was one of the primary career choices for women. Currently, young people, particularly young women, are not choosing to become nurses because they have more career options to choose from, and because the nursing profession seems less appealing. This is reflected in the fact that between 1998 and 2002, enrollments in registered nursing programs in Massachusetts decreased by 21% and the total number of graduates decreased by 39%.¹³ In addition, the well-publicized push for managed care in the 1990s resulted in reorganization within many healthcare facilities and, at times, nurses being laid off. This perceived lack of job

¹⁰ MECF Annual Employment Survey, 2002.

¹¹ Based on data from the US Department of Labor, Bureau of Labor Statistics at stats.bls.gov/oco/ocos083.htm

¹² From HRSA, Bureau of Health Professions: The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses at bhpr.hrsa.gov/healthworkforce/rnsurvey/

¹³ See Massachusetts Board of Registration in Nursing: Licensed Nursing Statistics at www.state.ma.us/reg/boards/rn/nedu/02rnstat/02cont.htm

security and the image of nursing as a demanding role may be keeping qualified new recruits away.

Retention issues and turnover also contribute to the vacancy rate. The MHA/MONE data indicates that turnover rates are highest in home health, skilled nursing, telemetry, rehabilitation and pediatric nursing. Data gathered by the Massachusetts Colleagues in Caring Collaborative (MACICC) indicates that nurses typically leave their positions due to workplace issues such as greater workloads, inadequate staffing, changing roles and workplace safety. Dissatisfaction with compensation and personal reasons also affect retention (MACICC, 2002). Nationally, one industry survey reported that the turnover rates for hospital nursing staff rose from 11.7 percent in 1998 to 26.2 percent in 2000.¹⁴ Research indicates that job turnover results from inadequate staffing, heavy workloads, demanding schedules, increased use of overtime and flat wages (USGAO, 2001).

Retention issues and turnover contribute to the vacancy rate.

Many efforts are underway to address the shortage. Employer-based solutions such as increased salaries, sign-on bonuses, referral bonuses and flexible scheduling options may offer short term solutions for their own vacancies, but typically do not bring new recruits into the nursing workforce. Long term recruitment strategies are being implemented to varying degrees. For example, marketing campaigns such as the one sponsored by Johnson & Johnson are working to change the image of nursing and attract new people to the profession. Legislative efforts at the federal and state levels are raising public awareness of the shortage and aim to provide funding to individuals interested in pursuing nursing education. Finally, collaborations between public and/or private entities including healthcare employers and schools of nursing are being developed to bring students into nursing programs and to build loyalty toward potential employers.

In Massachusetts, recruitment efforts to bring new workers into the field are ongoing across the state and include efforts targeting high school students and adult workers who may be considering a career change. Focus on these two groups is supported by research gathered for the 2002 Senior Nursing Student Survey sponsored by the Massachusetts Board of Registration for Nursing (MA BORN) which indicates that a large percentage of senior nursing students decided to become a nurse either before or during high school or at some point later in life, as a second career (MA BORN, 2002b). The survey also suggests that marketing efforts emphasize two distinct com-

¹⁴ Hospital and Healthcare Compensation Service, Hospital Salary and Benefits Report, 2000-2001 (Oakland, N.J.: Hospital & Healthcare Compensation Service, 2000).

ponents of the profession: being able to care for people and the opportunity to work in a challenging science-based environment.

Recruitment efforts may be paying off. After five years of declining enrollments and admissions (from 1996 to 2000), the MA BORN reports that admissions for all RN programs rose 9% in 2001, over the previous year and in 2002 rose another 3%. Enrollment figures remain constant. Of particular note are an 18% increase in the number of baccalaureate degree RN admissions for 2001 and an increase of 8% for 2002. Generic Master Degree Nurse programs continue to show increasing enrollments.¹⁵ At the ADN

level, an informal survey of the 15 Massachusetts colleges conducted in fall 2002 indicates that applications have increased and the majority of the programs have a waiting list of qualified applicants. At the national level, after a five year decline, enrollments at nursing schools across the country have also risen. Specifically, the American Association of Colleges of Nursing (AACN) reports that enrollments at entry-level baccalaureate programs rose in 2001 and 2002, ending a six-year decline, though enrollments in RN to BSN programs continue to decline. Enrollments in MSN programs also rose 3.5% in programs nationwide (AACN, 2002c).

Encouraging workers to enter the profession may not be effective if there is no space in nursing programs to educate them.

Unfortunately, encouraging workers to enter the profession may not be effective if there is no space within nursing education programs to educate them. During the 2000-2001 academic year, nursing schools turned away 5,823 qualified applicants across the U.S. due to insufficient numbers of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. More than a third (38.8%) of schools who responded to the survey pointed to faculty shortages as the major reason for not accepting all qualified applicants into entry-level baccalaureate programs.¹⁶ In Massachusetts, at the ADN level, administrators indicate that faculty shortages, limited sites for clinical rotations and inadequate lab facilities on campus contribute to their programs inability to accept more qualified applicants.

15 See Massachusetts Board of Registration in Nursing: Massachusetts Nursing Education Programs: Admissions, Graduations and Enrollment at www.state.ma.us/reg/boards/rn/nedu/nedp.htm

16 American Association of Colleges of Nursing. (2001) Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing.

The Nursing Faculty Shortage in Massachusetts

As healthcare employers are struggling with a shortage of registered nurses, schools of nursing are facing current and pending faculty vacancies and a very limited supply pipeline to fill these vacancies. The causes of the faculty shortage are complex. As with the nursing shortage in general, the faculty ranks within nursing education programs are aging and faculty are beginning to retire in large numbers. Other factors that contribute to the faculty shortage are the lower salary levels compared to clinical roles, the challenges of working in an academic environment, and the length of time that it takes to get a doctoral degree in nursing.

In Massachusetts, there are currently 41 Approved Registered Nurse Education Programs: 20 at the BSN level and higher, 20 at the ADN level, and 1 Hospital Based Diploma ADN Program.

These programs range in size from approximately 25 to 450 enrolled students. At the BSN level and higher, seven of the twenty institutions that offer RN programs are public, including three state colleges and four of the five UMass campuses.¹⁷ At the ADN level, the majority of the programs are within public institutions of higher education, specifically, the fifteen Massachusetts community colleges. All of the RN programs offer a full time day program of study, and many allow part time study and run some courses or entire programs on an evening/weekend schedule. At the ADN level, at least five schools offer RN programs on an evening/weekend schedule (with a mix of full and part time options) and two or three additional schools are planning to start an evening/weekend RN program for September 2003. For the 2001-2002 academic year, there were 1858 students enrolled in the BSN programs with an average enrollment of 265 and 1870 enrolled in the 15 programs at the community colleges with an average enrollment of 125 students.¹⁸

Within nursing programs, the faculty role has two distinct components. One is the academic role which involves preparing and delivering lectures, leading discussions, and preparing and administering exams, etc. The other role is that of the clinical instructor or supervisor. Most nursing courses contain a clinical practice component wherein students learn and practice skills and

Across the nation, the median age of nursing faculty is 51 years.

¹⁷ Framingham State College offers a bachelor of science with a major in Nursing for registered nurses who already have an associate degree or a diploma in Nursing.

¹⁸ This information is based on data collected by the MA BORN in the 2001-2002 Annual Reports submitted by each RN program.

Most of the schools surveyed for this report have reported difficulties in finding an adequate number of clinical instructors, particularly in Med/Surg, Maternity and Psych nursing.

concepts on site, often in a hospital setting, under the direction of a clinical supervisor or instructor.

Most full time faculty perform both the academic and clinical roles. However, because of the difference in the mandated teacher-to-student ratios, most nursing programs need to hire part-time or adjunct instructors to provide clinical supervision for some of the students. Most of the schools surveyed for this report have reported difficulties in finding an adequate number of clinical instructors, particularly in Med/Surg, Maternity and Psych nursing. Not only is it difficult to find interested and qualified instructors, but due to budgetary concerns, the institution or the program may not have the resources to support these positions.

In order to teach in a registered nurse program, whether the individual is providing classroom or clinical instruction or both, the Massachusetts regulations require the individual to have a current Massachusetts RN license in good standing, a Masters or doctorate in nursing, and specific experience and evidence of competencies in the area of instruction 244 CMR 6.04(2): Faculty Qualifications. Recently, a policy was adopted which allows the MA BORN to waive this requirement under specific circumstances. This will be discussed in further detail below.

The current faculty

As part of the annual report submitted to the MA BORN each year, schools of nursing which have RN programs are required to submit data regarding faculty. The required information fields include name, RN license number, date of initial faculty appointment, present title, an indication of full time or part time status, the educational credentials held and the institutions at which they were earned.¹⁹

There is currently no specific data regarding the age of nursing faculty in Massachusetts. Certain points of data indicate that the faculty corps is likely of an age in line with the national averages. First, the average age of nurses in Massachusetts is 45.7 years (MCICC, 2002). Nationally, the average age for nurses is 43.3 years and 51 years for faculty (AACN 2002b). Second, informal survey data collected from the publicly funded schools of nursing indicates that the average age for nursing faculty at the state colleges and the UMass campuses is between 50 -55, while at the community colleges, it may be a bit younger. There can be a wide variation between the fifteen commu-

¹⁹ To supplement this data and obtain information about faculty in programs at the MSN and higher level, an informal survey was disseminated. Approximately 40% of the schools at each level responded.

nity colleges, however, with one school reporting that the average nursing faculty is 55+ years old. Finally, a review of the faculty data submitted to MA BORN for the 2001-2002 academic year for the 22 programs addressed here indicates that most of the programs have at least 2 or 3 faculty who have taught in the program for 20 years or more. Several have more than 30% of their faculty who have taught for 20 years or more.

In terms of education, except for a few BSN-prepared nurses whose appointment was grandfathered or previously waived, all nursing faculty are required to hold at least a Masters degree in nursing. Most of the faculty at the ADN programs have an MSN as their highest degree, although many programs have one or two doctorally-prepared faculty members, and at least one member currently pursuing a doctoral degree. Nationally, at the BSN level and higher, only 50% of full time nursing faculty have a doctoral degree (Berlin & Sechrist, 2002). In Massachusetts, however, the percentage is much higher. At the four UMass campuses and three state colleges which offer RN programs, the percent of full time faculty with doctoral degrees is at least 80% and at two campuses, it's 100%. Individuals without a doctoral degree who teach at this level typically are not part of the tenure track leading to a full professorship (AACN, 1999). Most of these individuals provide clinical instruction as an assistant professor or part time adjunct professor.

Highest Nursing Education for RNs *

	US	MA
Doctoral Degree	Not available	0.60%
MSN	10.30%	13.20%
BSN	32.50%	35.90%
Associate	34.40%	22.20%
Diploma	22.80%	28.30%

* Percent of total RN population.

Source: MACICC, 2002.

Doctoral degrees held by faculty at the ADN and BSN programs include the PhD in nursing and related fields and EdDs in Education, Nursing Education, Human Development and other fields. The type of doctoral degree and the number of faculty required to hold them are based on a combination of the accreditation standards of the National League for Nursing Accrediting Commission, Inc. (NLNAC), university policies and the needs of the program. To meet the standards for faculty at the MSN level, the NLNAC requires that "nursing faculty are credentialed at a minimum of a master's in nursing degree, with the majority holding earned doctorates from regionally accredited institutions."²⁰ At the BSN and ADN levels, the Accrediting Commission requires that all members of the faculty hold, at a minimum, a master's degree in nursing.

20 For more information, see the NLNAC website at www.nlnac.org

Hiring policies at the university level require that full time faculty have their doctoral degree, regardless of the accreditation standards, in order to be on the tenure track. In addition, in order to broaden the scope of knowledge and training experiences of faculty, there may be restrictions about hiring faculty who have received their doctoral degree from the hiring institution. Finally, as vacancies arise within programs, hiring decisions regarding applicants with varied doctoral degrees are made based on the specific needs of the program.

The range in size of the faculty groups at each institution is reflective of the range in program size. The ratio of full time to part time faculty varies widely among the RN programs, although the majority have a greater than 1 to 1 ratio. A high number of part time faculty may be indicative of the programs inability to recruit or financially support full time faculty positions. However, since the majority of part time faculty do only clinical instruction, it may also reflect the need for flexibility within the program to be able to supervise different groups of students across specific specialty areas at several different clinical sites. Whatever the reason, having a high percentage of part time faculty can increase the burden on full time faculty in terms of program development, research and service.

Anticipated faculty vacancies

In order to understand the extent of the faculty vacancies across RN programs, the MA BORN conducted a Nursing Faculty Vacancy Survey in the spring of 2002.²¹ The survey was sent to the administrator of each of the 60 board-approved nursing education programs (including Practical Nursing programs). A total of 49 programs responded for a return rate of 82%. The return rate for all RN programs was 78%, with responses from 81% of the associate degree/hospital-based diploma programs and 74% of the baccalaureate and higher degree programs. 73% of the respondents represented public institutions. The survey included questions regarding the total number of FTE nursing faculty vacancies both for the current year and the number anticipated for the academic years 2002-2003 and 2003-2004. Respondents were also asked to provide data regarding current and anticipated student enrollment for these same periods. Although the survey was conducted before the state's early retirement program was implemented, the number of faculty expected to retire under the plan is incorporated in the number of anticipated vacancies for AY 2002-2003.

For the academic year 2002-2003, the number of anticipated FTE vacancies was 33.8 (17%) for Diploma/Associated Degree Programs and 18.5 (6%) for

21 For the complete survey results, go to www.state.ma.us/reg/boards/rn/nedu/02facvac.pdf

Baccalaureate or Higher Programs. For the next academic year, the number of FTE vacancies is projected to decrease slightly. Meanwhile, enrollments are projected to increase or remain constant. The slight decrease in the number of anticipated vacancies is not an indication that the shortage problem is easing. It may simply mean that there are fewer retirements expected during that specific academic year. The real problem, as outlined below, is that there are a minimal number of individuals in the nurse educator pipeline to replace those who do retire. To monitor the situation, the MA BORN plans to conduct a similar survey regarding faculty vacancies periodically during the next several years.

Anecdotal data collected during this academic year from many of the Massachusetts public higher education nursing programs supports these findings. Information from three of the public BSN and higher programs, suggests that the full time faculty at each of these schools is stretched thin in order to meet the needs of the students. Each of the programs has at least three vacancies, but administrators report that budget constraints allow them to fill only two of them. At the community colleges, most of the nursing programs currently have 0 or 1 full time vacancy, but anticipate at least 2 or 3 additional vacancies over the next few years due to retirements. At all levels, the following areas can be the most difficult to fill: Medical/Surgical, Obstetrics, Acute

Faculty Vacancies Among Board-Approved Nursing Education Programs in Massachusetts						
2001-2002 Through 2003-2004						
Spring 2002 Survey						
	2001-2002		2002-2003		2003-2004	
Program Type	Total Budgeted FTEs	Vacancy % of Total	Projected # FTE Vacancies	Vacancy % of 01-02 Total	Projected # FTE Vacancies	Vacancy % of 01-02 Total
Practical Nurse	105.5	19%	17.5	17%	11.5	11%
Diploma/Associate Degree Registered Nurse Program	200.2	4%	33.8	17%	31.6	16%
Baccalaureate and Higher Registered Nurse Degree	309.3	3%	18.5	6%	12.4	4%
Total Registered Nurse	509.5	3%	52.3	10%	44	9%

Source: MA BORN, 2002a.

Pediatrics, and Psych. Recruitment takes place through local, regional and national advertising as well as through word of mouth, particularly at clinical affiliates.

Unfortunately, schools won't be able to recruit nurse educators from other regions of the country because the shortage of nursing faculty is a problem throughout the country. In a survey conducted by AACN in 2000, 220 AACN member-institutions were polled. At that point, there were 5132 full time faculty positions across the programs. Of these, 4753 were filled and 379 or 7.4% were vacant (AACN, 2000).

Schools won't be able to recruit educators from other regions because the shortage of nursing faculty is a nationwide problem.

A recent study of the issue in the Southern Regional Education Board (SREB) states, which include 16 southeastern states and Washington, DC, indicates that a serious shortage of nursing faculty already exists and will get worse. Based on a combination of current vacancies and newly-created positions, the current vacancy rate is 12%, and is expected to worsen as faculty retire (AACN, 2002a). On the opposite side of the country, the projections are just as dire. In California alone, it is predicted that by 2003, due to anticipated retirements, BSN and higher degree programs will need to fill at least 163 full-time faculty positions (Berlin & Sechrist, 2002).

It seems clear that Massachusetts must either join in a national strategy to address the faculty shortage issue or develop mechanisms to grow its faculty corps from within state ranks.

The current faculty pipeline

In Massachusetts, only 10% of nurses have an MSN and 35.9% have their BSN (MACICC, 2002). Although these figures are slightly higher than the national averages, most of the registered nurses in Massachusetts (78.2%) do not plan to seek additional nursing education during the next two years (MACICC, 2002). Furthermore, in light of current trends, it is clear that the vast majority of students who are pursuing an MSN degree are not seeking the advanced degree in order to become nurse educators.

Across the country, the number of students interested in teaching, as indicated, in part, by the number in individuals in educator tracks, has decreased significantly in the last ten years. The number of educator tracks within graduate programs has also decreased due to a shift within the profession away from programs which focus primarily on nursing education as opposed to clinical practice. This will be discussed in greater detail below. In 1993, the number of students in educator tracks within MSN programs was 3,000,

representing 9.9% of all nursing graduate students enrolled at that time. By 1999, that figure was down to 1227 students or just 4.0% of the total number of students enrolled in graduate nursing programs. In 2000, across the country, only 2% of enrolled full and part time students are enrolled in this track (NLN, 2002). There has also been a decrease in the number of educator tracks within graduate programs. In 2000, only 64 of the more than 375 MSN programs offered an educator nursing track (NLN, 2002). In Massachusetts, a review of all nursing programs, both public and private, reveals only two that advertise an educator track or concentration at the MSN level. Instead of the faculty role, nurses pursuing a master's degree are choosing to become nurse practitioners, administrators, and in some cases, work in positions outside the care system in areas such as insurance, policy and biotechnology.

The vast majority of students pursuing an MSN degree are not planning to become nurse educators.

In terms of students pursuing a doctorate in nursing, the data is also discouraging. Although the number of doctoral programs in nursing has grown from 54 programs in 1992 to 79 programs in 2001, the number of actual graduates decreased (Berlin & Sechrist, 2002). In 1998, only “411 people graduated from doctoral programs in nursing. Of those, only 43 percent had an employment commitment to serve as nursing school faculty.”²² Of the 79 doctoral programs, only 13 offer nursing education as a specific option (NLN, 2002) although at other schools, students may be able to include nursing education as part of their studies.

22 See AACN, 1999, page 2.

The Complexities of the Nursing Faculty Shortage

Many factors are contributing to the current and projected faculty shortage. Aging faculty and program expansion are key causes. Most of the current vacancies are the result of faculty retirements. Others are the result of graduate-prepared nurses moving to positions outside academia for better salaries and more attractive working conditions. Still other complicating factors include the demanding work environment, the length of time it takes to obtain graduate degrees, the lack of graduate programs with educator tracks, and the fiscal crisis in Massachusetts.

Historic downsizing

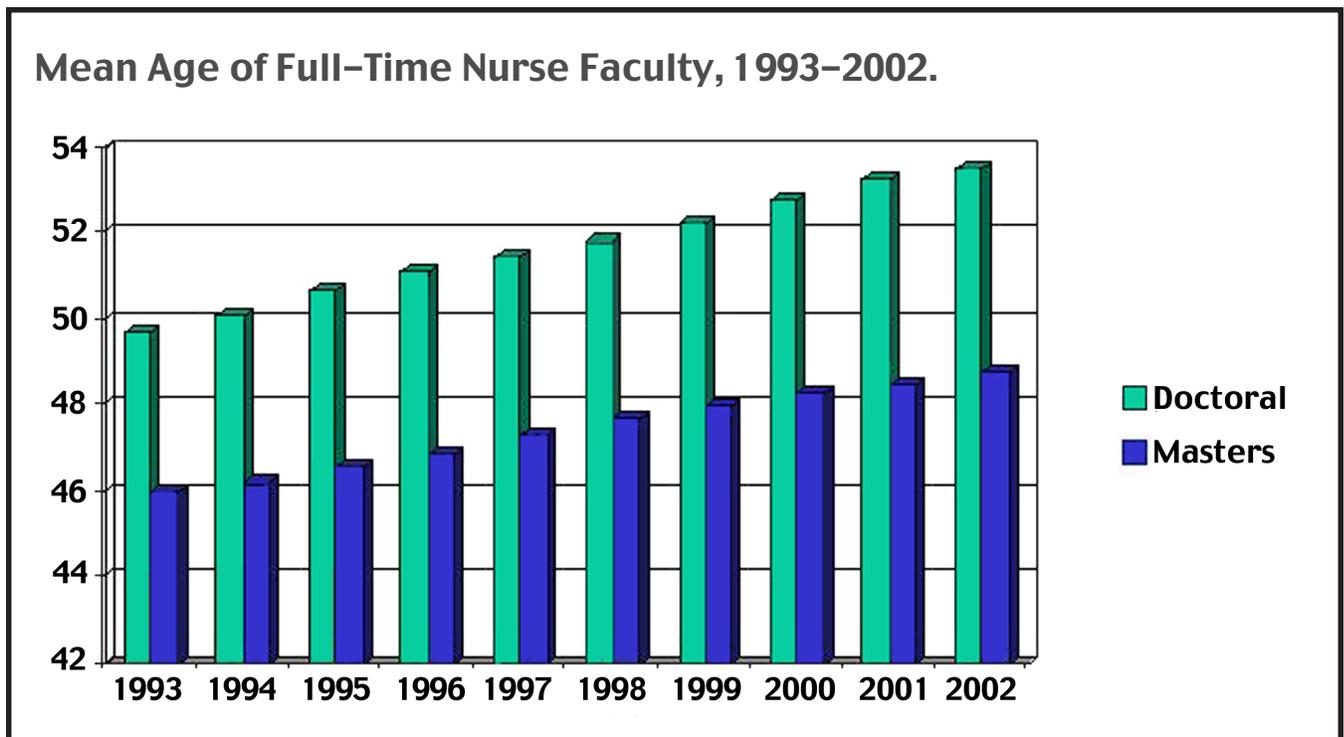
This faculty shortage has its roots in the dip in nursing employment in the 1980s. The healthcare industry underwent wide sweeping funding, infrastructure, and organizational changes in the late 1970s and early 1980s. In some cases, the changes resulted in nurse layoffs. In any event, the larger result was a public relations nightmare that caused numerous young women to rethink their potential career choices.

As nursing school enrollments declined, many schools reduced their number of full time faculty (Hinshaw, 2001). As enrollments increased in the early 1990s, many schools were unable to recruit full-time faculty, because they had found other positions outside of teaching. Schools were then forced to create part time positions and hire more adjunct professors. Most of the full time positions were not reinstated.

Nursing education in Massachusetts was never able to rebound from the downsizing of the 1980s. Starting from its already contracted position, the schools are having to cut back yet further. In response to the decreasing enrollment of the 1990s, many schools “froze” faculty positions as people retired or left. Now, as enrollments are beginning to increase, most of these positions will be filled by part time, adjunct professors or instructors (Hinshaw, 2001), if they can be found.

Aging faculty

According to the survey conducted by the AACN in 2002, the median age of nurse faculty is 51 years old (AACN 2002a). Informal survey data across the public nursing programs in Massachusetts suggests that the median age is the



*Age data not collected in 1996; midpoint of '95 and '97 used.
Source: American Association of Colleges of Nursing, 1993-2002 © 2003.*

same or higher. Given that most nursing faculty are likely to retire between the ages of 62 and 65, a wave of retirements is expected during the next ten years. The aging of faculty is of even greater concern with regard to doctorally prepared nursing faculty. For the 2001-2002 academic year, the average age for doctorally prepared faculty was 56.3 years for full professors, 53.8 years for associate professors and 50.4 for assistant professors (AACN, 2002a).

Salary issues

Salaries for nursing faculty tend to be considerably lower than salaries for MSN-prepared nurses working in clinical settings. According to data collected by the AACN in fall 2001, the annualized median salary for faculty at the doctoral level is \$73,055 (for associate professor) and \$63,430 (for assistant professor.) At the master's level, the median salaries are \$61,293 and \$55,000 respectively.²³ Actual salaries, based on an academic calendar are approximately \$10,000 to \$13,000 less.²⁴ As faculty move into administrative positions, they take on additional responsibilities and typically work a

²³ AACN, 2003.

²⁴ The actual salaries, for doctorally-prepared faculty members are \$59,700 for an associate professor and \$51,800 for an assistant professor.. Actual salaries for MSN-prepared faculty at the same levels would be \$50,100 and \$45,000.

twelve-month contract instead of an academic year calendar. The median salary for a doctorally-prepared faculty person who directs a program within a school of nursing is only \$68,536 while the salary for the dean of the nursing school may reach \$100,000. Salary information collected from the publicly funded schools of nursing in Massachusetts supports these figures.

Salaries for nursing faculty tend to be considerably lower than salaries for MSN-prepared nurses working in clinical settings.

Median salaries for MSN-prepared nurses, typically nurse practitioners start at approximately \$70,000 and increase to \$80,000 to \$85,000 depending on the area of specialty. For example, nurse practitioners working in the ICU earn between \$70,000 and \$80,000 while the salary range for MSN-prepared Perioperative nurses is \$80,000 to 88,000.²⁵

The comparatively lower salary for faculty positions affects both retention of current faculty and the recruitment of new faculty. In terms of recruitment, new MSN graduates tend to choose more lucrative options to teaching, as described below. Practicing MSN nurses who have been working in the field for many years may be considering a move away from the physical intensity of clinical practice. However, even with the positive change from a twelve month position to an academic year calendar, it may be unrealistic for MSN-prepared nurses who are earning \$70,000 to \$85,000 per year to move to a faculty position where they could easily be making \$20,000 to \$25,000 less.

In terms of retention, numbers of faculty are leaving for positions in the private sector as clinicians or administrators. Some are pursuing positions in healthcare administration, clinical research in hospitals, and QA within corporate settings. These positions typically pay considerably more than faculty appointments and may appeal to experienced faculty looking for a change from the teaching, research and service requirements of a career in academia.

The salary structure within the profession may also make it difficult for individuals who are considering a move to an academic position. Within academia, salary increases and professional advancement are closely tied to educational degrees obtained. In fact, at the BSN level and higher, a doctoral degree is typically required in order to become a full time professor within the tenure track. However, within the clinical practice sector of the profession, although a nurse may pursue specialty training within a specific area, a Master's degree is typically the highest educational degree that is expected. Within the practice setting, there is minimal incentive to pursue a doctoral

25 Sources: Berlin, L.E., Stennet, J., & Bednash, G.D. (2002a); Salary.Com (March 2002); and Tumolo, J. & Collins, A. (2001) as cited in AACN, 2003.

degree in nursing or a related field. Salary increases and professional advancement are more closely related to job experience than to degree. Therefore, an individual in clinical practice, who has achieved a high level of responsibility and commensurate salary, would have two potential obstacles to consider in making the switch to a faculty position—a dramatic decrease in salary and the need to pursue a doctoral degree.

Alternatives for MSNs: Advanced Practice Nursing

The vast majority of new MSN graduates are pursuing clinical advanced practice or nurse practitioner degrees. In 1997, 75% of students enrolled in MSN programs were planning to enter advanced practice roles as nurse practitioners, certified nurse midwives, clinical specialists, and nurse anesthetists (AACN, 1998). Over the past ten years, the advanced practice sector of the profession has grown at a phenomenal rate for a combination of reasons. First, the positions are attractive because they typically involve a relatively high salary and higher level of autonomy than other roles. Second, as healthcare systems underwent organizational changes during the 1990s, the media portrayed this position as cost-effective and related to positive patient outcomes. As a result, the advanced practice role for nurses received a lot of funding for individuals to pursue this role within the MSN degree and many schools adapted or expanded their programs in response to this interest (NLN, 2002).

Working conditions for faculty, especially clinical instruction, can be quite stressful.

Teaching environment

A salary that is not competitive with the service sector coupled with the expectations of teaching, research and service within the academic setting support the decision of many nurses to work in settings other than nursing education. As part of the teaching role, full time faculty provide formal and informal advising to students, develop and revise curriculum, and need to remain current within the profession (AACN 2003). In many settings, particularly at the ADN level, students may also need significant academic support in addition to that typically provided by a faculty member. Working conditions, especially in terms of clinical instruction, required for most faculty, can be quite stressful. Under the current model, the clinical instructor is responsible for oversight of a group of students who are administering complex care to patients. This oversight requires in-depth clinical knowledge as well as knowledge of systems within the clinical setting. Typically, the instructor must go to the clinical site before each shift in order to prepare for the students. A sharp increase in the acuity of the patients in the

clinical settings, a direct result of changes in healthcare delivery system, adds to the stress (AACN, 1999).

Collective bargaining provisions and related hiring policies may also make the working environment more stressful. In terms of the workload formula, hours spent in clinical instruction are typically discounted in relation to hours spent in didactic instruction. For instance, for faculty teaching in nursing programs in the community colleges, the workload formula equates three hours of clinical instruction to one hour of didactic instruction. At each of the three levels of public higher education, the collective bargaining provisions also require that adjunct faculty be hired on a semester-by-semester basis. This can contribute to a sense of instability both for instructors and for administrators who are working to meet the needs of the program.

Length of time to obtain doctoral degree

One of the problems that exacerbates the shortage of doctorally-prepared nursing faculty is the relatively short time for them to teach between the completion of their degree and retirement. Nurses with an MSN typically start their doctoral studies later than those in other fields, and the majority of them pursue the degree part time, further postponing the point at which they become faculty. In 1996, the average age of students earning a doctoral degree in nursing was 45, compared to the average of 33.8 years in all other fields (Brentro & Hegge, 2000). Also, in other fields, graduate students are often “pushed” and supported to begin and complete their graduate studies at an earlier point in their careers. This is not the case in nursing. In fact, it takes the average nursing graduate student 15.9 years from entry into an MSN degree to the completion of the doctoral degree (Berlin & Sechrist, 2002). The time to complete graduate work is also lengthened because many students need to work in order to support themselves and their families. Often they can only pursue the degree on a part time basis.

The average nursing graduate student takes 15.9 years from entry into an MSN program to completion of the doctoral degree.

Lack of educator preparation programs

There are currently thirteen colleges and universities in Massachusetts which offer an MSN degree. These programs all focus on preparing RNs for advanced nursing practice as nurse practitioners or clinical nurse specialists within different distinct specialties including Acute Care, Community and Public Health Nursing, Family Primary Care, Psychiatric/Mental Health and

Gerontological nursing. Other tracks within these MSN programs include Nursing Administration and Business Management and at Fitchburg State College, Forensic Nursing.

During the last 10-20 years, the profession as a whole had begun to move away from graduate programs which focus primarily on nurse education toward programs with a stronger clinical component. This change occurred as clinical practice environments became much more intense. In many programs, the courses included in a traditional “educator track” have been condensed and may be offered as an option within a master’s degree, but not as a primary component.

Because of a shift away from educator tracks at the graduate level and the drop in the number of individuals interested in teaching, there are very few programs in Massachusetts to educate nurses in the faculty role. One such program, at UMass Boston, was recently phased out due to a lack of enrollment. Only two schools advertise an “educator track” at the master’s level. Within the MSN program at Salem State College, in addition to a clinical specialty, students choose a role option as Nursing Administrator or Nursing Educator. The Nursing Educator option requires twelve credits, including Curriculum Development, Dimensions of Nursing Education and a Field Experience and Seminar in Nursing Education.²⁶ At UMass Medical School, students may choose an Advanced Practice Nurse Educator Specialty. Graduates of this program are able to use various teaching strategies to teach students and staff regarding patient care, to participate in scholarly research and to assume clinical leadership roles within schools of nursing.

For BSN-prepared registered nurses who are interested in teaching, UMass Dartmouth offers a 12 credit Certificate in Nursing Education. In addition to teaching skills, the program focuses on developing an understanding of varied approaches to nursing education and general principles of teaching, learning and assessment. Credits earned through this certificate may be applied toward their MSN program.²⁷

There are also programs offered on line. One program, called “Teaching in Nursing” is offered through the Center for Lifelong Learning at the Indiana University School of Nursing.²⁸ This program is part of an alliance between the University and the National League for Nursing to offer online courses and professional certificate programs to current or future nursing educators. The certificate program is taught entirely online and requires each participant

26 For more information, go to www.salemstate.edu/graduate/academic/flowsheets/msn_nursing.pdf

27 For more information, go to www.umassd.edu/nursing/academic_programs/graduate/images/cert_nursing_education.pdf

28 For more information, see www.nursing.iupui.edu/LifelongLearning/default.asp

to work with a preceptor of their own choosing in their workplace. Topics include teaching and evaluation as well as the use of computers to support the teaching and learning process.

Doctoral programs in nursing are offered at five institutions within the state. UMass Medical in Worcester collaborates with UMass Amherst, while UMass Lowell works in partnership with UMass Boston. Boston College also offers the degree program. Although each of the programs may have a specific focus such as Health Policy at UMass Boston or Health Promotion at UMass Lowell, each of these doctoral programs prepares graduates to become nurse educators, researchers and leaders in nursing practice and policy.

The fiscal crisis in Massachusetts

Budget cuts

In addition to the issues affecting nursing programs across the country, nursing programs in Massachusetts must also cope with specific problems that have arisen due to the condition of the Massachusetts economy. All of the institutions of public higher education are dealing with enormous cuts to their budgets. For FY 2002 and 2003, total funding for all public higher education was decreased by 7%. For FY 04, the continuing fiscal crisis is expected to result in further reductions across all of public higher education of 15-20%. On most campuses, this will result in program consolidation and reductions in expenditures including personnel at all levels. These cuts will have a direct impact on the ability of programs to expand, and may, in fact, impact current enrollments in some programs.

For FY 04, the fiscal crisis is expected to result in 15-20% reductions across all of public higher education.

Early retirement incentive program

In particular, the state budget crisis has exacerbated the faculty shortage problem through the Early Retirement Incentive Program (ERIP) which was implemented during the first half of 2002. Under this plan, eligible state employees were granted five years of age or five years of creditable service, or a combination of both. The plan is expected to save the state millions over the next several years, but has created substantial difficulties for the states' nursing schools.

The early retirement plan affects the campuses in three significant ways. First, the retirements were not supported by additional state funds. Payoffs, including those for accrued sick and vacation time, must take place from campus appropriations over fiscal years 2003, 2004 and 2005. Secondly, each campus lost valuable senior faculty and administrative staff in all disci-

plines. Across the state, a total of 874 Higher Education faculty and staff elected to take early retirement: 233 at the community colleges, 193 at the state colleges and 445 across the UMass campuses. Some nursing programs, with a high number of older faculty were particularly hard hit. At Northern Essex Community College, 4 of 7 full time faculty took advantage of the ERIP. Decisions to refill vacancies were made after a full campus review of program needs. The nursing program was allowed to use institutional funds to fill two vacancies. At the same time, in their LPN program, 2 of 3 full time faculty took early retirement. The program was not allowed to fill these two vacancies and had to reduce the size of the entering class by 33%. At UMass Lowell, two faculty members took advantage of the ERIP. Due to budget constraints, the school of nursing has been unable to fill either vacancy.

With regard to campus budgets, the ability to refill vacated positions was capped at 20% of the total compensation for 2003 and 2004. This means that of the vacancies resulting from retirement, the campus can only hire 20% of that salary value. For example, if five faculty members, earning a total of \$200,000, retired, the campus can only hire one faculty person at an annual salary of \$40,000. Clearly, this severely impacts all institutions which lost even a small number of senior faculty and staff.

*At Northern Essex
Community College, 4 of 7
full time faculty took
advantage of the Early
Retirement Incentive
Program.*

Strategies to Address the Faculty Shortage

Like the nursing shortage itself, solving the faculty shortage will require collaboration among RN programs, graduate schools of nursing, healthcare employers, and nurses themselves and other stakeholders such as legislators, regulating agencies and the general public. Strategies must address both recruitment and retention of faculty and include ways to address the many barriers described above. Both short and long term strategies must be implemented in order to maintain current enrollments and respond to future needs.

Short-term strategies

Resources

In some instances, local employers and other stakeholders may need to act quickly by supplying financial support to address the immediate needs regarding faculty vacancies within a specific nursing program. For example, due to the Early Retirement Incentive Plan, in the summer of 2002, Northern Essex Community College lost several nursing faculty, and could not refill many of the resulting vacancies. This meant that students currently enrolled in the program might not have been able to complete their course of study.

In response to this immediate need, Holy Family Hospital and Medical

Center, Lawrence General Hospital, Anna Jacques Hospital and Merrimack Valley Hospital each contributed \$15,000 to support the salary of one full time faculty person for the 2002-2003 academic year.

Increasing the pool of clinical instructors

Currently, most schools report that the immediate faculty need is for clinical instructors. Short term strategies to address this will involve finding nurses who are currently qualified for this role. In the long term, efforts to increase the number of nursing faculty will require bringing individuals into the pipeline, supporting them to become faculty and then assisting them once they are in this role.

Until recently, an individual had to possess an MSN in order to provide clinical instruction. Experienced BSN-prepared nurses who might be interested in teaching were not permitted to do so. However, in November, 2002, in response, in part, to the shortage of MSN nurses available to provide

In order to maintain current enrollments and respond to future faculty needs, both short and long term strategies must be implemented.

clinical instruction, the Mass. Board of Registration in Nursing adopted a policy which establishes criteria for the waiver of the regulation which requires an RN to have an MSN in order to provide clinical or skills laboratory instruction within a nursing education program. Specifically, in order to be granted a waiver, a prospective instructor must either possess a baccalaureate degree in nursing and be matriculated in a graduate nursing program with an expected graduation date within five years of the waiver OR possess an earned baccalaureate degree in nursing and a related non-nursing graduate degree 244 CMR 6.04(2)(b)3 Waiver Criteria. Administrators of nursing programs are hopeful that this will result in a larger pool of potential candidates both interested and eligible to do clinical supervision. As of March 2003, ten waivers have been requested and all requests which met the criteria were granted.

Partnerships between schools and employers

Typically, schools hire clinical instructors and pay them by the hour for time spent performing clinical supervision with a certain number of students. This rate varies across the different schools, and is generally less than what an RN could earn working in clinical practice. Also, as a part time position, it seldom includes benefits. This is making it more and more difficult for schools to find clinical instructors. To address the problem, schools of nursing are turning to the healthcare employers with whom they place nursing students for clinical experiences, typically acute care hospitals.

To meet the need for clinical instructors, nursing schools are turning to healthcare employers.

The examples below illustrate different models of collaboration between schools and employers to meet the immediate need for clinical instructors. Typically, the clinical instructor remains a full time employee of the hospital receiving the same salary and benefits as their previous position. The hospital may pay the full salary or the school may contribute and the employer makes up the difference. Implementing the different models requires collaboration between the human resources departments of both institutions and permission from the faculty collective bargaining unit.

Bristol Community College (BRCC) in Fall River, MA has implemented two partnerships with area healthcare employers. In both instances, the nurse is employed by the healthcare provider and his/her salary is paid by that provider. At St. Luke's Hospital, part of Southcoast Health System, an MSN-licensed nurse is released to work full time for BRCC as a clinical instructor. This person remains a Southcoast employee, with no change in salary or benefits. BRCC pays the hospital the equivalent of a half-time clinical instructor's salary. Southcoast pays the difference in salary as well as benefits

to the employee. BRCC has a similar arrangement with St. Anne's Hospital, also in Fall River. In this instance, an MSN-licensed nurse, who works full time at the hospital, is released two days per week to provide clinical supervision to BRCC students on site. St. Anne's continues to pay his full time salary. He remains an employee of St. Anne's, but is considered an adjunct faculty member by BRCC in all respects except payroll.

Northern Essex Community College in Haverhill, MA is working with Anna Jacques Hospital in Newburyport, MA in a slightly different arrangement. In this instance, the hospital hired two MSN-licensed nurses on a per diem basis specifically to provide clinical supervision. They are paid the hospital's rate for nurse educators. When not providing clinical instruction, one of the two works for the hospital in another capacity.

At UMass Dartmouth, in order to meet the need for clinical instructors, the School of Nursing plans to pay Southcoast Health Systems directly to have one of their full time master's prepared nurses provide clinical instruction, on a part-time basis, to a cohort of nursing students training within their facility. The instructor will remain a full time employee of Southcoast, with no change in salary or benefits.

Similar partnerships are forming in other states as well. In 2001, in Texas, Houston area hospitals and schools of nursing launched the Nurse Faculty Initiative. Through their efforts, nineteen area hospitals "loaned" 65 individuals to nursing programs at four community colleges and five schools with BSN programs (AACN, 2002d). In Washington, the University of Washington Medical Center implemented a plan whereby an experienced staff nurse may "take a sabbatical as a clinical instructor of BSN students. The medical center, which continues to pay the nurse's salary, benefits by rewarding and ultimately retaining a valued staff member."²⁹

Dual Appointments

UMass Amherst has developed partnerships with area healthcare employers which focus on recruiting nurses into the workforce and retaining those currently employed. In particular, these partnerships have allowed the school of nursing to maintain level enrollments in their program by providing resources to allow the school to hire additional faculty. As part of their joint appointment, the faculty members supported by Baystate Medical Center in Springfield engage in clinical supervision, support other BMC nurses who are providing clinical supervision, work with staff developers at BMC re: the professional nursing culture within the facility and are involved in recruit-

²⁹ AACN, 2002d, p. 2.

ment and retention activities. A similar arrangement with Cooley Dickinson Hospital in Northampton has also been extremely effective.³⁰

Long-term strategies

In addition to ongoing collaboration between schools of nursing and employers to find and financially support part time clinical instructors, long term strategies will need to look at ways to recruit and retain full time academic faculty. In order to do this, the profession as a whole will need to address salary and collective bargaining issues, support schools of nursing to address the differing needs of senior and junior faculty, market the educator role and maintain nurse educator courses within graduate programs.

Salary

This may be the most important issue to address and the most difficult to solve. In order to maintain or increase salaries, schools will need to be creative. Given the current economy, ongoing direct financial support from employers or the state or federal government to fund full time faculty is unlikely, at least at this point. There are other potential solutions. Dual appointments, as described above, which are substantially supported by the employer, are one model. Schools might also find ways to be more supportive of faculty who must work part time in clinical settings, to supplement their teaching salary. In recognition of this, the Georgetown University School of Nursing started a faculty practice center as a way to increase compensation for its nursing faculty (AACN, 1999). Such efforts also support the need for faculty to remain active in clinical practice in order to remain effective teachers.

Schools will need to be creative to find ways to maintain or increase salaries.

Support for faculty

With regard to senior faculty, universities and schools of nursing need to respect and foster the expertise of experienced faculty by supporting new challenges and innovative avenues for professional growth. With this goal, some nursing programs have developed “Centers of Excellence” which focus on research and teaching as well as leadership. Other schools have developed international programs and have engaged senior faculty to lead these efforts (Hinshaw, 2001). Finally, as faculty approach retirement age, schools should find ways to phase in retirement over several years by allowing and encouraging faculty to work part time by mentoring new faculty or conducting research (Hinshaw, 2001).

³⁰ For more information on both of these partnerships, go to www.aacn.nche.edu/Publications/issues/Oct02.htm and click on “Click here for in-depth profiles of successful partnerships” at the top of the page.

Schools also need to actively support junior faculty. Developing and implementing formal mentoring programs and other support systems are crucial. Schools should be cognizant of the fact that pursuing a doctoral degree while carrying a full teaching load and raising a family may be unrealistic for many MSN-level faculty. Schools should consider reducing workload expectations and providing financial assistance to junior faculty who are pursuing doctoral degrees. Schools should also seek out employers who might provide financial support to individuals engaged in doctoral study.

As we encourage nurses to consider the faculty role, the current debate at the national level and in many states grappling with the faculty shortage focuses on which doctoral degree we should be encouraging nurses to pursue. Should we provide support and funding solely to individuals pursuing a PhD in nursing or to MSNs who are pursuing related degrees such as a doctorate in nursing education as well? This is a multi-faceted issue which involves

balancing several goals including the need to continue to develop the science of nursing through research and other scholarly work.

Educators need to publicize the rewards of teaching, research, and service within the academic setting.

Marketing the educator role

In order to recruit new nursing educators, schools must find ways to make the faculty role more attractive and easier to attain. To pique their interest, schools should expose students to research projects early in their education, by involving them in faculty research projects (AACN, 1998). Bringing former graduates in to

do clinical supervision for your program may provide another opportunity to interest them in the faculty role. Although the institutional expectations for nursing faculty can be quite high, faculty themselves need to publicize the rewards of teaching, research and service within the academic setting.

“Academia provides many opportunities, e.g.

- To develop and shape new professionals through education
- To engage in creative, intellectual discussion with faculty colleagues and students
- To pursue a research and/or scholarly program of professional and personal interest
- To contribute to improving health care through student education and the generation of knowledge
- To provide professional, disciplinary, and interdisciplinary leadership and
- To shape health policy based on professional and scholarly expertise.”³¹

³¹ See Hinshaw, 2001, p. 8.

For experienced nurses seeking an alternate role, nurse faculty positions can provide a different perspective and an opportunity to “give back” to the profession and support its future growth.

Compress the time to PhD

One way to make the role more attractive is to shorten the number of years it takes individuals to complete their graduate study. In order to do this, the profession as a whole must help individuals shift their belief that they must first spend many years in clinical practice settings before pursuing an advanced degree. Although clinical expertise is an important prerequisite for effective teaching, perhaps two or three years would suffice. In recognition of the need to compress the time required to obtain a PhD in nursing without diluting standards, several schools—including the University of Texas, the University of Maryland and the University of Pittsburgh—have developed fast track programs from the BSN degree to the PhD degree, which includes the MSN degree (AACN, 1999).

Keep the educator track within graduate programs

Despite declining enrollments, schools of nursing must work to maintain educator programs especially at the master’s level, as this is typically the entry point into the educator role. At a minimum, schools should retain several nurses’ education courses and allow flexibility within the structure of students’ programs to allow them to take these courses. In practical terms, the development of more on-line course and degree programs, like the one at the University of Indiana, would allow students the flexibility to fit the courses into their already busy lives. Then, as individuals receive their MSN and begin to teach within the classroom, they must be supported to work on their doctoral degrees.

At a minimum, schools should retain several nurses’ education courses and allow flexibility within the structure of students’ programs to allow them to take these courses.

Policy implications

The nursing profession through national nursing organizations, such as the National League for Nursing, the American Association of Colleges of Nursing and the National Organization for Associate Degree Nursing must work to bring the shortage of nursing faculty to the public agenda at both the state and national levels. The media has ensured that the public is aware of the shortage of nurses and how it will affect all of us. Policy makers and the general public need to understand the direct connection between the shortage

of nurses and the shortage of nursing faculty. The profession needs financial support from both the public and private sectors to support the development of the nursing faculty corps. Current supports include funding provided through Johnson & Johnson's Campaign for Nursing's Future, the Nurse Reinvestment Act and the Faculty Loan Repayment Program of the Health Resources and Services Administration.³²

At the state level, legislation has been put forth to support recruitment efforts to bring more individuals into nursing. In March 2001, Senator Richard T. Moore introduced two bills to address the shortage: the Clara Barton Nursing

Excellence Program and the Clara Barton Nursing Scholarship Program. These bills, if funded, would provide scholarships for nursing students as well as loan repayment, and funding to healthcare employers and schools of nursing to provide mentoring and other support services. This legislation should be expanded to include resources to support and expand the nursing faculty corps.

Legislation was also recently enacted to establish a Center for Nursing in Massachusetts. Many other states, including North Carolina have developed and sustained web-based Centers for Nursing with very positive results. Modeled on these examples, "the purpose of the center [in Massachusetts] shall be to develop and implement strategies to address the supply and demand of the nursing workforce... and serve as a clearinghouse for nursing workforce data, educational resources and career opportunities."³³

One of the primary goals of the center is to collect information about nurse education programs, employment opportunities and financial resources supplied by schools, employers or government initiatives and make this information readily accessible to anyone who might be interested in pursuing a career in nursing. Efforts to establish this virtual information center may be very effective in recruiting more individuals into the profession. Without sufficient faculty within the schools, however, these efforts may not have a significant impact on the nursing shortage in Massachusetts.

Current support for faculty includes funding through Johnson & Johnson's Campaign for Nursing's Future, the Nurse Reinvestment Act and the Faculty Loan Repayment Program of the Health Resources and Services Administration.

32 For more information on the Faculty Loan Repayment Plan, go to bhpr.hrsa.gov/DSA/flrp

33 M.G.L.c. 16A, ss. 16, An Act Establishing a Center for Nursing in Massachusetts.

Conclusion

Solving the nursing faculty shortage will require sustained efforts by all stakeholders. Because the shortage of nurses and nursing faculty are directly related, as efforts continue to recruit individuals to become nurses, stakeholders will need to work diligently to keep the faculty issues in the forefront. Short- and long-term strategies, as described above, must be implemented to address all of the causes of the faculty shortage. The following list can be a starting point for discussion of solutions.

- Recruiting faculty
 - Target individuals
 - Start recruitment early, while individuals are still in RN programs
 - Provide support to individuals pursuing graduate degrees
 - Employers should consider financial support to faculty members to support full time pursuit of advanced degrees.
- Supporting faculty
 - Retain senior faculty and find ways to support new challenges and professional growth
 - Mentor junior faculty and finds ways to support them to pursue their doctoral degree
 - Address collective bargaining issues related to workload and hiring
- Supporting schools of nursing
 - Find faculty to teach and the resources to support them to maintain programs enrollments and perhaps expand
 - Find resources to maintain and expand lab facilities
- Supporting collaboration between schools and employers
 - Have the dialogue
 - Establish partnerships beyond the 'clinical site' connection
 - Standardize Dual Appointments
- Working with the profession to identify and actualize changes needed
 - Work environment
 - Compressing time to PhD
 - School hiring policies
 - Marketing the educator role
 - Exploring the preceptor role
- Working with all stakeholders to generate resources
 - Salary and program needs
- Working with state and national professional organizations and all stakeholders to bring these issues to the attention of legislators and the public

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