

UNDERSTANDING RN WORKFORCE EDUCATION IN THE  
RURAL NORTH-CENTRAL REGION OF MICHIGAN

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## ABSTRACT

Susan J. Owens

### UNDERSTANDING RN WORKFORCE EDUCATION IN THE RURAL NORTH-CENTRAL REGION OF MICHIGAN

National calls for a better-educated nursing workforce are proliferating. The Institute of Medicine (IOM) challenged the nursing profession by setting the goal of having 80% of the nation's nurses prepared at the baccalaureate level (BSN) or higher by 2020. This is an ambitious goal given that, nationally, only 50% of nurses have a BSN. In fact, only 40% of nurses in Michigan have a BSN, and in the rural North-Central Region of this state, only 29% (the lowest in the state) of the nurses have a BSN. The purpose of this hermeneutic phenomenological study was to understand and interpret the meaning of being an associate degree (AD) nurse, the meaning attaining a BSN has for rural registered nurses who currently have an AD, and the barriers they experience that inform their decisions to return to school (or not). The investigator interviewed 11 AD nurses from rural North-Central Michigan and analyzed interview transcripts to identify common experiences and shared meanings using methods identified by Diekelmann, Allen, and Tanner (1989). Two themes were explicated in this study: "Getting in and Getting out" and "What Difference Does it Make?" The findings in this study challenge many of the common assumptions about academic progression in nursing and provide educators, administrators,

and legislators with insight about the strategies that may be most helpful for achieving the IOM goal in rural Michigan.

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## LIST OF ABBREVIATIONS

AACC	American Association of Community Colleges
AACN	American Association of Colleges of Nursing
AD /ADN	Associate Degree / Associate Degree in Nursing
ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
AONE	American Organization for Nurse Executives
BSN	Baccalaureate / Bachelor of Science in Nursing
CCBA	Community College Baccalaureate Association
CEP	Continuing education programs
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine of the National Academies
MACN	Michigan Association of Colleges of Nursing
MCN	Michigan Center for Nursing
MCNEA	Michigan Council of Nursing Education Administrators
MDCH	Michigan Department of Community Health
MONE	Michigan Organization of Nurse Executives
NACNEP	National Advisory Council on Nursing Education and Practice
NCLEX	National Council Licensure Exam
NCSBN	National Council of State Boards of Nursing
NDBON	North Dakota Board of Nursing
NLN	National League for Nursing
NLNE	National League for Nursing Education

OCNE	Oregon's Consortium for Nursing Education
PPACA	Patient Protection and Affordable Care Act
RN	Registered nurses
USDHHS	United States Department of Health and Human Services

## CHAPTER 1 INTRODUCTION

### **Background**

The Institute of Medicine of the National Academies (IOM) has called for a better-educated nursing workforce to expand access to healthcare services and quality outcomes in their report entitled, “The Future of Nursing: Leading Change, Advancing Health” (Future of Nursing, 2010). To achieve this change, the report issued a bold goal recommending that 80% of the nursing workforce be prepared by at least the baccalaureate level by 2020. Similarly, the Carnegie Foundation for the Advancement of Teaching and Learning (Benner, Sutphen, Leonard, & Day, 2010) conducted a national study of nursing education as part of their “Preparing the Professions” study. The results of this study led investigators to call for a better-educated nursing workforce, specifically recommending that nurses attain a Master’s Degree in Nursing within 10 years of initial licensure (Benner et al., 2010). Currently in the United States, however, only 50% of the nursing workforce is educated at the baccalaureate level or higher (United States Department of Health and Human Services [USDHHS], Health Resources and Services Administration [HRSA], 2010). The recommendations from these two national studies reflect the broader literature in nursing. Growing evidence has shown that (a) the increasing complexity of health care is placing greater demands on the nursing workforce (IOM, 2000, 2001); (b) the identification of risk, the prevention of error, and the recognition of deteriorating conditions relies on well-prepared nurses because of their proximity to and persistent interaction with the patient (Benner et al., 2010; IOM, 2010); (c) the patient care delivered by

nurses with a baccalaureate of science in nursing degree (BSN) or higher produces better patient outcomes (Aiken, Clarke, Cheung, Sloan, & Silber, 2003; Friese, Lake, Aiken, Silber, & Sochalski, 2008), and (d) the United States has too few existing baccalaureate-educated nurses to achieve the expected outcomes (USDHHS HRSA, 2010).

### **Preparation for Role**

Three education options for registered nurses<sup>1</sup> (RNs) exist to enter the nursing workforce: diploma, associate degree/associate degree in nursing (AD/ADN), and baccalaureate degree. The three-year diploma typically is housed in a hospital or medical center; the two-year AD is offered by community colleges and some universities; and the four-year BSN is offered at colleges, universities (Fondiller, 2001; Waters, 1990), and some community colleges. Despite their differences, students from all programs prepare for the same licensure examination (National Council Licensure Exam [NCLEX] for registered nurses).

The issue of education level required for entry-into-practice is not unique to nursing. Other healthcare disciplines, such as occupational therapy, physical therapy, audiology, speech pathology, pharmacy, and social work have required baccalaureate education as the minimum preparation level for practice for decades (Nelson, 2002). In fact, most healthcare disciplines now require masters or doctoral degrees prior to entry (Nelson, 2002). Yet the majority of RNs

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<sup>1</sup>In this study, nursing education is limited to registered nurse education.

currently entering the workforce have an AD (National Council of State Boards of Nursing [NCSBN], 2011), making nursing the least educated of the health professions (Barter & Lenihan, 2001; Nelson, 2002). Given nursing's central role in coordinating care, identifying risk, preventing error, and detecting subtle changes in patient condition, it is not surprising that the adequacy of AD preparation is called into question (Benner et al., 2010; IOM, 2010).

### **Increasing Nursing Education Levels**

Some nurses do increase their education past their initial preparation. Nearly 32% of diploma-prepared nurses return to school to obtain a BSN (USDHHS HRSA, 2010). For these students, the average time in practice before returning to school is 10.5 years. Nurses prepared in AD programs, however, return to school to continue their education at a lower rate than diploma graduates with only 20.8% returning for further education (USDHHS HRSA, 2010). The average time of returning for further education for AD graduates is 7.5 years. Baccalaureate-educated nurses return to school to increase their education to a master's degree in nursing at a somewhat higher rate of 21.6%, taking an average time of 8.2 years to do so (USDHHS HRSA, 2010). While there is a modest trend of continuing formal educational preparation and attaining successively higher nursing degrees, the rate of change is not high enough to meet the goal for a more highly educated nursing workforce as identified by the IOM report (2010) and the Carnegie Study (Benner et al., 2010). Importantly, this trend is inconsistent across the states, making a single national strategy to increase the preparation of the nursing workforce a challenge at best.

If efforts to increase the educational preparation of the nursing workforce are to be successful, the discipline must understand the experiences of those most affected and targeted by these initiatives. This study aims to investigate the meaning of being an AD nurse and what it would mean to return to school to attain a BSN. Understanding the meaning of returning to school will help the discipline identify and effectively implement strategies to encourage more AD-prepared nurses in the United States to pursue a higher degree.

### **Associate Degree Education in Nursing**

In 1952, AD nursing education began as a pilot project in seven community colleges nationwide in an attempt to create a new nursing position. This project focused on preparing nurses for the workforce in a shorter period of time in order to meet the demand for nurses at the bedside and thus focused on the technical aspects of care (Montag & Gotkin, 1959). Breaking with the tradition of hospital-based diploma education in the United States, this pilot project situated rapid preparation in community colleges (Brown, 1948; Ginzberg, 1948). Evaluation of the project found preparation for nursing practice at the AD level successful because (a) graduates passed the Registry Licensure Exam (now called NCLEX-RN) at rates comparable to (and at times exceeding) those from baccalaureate programs (Montag & Gotkin, 1959); (b) the nursing education curriculum remained outside of traditional hospital organizations and thus was more autonomous and focused more on education than service (Gardenier, 1990); and (c) a more diverse student population had access to the degree, which ultimately led to a more diverse nursing workforce (Montag, 1988; Rines,

1977). The ADN thrived, and by 1974, the number of programs had doubled every four years since its inception (Rines, 1977).

Since inception, ADN programs have grown exponentially, despite disagreement within the discipline about what constituted appropriate educational preparation for entry-into-practice. In 1959, the American Nurses Association (ANA) took the position that education for all RNs should take place exclusively in institutions of higher learning (ANA, 1965). This recommendation tended to move nursing education away from hospitals and supported the increasing prevalence of the AD level of preparation. In response to the growing ADN movement, one of the ANA's long-term goals in 1960 was to establish baccalaureate nursing education as the entry level for the nursing profession (Haase, 1990). This goal was considered necessary because of the "current explosion of knowledge affecting health practices, the increasing level of education in the United States, and public demand for more health care" (ANA, 1965, p. 106). However, the ANA's position paper outlining this goal created controversy throughout the discipline because at that time 78% of RNs were diploma graduates (Haase, 1990). Rather than seeing this goal as a way of responding to the public demand for more highly skilled health care, many nurses with diplomas and ADs felt that their educational preparation was belittled and undervalued (Gardenier, 1990). The controversy was fueled by the fact that graduates from all three program levels (associate, diploma, and baccalaureate) took the same licensure examination to enter practice—a means by which the discipline assures the public of safety. These issues have been debated for more



than half a century. Today, the question of the appropriate entry level into nursing practice continues within the profession without resolution.

### **Nursing Workforce in the United States**

The current RN workforce in the United States reflects diverse entrance options, with initial preparation for nursing practice occurring in diploma programs (20.4%), AD programs (45.4%), and baccalaureate degree programs (34.2%; USDHHS HRSA, 2010). Within the cadre of new and recent nursing graduates, however, ADN and BSN programs are clearly predominate. The NCSBN (2011) reported that new graduates taking the NCLEX-RN in 2010 received their initial preparation for practice in diploma programs (2%), AD programs (58%), and baccalaureate degree programs (39%). It is noteworthy that the widespread closure of diploma programs has most dramatically affected (increased) the number of AD graduates, with the total percentage of graduates from baccalaureate programs remaining consistent (Orsolini-Hain & Waters, 2009).

The predominance of nurses prepared at the AD level is most noticeable in rural areas of the country. “The Future of Nursing” report (IOM, 2010) documented a disparity in nursing education between urban and rural areas. Many rural areas have significantly fewer BSN-prepared nurses than urban areas, as well as fewer available educational programs in which ADN-prepared nurses can continue their education. For example, urban areas of the United States have approximately 52% of their nursing workforce educated at a baccalaureate level or higher, whereas rural areas of the United States have only 38% of their workforce educated at a baccalaureate level or higher (IOM, 2010).

In the state of Michigan as a whole, approximately 39,887 nurses have a baccalaureate degree or higher—or 40% of the total nursing workforce (Michigan Center for Nursing [MCN], 2011). Comparatively, the rural North-Central Region shows the state’s lowest numbers of nurses educated at the baccalaureate degree level or higher, at 688 nurses or 29% of this region’s nursing workforce (MCN, 2011). In this same rural area, there are approximately 1,860 (73%) AD-prepared nurses. Educational programs for attaining a BSN are available throughout university centers and, more recently, through online options. However, increased access has not significantly changed the number of nurses choosing to further their education in the North-Central Region of Michigan. To increase the education level of the nursing workforce, it is imperative to consider the unique challenges faced by nurses in rural regions such as North-Central Michigan.

### **Educational Preparation of the Michigan Workforce**

While 50% of the nation’s nursing workforce holds a BSN or higher (USDHHS HRSA, 2010), only 40% of nurses in the Michigan workforce are educated at or above a baccalaureate degree (MCN, 2011). In 2010, 58.6% of Michigan’s new graduates sitting for the NCLEX-RN exam were prepared with an ADN (NCSBN, 2011). This percentage is slightly higher than the national average of 57.9% (NCSBN, 2011). There is no evidence to suggest this will change soon, as the percentage of baccalaureate-educated nurses in Michigan has remained stable for the last three years. The percentage of eligible

NCLEX-RN candidates educated at the baccalaureate level was 39.2% in 2008, 39.4% in 2009, and 41.3% in 2010 (MCN, 2011; NCSBN, 2011).

Specifically, the educational preparation of RNs in the rural region of North-Central Michigan is the state's lowest, with only 29% of nurses attaining a BSN or higher (MCN, 2011). In order to achieve the goal set by "The Future of Nursing" report (IOM, 2010), 51% of the current RN workforce (1,350 nurses) in the North-Central Region of Michigan needs to increase their current educational preparation.

### **Nursing Education in Rural Michigan**

The 18 counties in the North-Central Region of Michigan count 46 people per square mile and 603 RNs per 100,000 people (MCN, 2008; Michigan Department of Community Health [MDCH], 2009b). The five community colleges within this area offer programs that result in an AD in nursing. There are no universities offering baccalaureate programs in these counties, but there are two university (extension) centers. One university center offers both face-to-face and online options, and one offers a face-to-face program only (Northwestern Michigan College University Center, 2011; University Center Gaylord, 2011). To access the face-to-face program, an AD nurse must drive approximately one hour from the furthest counties to the university centers. Recently, there were 28 students participating in the face-to-face programs with 22 graduates in the spring of 2011 (D. Couture, personal communication, July, 11, 2011). Forty-two students participated in the online program, with 14 graduates in the spring of 2011 (K. Laier, personal communication, August 22, 2011). The sustainability of

face-to-face programs in this area is complicated by winter driving conditions, the predominance of two-lane highways, and the relatively high price of gasoline. Online options for BSN completion overcome these challenges but are confounded by limited high-speed access to the Internet in the area. Internet service varies from county to county and is affected adversely by weather conditions, cable and satellite access, and the cost of high speed service. It is important that strategies to increase the educational level of the nursing workforce account for these challenges for nurses returning to school in different geographical contexts.

Although the issues around access to baccalaureate programs are known, it remains unclear why more rural AD nurses are not returning for a BSN degree. No studies have focused on nurses living in rural areas to ascertain how they decide whether or not to return to school. Given that North-Central Michigan has the lowest percentage of baccalaureate-prepared nurses in the state, it is important to understand why more of the AD nurses from this rural area are not returning to school.

### **Educational Mobility**

Despite the need for AD nurses to return for a BSN, significant barriers have been documented across the country. These barriers include a lack of financial resources, inconvenient timing of academic courses, a lack of available options for degree completion, programs that are not focused for the working RN, burdensome commuting, advanced age and work-life potential, a lack of peer support, and lack of recognition from employers (Altmann, 2012; Cheung &

Aiken, 2006; Delaney & Piscopo, 2004, 2007; Lillibridge & Fox, 2005; Morrison & McNulty, 2012). These barriers will be more thoroughly explored in Chapter 2.

Strategies for addressing the barriers to educational mobility (in order to achieve the 80% goal proposed by the IOM) are as diverse as the barriers themselves. Most recently, attention within the discipline has focused on (a) increasing the number of pre-licensure programs or admitting more students to current programs (American Association of Colleges of Nursing [AACN], 2011a); (b) offering BSN completion at degree-granting community colleges (Community College Baccalaureate Association [CCBA], 2011); and (c) requiring AD and diploma nurses to return for completion of education at the baccalaureate degree level or higher (AACN, 2010).

Increasing the number of pre-licensure nursing education programs or admitting more students into current nursing programs appears to be a logical solution to achieving the goal of an 80% baccalaureate-prepared workforce, and it has been attempted for years (Orsolini-Hain & Waters, 2009). However, the AACN (2011a) contends that this solution has not been successful because many baccalaureate programs are already at capacity. In 2009, 42,981 entry level applicants were turned away. Additionally, the persistent shortage of nursing faculty to teach more students has prohibited substantive growth in the number of programs or the number of students admitted (AACN, 2011b). The shortage of adequate clinical placement sites to accommodate more programs and more students also limits growth in numbers (Ironsides & McNelis, 2010).

Offering BSN completion options at degree-granting community colleges is another way to promote higher education for nurses (Murray, 2007). A minimal number of states have allowed faculty of community colleges to provide baccalaureate nursing education including Florida, Indiana, Nevada, New Mexico, and Washington (CCBA, 2011; Murray, 2007; Orsolini-Hain & Waters, 2009). All of these programs are geared for the working RN with AD preparation. In these five states, a total of 15 BSN programs are offered at community colleges. Florida has the most, with 11 community colleges offering BSNs (CCBA, 2011). The Florida Center for Nursing (2010) has not reported on baccalaureate education at community colleges; thus, no documented evidence could be found regarding the success or failure of these programs in substantively improving the number of BSNs in that state. They further report only 44% of nurses have at least a BSN (Florida Center for Nursing, 2011); 6% below the national average (USDHHS HRSA, 2010). No other states that have BSN programs at community colleges have reported any increase in BSN percentages (Indiana Center for Nursing, 2011; New Mexico Center for Nursing Excellence, 2011; Packman, 2003; Washington Center for Nursing, 2011).

Associate- and diploma-prepared nurses comprise a large pool in the United States that could be used quickly to increase percentages of BSN graduates. Programs such as RN-to-BSN, designed to augment the curriculum of the ADN program to meet the essentials of the BSN curriculum, are an efficient option as these potential students are RNs who already are licensed and may be currently in practice. These programs do not require traditional clinical

experience and thus do not impact the clinical placement challenge of pre-licensure programs. There are 634 RN-to-BSN programs available from four-year colleges and universities throughout the United States, with 400 of these offering online options and many offering geographically based on-site options (AACN, 2011c). Despite increased access, AD nurses are not returning for further education in proportion to the availability of programs. Only 21% of AD graduates and 32% of diploma graduates have returned for a BSN or higher (USDHHS HRSA, 2010). Furthermore, these percentages have not changed since 2004 (USDHHS HRSA, 2006). In order to meet the demand for baccalaureate-educated nurses, ways to mobilize these potential nurses to continue their education must be developed and tested. Understanding how current AD nurses perceive returning to school for a baccalaureate degree is one way to begin.

### **Significance of the Study**

The need for a more highly educated nursing workforce has taken on a new urgency with the passage of the Patient Protection and Affordable Care Act (PPACA; Centers for Medicare & Medicaid Services, 2010b) and growing concerns about patient safety (Benner et al., 2010; IOM, 2010). The PPACA was designed to reform existing private health insurance in the United States and to provide health insurance coverage to more people (Neidhardt, 2010). The IOM forecasts that the PPACA will result in 34 million more people having access to health care by 2020 (Short, Swartz, Uberoi, & Graefe, 2011) resulting in a demand for more health care in general and more nursing care specifically

(Ladden, 2009). Because the baccalaureate-prepared nurse is educated to provide care to a diverse group of people, to understand the increased complexity of health care, and to improve quality with systems thinking and health promotion (AACN, 2008; Ladden, 2009), the need for increasing the number of BSN-prepared nurses in the workforce is a crucial aspect of implementing PPACA.

Concerns about patient safety also are making the efforts to improve the educational level of the nursing workforce a priority. In large part, these efforts reflect the documented improvement in patient outcomes that occur with improved educational level of bedside nurses (Aiken et al., 2003; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Friese et al., 2008; Tourangeau et al., 2007). Better patient outcomes include decreased mortality rates (Aiken et al., 2003; Tourangeau et al., 2007). In addition, the baccalaureate nurses demonstrate an increased ability to recognize deteriorating patient status, thus avoiding the commonly identified phenomenon known as failure-to-rescue (Aiken et al., 2003; Estabrooks et al., 2005; Friese et al., 2008). Specifically, Aiken and colleagues (2003) found in a landmark study of 168 acute care organizations that increasing the number of baccalaureate-educated nurses by 10% decreased mortality and failure-to-rescue by 5% in surgical patients. Therefore, increasing the number of baccalaureate-educated RNs by 10% means for every 100 patients, 5 would be rescued instead of being lost to substandard care. Other studies have shown similar results (Estabrooks et al., 2005; Friese et al., 2008; Tourangeau et al., 2007) in mortality and



failure-to-rescue in medical and surgical patients. Furthermore, Goode and colleagues (2001) surveyed 44 chief nursing officers of academic medical centers and found they perceived BSN graduates as “being greater critical thinkers, less task-oriented, stronger leaders, more focused on continuity and outcomes of care, and more professional compared to non-baccalaureate-prepared nurses” (para. 17). The findings of these safety studies, explored more fully in Chapter 2, demonstrate that increasing the educational level of the nursing workforce is a key to improving patient safety.

Increasing the educational level of the nursing workforce will require strategies to attract and retain AD nurses in completion programs. Cheung and Aiken (2006) studied six hospital systems that were successful in advancing the education of all nurses and reported that bringing academia and healthcare organizations together increases the number of AD nurses returning for a BSN. Such efforts include offering on-site courses at the employment site and aligning courses with work schedules, thereby cultivating a learning culture. Other studies have shown that easing financial burdens with tuition reimbursement and guaranteeing post-graduation salary increases further support attracting and retaining AD nurses in completion programs. For instance, Orsolini-Hain (2008) found it was a burden for AD nurses to work and return to school during the same period of their lives. Nurses with ADs stated that if the stipends for tuition received up-front would cover all education costs and if employed nurses returning for a higher degree could have one day off per week for study, returning to school would be a more realistic possibility (Orsolini-Hain, 2008). While these

findings are promising and suggest practical ways to increase the educational level of the nursing workforce, further study is needed to understand if and how these strategies reflect specific characteristics of AD nurses. For instance, Orsolini-Hain's (2008) sample was comprised of 22 AD nurses, representing the experiences of nurses living in urban areas of the West Coast. More research is needed to determine if nurses living in other areas, such as the rural Midwest, see these strategies as realistic possibilities for advancing their educational level.

### **Statement of the Problem**

As the discipline of nursing prepares to meet the challenges of a rapidly evolving healthcare system (and with multiple calls for increased educational preparation of the nursing workforce), describing the meaning of advancing education for AD nurses and how they decide to return to school or not will enhance and refine disciplinary efforts to address the low percentage of baccalaureate-prepared nurses. This hermeneutic phenomenological research study sought to understand the meaning and significance that baccalaureate nursing education has for the AD nurse in the rural area of North-Central Region of Michigan.

Specific aims of this study were to:

1. Understand and interpret the meaning being an AD nurse holds for participants in rural North-Central Michigan.
2. Understand and interpret what it would mean for these AD nurses from a rural area to attain a BSN, and the barriers that prevent this from happening.

## **Purpose**

The purpose of this study was to understand and interpret the meaning of being an AD nurse, the meaning that attaining a BSN has for a rural registered nurse who currently has an ADN, and the barriers an AD rural registered nurse experiences that inform her/his decision of whether or not to return to school. Findings from this study can inform educators', administrators', and legislators' efforts to increase the educational level of the nursing workforce by offering insights into the strategies that may be the most helpful for achieving this goal in rural Michigan.

## **Definitions of Terms**

The following terms are defined as used in this study:

ADN or ASN: nursing education programs of 60 to 70 credit hours, generally occurring through a community college, designed to take two to three years to complete, and resulting in meeting the requirements to take the NCLEX-RN exam.

BSN: nursing education program of 120 to 125 credit hours, generally occurring through a college or university, designed to take four years to complete, and resulting in meeting the requirements to take the NCLEX-RN exam.

Diploma in nursing: a nursing training program traditionally using an apprenticeship model occurring in a hospital over approximately a three-year time period resulting in meeting the requirements to take the NCLEX-RN exam.

RN-to-BSN completion program: nursing education for the diploma- or associate degree-prepared nurse who holds a nursing license, generally comprised of 35–50 credit hours, designed to take one to two years to complete, and resulting in a baccalaureate in nursing degree.

Rural: counties outside of metropolitan areas or having populations of 50,000 people or less (United States Office of Management and Budget as cited in Cromartie & Bucholtz, 2003).

### **Summary**

National calls to increase the educations of RNs have emphasized what is evident in the broader literature: Health care is continuing to become more complex; patient outcomes rely on well-prepared nurses because of their proximity to and persistent interaction with patients; too few baccalaureate-educated nurses exist. The disparity of BSN-prepared nurses nationally and in rural areas, like the North-Central Region of Michigan, should be addressed. Evidence indicates that when nurses are educated with a baccalaureate degree, there is a reduction in mortality rates and failures-to-rescue. Chapter 2 will review the current literature surrounding this issue; Chapter 3 will describe the methodology for this study; Chapter 4 will present findings; Chapter 5 will discuss implications for nursing education and practice.

## CHAPTER 2 REVIEW OF LITERATURE

The purpose of this study was to understand and interpret the meaning of being an AD nurse and the meaning to an AD nurse of attaining a BSN. Insight is needed regarding these issues for several reasons: There are renewed national calls for an RN workforce that is proportionately more BSN-educated; the number of AD nurses is a large resource for more BSNs; little research is available to understand why more AD nurses are not advancing their education. This chapter reviews literature that has given understanding to the research aims:

1. Understand and interpret the meaning being an AD nurse holds for participants in rural North-Central Michigan.
2. Understand and interpret what it would mean for these AD nurses from a rural area to attain a BSN, and the barriers that prevent this from happening.

Beginning with a review of the evolution of ADN education in the United States, this chapter presents information about seven items, as follows: (a) the nursing workforce in the last decade; (b) patient quality and safety skills as indicators for BSN preparation; (c) the Magnet Recognition Program<sup>®</sup> (American Nurses Credentialing Center [ANCC], 2011) and BSN education; (d) differences in the skill sets of AD and BSN nurses; (e) experiences of AD nurses advancing their education; (f) current strategies used to increase the BSN workforce; (g) and a description of the North-Central Region of Michigan, the context for this study.

## **The Evolution of Associate Degree Nursing in the United States**

Nursing has three educational options to prepare students for entry-into-practice via licensure as an RN: the diploma, the AD, and the BSN. Diploma and BSN programs have been in existence for more than 100 years (McBride, 1996; Orsolini-Hain & Waters, 2009). The ADN is much newer, with the first programs having been established just more than 50 years ago. The result of having three different educational options for entry into the nursing practice has been the subject of debate within and outside the nursing discipline (Haase, 1990; Harrington, 2009), and the adequacy of preparation for practice of the different degrees has come under intense scrutiny.

Education for ADN was conceptualized to address the real and anticipated nursing shortage that followed the end of World War II. This shortage was intensified by medical advances, rapid expansion of hospital systems, and increased access of the citizenry to private healthcare insurance, which resulted in more persons entering the healthcare system (Haase, 1990). Additionally, the social norms at the time led many nurses to stop working after they were married, and many nurses who entered the workforce during the war did not continue employment when their spouses returned home (Haase, 1990). The ANA reported that only 300,533 nurses were engaged actively in nursing in 1949 and estimated the need for 447,000 nurses by 1950 and 550,000 nurses by 1960 (as cited in Montag, 1951).

In 1947, the National League for Nursing Education (NLNE, now known as the National League for Nursing, [NLN]) issued a position paper that nursing

programs should take place in institutions of higher education (Haase, 1990). The NLNE argued that professional nursing education should not be under the purview of employers but rather housed within institutions of higher learning. By 1948, two national reports (Brown, 1948; Ginzberg, 1948) on nursing and nursing education supported this position and recommended that the preparation of nurses move to colleges and universities—away from the then current hospital-based, apprenticeship (diploma) programs. Concurrently, the United States Office of Education had been exploring expansion of community colleges to meet workforce demands in the post-war era (Haase, 1990). The American Association of Junior Colleges took an interest in including nursing among the programs offered and formed a committee with the NLNE to consider the development of nursing education in community colleges. In 1949, the American Association of Junior Colleges and NLNE collaborated to solidify the development of this educational option. Mildred Montag was appointed to this committee in 1951 and presented her idea of a new ADN program (Haase, 1990). The ADN was viewed as an important mechanism to address the significant shortage of nurses at the time.

Montag (1951) conceptualized the AD option for nursing education using a model of technical nursing. This option streamlined the educational process so that a post-secondary degree could be earned at a community college in two years, less time than required for both the four-year BSN and the three-year hospital-based diploma program.

Furthermore, Montag (1951) proposed that nursing functions fall on a continuum—one end of the continuum being simple tasks that a nursing assistant might carry out, and the other end a complex functions that required expert skill and judgment from professional nurses with a BSN. In the middle of the continuum, Montag suggested there were intermediate tasks that required skill and judgment beyond a nursing assistant but not at the expert level. These intermediate tasks, she contended, could be carried out by a semi-professional or technical nurse. The technical nurse could help plan patient care, provide patient care with supervision, assist with patient monitoring, and evaluate the plan of care (Montag, 1951), freeing the professional (baccalaureate-prepared) nurse for more complex functions. As the primary preparation for the technical nurse role, the ADN was not intended as a competitor to the BSN, which would prepare the professional nurse (Montag, 1951; Orsolini-Hain & Waters, 2009). According to Montag (1951), the technical nurse would work with and support the professional nurse. In other words, the technical nurse was not intended to replace or to provide an alternative to, but rather to support the work of, the professional nurse (Montag, 1951; Orsolini-Hain & Waters, 2009). Although in a supporting role, the technical nurse would be required to take the same licensure exam to become a registered nurse as the professional nurse.

A five-year pilot program was developed to test the idea of the technical nurse in 1952, with seven schools participating in the states of California, Michigan, New Jersey, New York, Tennessee, Utah, and Virginia (two colleges in the last state). Four of these schools were community colleges that only issued



two-year degrees, and three were universities that issued two- and four-year degrees. All of the colleges were co-educational. The first classes of AD nurses graduated in 1954, and a total of 811 nurses graduated from 1954 to 1956.

Montag and Gotkin (1959) evaluated the first five years of new technical (AD) nursing programs by surveying a sample of graduates, head nurses, and directors of nursing from 1954 to 1956. Graduates were surveyed by questionnaire to ascertain their preparation for nursing practice from the education they received. Head nurses (now commonly called unit managers) evaluated 85 of the total 167 AD graduates in their institutions. Sixty-three of those evaluated were interviewed. Additionally, 23 directors of nursing (representing 27 healthcare organizations) supervising these AD graduates were interviewed. Evaluation data demonstrated that (a) the technical nurse graduates passed the RN licensure exam at rates equal to or better than diploma or BSN graduates, (b) the head nurses of units employing technical nurses reported that AD graduates were comparable to other RN graduates in terms of practice abilities, (c) students were attracted to ADN programs, and (d) the community college setting fit well administratively and financially with the nursing program and fit well socially with the student (Montag & Gotkin, 1959). However, Montag and Gotkin (1959) also noted difficulties. First, the employers surveyed did not understand the philosophical underpinning or the role of the technical nurse and expected them to function as other graduates (BSN and diploma) did. Likewise, the AD graduates found that they were expected to work in a supervisory capacity (rather than in a support capacity), and they were ill-prepared to meet

this expectation either through their pre-licensure education or new employee orientation (Montag & Gotkin, 1959).

As a result of taking the same licensure exam and the lack of role differentiation in the workplace (Frederickson, 1978), the new cadre of AD nurses soon became interchangeable with nurses that held other levels of preparation. The pilot project that had begun with a differentiated role for the technical nurse was producing graduates who were not differentiated from their co-workers. Evaluation discovered this problem and pointed the way toward remediation. Employers adapted to the differences in preparation by adding structured new-employee orientations (Haase, 1990), and ADN programs adapted to employers' needs by adding leadership content to the ADN curriculum (Orsolini-Hain & Waters, 2009).

During this time, community colleges were successful in attracting many different types of students to the ADN programs. These students tended to be older, ethnically diverse, male, single mothers, and married women (Haase, 1990; Montag & Gotkin, 1959). It is important to note that these students would not have been eligible for admission to diploma or baccalaureate programs at the time because of strict admission and progression criteria, such as being single or living with other nursing students in the hospital dormitory, which were common expectations of nursing students during the 1950s. During the first five years of ADN programs, 14% (111) of students were 26 years or older, 3% (21) were male, 12% (94) were married, and 8% (69) had children (Montag & Gotkin, 1959). This trend continues today as 49% of ADN students (compared to 15% of

BSN students) are 30 years or older (Kaufman, 2010). Currently, ethnicity (27%) and the percentage of males (13%) are similar in ADN and BSN programs (Kaufman, 2010). Data regarding rates of marriage (73%) and having children (61%) were available only by total sample of diploma, AD, and BSN nurses (USDHHS HRSA, 2010).

In the five decades after the first AD nurses graduated in 1954, the popularity of the ADN grew as community colleges flourished, particularly in the rural United States (Orsolini-Hain & Waters, 2009). During this time, many communities invested in two-year colleges to provide local, post-secondary education to their citizens because graduates, including those in nursing programs, tended to stay and work in the communities where they had lived and attended classes (Fulcher, 2002; Larowe, 1978). Today, ADN programs produce 50% more registered nurses than BSN programs (NCSBN, 2011).

Many students still are attracted to ADN programs in their communities because they are less costly and more accessible, and graduates are successful finding jobs as RNs. In the United States, there are 1,167 community or junior colleges (American Association of Community Colleges [AACC], 2011a), of which 904 have ADN programs (AACC, 2011a). The AACC (2011a) notes that an ADN costs an average of \$2,544 per year, compared to a BSN that costs about \$7,020 per year. In general, ADN programs also are more accessible because 29% of community colleges are in rural areas as compared to 9% of colleges and universities (U.S. Department of Education, National Center for Educational Statistics, 2008). The accessibility of ADN programs also supports

students' ability to continue working in their communities and live at home while attending school. ADN programs also consistently have graduates who have been successful in receiving RN licensure and finding employment upon graduation (AACC, 2011b; Mahaffey, 2002). The AACC reports (2011b) that 98% of ADN graduates find employment within six months of graduation. Despite the success of ADN programs, however, there have been continuous calls for an increase in education past the AD level.

### **Nursing Workforce in the Last Decade**

In 2001, the National Advisory Council on Nursing Education and Practice (NACNEP) set a goal that 66% of the nursing workforce in the United States would hold at least a BSN by 2010. However, the number of graduates with a BSN increased by less than one percent per year between 2000 and 2008. Currently, only 50% of RNs in the United States have a BSN or higher (USDHHS HRSA, 2010). As of 2010, the number of BSNs had increased by only 6% (from 44% to 50%) since 2000 according to the 2008 National Sample Survey of Registered Nurses (USDHHS HRSA, 2002, 2010). Orsolini-Hain (2008) contends that this relatively slow growth may be attributed to many factors including the lack of available BSN programs and role differentiation by employers who have not distinguished between the work of nurses and the accompanying lack of compensation based on educational preparation. This lack of role and incentive differentiation by employers reflects the absence of substantial evidence to support the need to re-examine the composition of the nursing workforce by educational preparation. However, the IOM has initiated several reports over the

last 10 years (IOM, 2000, 2001, 2003, 2004, 2010) that have pointed to concerns in the quality and safety of patient care and have focused attention on system issues, including nursing education as a root cause.

### **Patient Quality and Safety Skills as Indicators for BSN Preparation**

The Committee on the Quality of Health Care in America (IOM, 2001) brought a focus on quality and safety across health care in the early 2000s. The Committee challenged all healthcare professionals to “develop new skills” that would maximize the use of a growing science base in delivering evidence-based care to a diverse population. The development of new skills requires additional knowledge and cognitive abilities (IOM, 2001).

The IOM (2000) reported in “To Err is Human” that many preventable healthcare errors occur that endanger patient safety. This report provided specific quality and safety indicators that have a direct link to nursing care. For example, because bedside nurses commonly act as the last check before medications are given or procedures are performed (Clarke & Aiken, 2006; IOM, 2000, 2004), they shoulder great responsibility and accountability for the quality and safety of care for patients. The bedside nurse also has the responsibility of ongoing assessment and intervention to ensure patient safety after medication administration or patient procedures (IOM, 2004). The IOM recommendations came on the heels of compelling evidence that showed that having a BSN-prepared nursing workforce decreases patient mortality and failure-to-rescue (Aiken et al., 2003; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Estabrooks et al., 2005; Friese et al., 2008; Tourangeau et al., 2007).

Aiken et al. (2003) studied 30-day mortality rates and failure-to-rescue in 232,342 surgical patients throughout 168 hospitals in Pennsylvania and found mortality decreased by 5% when there were 10% more nurses with a BSN caring for patients. Aiken et al.'s (2003) work has provided significant evidence that surgical patient mortality is inversely proportional to the number of BSN-prepared nurses caring for the patients. Likewise, the failure of nurses to rescue a patient who was rapidly deteriorating declined proportionally when the number of BSN-prepared nurses increased by 10% (Aiken et al., 2003). Using regression analysis, Aiken et al. (2008) also found that for every 10% increase in the number of nurses with a BSN, there was an associated 4% reduction in the risk of death in surgical patients. Furthermore, "the odds of patients dying in hospitals in which 60% of the nurses held a baccalaureate degree...would be lower by 15% than in hospitals with 20% BSNs" (Aiken et al., 2008, p. 227).

Many organizations—health care and non-health care alike (e.g., California Nurses Association, The AFGE [American Federation of Government Employees] Professional Activists, Santa Ana College, the American Association of Community Colleges and others)—criticized mortality and failure-to-rescue research because investigators reviewed data from only one state (Pennsylvania) and this data reflected hospitals, not individual nurses. The fact that investigators did not account for different types of hospitals and resources (i.e., urban or rural), different staffing models or philosophies of the hospitals, or differences in physician board certifications were other sources of criticism (Atkins & Nygaard, 2004; Boggs, 2004; Broome, 2004; Burger, 2004; Comeau,

Crook, & Hirsch, 2004). Also, there was no differentiation for the type of BSN earned by nurses in the sample—a traditional baccalaureate degree (typically completed in four years) or the RN-to-BSN (where an AD nurse returns to school for additional coursework and attains a BSN using some of the credits earned from the earlier program). All of the critiques indicated that the research needed replication. Aiken and colleagues (2003) received scrutiny from the National Institute of Health when funding was requested for follow-up studies and the *Journal of the American Medical Association* during the publishing of subsequent findings, both being scientific review processes (AACN, 2003). Eight years later, the studies were replicated and expanded upon, with similar results in mortality and failure-to-rescue statistics throughout the United States and other countries (Estabrooks et al., 2005; Kendall-Gallagher, Aiken, Sloane, & Cimiotti, 2011; Tourangeau et al., 2007).

Similar findings have been reported internationally in studies of medical patients. In Canada, Estabrooks et al. (2005) and Tourangeau et al. (2007) found that mortality decreased when BSN-prepared nurses were at a higher number in the institutions studied. Specifically, when the number of BSN-prepared nurses increased by 10%, deaths decreased by nine in a sample of 1,000 acute medical patients (Tourangeau et al., 2007), and a higher number of nurses with a BSN was significantly correlated to a decrease in patient mortality in patients with diagnoses of acute myocardial infarction, congestive heart failure, chronic obstructive pulmonary disease, pneumonia, and stroke (Estabrooks et al., 2005).

Investigators also have reported findings consistent with those described previously in oncological (Friese et al., 2008), cardiac surgical (Van den Heede et al., 2009), and surgical patients with a comorbidity of mental illness (Kutney-Lee & Aiken, 2008). When there were a higher number of BSN-prepared nurses caring for surgical oncology and cardiac patients, patient mortality rates decreased (Friese et al., 2008; Van den Heede et al., 2009). Coupled with enhanced nursing staffing and favorable work environments, there was an overall reduction in mortality rate and failure-to-rescue (Friese et al., 2008). Kutney-Lee and Aiken (2008) found that education level among nurses influenced the length of stay in surgical patients with comorbidity of mental illness, and hospitals with more BSN-prepared nurses had 14.8% shorter hospital stays.

Most recently there has been similar research across many states in the United States. Kendall-Gallagher et al. (2011) studied the effect of nursing education and nurse specialty certification (only BSN nurses are eligible for nurse specialty certification) on mortality and failure-to-rescue, utilizing data from 1,283,241 surgical patients in 652 nonfederal hospitals in California, Florida, New Jersey, and Pennsylvania and 28,598 nurse survey responses. They found that when the number of BSN-prepared nurses and certified BSN-prepared nurses increased by 10%, there was an associated decrease in hospital mortality and failure-to-rescue by 6% with BSN preparation alone and 8% with BSN preparation and certification.

The consistent link in these studies demonstrates that when there is an increased proportion of BSN nurses at the bedside, there is a significant



decrease in patient mortality (Aiken et al., 2003; Estabrooks et al., 2005; Kendall-Gallagher et al., 2011; Kutney-Lee & Aiken, 2008; Tourangeau et al., 2007; Van den Heede et al., 2009). Together, these studies examined 1,818,205 patients, 1,129 hospitals, and 61,277 nurses. This research is compelling and significant for many reasons. It is important to the healthcare organizations that have a renewed focus on quality and safety as well as better patient outcomes; all of which are fostered through new federal regulation and oversight agencies (Centers for Medicare & Medicaid Services, 2010; WHO Collaborating Centre for Patient Safety Solutions, 2010a). This evidence and the support of many national organizations (AACN, 2009; ANA, 2000; American Organization for Nurse Executives [AONE], 2004; IOM, 2010; NACNEP, 2001) provide employers with incentives to increase the number of BSN-prepared nurses they employ and also to differentiate the work assigned to ADN- and BSN-prepared nurses (Cheung & Aiken, 2006). This research also has influenced the IOM's (2010) report focused on nursing and its recommendations for increasing the proportion of BSNs in the nursing workforce.

In 2010, the IOM examined nursing practice and education specifically (IOM, 2010) and set the national goal to increase the percentage of RNs with a BSN to 80% by 2020. The IOM (2010) explicitly correlated this need to the complexity of care required in the current healthcare system evident today, compounded with sicker patients in the healthcare systems. This level of patient care requires solid skills in analysis and synthesis—hallmarks of the BSN-prepared nurse (IOM, 2010). In one segment of the American healthcare

system—the Magnet Recognition Program® (Aiken, Havens, & Sloan, 2000; ANCC, 2011)—higher numbers of nurses with a BSN can be found.

### **Magnet Recognition Program® and BSN Education**

The ANCC developed the Magnet Recognition Program® to recognize hospitals that have exemplary nursing practices (ANCC, 2011). Magnet designation is an opportunity to let consumers know that the nursing care is excellent at that particular hospital. In the original study for the Magnet Recognition Program®, 14 factors, known as the forces of magnetism, were recognized to contribute to the ability to recruit and retain nurses (ANCC, 2011). Magnet facilities must demonstrate excellence in all 14 factors including quality of nursing leadership, organizational structure, management style, personnel policies and programs, professional models of care, quality of care, quality improvement, consultation and resources, autonomy, community and health care organization, nurses as teachers, image of nursing, interdisciplinary relationships, and professional development (ANCC, 2011). Magnet designation does not require a specific number of BSN-prepared (or higher) nurses working at the organization, only which the forces of magnetism are demonstrated (ANCC, 2011).

While nursing education is not one of the 14 factors involved in Magnet status, it is valued in a Magnet-designated facility (ANCC, 2011; Murray, Havener, & Jastremski, 2011), and a higher BSN rate often is observed. For example, Aiken et al. (2000) found that the Magnet-designated hospitals had an average of 59% of BSN-prepared nurses compared to the national average at

that time of 34%. Magnet-designated hospitals also report lower burnout and higher job satisfaction and rate the nursing care quality among nursing staff higher than non-Magnet designated hospitals (Aiken et al., 2000). Kramer, Maguire, and Brewer (2011) studied 34 U.S. Magnet-designated facilities with 12,233 nurses on 717 hospital units in a descriptive study. They found more nurses educated with a BSN or higher reported being employed in healthy work environments, which correlated with a nurse's perception of increased patient safety.

Murray et al. (2011) described their experiences at a rural Magnet-designated hospital. In a rural region in the state of New York, recruitment of RNs is more difficult than in urban areas. Having Magnet designation and a dedicated program to increase the education of their nursing workforce has been vital to the retention of nurses. In this region, the pool of new nurse graduates commonly comes from the local ADN program. Through partnership with a university, this Magnet-designated hospital offers on-site baccalaureate and graduate courses to their nursing workforce. They also were able to decrease RN turnover and vacancy by 12.2% (Murray et al., 2011). Improving the environment of healthcare delivery through Magnet designation also has enhanced collaboration between nurses and other healthcare providers, reduced the incidence of lateral violence, and has been one of the best ways to reform an organization for patient safety and nurse retention (Murray et al., 2011). Although Magnet designation supports nursing education at the BSN level, it does not shed light on the differences between AD and BSN nurses.

## **Differences in the Skill Sets of Associate and Baccalaureate Degree Nurses**

Differences in the practice of AD and BSN nurses have been widely researched since the ANA (2000) published the policy statement in 1965 that stated that BSN education should be the education level for entry into professional nursing practice. Not until 2003 was the influence of educational preparation of nurses linked to patient safety and quality of care. In general, however, differences in practice are described in the literature in terms of critical thinking, evaluating professional attributes, and understanding the transition that takes place with AD nurses who increase their education to a BSN (RN-to-BSN).

Critical thinking skills are used daily by nurses to help inform decisions about increasingly complex problems in patient care. “Critical thinking is purposeful, self-regulatory judgment which results in interpretation, analysis, evaluation and inference” (“The Delphi Report”, as cited in Facione & Facione, 1996). Critical thinking in nursing has been researched using tools designed for education specific to nursing (Facione & Facione, 1996). One study found a significant difference in critical thinking between AD and BSN students in Korea (Shin, Jung, Shin, & Kim, 2006). Others have found no difference between the two (del Bueno, 2005; Fero, Witsberger, Wesmiller, Zullo, & Hoffman, 2009; Lauder & James, 2001). The development of critical thinking over time, from preparation into practice, has not been well-documented.

Professional attributes of RNs with differing educational preparation, however, has been studied—again with mixed results. Clark (2004) found no significant difference between traditional BSN students and AD nurses returning

for a BSN (RN-to-BSN) in professional socialization as measured by the Nursing Activity Scale. Professional attitude also was studied in RN-to-BSN students on entry to the program and at graduation; again with mixed results. White and Gomez (2002) found no change in professional attitude while Periard, Bell, Knecht, and Woodman (1991) found a significant increase in professional attitude. Witt (1992) also found a significant increase in professional behavior by RN-to-BSN students, demonstrated through a change in the teaching/collaboration, planning/evaluation, interpersonal relations/communication, and professional development processes of nursing. Waters, Chater, Vivier, Urrea, and Wilson (1972) found that 100% of the (24) AD nurses in their study described their nursing care in technical terms while only 33% of those with a BSN (8) did. The AD nurses described nursing problems in concrete and specific (technical) terms, more often physiologically than psychologically or socially (Waters et al., 1972). Gray, Murray, Roy, and Sawyer (1977) also found that AD nurses viewed their patient care in technical terms providing standardized teaching and focusing on patients' immediate needs.

This is contrasted with BSN-prepared nurses who viewed and practiced nursing in more professional terms such as providing individualized teaching and anticipating long-range patient needs, including discharge and preventive care. A meta-analysis of 139 research studies (Johnson, 1988) had similar findings: AD nurses "tend to be more bureaucratically oriented and perform technical skills better" (p.191) and BSNs "perform better than technical nurses in behaviors

identified with professional education and practice: communication, knowledge, problem solving, professional role and teaching” (p.191).

The literature investigating nurses’ experiences returning for a BSN after receiving an ADN reported other transformative experiences. For instance, investigators noted how AD nurses developed a sense of becoming professionals and building professional confidence (Crooks et al., 2005; Delaney & Piscopo, 2007; Haffer & Raingruber, 1998; Megginson, 2008) by returning to school for a BSN. By becoming BSN-educated nurses, participants were able to gain knowledge through exposure to theory and research that improved their communication and construction of arguments (Crooks et al., 2005; Delaney & Piscopo, 2007; Haffer & Raingruber, 1998; Osterman, Asselin, & Cullen, 2009; Zuzelo, 2001). Participants identified gaps in their past clinical practice, and newly-gained knowledge and nursing theory helped fill these areas (Crooks et al., 2005). Diploma nurses also developed an expanded worldview (Lillibridge & Fox, 2005; Osterman et al., 2009) that led to more holistic nursing practice (Delaney & Piscopo, 2007; Zuzelo, 2001) or led them to practice nursing differently by using research and better communication skills (Lillibridge & Fox, 2005; Zuzelo, 2001). Delaney and Piscopo (2007) reported that RN-to-BSN students thought their education had a direct benefit for their patients and gave the example of replacing task orientation with a more holistic view of patient care. Lillibridge and Fox (2005) reported that one RN-to-BSN student said, “While I think I was a very clinically astute RN...you don’t know what you don’t know” (p.15) before returning to school. Despite these qualitative

reports from nurses in RN-to-BSN programs, no empirical research quantifies how AD- and BSN-prepared nurses practice differently that attributes to the reasons for better outcomes with mortality and failure-to-rescue when the nursing workforce is proportionately more educated at the BSN level.

### **AD Nurses' Experiences Advancing their Education**

Much is known about the experiences of attending an RN-to-BSN program from AD nurses, but little is known about AD nurses before they return to school and how they make the decision to increase their education in nursing. A review of literature includes information about the decision to return to school and the associated incentives, barriers, and changes occurring in those nurse's lives, which informs what is known about the process of attaining a BSN. Since the 1970s, investigators have identified the lack of role differentiation in pay and opportunity between educational preparation of RNs as reasons that delayed education advancement (Megginson, 2008; Orsolini-Hain & Waters, 2009).

### **Reasons for the AD Nurse to Increase Education**

In the last ten years, the most commonly documented reason that AD nurses return for a BSN was their desire to advance into roles in nursing beyond bedside care (Megginson, 2008), many of which require a BSN (Delaney & Piscopo, 2004; Lillibridge & Fox, 2005; Osterman et al., 2009; Rapley, Nathan, & Davison, 2006; Zuzelo, 2001). Two other motivating factors associated with AD nurses' decisions to return to school include the perceived advantages of career advancement associated with having a BSN and the work environment acting as a catalyst to return to school when they perceived feeling stagnant or "stuck" in

their jobs (Kalman, Wells, & Gavan, 2009, p. 13; Lillibridge & Fox, 2005). Altmann (2012), Megginson (2008), and Zuzelo (2001) reported that the desire to achieve a personal goal, the associated enhancement of credibility and professional identity, and the encouragement from peers also were influencing factors. Others reported the availability of user-friendly RN-to-BSN programs (Megginson, 2008; Rapley et al., 2006), the appeal of investment or self-preservation, and a “love of learning” (Delaney & Piscopo, 2007, p. 170) as important factors for advancement. Support from colleagues was another motivator despite the fact that some colleagues were not always encouraging (Delaney & Piscopo, 2007; Kalman et al., 2009; Lillibridge & Fox, 2005; Rapley et al., 2006). Finally, state laws requiring the attainment of a BSN in a pre-specified period of time to retain licensure to practice (A02079B, 2010; S803, 2010) is an emerging factor influencing AD nurses’ decisions about returning to school.

The availability and accessibility of completion programs influence the decision for RNs to attain a BSN. In a phenomenological study investigating facilitators and barriers, Megginson (2008) reported RN-to-BSN students looked for user-friendly programs that accepted previous coursework, required fewer clinical hours, waived out-of-state tuition, and offered face-to-face versus online courses. Flexibility with scheduling and format of classes also helped RNs make the decision to return to school (Altmann, 2012; Kalman et al., 2009; Rapley et al., 2006; Sizemore, Robbins, Hoke, & Billings, 2007), although timing was very influential in AD nurses advancing their education.



Many investigators describe how timing is a common predictor of nurses advancing their education (Kalman et al., 2009; Megginson, 2008; Osterman et al., 2009). For instance, Kalman et al. (2009) contend that children and family exerted the most influence over AD nurses' decision to increase their education, while Osterman et al. (2009) state that life events (marriage, divorce, and children) coupled with working and having access to the right program were important aspects of timing that influenced the same decision. Similarly, investigators have described how juggling commitments influenced the ability of the AD nurse to advance toward a BSN (Kalman et al., 2009; Lillibridge & Fox, 2005), and balancing work, school, and family was necessary for it to be feasible for the RN to attain a BSN.

Most RNs attaining a BSN found the process to be a significant life-changing experience, both personally and professionally. They reported a transformation in their thinking and they became more confident, communicated better, and developed a broader worldview of their practice (Crooks et al., 2005; Delaney & Piscopo, 2007; Haffer & Raingruber, 1998; Osterman et al., 2009; Zuzelo, 2001). These nurses discovered that they did not know as much as they thought they did, and they appreciated the knowledge that they gained through advancing their education (Lillibridge & Fox 2005; Rapley et al., 2006).

This review of literature has given an overview of reasons that move AD nurses toward pursuing a BSN, but this overview neither has been tested nor developed any theories to help understand why more than one in five AD nurses (USDHHS HRSA, 2010) do not further their education. Extant research cannot

predict who will increase their education. The facilitators of availability and flexibility of RN-to-BSN programs and timing does make the case for offering nursing education in a seamless transition as the Oregon's Consortium for Nursing Education (AONE, 2005) has done. More research is needed to understand what increasing education means to AD nurses before they enter an RN-to-BSN program, especially in populations not represented in the literature, such as rural areas.

### **Barriers to Advancing Education for AD Nurses**

Despite concerted efforts to encourage AD nurses to return to school (discussed in Chapter 1) it is unclear why only 21% have done so nationally (USDHHS HRSA, 2010). This percentage did not change from 2004 to 2008 (USDHHS HRSA, 2006, 2010). Reviewing barriers may help administrators and legislators understand some of the underlying reasons and consider if and how these barriers can be addressed. Barriers identified in the literature include lack of availability of completion degree programs, class times interfering or conflicting with work or family, programs focused on the traditional student rather than the working RN, burdens of commuting, financial difficulty, inopportune age, lack of peer support, requirements to be on campus, and lack of recognition from employers (Altmann, 2012; Cheung & Aiken, 2006; Delaney & Piscopo, 2004, 2007; Hader, 2011; Lillibridge & Fox, 2005; Morrison & McNulty, 2012).

Megginson (2008) found that time, fear, lack of recognition of past education or life accomplishments, undifferentiated role expectations for all RNs regardless of educational preparation, and prior negative educational

experiences contribute to RNs not returning for a BSN. Although some AD nurses found their colleagues' encouragement to be an incentive, others reported that they were not supportive (Zuzelo, 2001). Rather (1994) found that returning AD nurses felt coerced to return, did not place the same value on education as their instructors, felt they were already professionals, and did not see the difference that a "piece of paper" (p. 266) would make.

The Joint Commission on accreditation of healthcare organizations (2003) recognized that not distinguishing a role difference in skill sets or compensation of BSN and AD nurses has served as a disincentive to attaining a BSN. Pay differentials based on education are available in about 26% of hospitals in one state, but few hospitals consistently offer this type of pay differential (University of Vermont, 2003).

Investigators agree that these barriers, relatively unchanged since the 1970s, have contributed to the very low percentage of AD nurses returning for a BSN (Frederickson, 1978; Megginson, 2008; Orsolini-Hain, 2008). The lack of available and accessible BSN degree-completion programs also has been a historic problem (Megginson, 2008).

While many new programs have been initiated with financial contributions made by the federal government and local healthcare organizations, and despite improvements having been made in the flexibility and delivery of classes, low matriculation continues. There has been only a 6% increase in BSN nurses from 2000 to 2008 (USDHHS HRSA, 2002, 2010). Further exploration is needed to better understand and describe reasons that are unique to rural environments.

## **AD Nurses before Advancing their Education**

One unpublished dissertation (Orsolini-Hain, 2008) explored 22 AD nurses' beliefs about their education and advancing (or not advancing) their education. Orsolini-Hain (2008) conducted an interpretive phenomenological study, interviewing AD nurses who had been in practice at least 10 years and were not enrolled in any nursing education program. Orsolini-Hain aimed to understand and interpret the meaning of being an AD nurse and what it would mean to increase the nurse's education, as well as to articulate barriers to enrolling in a BSN program. The AD nurses interviewed felt that they were prepared already for practice; they valued hands-on direct patient care, had a strong identification as a nurse, were advocates for patients, were able to advance their career without increasing their education, and had little or no belief that BSN education would advance or improve their practice (Orsolini-Hain, 2008). Participants also noted that they could advance in clinical ladders and become supervisors and nurse managers without a BSN and that current employers valued their hands-on practice. Orsolini-Hain, however, observed that in the interviews most of the nurses did not actually demonstrate strong leadership skills such as being a change agent or engaging in systems thinking. Orsolini-Hain concluded, "there was a built-in secondary ignorance about what they do not yet know in relation to their work" (p. 149).

Using open-ended questions, Delaney and Piscopo (2004) surveyed 101 RNs from an urban area who did not return for a further degree after receiving an AD or diploma. Most participants identified several benefits to returning for a

BSN, but 10% saw none. This is consistent to the studies on AD nurses already in RN-to-BSN programs; most of them were able to identify benefits (Crooks et al., 2005; Delaney & Piscopo, 2007; Haffer & Raingruber, 1998; Lillibridge & Fox, 2005; Osterman et al., 2009; Rapley et al., 2006; Zuzelo, 2001) while some did not see any benefits (Rather, 1994). In their research, Delaney and Piscopo (2004) found four themes, one of which was based on the perceived benefits of having a BSN. "Raising potential" was a theme defined as personal and professional growth, improved self-image, and job mobility. Another theme identified barriers that were discussed previously in this chapter, and the remaining two themes discussed incentives to help more AD nurses continue their education.

When asked how to motivate more AD nurses to get a BSN, "simplify the process" and "make it worthwhile" were two additional themes identified (Delaney & Piscopo, 2004, p. 159). Simplify the process referred to access to classes, flexibility in class offerings, availability of scholarships, and recognition within the coursework of prior experience as practicing RNs. Make it worthwhile referred to employers recognizing the value of the additional education, making it worth striving for by offering a difference in pay or responsibilities after the degree is obtained, and providing tuition reimbursement at the time of registration. Delaney and Piscopo (2004) found 28.7% of their sample intended to return for at least a BSN, but only 8.9% intended to return within two to three years. The authors gave no explanation for these percentages, and this gap is evidence that further study is needed. Strategies are in place to facilitate the

process of attaining a BSN, but they are not consistent from state to state and do not yet have sufficient results to show they are increasing the percentages of the BSN workforce.

### **Current Strategies to Increase the BSN Workforce**

The disparity between the numbers of BSN-prepared nurses and the numbers of AD and diploma nurses in the United States continues into the twenty-first century. Many national organizations promote the BSN as the entry level for RN practice and also recommend AD nurses seek to complete a BSN as a criterion for continued employment in nursing (AACN, 2000, 2002; ANA, 2000; AONE, 2004; NACNEP, 2001). Reasons cited for increasing the percentage of BSNs in the workforce include the increasing complexity of the healthcare environment, multiple and varied work settings, quality and safety issues, and increasing diversity in nursing roles with recognition of a need for more autonomy (AACN, 2002, 2009; ANA, 2000). “This [BSN] educational preparation will prepare the nurse of the future to function as an equal partner, collaborator and manager of the complex patient care journey” (AONE, 2004, para. 3).

The evolution of the healthcare environment and increasing education levels have been recognized by other healthcare professions, which have been requiring more than an ADN since the 1960s and are currently increasing their requirements to master’s and doctoral levels (Barter & Lenihan, 2001; MCNEA [Michigan Council of Nursing Education Administration] / MACN [Michigan Association of Colleges of Nursing] / MONE [Michigan Organization of Nurse Executives] (3M) Task Force, n.d.; Nelson, 2002). Athletic trainers and physician

assistants must have at least a baccalaureate education to practice (MCNEA/MACN/MONE, n.d.). Physical therapists, occupational therapists, speech pathologists, and social workers must earn a master's degree to practice (Barter & Lenihan, 2001), and physical therapy is in the process of requiring a doctorate for entry into practice (Nelson, 2002). Pharmacists have needed a doctorate since 2002 (Barter & Lenihan, 2001; MCNEA/MACN/MONE, n.d.) to enter practice. Recognizing the educational level of other healthcare professions is important for the nursing discipline because collaboration in the changing healthcare environment may depend upon raising the average level of nursing education to keep pace.

Most nursing organizations and certification bodies have begun to require nurses to have a BSN to be eligible for participation and certification (ANCC, 2010; Sigma Theta Tau International, 2010). Although the ANA has supported a BSN as the entry into professional nursing practice since 1965 (ANA, 2000), no formal action has been taken to enact this as a national policy (NCSBN, 2011). Despite position statements and support for the baccalaureate degree as the entry-to-practice requirement for nursing, efforts to change the educational requirements of nurses for licensure have not been successful. The failure to reach agreement within the discipline has led to contentious debates and disagreements and has fostered confusion for the public.

Several states are seeking to increase the percentage of BSN-prepared nurses by mandating that AD nurses obtain a BSN within a certain number of years after becoming an RN, which is one solution to the shortage of BSNs. This

solution has been successful in specific states and regions of the country where there are a number of programs designed to accelerate BSN completion while allowing participants to work and build on prior education and experience (AACN, 2010; USDHHS HRSA, 2010). These programs can mobilize an existing AD nurse pool toward a BSN degree. Some states like New York and New Jersey introduced legislation (that was defeated) that would require AD nurses to pursue a BSN within 10 years of becoming an RN (A02079B, 2010; S803, 2010).

### **North Dakota**

The North Dakota Board of Nursing (NDBON) used their authority to define the BSN as the entry-into-practice for RNs in 1986, beginning with the classes graduating after 1987 (Wertz & Rambur, 1997). In practice, this resulted in the BSN nurse practicing as an RN, and AD graduates beginning in 1987 practicing as licensed practical nurses. The AD graduates before 1987 were allowed to continue to practice as RNs. After a tough legislative battle (Wertz & Rambur, 1997), the North Dakota Supreme Court ruled that the NDBON had the right to differentiate practice and entry level requirements. Nursing education in ADN programs across North Dakota adapted to this change, creating a transition to the BSN immediately after graduating with an ADN and forming a two-plus-two option (two years to ADN; an additional two years for BSN). The BSN (and higher) educated workforce has grown in North Dakota from 54% in 1997 (Wertz & Rambur, 1997) to 66.2% in 2008—the highest level seen thus far (USDHHS HRSA, 2010). However, this definition of educational preparation for entry level to RN practice changed through legislation in April 2003, reverting to



previous and customary definitions (Rambur, McIntosh, Palumbo, & Reinier, 2005). Because no one in the legislative assembly seemed to question the decisions the North Dakota Board of Higher Education made, legislation was introduced to change the over-sight of nursing education from the NDBON to the North Dakota Board of Higher Education (Mooney, 2003). This introduction of legislation was the opening needed for those opposing the BSN as the entry level for RNs to make changes. The bill was rewritten several times, and what was intended to change the NDBON authority over nursing education ended as a bill that lowered the level of nursing education to the previous 1986 standards (Mooney, 2003). The authors of the final bill convinced legislators this was needed so that North Dakota would educate nurses as the rest of the United States did and because nursing homes needed a less expensive option for RNs.

This regulatory approach forced nursing education in North Dakota to plan processes that would allow students to earn an ADN easily on the way to attaining a BSN. With this plan in place, the percentages are still growing and they nearly met the NACNEP (2001) goal of two-thirds of the RN workforce having a BSN by 2010, despite the repeal of the law in 2003. North Dakota moved the closest to meeting the NACNEP goal (2001), but to-date, no other state has followed this lead.

### **Role Differentiation Based on Nursing Education**

In South Dakota, the differences in preparation for practice were addressed following graduation. For example, in 1987 Sioux Valley Hospital in Sioux Falls, South Dakota, implemented a pilot program with a differentiated

model for the education of RNs after the South Dakota Board of Nursing issued a call for a statewide plan for nursing education in 1984 (Koerner, Bunkers, Nelson, & Santema, 1989; Primm, 1987). Stakeholders met and planned the differentiated model for RNs based on ADN and BSN education, and Sioux Valley Hospital had nursing units that volunteered to demonstrate the model. The model had two levels of nursing practice; one model was assumed by the AD nurses and the other by the BSN nurses. There were five regional sites in five other states that piloted this differentiated model of nursing education as well (Primm, 1987). Sioux Valley Hospital's findings from nursing job satisfaction surveys and unit cost analyses were encouraging: where this model was put into practice there was greater continuity of care, patient care cost less, and the model provided building blocks for differentiated nursing education curriculum by providing clinical experiences (Koerner et al., 1989).

More studies between 1989 and 1999—using the common metrics of satisfaction and cost analysis concerning differentiation of RN practice—reported positive beneficial outcomes such as increased patient satisfaction, efficient utilization of limited nursing resources, empowered decision making, and preparation of graduates for a more specified role (Bellack & Loquist, 1999; Koerner et al., 1989; Malloch, Milton, & Jobes, 1990; Vena & Oldaker, 1994). There were no reports of negative outcomes of differentiation of RN practice, only barriers to implementation.

Two studies in the 1990s reported barriers to the implementation of differentiated practice. The barriers were (a) lack of appreciation for the AD and

BSN nurses working side-by-side, (b) undifferentiated salaries, (c) failure of the profession to reach consensus on differentiation in practice by RN education, and (d) undifferentiated use of RNs by health care facilities (Bellack & Loquist, 1999; Pitts-Wilhelm, Nicolai, & Koerner, 1991). Although beneficial evidence supporting differentiated practice has existed in the literature, the differentiation between AD and BSN RNs has not been implemented widely in practice and has not shown sustainability to the present time in healthcare facilities.

In the 2000s, several states (Texas, Indiana, Nebraska, New Mexico, Colorado, North Dakota, and South Dakota) differentiated entry-level competencies for graduates from ADN, diploma, and BSN programs (Poster, 2004). Although the competencies are beneficial to nursing education for providing clarity and consistency to educational outcomes and designing smooth plans for educational mobility (Poster, 2004), these have not consistently affected public policy or nursing practice in hospitals or other organizations hiring RNs.

### **New York State**

The State of New York had legislation in process (A02079B, 2010) to mandate a “BSN in 10” for continuing to practice in nursing. This means AD nurses have 10 years after graduation to complete a BSN or they will not be able to be licensed as an RN. Along with the legislation, nurse leaders have collaborated and created three objectives (Zimmerman, Miner, & Zittel, 2010) to help nurses achieve this goal: (a) standardize nursing education requirements (all AD or diploma nurses will have a BSN within 10 years); (b) provide fluid transition to the BSN level of education (prerequisites, admission criteria, and

curricula are standardized between levels of education); and (c) address the financing this initiative will require. New York nursing leaders and educators agree that a standardized curriculum, a process for concurrent admission into associate and baccalaureate programs, and standardized prerequisites and admission criteria will contribute to the achievement of this legislative mandate. Ninety percent of healthcare employers offer financial assistance for the tuition in this model (Zimmerman et al., 2010). The time-frame of 10 years for completion allows for the opportunity to space class offerings, create scholarships, and have students pay the remainder as part of their professional responsibility. This time-frame aligns with the IOM's "Future of Nursing" report goal of 80% baccalaureate-prepared nurses by 2020.

The stakeholders that do not support this legislation, such as community college presidents, state healthcare association, and labor unions, have fears that it will exacerbate the nursing shortage and do not understand the need for increased education when both education levels of graduate (ADN and BSN) sit for the same licensure exam (Zimmerman et al., 2010). There is no data yet evaluating the New York objectives for nursing education, and the legislation has been stalled.

Teachers in grades K-12 are another professional group that mandated baccalaureate preparation legislatively. In 1946, 15 states required a four-year degree, and by 1956 there were 34 states that demanded this level of education (Sedlak & Schlossman, 1986). In 1935, approximately 50% of teachers had baccalaureate preparation, and by 1955, approximately 80% had a four-year

degree (Sedlak & Schlossman, 1986). It is interesting to note that this increase between 1935 and 1955 occurred when there was a severe teacher shortage. Raising the educational requirements did not cause a further shortage in teachers; in fact, it made the profession more attractive (Sedlak & Schlossman, 1986). By 1971, 96% of teachers had a four-year degree, and by 1981, 50% held master's degrees (Sedlak & Schlossman, 1986).

### **Onsite Education**

Having on-site, affordable education is a common model to help break barriers and motivate AD nurses to increase their education to a BSN. Several hospitals have partnered with colleges and universities to offer BSN education at places of work (Cheung & Aiken, 2006; Murray et al., 2011; Reams & Stricklin, 2006; Zimmerman et al., 2010). Cheung and Aiken (2006) reported in a case study that Hackensack University Medical Center increased its BSN workforce percentage to 55% but did not state where the percentage started before onsite BSN education. Benefits to the organization have been documented and include retention of nurses, collaboration between nurses throughout the hospital, and a commitment to stay and grow with the organization. However, there is no longitudinal measure of how the BSN percentages have changed (Cheung & Aiken, 2006). The need for academia and the healthcare system to have a good partnership and objectives is a documented difficulty for onsite BSN courses (Cheung & Aiken, 2006; Murray, 2007; Zimmerman et al., 2011). This may be a concern if the two do not agree regarding the model of delivery of nursing education.

## **Online Education**

Offering BSN courses online also increases opportunities for furthering education (Murray, 2007). Currently there are more than 400 of these programs available (AACN, 2011c). Online instructions offer flexibility and convenience for students (Megginson, 2008). Students are able to attend school around their work and family schedules, and the student and instructor do not have to be in the same location. Schooling takes place by using technology to support an asynchronous or synchronous environment via the Internet. Success of online schooling is measured by the support that the academic institution gives students in the online environment (Murray, 2007) coupled with student satisfaction. Online coursework may be a source of frustration for students and faculty when technical support is not given by the institution (Atack & Rankin, 2002). No documentation exists to show that online BSN programs have impacted the numbers of advancing AD nurses to a BSN.

## **Community College BSN**

Murray (2007) reviewed innovative trends in nursing education and found that community colleges were interested in offering a BSN in order to decrease costs of education and maintain accessibility to BSN education. Community colleges in Florida, Indiana, Nevada, New Mexico, and Washington offer an RN-to-BSN option (CCBA, 2011). The AACN (2005) supports these efforts and recommends that community colleges follow The Essentials of Baccalaureate Education for Professional Nursing Practice (AACN, 2008) if they are going to offer nursing education at this level.

Benefits from community colleges offering BSN degrees include accessibility and student comfort in that educational setting. Furthermore, community colleges offering a BSN completion option support the idea that community colleges recognize there is a difference in competencies expected with the two degrees (Murray, 2007). Investigators have yet to study the impact of these programs on the percentage of a baccalaureate-prepared nursing workforce, as there is no data reported thus far. Only 15 of the 903 ADN programs in the United States offer the BSN degree (AACC, 2011a) and all of the programs are operated as RN-to-BSN completion programs. The nursing student will spend at least three years earning an ADN (having eligibility then to take the NCLEX) and one or two more years completing the BSN portion of the education.

### **Oregon State Consortium**

Oregon's Consortium for Nursing Education (OCNE) is an example of a state initiative to address RN-to-BSN education that has gained national recognition (AONE, 2005; Center to Champion Nursing in America, 2012). The OCNE created a formal consortium relationship between the state's flagship university and eight community colleges with the goal of transitioning AD students directly into a BSN program. University prerequisite courses can be taken at any one of the participating community colleges or at the university campus. The last four semesters of the BSN completion program occur after the ADN is obtained and consist of standardized nursing courses that are taught at the university campus and several other community college sites around the state. This model increases AD nurses' access to baccalaureate programs

through a streamlined process, without students needing to leave their communities. The percentage of nurses with BSN or higher degrees in Oregon has increased in eight years from 44.4% in 2000 to 52.4% in 2008 (USDHHS HRSA, 2010). However, since the first graduating ADN class in this program occurred in 2008 and the first graduating BSN class was in 2009 (Tanner, Gubrud-Howe, & Shores, 2008), the full effect of the OCNE has not yet been evaluated. A three year report was published in 2012.

Munkvold, Tanner, and Henrinckx (2012) compiled data from the first three graduating classes from the OCNE. Thirty percent of the ADN graduates continued toward a BSN within three years. The National Nurse's Survey 2008 (USDHHS HRSA, 2010) reported the national average of AD nurses returning for a BSN within the first five years of practice at 9.7%. The OCNE model was able to triple the progression of returning BSN students compared to the national average.

The advantages of the consortium model include not only a seamless transition to move AD nurses into a BSN, but also the creation of a collaborative relationship between all of the participating schools as they helped develop the curriculum (Tanner et al., 2008). This is particularly significant to rural areas that serve nursing students who might not otherwise have access to a BSN education (Tanner et al., 2008).

Other states following Oregon's lead with similar design, curriculum, and partnerships include Arizona, Wisconsin, Massachusetts, California, Hawaii, and North Carolina (Cleary et al., 2010; Jorgenson, 2005; Lewis, 2010a, 2010b,



2010c; McNamara, 2000), and New York (Zimmerman et al., 2010). These states have found ways to offer an accessible BSN-completion option to AD nurses by addressing a common barrier. Unfortunately, since the initiation of the OCNE strategies and other state models of nursing education, there has been a national increase of only 6% in the number of BSN-prepared nurses during the last eight years (USDHHS HRSA, 2002, 2010).

### **Michigan**

The MCN was founded in 2003 with the purpose of maintaining a high-quality nursing workforce, creating opportunities for collaboration with statewide nursing and healthcare organizations, and collecting data on the nursing workforce in the state of Michigan (MCN, 2009). Since 2006, the MCN has endorsed moving AD nurses to a BSN expeditiously as part of the Nursing Agenda for Michigan on nursing education for the five-year period encompassing 2005–2010 (MCN, 2009). This agenda recognized that only 40% of nurses in the state were BSN-prepared, which is 10% below the national average (MCN, 2009). However, while there is widespread agreement among the MCN and nursing leaders in the state, they have not defined this expeditious movement of AD nurses to a BSN or strategies to enact it (MDCH, 2012) with a specific plan to achieve the increase in education for the nursing workforce.

As part of this Nursing Agenda for Michigan in 2005–2010 (MCN, 2009), three state nursing organizations formed a task force to review the situation and make recommendations on nursing education in Michigan. The first is the Michigan Organization of Nurse Executives (MONE), an affiliate of the American

Organization of Nurse Executives representing nursing leaders in this state. The MCNEA, the second organization involved, draws its membership from leaders of AD and practical nurse programs<sup>2</sup>. Finally, the MACN, affiliated with the AACN, is the third organization in this alliance and represents nurse leaders from BSN and nursing graduate programs within universities throughout Michigan. Together MONE, MCNEA, and MACN formed the 3M Taskforce (MCNEA, n.d.) for the purpose of working together to review issues related to nursing education.

The 3M Taskforce's (MONE, 2007) objectives are to (a) form partnerships and develop a new clinical education model to address The Nursing Agenda for Michigan: 2005–2010, (b) increase the percentage of BSN nurses in the workforce, and (c) increase the number of nursing faculty in the state. To date, the 3M Taskforce has a white paper (MCNEA, n.d.) that calls for an increase in the number of BSN-prepared nurses to 60% with the recommendation that the state legislature take action to ensure that AD nurses obtain a BSN within 10 years of their initial licensure. This legislation, however, has not yet been proposed to either house or senate sessions and has become stagnant in the current economic and political climate (MDCH, 2009a, 2012).

### **Rural North-Central Michigan**

The North-Central Region of Michigan is a rural area of the state. For the purpose of this research, land-use will be used to define rural, as the region of

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<sup>2</sup>Practical nursing programs are generally one-year training programs resulting in a certificate to give nursing care under the direction of an RN.

concern is over an 18-county spread of land in northern Michigan (Cromartie & Bucholtz, 2008). Rural is defined as counties that are outside metropolitan areas or that have populations of less than 50,000 people (United States Office of Management and Budget as cited in Cromartie & Bucholtz, 2003).

Rural populations face health obstacles that urban settings do not.

“Economic factors, cultural and social differences, educational shortcomings, lack of recognition by legislators and the sheer isolation of living in remote rural areas all conspire to impede rural Americans in their struggle to lead a normal, healthy life” (National Rural Health Association, 2010, para.1). Specific obstacles include: (a) more rural Americans living below the poverty level than Americans in urban areas; (b) two-thirds of the Health Professional Shortage Areas defined as “areas designated by HRSA as having shortages of primary medical care, dental or mental health providers” (USDHHS HRSA, 2011, para.1) are in rural areas; (c) transportation difficulties are more common and impact the ability to travel to healthcare providers or hospitals; and (d) people in rural areas are less likely to have insurance or Medicaid than populations in urban areas (National Rural Health Association, 2010). Taking these obstacles into account, rural patients may be more ill when they need nursing care.

The 18 rural counties of North-Central Region of Michigan are (MCN, 2007) Manistee, Wexford, Missaukee, Benzie, Grand Traverse, Kalkaska, Crawford, Oscoda, Alcona, Alpena, Montmorency, Otsego, Antrim, Leelanau, Charlevoix, Emmet, Cheboygan, and Presque Isle. There are 47 people per square mile in this area compared to the Michigan average of 173 people per

square mile and the U.S. average of 87 people per square mile (MDCH, 2009b). The majority of the population in the region is White non-Hispanic (95%), compared to Michigan's overall rural population (92%) and the rural United States (81%; United States Department of Commerce, United States Census Bureau, 2010). Poverty, unemployment, and obesity levels are not available data for this specific region, but the number of people living in poverty in rural Michigan overall is 32%, compared to 25% in urban Michigan areas (MDCH, 2008). Unemployment is higher in rural Michigan at 13%, compared to 11% in the state's urban areas, and obesity is higher in rural Michigan at 30% versus 26% in urban Michigan areas (MDCH, 2008).

Access to health care is limited in rural areas because of lower income levels, lack of insurance, and decreased availability of healthcare professionals (Eberhardt, Ingram & Makuc, 2001). Access to health care is a concern in rural Michigan. Fifty-two of the state's 57 rural counties are designated Health Professional Shortage Areas, and all 18 counties in the North-Central Region have this designation (MDCH, 2008). Physician supply is 135 per 100,000 people in rural Michigan compared to 273 per 100,000 in the state overall (Barnas, Barnett, Wightman, Emge, & Johnson, 2008). Registered nurse supply in rural Michigan and the entire state are similar. Overall in Michigan there are 1,044 RNs per 100,000, and in rural areas there are 960 RNs per 100,000 people (MDCH, 2008); this is higher than the national average of 864 per 100,000 people. However, the RN ratio is only 604 per 100,000 people in the North-Central Region of Michigan, about 350 less than the state rural average

(MCN, 2007, 2008; United States Department of Commerce, United States Census Bureau, 2010). Twelve of Michigan's 180 hospitals are in this North-Central Region, and three are critical access hospitals (MDCH, 2008). Two of the hospitals have Magnet Recognition Program<sup>®</sup> designation, while one is currently working toward this designation. Six of the counties have no hospitals, and the longest distance to travel to a hospital in this area is 40 miles (Google Maps, 2011a).

A consequence of limited access to health care is a higher discharge rate (more people are admitted to the hospital) in the adult (ages 18–64) population because patients are sicker when accessing care and are in greater need of hospitalization (Eberhardt et al., 2001). A delay in seeking care in rural areas contributes to the hospital discharge rate (Eberhardt et al., 2001) and the need for more nursing care. The hospital discharge rate in the North-Central Region of Michigan is 129 per 1,000 people, which is slightly below the state average of 132 discharges per 1,000 people (MDCH, 2009b). The U.S. discharge rate is 126 per 1,000 people (Commonwealth Fund, 2007). The rate in this region falls between the national and state average, although two-thirds of the counties have more hospital discharges than the regional average, ranging between 130 and 181.3 discharges per 1,000 (MDCH, 2009b). Although the average for hospital discharges in this region is comparable to state and national data, counties above the average increase concerns for delay of care and the need for close surveillance by nurses. Increasing the number of RNs with a BSN-level education in this rural region is necessary when considering the surveillance needed by

nurses, hospital discharges, healthcare access issues, and lack of resources of its constituents.

Nursing education in the North-Central Region of Michigan is available through five community colleges, all offering ADN programs. No colleges offer a BSN, but there are two university centers available, one offering both face-to-face and online options, and one offering a face-to-face program only. The longest distance to a university center in this region is 99 miles (Google Maps, 2011b). Given this limited access to BSN programs, it is understandable why 71% (MCN, 20011) of RNs in this area hold an AD degree.

### **Summary**

In conclusion, national calls for increasing the nursing workforce's education levels are in alignment with national quality and safety goals. Because there is a 30% shortfall of BSN nurses (USDHHS HRSA, 2010) in the goal identified by the IOM (2010) nationally, it is critical to understand how to increase the nursing workforce's education to meet the 80% goal by 2020. Originally initiated to fill a nationwide gap, AD nursing education provided the large numbers of RNs needed to provide care in communities across the U.S. from the 1950s until today. Although healthcare facilities that employ RNs have not consistently differentiated nursing practices, increasing evidence supports improved patient outcome with a larger number of BSN-prepared nurses on staff. Additionally, regulation bodies and certification agencies continue to advocate for BSN preparation instead of an ADN.

It is likely that these initiatives will both encourage AD nurses to return for a BSN and employers to adopt hiring practices that exclude non-BSN-prepared nurses in the future. Assisting AD nurses to return for a BSN within a prescribed period after becoming an RN—while they are also working as a nurse and gaining experience in the workforce—is another option for increasing the number of BSN nurses. The North-Central Region of Michigan has the lowest percentage of BSN nurses in the state; this was an ideal place to interview AD nurses practicing in a rural area in order to understand and interpret their perspectives on being an AD nurse and attaining BSN education.

The rationale for this chapter was to provide an overview of the history of ADN and BSN nursing education and to seek to explain why only 40% of Michigan's current nursing workforce has a BSN. The chapter also reviewed recent initiatives that call for more BSN nurses in the workforce and current strategies used to help AD-prepared nurses attain a BSN. This study explicated the meaning of BSN education to the AD-prepared RN and the reasons associated with choosing to pursue a BSN or not. It also will help the academic and clinical communities in rural Michigan understand how AD-prepared nurses in this area could be encouraged to return for a BSN.

## CHAPTER 3 METHODOLOGY

Understanding and interpreting the meaning that furthering an education in nursing has for AD nurses is important because, while calls for increasing the percentage of baccalaureate-prepared nurses are proliferating (Benner et al., 2010; Brown, 1948; Ginzberg, 1948; IOM, 2010; NACNEP, 2001), AD nurses are not returning to school to increase their education in numbers sufficient enough to meet the IOM goal of an 80% baccalaureate-prepared nursing workforce by 2020 (IOM, 2010). This is particularly problematic in rural areas, such as the North-Central Region of Michigan, where the number of AD nurses returning to school to increase their education falls below the national and state averages. Because preparation for practice at the baccalaureate level has been correlated with the quality and safety of health care, there is a sense of urgency across the discipline to design and implement strategies to increase the percentage of nurses in the workforce that hold a BSN. If such initiatives as returning to school for increased education, as well as those yet to be proposed, are to be successful, it is important to understand the meaning and significance assigned by those most affected by these. This study used hermeneutic phenomenology to understand and interpret the meaning and significance that returning to school to increase their education has for AD nurses in a rural area.

Chapter 3 is organized into five sections: (a) method, (b) participants, (c) data collection, (d) data analysis, and (e) rigor and trustworthiness.

Hermeneutic phenomenology is a methodology used to study how humans understand and interpret the experiences in which they are engaged. In



other words, it is a methodology used by an investigator who seeks a deeper understanding of how humans are situated in the world and the shared meanings and significance of their experiences (Benner, Tanner, & Chesla, 1996). Hermeneutic phenomenology reveals the habits, activities, practices, and meanings of concern to people as they are engaged in their world (Benner, 1994). This methodology provides a different view of a phenomenon of interest than empirical research (Baker, Norton, Young, & Ward, 1998). The current literature investigating AD nurses returning to school have predominantly used quantitative or mixed methods (Clark, 2004; Periard et al., 1991; White & Gomez, 2002; Witt, 1992). In these cases, the experience of returning to school is reduced to particular characteristics or factors identified by or exemplified by subjects. While these studies are important, they cover over the “inside-out” view of those experiencing calls for AD nurses to return to school to increase their education. When phenomenology has been used to study this experience, investigators have focused on AD nurses but only while in the process of or after obtaining a BSN (Delaney & Piscopo, 2007; Megginson, 2008).

A review of the literature has revealed only one prior study that used hermeneutic phenomenology to investigate the meaning and significance of AD nurses returning to school to increase their education. This study, an unpublished dissertation (Orsolini-Hain, 2008), focused on understanding the AD nurses’ experiences, but the sample was derived from an urban area on the West coast. The current study reported here replicated and expanded upon these findings by

investigating the meaning of returning to school from the perspectives of AD nurses from a rural, Midwestern area.

Hermeneutic phenomenology is an appropriate methodology for this study because the meaning and significance of an experience can never be discerned completely, isolated, or described by a set of characteristics, demographics, or factors. Rather, by hearing participants narratively describe their experiences, the investigator can glean a richer understanding of the ways participants understand their experiences and the contexts in which they are engaged (Benner, 1994). Participant narratives of their experiences are a way to elicit the meaning of phenomena using the everyday language of the participants (Benner et al., 1996). Narratives retain an emphasis on “the temporal, the social and the meaning structures” (Kvale, 2007, p. 72) of the participants’ experiences. Narratives reflect language, understanding, and situatedness in ways other methodologies cannot.

Hermeneutic phenomenology was introduced into the discipline of nursing by Patricia Benner (1984). Drawing heavily on the work of German philosopher Martin Heidegger and others such as Hans-Georg Gadamer and French philosopher Maurice Merleau-Ponty, this methodology is directed toward deriving a richer, more nuanced and complex understanding of the world as it is experienced (Diekelmann & Diekelmann, 2009). According to Heidegger (1962), human understanding comes through experiencing the world, and the world shows up to humans as meaningful. In other words, humans are concerned with existence, and existence is always/already meaningful. Heidegger’s philosophical

project was to provide a way of accessing this understanding that overcame the inherited Cartesian subject/object view of human experience in the world (which was understood as an object). For this study, Heidegger's notion of the hermeneutic circle is particularly important along with Gadamer's discussion on fusion of horizons. The hermeneutic circle is described here but is explicated more fully during the hermeneutic process.

### **The Hermeneutic Circle**

The hermeneutic circle of understanding is how Heidegger sought to describe the ongoing, situated nature of human understanding. Importantly, humans are always/already part of the hermeneutic circle and the task of the investigator is to make that understanding explicit (Palmer, 1969).

Heidegger referred to the hermeneutic circle as the forestructure (Dreyfus, 1991) of understanding. This forestructure is comprised of fore-having, fore-sight, and fore-conception. Fore-having means that one always comes to an experience with a background understanding (or pre-understanding) of it; the experience is understood as this or that. Fore-sight means that one also experiences the world from a particular perspective, and fore-conception means that one also has an anticipated sense of what the experience will hold (Benner, 1994). In this way, the hermeneutic circle is not a human trait or analytic process that one chooses to employ or not employ but is how humans experience the world in an engaged, day-to-day manner. Again, the task of the investigator is to make this understanding explicit. So throughout a hermeneutic phenomenological study, the research continually seeks to understand the

meaning and significance of the experience in a fluid or circular manner (Diekelmann & Ironside, 2002), rather than through a step-by-step, categorical, or linear manner. This requires the investigator to attend to the participants' language (how an experience is described), as well as the participants' interpretation of events and life activities that reveal their understanding of their world.

Importantly, the investigator conducting a hermeneutic phenomenological study cannot extricate him/herself from a personal hermeneutic circle of understanding. This is important, because from a scientific view, the investigator must remain "objective" to prevent influencing the data being collected or analyzed. This means that the investigator distances him/herself from the subjects, asking only pre-determined questions or collecting specific data. In studies in which hermeneutic phenomenology is used, the opposite is true. That is, in seeking to understand the experience, the investigator must be involved and engaged with participants to understand their language and the worlds in which the participants live. However, a hallmark of rigor in this kind of research involves the investigator to make his/her pre-understandings as explicit as possible (Allen, 1995).

### **My Pre-understanding of the Phenomenon of Study**

I came to this study of rural AD nurses after being an instructor in AD nursing programs in rural areas of Michigan for the previous 15 years. I began to notice how many of these students, despite their interest and capability, did not continue their education to attain a BSN. This phenomenon interested me

because my first degree in nursing is a BSN, and I felt that I emulated for my students the importance of attaining that degree. I always valued the AD nurse but considered this level of education as an entry-point into nursing. Embedded in this understanding is my assumption that students should want to pursue additional education if at all possible. Yet at the same time, I realized that many students did not have access (either financially or geographically) to a university where they could increase their education. It was very concerning to me to find out that only 21% (USDHHS HRSA, 2010) of AD nurses nationally went on to attain a BSN. This statistic puzzled me for several reasons. In my own life, returning to graduate school afforded me many career opportunities as well as the ability to research this phenomenon. My experiences as a nurse educator in AD programs, as well as my experiences as a nurse and returning to school to increase my education, give me a particular unique view of the phenomenon; this view piqued my interest to a better understanding the experiences of AD nurses. Since I am not an AD nurse, however, my understanding (as all understanding) is limited.

### **Methods**

This study was a hermeneutic phenomenological study to understand and interpret the meaning and significance that returning to school has for AD nurses. As previously described, hermeneutic phenomenology is a methodology that seeks to explicate how participants understand their experiences. As such, this methodology is situated, descriptive, and interpretive. Importantly, hermeneutic phenomenology and the research methods used are not a way of explaining

experiences but rather a way to describe and interpret them. Using hermeneutic phenomenology, the goal of the investigator is to understand the experience as it is lived by participants, staying engaged in the experience from data collection through interpretation to bring forth the meanings from the narrative in the research report. Unstructured interviews were used to obtain participants' narrative accounts of their experiences (involving how rural AD nurses are engaged in and understand themselves related to their education).

This hermeneutic phenomenology study sought to understand the meanings and significance that attaining a BSN has for nurses who currently hold an ADN and how those meanings and self-understanding influence the possibilities they envision for advancing their formal education. Specific aims of this study are to:

1. Understand and interpret the meaning being an AD nurse holds for participants in rural North-Central Michigan.
2. Understand and interpret what it would mean for these AD nurses from a rural area to attain a BSN, and the barriers that prevent this from happening.

### **Participants**

Participants in this study were recruited using convenience sampling from a population of rural AD nurses who work in the North-Central Region of Michigan. In this study, the criteria for inclusion were AD nurses without a baccalaureate degree in another field and at least eight years of experience as an RN. This time-frame was selected because it represents the average time that

AD nurses choose to continue their education (USDHHS HRSA, 2010). The criteria for inclusion ensured selection of those who experience the phenomenon being studied. The purpose of hermeneutic phenomenology is to examine phenomena experienced by those affected; therefore, participant selection must be purposeful and strategic (Speziale & Carpenter, 2003). A total of 11 participants were recruited and interviewed for this study. The investigator suspended data collection when data saturation was achieved. Data saturation occurs when subsequent interviews yield no further insight into the phenomenon (Benner, 1994).

The research proposal was submitted for exempt status approval to the Indiana University Institutional Review Board. Exempt research status was indicated because this research involves human subjects to find their subjective meanings but does not involve an experiment or testing (Appendix A). Following an institutional review board approved procedure, participant recruitment began when the investigator sent an email to all AD nurses listed in the MCN database (Appendix B). This email explained the research, the data collection process, and the risk and benefits of being in the study. Contact information was included so that potential participants could contact the investigator directly to arrange for a convenient date, time, and location for the interview. Because of the low response rate to the email invitation, further recruiting was conducted via snowball sampling by asking existing participants to provide names of other potential participants known to meet the inclusion criteria. Interviews were

scheduled at the convenience of the participant and in a location chosen by the participant where a confidential conversation could occur and be recorded.

Before interviews began, the investigator explained the purpose and aims of the research to each participant. Participants were assured that their participation was voluntary and confidential. The investigator asked each participant to sign a consent form prior to the interview, only if they did *not* agree to being contacted further if the investigator had a clarification (Appendix C). The investigator reviewed the consent form with each participant, emphasizing how confidentiality was maintained, the risks and benefits of participation, and that participants were free to withdraw from the study or stop the interview at any time without penalty. As an incentive to participate, participants were given one \$25 grocery gift card at the completion of the interview.

Demographic information from the participants was collected using a simple questionnaire designed by the investigator of this study (Appendix D). This demographic information was used to describe the sample and contextualize the stories shared by participants. Participant identity and demographic data was kept secure in a password-protected computer, accessible only by the investigator and transcriber. For the purposes of data analysis, participants were de-identified and given pseudonyms by the transcriptionist before returning the data to the investigator.

### **Data Collection**

Interviews began with the statement, "Tell me about your decision to become a nurse." This item was intended to illicit the participant's experience of



deciding on nursing as a career and continued to probe on the choice of nursing school. Throughout the interview, the investigator encouraged participants to describe experiences in as much detail as possible, and when necessary, used probing questions to help the participant clarify or extend the account being shared. For instance, participants were asked, “Can you give me a ‘for instance’...?” or, “Can you say more about...?” Other questions emerged in the course of the interview and also were addressed with probes (Glesne, 2011). Importantly, the investigator strived to have the participants describe their experiences as fully as possible with questions being interjected only as needed, so the experience being shared could be understood by the investigator. Field notes were written shortly after each interview by the investigator to track observations and record the investigator’s thinking about the phenomenon of interest.

Interviews lasted up to 60 minutes and were recorded digitally using a small, portable digital recorder. An experienced transcriptionist was hired to transcribe the recorded interviews into a verbatim text for analysis. The transcriptionist signed a confidentiality form prior to beginning the transcription process (Appendix E). The investigator reviewed the data handling process with the transcriptionist to ensure participant confidentiality and that the integrity of the data was maintained. Following each interview, the investigator hand-delivered the recorder to the transcriptionist. The transcriptionist downloaded the recorded interview to her computer for transcription and transcribed the recording into a verbatim text. The transcriptionist also de-identified the data by inserting

pseudonyms for names of people or places identified in the interview.

Transcriptions were compared to the recorded interviews by the transcriptionist before returning the text to the investigator. When the transcription was complete and verified, the investigator returned to pick up transcribed files on a dedicated, password-protected flash drive containing only completed transcriptions.

After the investigator verified the accuracy of the transcription, the transcriptionist deleted the recording and transcribed computer files from her computer. The investigator maintained flash drives in a locked file, and electronic copies were kept on a password-protected computer hard drive in the investigator's office.

Data sources were from: (a) demographic tool, (b) digitally recorded and transcribed interviews of AD nurses, and (c) investigator's field notes.

### **Data Analysis**

A major strategy for data analysis was for the investigator to become immersed in the data. Immersion in the data began when the investigator was wholly present during the interviews, carefully attended to the participant's account, and made extensive field notes of impressions during and immediately following each interview. Before taking the recorded interview to the transcriptionist, the investigator listened to the interview in its entirety. The investigator again listened to the recorded interview during the verification of the accuracy of the transcription. Throughout this time the investigator compiled field notes containing first impressions, reflective thinking about the interview (both content and process), emerging themes, questions that arose regarding

phenomena, and areas that needed to be clarified by this or future participant(s) in subsequent interviews. The field notes served as a chronicle of the investigator's interpretive understanding of the phenomenon.

Interpreting each text began (Diekelmann, Allen, & Tanner, 1989) when the interview text was read again in its entirety. As the text was read, themes were identified. Themes are descriptions that stood out to the investigator and were supported with quoted excerpts (narratives) from the text (Ironsides, 1997). Working collaboratively with a research team comprised of two experienced hermeneutic phenomenological investigators, two doctoral students, a master's student specializing in nursing education, and colleagues of the investigator experienced with qualitative research and doctoral students, the meanings emerging from the data were explored, the biases of the investigator and the field were probed (Crist & Tanner, 2003; Lincoln & Guba, 1985), and emerging themes were discussed and clarified. As the next interview text was read, it was informed by previous interviews and team discussions. As the investigator and research team worked through the study data, the themes identified in previous interviews were revised, refined, extended, or overcome. New themes were explored as they surfaced. Gaps that emerged from the interview texts were explored further by reviewing the literature.

### **Rigor and Trustworthiness**

Because of the philosophical differences in studies conducted using hermeneutic phenomenology and those conducted using empirical or scientific methods, different criteria must be used to assess and assure rigor. Maintenance

of quality in qualitative research must be upheld (Gibbs, 2007; Kvale, 2007; Lincoln & Guba, 1985) to sustain rigor and trustworthiness. Rolfe (2006a) defines trustworthiness “as an assurance that the investigator has adhered to the rules and method dictated by the paradigm they are following” (p. 10). Rolfe (2006b) discusses that there is not a “one-size-fits-all” for rigor or trustworthiness in every research study. The research study must be reviewed in light of the phenomenon, the situation, and the specific methodologies and methods used.

To establish trustworthiness (Lincoln & Guba, 1985), the investigator used the criteria of credibility, dependability, and confirmability to guide this study. Credibility is the confidence that data and analyses address the aims of the research (Graneheim & Lundham, 2004). To establish credibility in the design, the participants interviewed were AD nurses for at least eight years, because this is the average time for deciding to increase their education to a BSN (USDHHS HRSA, 2010). The investigator worked closely with the research team to extend the credibility of the research by helping to expose insights, oversights, and misunderstandings in the investigator’s analysis and emerging themes (Allen, 1995; Lincoln & Guba, 1985). The research team also reviewed the continuing data analysis with the investigator, raising questions, clarifying explications, checking biases, and exploring meanings.

Dependability is the consistency of data collection and analysis (Graneheim & Lundham, 2004). Dependability was assured by having only one interviewer collect all study data. The research team members used the same

analysis process (as described by Diekelmann et al., 1989), further contributing to the dependability of the data analysis (Allen, 1995; Lincoln & Guba, 1985).

Confirmability is the careful collection of data and being able to trace back to the original source of the data (Lincoln & Guba, 1985). Deidentified transcripts were accessible to team members throughout the analysis, and the investigator kept field notes to track changes in understanding, questions, or insights. Additionally, to further maintain confirmability, excerpts from transcripts were used in the presentation of findings to support the themes and definitions and to allow the reader to participate in the analysis (Ironsides, 1997).

This work was conducted with the spirit of holding a deep curiosity of the phenomenon under study during the interview process. The participants' concerns and meanings were not pre-conceived or assumed by the investigator; the investigator invited her assumptions (and those of team members) to be deconstructed so that a maximum grasp and understandings of the practical situations as presented by the participant could emerge.

### **Summary**

With national calls to increase the education of RNs, having AD nurses from rural areas attain a BSN is a significant strategy to reach these goals. For that to occur, the phenomenon of AD nurses from rural areas who have not attained a BSN needs to be further researched and better understood.

Hermeneutic phenomenological research, based on Heidegger's philosophy, is valuable for disclosing what holds meaning for these nurses and what the barriers are for them to attain a BSN.

This study was a replication of the first instance where hermeneutic phenomenology methodology was employed to research AD nurses who had not attained a BSN (Orsolini-Hain, 2008). It contributes to the literature because it is situated in a rural area instead of urban and uncovered nuances not yet disclosed in previous research. These nuances illuminated barriers for AD nurses to return to school and suggested strategies that would be better suited to the rural AD nurse.

## CHAPTER 4 FINDINGS

The IOM has called on the nursing profession to increase the percentage of nurses prepared at the baccalaureate level to 80% by 2020 (IOM, 2010). At this time, only 50% of the RN workforce has a BSN or higher degree (USDHHS HRSA, 2010). Advancing the education of nurses prepared at the AD level is critical to meeting this challenge (Starr, 2010). Currently, 36.1% of nurses across the country are AD-prepared nurses (USDHHS HRSA, 2010), and graduates from ADN programs in 2010 comprise 57.9% of all nursing graduates (NCSBN, 2011). To effectively mobilize this group of nurses to return to school for a BSN, it is important to understand what returning to school means for AD nurses. This study is an investigation of the experiences of AD nurses; specifically those living in rural North-Central Michigan. Findings are presented in two themes: “Getting in and Getting out” and “What Difference Does it Make?”

### **Theme: “Getting in and Getting out”**

The two-year ADN was designed amid a nursing shortage and disciplinary efforts to move nursing education into colleges and universities (Haase, 1990). The ADN was conceptualized to shorten the amount of time it took to earn a nursing degree in order to prepare more nurses for the shortage. Despite this, ADN programs have not solved the nursing shortage of the past decades (AACN, 2012). The two-year nature of the ADN has drawn many nurses to choose this type of education because of its perceived expediency and the potential for students to enter the workforce more quickly. In fact, it is still advertised today as

“offer[ing] a faster and more cost-effective route to nursing education” (All Nursing Schools, 2012, “Nursing Diploma or Associate's Degree”).

Participants in this study commonly described how they entered nursing by choosing to pursue an AD. In each and every case, participants' decisions were based on expediency. In other words, participants consistently described choosing the program that was the quickest and/or the closest, so they could “get in and get out of” school and begin practice. When a community college was the closest available option, the decision was “very simple” for many participants who readily chose their school based on location rather than degree offered. Trina described how she chose a nursing school:

Well again it [choice of school] was locality, because I lived in this town, so the closest available nursing school was this community college, so that kind of made it very simple...at the time this was the only option for me was an associate degree...I also think it was two years versus four years for me and financially with my family and everything that I think that [the time required to complete the degree] also played into it. I needed to get out and get a job. You couldn't go to school forever.

For others, waiting lists for admission to baccalaureate programs prompted them to choose an ADN program so they would not “waste time.” The claim of expediency dominated the interviews, and in the absence of other criteria by which to differentiate ADN and BSN programs, it remained salient. Mica, who has been an RN for 10 years, stated:

Personally I didn't spend that much time looking into the bachelor's [program] because I knew it would take longer and that it wouldn't get me anywhere faster than what the associate would do for me. Like I said, the pay [earned by nurses with different preparation] wasn't any different. Again, when I talk to people, it [having an associate degree] didn't seem to put me ahead or behind another candidate when I interviewed at that time. That's why I choose the associate [degree]. I was more interested...[to] get out and save



the world and work the floor...[with] the minimum of what I wanted to do in the minimum amount of time that it would take me, that is why I didn't do the bachelor's. Nobody talked about having a minimum of a bachelor's at the time. You needed an associate for the job I wanted, to get the pay that I wanted, and when I thought of a bachelor's I thought more of a manager sitting at the desk...

Where we lived there was the university that offered the bachelor's and the community college for the associates; I chose the community college for the associate degree. The waiting list, that was another thing. When I first started, the waiting list to get in a [bachelor' degree granting] nursing school was like a year. But by the time I had gotten through all my pre-requisites, I got right into the [associate degree] nursing program. I think the university had a little bit longer waiting, so that played a role in why I chose the community college; they also have a very good reputation at the community college for their nursing program.

Like many participants, Mica chose an ADN program because it was a fast way to enter the nursing profession; taking a "minimum amount of time." Mica recalled how the university would take longer, and "wouldn't get [her] anywhere faster," so she "didn't spend that much time looking into the bachelor's program." In addition, her understanding was that the university had a "little bit longer waiting list," which reinforced her decision. She noted that the community college "also has a very good reputation" for its nursing program.

Taken at face value, many students find the expediency of an ADN program, designed to be completed in two years (Montag, 1951; Orsolini-Hain & Waters, 2009), more appealing than the four years of a baccalaureate program (Mahaffey, 2002). Given the rising cost of tuition and the decrease in federal loans and scholarships to support students (McCluskey, 2011), this decision seems appropriate. However, the literature has revealed that graduation from an ADN program actually takes longer than the anticipated two years. The National Center for Educational Statistics (Aud et al., 2011) reported 29.3% of all 2002

and 27.5% of all 2005 ADN graduates actually complete their degree requirements within three years (1.5 times the anticipated two-year timeframe). With less than 33% of ADN graduates completing their program within three years, the possibility of saving time is far from assured. Indeed, in a recent study of AD nurses, Orsolini-Hain (2012) reported that the 22 participants in her study spent, on average, 3.67 years in the AD program before earning the degree. Participants in this study spent, on average, 3.5 years in their AD program before earning the degree. In addition, the extent to which community colleges provide a more financially feasible route to post-secondary education also has been questioned. For example, while community colleges are often an entry-point for first generation college students, the dropout rate among these students is high. The hidden costs of community college education was reported by Schneider and Yin (2011) who contend that nationally \$4 billion of tax revenue provided to support students' entry into community colleges was lost in a five-year period when these students dropped out of school.

However, the average time to graduation for students seeking a baccalaureate degree also exceeds the anticipated four years. Nationally, the number of students completing a baccalaureate degree in any field of study in 2002 within four years was 36.4%, within five years 52.3%, and within six years (1.5 times the anticipated four-year timeframe) 57.2% (Aud et al., 2011). Thought of this way, whether seeking an associate's or baccalaureate degree, students can spend more than the anticipated semesters to earn their degree. Yet, more baccalaureate degrees are awarded on-time than ADs, and because each

completion rate is at 1.5 times the anticipated time-frame, more baccalaureate degree-seeking students have completed degree requirements than associate's degree-seeking students within the same time frame. With more baccalaureate degrees awarded within this timeframe, the likelihood of students seeking further education (in this case, graduate education) also occurs earlier (Ellenbecker, 2010). Thus, designing strategies to shorten the time-to-degree for students may be one mechanism to increase the educational level of the nursing workforce (Benner et al., 2010; IOM, 2010).

Additionally, before entering the field, prospective students often have little in the way of criteria to judge the merits of different educational paths (Mahaffey, 2002). As Mica stated, "*I think* the university had a little bit longer waiting" (emphasis added). Because she "didn't spend that much time looking into the bachelor's [program]" she made her decision based on assumptions about a shorter wait for admission and reputation without "looking into" the available options. Without an understanding of the differences between nursing degrees, choosing a school based on time-to-degree, location, assumptions relating to reputation, or "waiting time," may be the only way students differentiate their options. Selection criteria such as these have been reported in the literature for more than 30 years (Nash, 1981; Coulter, 1988). Importantly, this trend has continued despite the proliferation of online and hybrid program options (USDHHS HRSA, 2010).

The literature has suggested some benefits to students choosing a school based on proximity. Merely a decade ago, Bernier (2003) stated that, "the

majority of the students who attend community college nursing programs are established residents of the community in which they live, and they remain in their communities to work after graduation” (p. 138). While online nursing programs continue to proliferate, and future students increasingly will have a plethora of options for their education, an important outcome of retaining nursing programs in community colleges (situated locally) is that graduates tend to stay in the community after graduation (AACC, 2011b; Bernier, 2003; Fulcher, 2002; Larowe, 1978).

Because ADN programs are available in the community colleges located in rural areas, many potential nursing students select them because they are close to home and are perceived to be a faster way into the workforce while having fewer personal or financial costs. While in fact, getting the ADN first (when the BSN is inevitable) increases costs and extends the total time in school (Orsolini-Hain, 2012), and for many students, the personal and financial tolls only increase over time (Cheung & Aiken, 2006; Delaney & Piscopo, 2004, 2007; Lillibridge & Fox, 2005). Students’ desires for the most expedient way to get into the program then graduate make them unaware of how program costs continue to grow before they return for another degree. In rural areas, incomes increase more slowly than in urban areas (United States Department of Labor, Bureau of Labor Statistics, 2011), and the mis-match between growth in income and costs of nursing programs may offset any financial advantage of working prior to returning to school.

Yet, personal costs of delaying efforts to earn a baccalaureate degree also were prominent for participants. Trina began her post-secondary education in an urban university, and when her family moved to a rural area, the choice to change to a local community college (where a BSN was not available) became more expedient. While she considered returning to school later to complete her BSN, the costs of doing so loomed large. She stated,

I had the information [from the university] as far as what I had and what they would accept moving forward and what I would have to take of what I didn't have in order to do something like that. I sat down and was currently working the 7-3 shift at the hospital; I think it was an eight-hour shift... I sat down with the list of classes I would have to take, when they were offered and logistics and everything, I would have to go to the afternoon-shift because most of the classes I needed were in the morning or early afternoons. So I would have to move to afternoons and that would mean coming in very early, doing the school thing, and then go to work for eight hours and the commute was 45 minutes to an hour. If you worked eight hours you were gone for nine and a half; and if you worked 12 hours it was closer to a 14-hour day, and then you add the school part of it. And if I had a day off at the hospital, I still had to come in for classes. Some days it was just work, some days it was just classes and some days it would be both. In a two-week period I worked every other weekend; in a two week period the only time I wouldn't get in the car and drive to [the city] was every other Saturday and Sunday. I basically said I can't do that, for my family and for a number of reasons I can't, and then when am I going to study and still have family-time and work-time and everything? [If I did choose to go back to school] as long as another person wanted to trade [schedules] with me, and come to days that wouldn't have been an issue. They wouldn't have created a position for me, "Oh you can work afternoons, and we'll be short on days and have an extra nurse on afternoons"; that wouldn't have happened. But if somebody wanted to trade shifts with me and there were opportunities, I guess I could have gone to midnights too. Most people want ... to get on a day-shift; I could have found somebody that would have changed with me. Would they have changed back at some point if I wanted? Maybe not.

For Trina, the cumulative costs of returning to school now (taking one to two years) for a BSN (McEwen, White, Pullis, & Krawtz, 2012) included

potentially losing her day-shift position and finding someone to trade schedules. She realized this meant trading away a coveted (day-shift) position; one she might not get back when she finished the program. She also would take on long commutes to the university center for classes, which would leave her with few days off for family-time or to fulfill other responsibilities. When assessing these barriers, she concluded, “I basically said I can’t do that.”

In rural areas, efforts to create program options that take advantage of local community colleges while helping students make a seamless transition to the BSN are promising. Although relatively new, such progression programs have been spreading throughout the country. For instance, the OCNE is designed so students seamlessly transition to the flagship university school of nursing upon completing the AD (Tanner et al., 2008). When students are admitted to the community colleges in Oregon, they also are admitted to the university. In the OCNE model, students are eligible for the NCLEX-RN examination once they complete the AD (Tanner et al., 2008), but their progression to the BSN is uninterrupted. Data collected from the first three years of the consortium showed that 30% of their graduates continued or returned for a BSN (Munkvold et al., 2012); compared to 10% nationally (USDHHS HRSA, 2010). Moreover, USDHHS HRSA (2010) data showed only 21% of AD-prepared nurses return overall during their career, further highlighting the impact of OCNE in assisting AD graduates return or continue on for a baccalaureate. The OCNE model has tripled the overall national rate for RNs returning for a BSN in the first three years and has been touted as one way

to “lessen regional inequalities” of BSN preparation in the nursing workforce in rural areas (Blustein, 2011, p. 773).

For other participants, the cost of returning to school includes concerns for covering patient care needs in their work setting. In rural hospitals, the number of nurses often leaves little “flex” in staffing. Trina described this stating,

As long as another person wanted to trade [schedules] with me, and come to days that wouldn't have been an issue. They wouldn't have created a position for me, “oh you can work afternoons, and we'll be short on days and have an extra nurse on afternoons;” that wouldn't have happened.”

Indeed, for Trina, returning to school meant trading away (perhaps permanently) her current work schedule.

Because rural areas have more nurses (by percentage) needing to return to school for a baccalaureate degree and fewer options for varying school schedules, the difficulties faced by AD nurses returning to school also were felt by their organizations. For instance, Kris, a manager of a CCU, echoed Trina's concerns stating:

I can tell you that right now, today is Wednesday and if I have call ins, I will not be able to cover them, because we have seven or eight nurses who work their fair share of overtime who will not be able to work tonight, because they all carpool together and go up to another town for their BSN class and it's like that every Wednesday. Even in a small place like this, CCU only has 14 warm bodies to cover two shifts seven days a week; that's all the staff I have and six of them will be in school tonight. I have three people that can work tonight and I rarely reschedule, and if one of them calls in sick, I'm scrambling to find someone because everyone else is in school and the other two are here until 11:00 tonight. So there is that little bit of manpower drag in a small place like this when too many people are in school at the same time.

The literature on RN-BSN completion programs has focused exclusively on what AD nurses gain by returning to school or the barriers they face in doing

so. Yet for Kris, a manager in a small rural hospital, the complexities of staffing the unit when a group of nurses returns to school created “that little bit of a manpower [*sic*] drag.” He recognized that if one scheduled nurse “calls-in” (to report an absence due to illness, etc.) he would not be able to cover the patient care needs of the unit. In the face of persistent national calls for AD nurses to return to school for a baccalaureate degree, the difficulties small rural healthcare organizations face in supporting these efforts are often overlooked. Indeed, while the fact that graduates tend to stay in their rural communities is an advantage of community college education, as these nurses return to school in response to the IOM (2010) challenge (having an 80% baccalaureate-prepared workforce by 2020), the costs may be disproportionately borne by rural healthcare organizations.

Gadamer (2004), a twentieth century philosopher, described how all understanding has a horizon or a “range of vision that includes everything that can be seen from a particular vantage point” (p. 301). Such a horizon is not a rigid vision but, rather, is flexible and moves as the “vantage point” of the one seeking to understand how a particular experience changes. There is consensus in the discipline about the importance of increasing the education level of the nursing workforce (Aiken et al., 2003; ANA, 2000; Benner et al., 2010; IOM, 2010). Yet, as efforts to achieve this are discussed and debated, it is important to understand the horizon of AD nurses and the organizations in which they work, particularly those in rural areas. Finding ways to “fuse horizons” (Gadamer, 2004) may illuminate new possibilities for advancing the preparation of the workforce in



rural areas which is responsive to the understanding that nurses in this area have of their work and the possibilities for returning to school.

There are promising initiatives to facilitate AD nurses to return for a BSN that make it easier on individuals and organizations. For instance, as described in Chapter 2, some community colleges now are offering baccalaureate degrees, making use of the organization to meet the demands for more baccalaureate-prepared nurses and doing so in rural communities (Murray, 2007). The Community College Baccalaureate Association (2011) reported that five states now allow baccalaureate nursing education to be provided by faculty at the community college level: Florida, Indiana, Nevada, New Mexico, and Washington. The benefits of community colleges offering BSN degrees include accessibility and students' familiarity with the setting.

Several hospitals also have partnered with colleges and universities to offer BSN education in the workplace, a model offering a way to motivate AD nurses to return for a BSN while keeping them on-site and decreasing commuting time (Cheung & Aiken, 2006; Murray et al., 2011; Reams & Stricklin, 2006; Zimmerman et al., 2010). As discussed previously, Cheung and Aiken (2006) reported in a case study that Hackensack University Medical Center increased their BSN percentage to 55% by providing an onsite option for earning a baccalaureate degree; however, there are currently no such options available in North-Central Michigan.

This raises important questions for the discipline of nursing, particularly for those in rural areas where attracting staff nurses from outside the area is difficult.

Rural areas are disadvantaged in terms of resources for higher education and lag behind advantaged areas of the United States (Blustein, 2011). For example, Blustein (2011) found hospital RNs are more likely to work in urban counties with a more educated population and where there is a greater proportion of BSN nurses—55.2% compared to 34.9% in rural counties.

In rural North-Central Michigan, there are fewer RNs with baccalaureate degrees than in any other region in Michigan (MCN, 2011). Additionally, the only pre-licensure programs for RN candidates in rural North-Central Michigan are ADN programs; there are no universities in the region, and the closest universities that offer pre-licensure programs are 44 to 150 miles away (Google Maps, 2012). When baccalaureate nursing programs are scarce, the ambitious agenda to increase the education level of the nursing workforce to 80% baccalaureate-prepared by 2020 may be problematic for rural areas.

In summary, participants in this study chose to attend an ADN program because it was “faster” and closer to where they lived. In the absence of other criteria to inform program choice, “getting in and getting out” became paramount to participants. In large part, attempts to get in and get out were fueled by the financial implications of staying longer in school and the desire to begin practice and “save the world.” Participants described how completing the ADN and entering the workforce in a “minimum amount of time” allowed them to “not go to school forever,” despite the fact that, on average, participants took 3.5 years to complete their degrees. No participant appeared aware that this amount of time (3.5 years) was nearly the same as the four years it takes 36.4% of students

seeking BSNs to complete the degree (Aud et al., 2011). However, time was not the only factor influencing participants' decisions to pursue an ADN. In rural North-Central Michigan, there are no universities, only community colleges that offer AD nursing programs. Because of this, the location of the community colleges reinforces the "very simple" decision to pursue an ADN.

Advantages of ADN programs include being less costly and more accessible and having successful graduates find jobs as RNs. The ADN programs are more accessible in rural areas because 29% of community colleges are in these areas, compared to 9% of colleges and universities (Aud et al., 2011). Accessibility of ADN programs also supports students' ability to continue to work in their communities and live at home while attending school. The ADN programs also have the appeal of being successful in receiving RN licensure and finding employment upon graduation (AACC, 2011b; Mahaffey, 2002). However, the delayed costs of returning to school were not appreciated by these participants, whether on an individual or an organizational basis.

Embedded in these participants' accounts was also a concern for the lack of differentiation among degrees. For example, Mica stated,

When I talk to people it [having an AD] didn't seem to put me ahead or behind another candidate when I interviewed at that time... You needed an associate for the job I wanted, to get the pay that I wanted, and when I thought of a bachelor's I thought more of a manager sitting at the desk.

This lack of differentiation and assumptions about the work of nurses prepared at the associate and baccalaureate level led many participants to question what difference it makes if they have a baccalaureate degree or not.

### **Theme: “What Difference Does it Make?”**

Upon completing degree requirements, AD-prepared nurses take the same licensure exam to enter practice as baccalaureate entry students and have traditionally competed for staff positions with these nurses. Most healthcare organizations have a long history of providing little, if any, differentiation in terms of position, responsibility, role, or salary for AD and BSN nurses (Megginson, 2008; Orsolini-Hain & Waters, 2009). Consistent with the literature, participants in this study noted this lack of differentiation when choosing a nursing program, upon entering the nursing profession, and also over the course of their career. In many cases, the impetus to return to school was inextricably linked to the desire for a different nursing position or the opportunity to change employers to where nurses with baccalaureate degrees were preferred. In the absence of a desire for a new position, many participants did not see the need to return to school for a higher degree. Instead, some chose to add to their responsibilities on their current unit or within their organization where a BSN was not mandatory. Mica stated,

I think it's just that in the last couple years that [this organization] started talking [about requiring a bachelor's degree] because when I interviewed for my first job here, it didn't really affect anything [and] choosing where I wanted to work didn't affect that I didn't have a bachelor's. When I interviewed at the hospital they weren't requiring [it]; I mean at this hospital they weren't requiring a bachelor's, it was a minimum of an associate. Over the last two years or so, it's starting to come up; where you're hearing that a bachelor's is the minimum for a position. So other than that, I've been here for almost nine years [and I] haven't changed positions at all, and I increased my role [to charge nurse] on the same floor but I haven't changed departments. I've been in the same department. We've [Mica and her family] been talking about moving. Some of the other hospitals are —requiring — in the last

year or two – I started noticing the bachelor’s program is a minimum or a requirement of hire to complete your bachelor’s.

Even with an ADN, Mica has been able to “increase [her] role” from a staff to a charge nurse on the unit she works and has not looked to change employment for nine years. Her organization has recently “started talking” about requiring a BSN as a minimum requirement for RN positions, and upon exploring a family move, Mica recognizes that other organizations also are starting to require a BSN for employment.

In this study, three-fourths of the participants held positions that were advertised as “BSN preferred.” Trina described her experiences as a manager of a hospital unit for the last seven years:

I was probably not prepared for it [a manager position]; I didn’t go to school and take any management classes. The hospital offers things for their managers and directors, and I go to those things a couple times a year. They have conferences and bring speakers in which are helpful, but managing people was not what I did for 30 years; I took care of people, but there [is a] certain amount of taking care of [people] involved in management. If something goes wrong, or if you need to talk to somebody about something they did or didn’t do, sometimes I don’t always handle it probably the right way. I guess I would handle that differently the next time, but I have someone I bounce things off of at our management meetings. I can say that I haven’t handled everything the best way, and I don’t know if that is any different from somebody that has been in management background and how to handle people and situations. [Every manager] has probably looked back and said they would have done something differently.

Trina discusses how she “probably wasn’t prepared” for the manager role but feels supported by “conferences” sponsored by her hospital, and she has “someone to bounce things off” at the manager meetings. Orsolini-Hain (2012) described how healthcare organizations give “mixed messages” when they promote nurses with an AD into positions in which a nurse with a baccalaureate

degree is sought. Mixed messages about role and educational preparation can lead the AD nurse to assume his/her knowledge, skill, and ability acquired through experience is equivalent to a higher degree when that is not what the organization intends. Furthermore, without exposure to new information and ideas through the educational process, the AD nurse may not realize what they do not know. As Orsolini-Hain (2008) points out, among AD nurses there is a “secondary ignorance” (p. 163) about the knowledge, skills, or abilities they do not have, which only becomes apparent when they are exposed to new concepts and thinking.

Recent studies report a continuation of these mixed messages from some nurse administrators, further reinforcing that an ADN is sufficient for many positions despite a BSN being “preferred.” Weinberg and colleagues (Weinberg, Cooney-Miner, Perloff, & Bourgoin, 2011) reported only 3 out of 27 nurse managers from an eastern state actually preferred BSN-prepared nurses to fill open positions. Rather, the vast majority of respondents preferred hiring RNs based on attitude and personality alone. Of the 27 nurse managers surveyed in this study, 20 held a BSN or higher degree, and 6 held a diploma or AD as their highest degree (Weinberg et al., 2011). The six with less than a BSN managed units at small rural community hospitals. Similarly, a study conducted in Texas by Sportsman and Allen (2011) found that of the 26 nurse administrators studied, 88% encouraged RNs to attain a BSN and 34.6% supported RN-to-MSN programs, while half of the participating nurse administrators themselves had an AD as their highest degree. Although AONE promotes the BSN as the entry level

for RN practice and also recommends AD nurses complete a BSN as a criterion for continued employment in nursing (AONE, 2004), there are areas of the country reporting very different preferences for hiring RNs and support for continuing nursing education (Sportsman & Allen, 2011; Weinberg et al., 2011).

Yet it is not that nurses prepared at the AD level do not make meaningful and important contributions to health care in their communities. Some participants described very high-level practice and the important contributions they make to patient care, often in settings where recruiting and retaining nurses with baccalaureate degrees is difficult. For instance, Alison, an AD nurse with 16 years of experience, described the significant role she plays in staffing and sustaining a school-based clinic for vulnerable teens in rural North-Central Michigan, which would typically be a position held by a BSN-prepared nurse. Her story, a paradigm case<sup>3</sup>, was shared in the context of her decision not to return to school for a BSN.

It's funny how things happen. [At our clinic] we have to do community assessments ... to push our program forward and we have to meet state requirements. We have to renew our grant; our manager here retired; we've had other staff members not being team players. Even though this was supposed to be a work team and work together to keep moving the program forward, there were people that weren't willing to put in the effort. Since then, those people have left. I am the only original person still left at this clinic, because people didn't want to take on more when the manager retired, even though when she retired she focused on getting us to be an independent team and to work together. But when your other team members don't want to do any more work, then they just leave their position, and that is what happened here. I believe strongly in the work that we do here.

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<sup>3</sup>A paradigm case is a strong example of the lived experience of the participant regarding the phenomena of interest (Benner, 1994).

I am the coordinator here, now I am the “manager,” but it is not a manager title; it’s a coordinator. I train and hire all the staff, including the PAs [physician assistants] and nurse practitioners. I don’t train the practitioners and PAs, but I acclimate them to what we do here... It’s been interesting, because we only had this [one] clinic, and then I took the initiative to write for more grants, actually for four grants, alone, last year. We, as a hospital, received all four, and one was for a second adolescent clinic at another town which we got, so now we have another clinic that is open. We have more staff now; we used to just have this building, an outreach worker or two, and we had a PA, myself and a receptionist, was our original crew and a manager, so we were 6 staffed. There have been a lot of changes. I wrote the grant and we have 2 sites and we have a PA there today and our medical assistant is down there with her. We’ve moved from a receptionist to a medical assistant, because some of the stuff we do is outreach to the schools. Today we have to go give vaccinations at school, so we hired an MA [medical assistant]. We were one of the first [clinic’s] with an MA for the hospital, because the hospital never hired an MA before. We needed more flexibility to be able to keep the clinic going, and she can register and do the stuff in the back [intake from kids, vital signs, labs]. She doesn’t know all the things nurses know, but it’s not often or all the time that she is alone, because we have a physician that works here and we just hired a nurse practitioner. Now we have a nurse practitioner, physician, a nurse, medical assistant, and another nurse and PA between the two clinics. We used to have a health educator that did our outreach. We needed an outreach person so the kids could identify with what was a representative of the hospital and you could go see them if you had a health question; what do you do about this? That position has been very difficult to keep people in; it’s kind of a stepping-stone for a lot of people on a different career path. Our first outreach worker had a political science major and one had an English teacher’s degree, both of those people have moved on to other things and we have a person with a degree in human services [who] has left. We had a person in college for counseling and she is gone, then we purposely hired a health educator because we thought the person would stay. She moved [here] from out of state and moved back for a boyfriend. We are now in a new direction on how we are utilizing our clinic staff. Our nurse practitioner is new; she just started a couple weeks ago; we are going to build outreach into our schedule and it is a clinical person actually in the school. The kids have a hard time understanding what an outreach worker was, but they know what a nurse is, they know what a nurse practitioner is; they know what a PA is. It’s an easier concept for them. I’m doing all of the scheduling; payroll check-offs; all the training and handling all of



the meetings; we have an advisory board for each center. We contract with a counseling center and provide counseling for the kids; I handle all the contracts; credit card billing and all that kind of stuff. We do have some mentoring monies that we've gotten for small grants and some donations. We decide as a clinic staff where we want... some kids might not be able to get medication... we will say we will get that or we've paid for CPR class for students before, or for different things that have come up. We had a student with no running water, who had a terrible UTI, so we got cases of water; so it depends on what those other needs are. I don't handle big amounts of money, but I do the budget; I do the overall budget. We do a lot of health programming; a food and fitness programming and will order t-shirts. We have a credit card that we can order things and I manage those things, I say yeah we can do that or no, but everything has been budgeted... Plus I'm a clinic nurse; I'm working with the physician or the nurse practitioner or the PA, it just depends. Sometimes we are in the classrooms. Right now we are doing a healthy relationships class and health class; we've been teaching a class every day for three weeks. We did tobacco prevention for the 6th grade for two weeks, those are in our work plans; those are some of our goals. Some of our goals with the population working with our kids, sometimes we are teaching it all; [it] depends, you never know [each day] what I will be doing.

Although Alison notes she is not called a “manager,” but rather is a “coordinator,” she clearly manages a community-based practice setting designed to address the needs of a complex and diverse population. Writing grants, managing budgets, hiring and training staff, managing persistent turn-over, and creating new programs and ways to connect with students sustain this clinic. Her practice exceeds the usual conception of the AD nurse, and Alison does this work successfully (the clinic received all four grants that she submitted and programming is growing despite persistent staff turnover). Amid her management responsibilities, Alison also continues to practice nursing and takes pride in her work.

I just love the kids.... I always see good in all of them. It doesn't matter what they have done or what they say and all of their concerns are valid; it takes a lot of courage for them to come. The

kids are the best part. When we originally opened, we were servicing two high schools, an alternative high school, a middle school; well one high school has a middle school. The alternative school has the bad reputation; [and people say] those kids aren't going to make it; they are the bad kids, [but] for whatever reason, they aren't staying focused, staying on track in high school; might be some issues at home, there are some problems. I can think of a few students from that bad school that have gone on to college, the [military] service. It is amazing what those kids have overcome; some may have a history of rape or alcoholism, problems with drugs, all kinds of stuff that you would not believe... It's interesting because it's great when they keep going back and you know that they understand they can come and they trust you...[crying] It's just good to know that you can encourage them and that someone believes in them...the one I am thinking of, she moved away and went to college. We have a lot kids that go on to college. We try really hard [crying] to let the kids know that they can do it and they can get past it, and there is more to the world than what they've known or seen. I really do like my job. I always look for the best. It doesn't matter, what some of the [students'] baggage is. The people that we strive to work with here; I always feel like we have to have that kind of goal, the kids are first. I don't mean to get emotional. I am just so invested in the kids...Sometimes I just say, how you doing, what's going on? I want the kids to know that I am interested in who they are, not just what they are [coming to the clinic] for. I always try to make them feel welcome.

Clearly, Alison is invested in her work with troubled and at-risk adolescents. She takes pride in the successes, such as when students from a school with a "bad reputation" go to college. She attends to creating a positive, welcoming, and accepting environment for these teens to seek health care for the many issues they face in this rural area. Alison has continued to "push [their] program forward" while the clinic has gone through "a lot of changes," and when there are positions "very difficult to keep people in."

The literature reveals growing concerns about AD nurses' practice and the inverse correlation between nurse education level and patient safety in acute care settings (Aiken et al., 2003; Estabrooks et al., 2005; Friese et al., 2008;

Tourangeau et al., 2007). Yet Alison defies these descriptions, providing important care quite successfully in a community-based, rural setting where retaining more highly educated staff is difficult. She is the only one of the core team that initiated the first clinic who continues to work there. She took responsibility for sustaining the original clinic and obtained funding for another clinic. In a region of Michigan that has the lowest numbers of baccalaureate-prepared nurses in the state (MCN, 2011) she is meeting a demand for specialized community-based care that is highly needed, amid a very complex practice area.

Alison calls into question the universality of concerns about AD nurses' contribution to health care and the safety of those for whom they care. Her account highlights how, in the discipline's zeal to improve the education of the nursing workforce, it is easy to overlook the contributions these nurses make to the health of their communities. Nilsen, Huemer, and Eriksen found (2012) that nurses who "are familiar with the local culture and specific needs of the population in remote areas" (p. 5) are a valuable asset and difficult to replace. Who would take Alison's place if she were to cut her hours or move to a different position or to a different shift so she could return to school? How would returning to school extend Alison's practice?

BSN completion programs vary considerably in scope, breadth, and depth (Robertson, Canary, Orr, Herberg, & Rutledge, 2010; Spencer, 2008). In most cases, completion programs are designed merely to add the courses from the baccalaureate curriculum not found in the completed ADN program curriculum.

Courses like nursing research, community health, and leadership and management are common. Some programs allow a great deal of individualization based on students' experience, while others allow very little (McEwen et al., 2012). The expertise Alison has gained in her current position goes well beyond the typical community health or management courses offered in baccalaureate curricula. How would taking these courses advance her practice abilities? If coursework does not advance her *practice* knowledge, then how does mandating a BSN in a particular timeframe (like New York and other states are doing) enhance patient safety in more than a theoretical way?

Completion programs in nursing (RN-to-BSN) are designed for diploma- or AD-prepared nurses who already are licensed. Generally, completion programs are comprised of 35–50 credit hours, taking one to two years to complete, and result in a baccalaureate in nursing degree (McEwen et al., 2012). Courses taken often include a limited number of general education courses along with nursing-specific courses in communication, community health, research, and leadership/management. The curriculum in completion programs are often the same whether the student continues directly from the ADN program (e.g., OCNE model; Tanner et al., 2008), or if the student comes with a highly developed practice and years of experience. Keeling and Hersh (2011) assert that programs that are one-size-fits-all focus solely on intellectual development—doing little for more practical, social, moral, and professional aspects of being critically aware of oneself in relation to the challenges one faces. Furthermore, this emphasis on “abstracted knowledge without personal significance or grounding for any

student” (Keeling & Hersh, 2011, p. 64) does little to help students integrate their experience, current and developing knowledge, and the broader questions of human life in a global society. Ten years ago Eckhardt (2002) suggested RN-to-BSN education should be modified based on the learning needs of individual nurses by having flexibility built into the curriculum, yet little flexibility is found in these programs. This certainly raises questions about the adequacy of current BSN completion programs, particularly in light of national efforts to drastically increase the numbers of students seeking these programs.

That is not to say, given Alison’s achievements with an AD education, she may very well have the ability to accomplish even more at local, state, and even national levels with an increased degree. Yet paradoxically, focusing on potential achievements outside her current work environment perpetuates the assumption that completing the baccalaureate (or higher) degree only is required for obtaining a *new* position and that advancing one’s education takes nurses away from the bedside or from direct care roles. It also fosters the problems rural areas face of retaining nurses with higher levels of education (Blustein, 2011; Nilsen et al., 2012).

It is timely for the discipline to critically examine BSN and higher degree completion programs to ascertain the extent which these programs are having on the desired effect of advancing the practice level of AD nurses and the safety of the patients for whom they care. This examination must include the evaluation of quality as well as content and ascertain the impact of this education on practice. Such evaluation is timely amid national concerns about the general effectiveness

of higher education and the scholarship which challenges the assumption that any education is beneficial (e.g., Arum & Roksa, 2011; Keeling & Hersh, 2011; Schneider & Yin, 2011).

Nursing professional organizations do provide competencies for graduates (e.g., the essentials of baccalaureate education [AACN, 2008] and outcomes and competencies for graduates [NLN, 2010]), and most baccalaureate and higher degree programs are accredited by professional organizations based on these competencies. Additionally, the colleges and universities in which these programs are located also undergo a series of accreditation processes. Yet these processes are far removed from individual students and commonly reinforce uniformity (Diekelmann et al., 1989) rather than flexibility and individualization. Perhaps investigating the “value-added” of BSN completion programs, and the features of curriculum and instruction most likely to produce the desired improvements in returning students’ practice, would provide the discipline with insights to guide ongoing improvement.

AD nurses who complete their baccalaureate degrees do recognize a change in their practice. Indeed, research has shown that students completing a BSN report a transformation in their thinking and that the completion program positively affected their confidence, communication, and view of their practice (Crooks et al., 2005; Delaney & Piscopo, 2007; Haffer & Raingruber, 1998; Lillibridge & Fox, 2005; Osterman et al., 2009; Zuzelo, 2001). As the discipline endeavors to entice AD nurses to complete their baccalaureate degree, it is important to recognize that these differences are recognized only in hindsight;

they are not necessarily anticipated. Thus, making the gains students achieve upon completion more visible to potential students is critical.

On the other hand, nurses in this study did see returning to school as a way to maintain flexibility with obtaining a job if they chose to leave their current positions. They described the possibility of having more choices of positions (e.g., travel nurse) if they obtained more education. Though they identified no added value to their *current* position, many participants could foresee a cost of *not* returning. Kelsey discussed how she enjoyed being able to “change” positions in nursing but is concerned about the ability to continue to change positions if she does not have a BSN.

That is what I loved about nursing. You can change, you get tired of surgery, you go to maternity; you get tired of that, you go to pediatrics. I like the home care, office care, bedside nursing, the hospital...a lot of areas to change to if I was interested. But I love where I'm at right now. I love being able to help patients and know that you are making a difference. I have some concern about my future, would I be limited in jobs I could take because of that [not returning for a BSN]? Would I have to work in the office or could I work as a bedside nurse in a critical care unit? If I had my bachelor's it would mean security, being able to be employed if I left here. I don't know if it would make me a better nurse for the way I practice now or not...I love what I do, if I didn't like the area [of working in nursing] then I can switch it out, you can kind of move around still. But I am worried about the future if I don't have a BSN. I won't be able to move around like I would want, so there's concern...especially since I know I don't want to retire from this organization.

Kelsey understands she may be “limited” if she does not return for a BSN, and that she would lose the ability to “move around” to different specialties in her nursing career. Though she understands this loss, the barriers to returning for a BSN are more abundant than her “concern” at this point in her career. Kelsey understands that having a BSN will not affect her practice (“I don't know if it

would make me a better nurse for the way I practice now or not”) but rather, will only give her “security” and the ability to “be employed if I left here.”

Apart from seeking higher academic degrees, many AD nurses, like the participants in this study, do seek ways to enhance and extend their practice. For example, many participants referred to continuing education opportunities or self-study that helped them keep up with changes in practice and augment their practice knowledge. Additionally, many states (including Michigan) and employers require continuing education for all practicing nurses, because it is viewed as a mechanism to foster continued practice improvement (Wood, 1998). Participants in this study viewed continuing education as a more expedient way to extend their practice knowledge than returning to school. Mica stated,

Like when I first wanted to go back to school, I wanted that more education or taking some more CEU's [continuing education programs], doing some conferences [was an option]. When I went from a floor nurse to a charge nurse that kind of gave me a little bit more satisfaction.[I] got out of the routine of normal floor nursing, a little more to strive for a little bit more of a challenge, I think I was needing that. I think that is when I first started looking for a bachelor's; I felt kind of stagnant in my career where I was. I was looking for something, and I knew the bachelor's program was like a long-term, taking short-term classes, but long-term goal. Then the conferences would have been a little bit more short-term obtainable, doable I wouldn't have the commitment of the classroom and the papers all the things that school would [entail]. So when I switched to my charge nurse [position], that kind of fulfilled a little bit more because I had more to learn and a new goal, so that helped a little bit too [feel more satisfied].

As Mica's career progresses, she begins to seek avenues for advancement; finding she has become “stagnant in [her] career.” Weighing the options of returning to school and going to conferences, she finds that



“conferences would have been a little bit more short-term obtainable, doable, and I wouldn’t have the commitment of the classroom and the papers and all the things that school would [entail].” Here again, Mica chooses her path based on expediency. Conferences do offer a mechanism to learn more about her practice without the burdens of “classrooms” and “papers.” Indeed, on one hand, it might be argued conferences are “just-in-time” education (Phillips, 2005) and provide access to the latest knowledge development in the field and opportunities to network with colleagues in similar practice settings. Continuing education programs (CEP) in nursing are designed to present current scientific knowledge and disseminate research findings to promote nurses’ competency and safety. These programs often are offered in small segments and at a (comparatively) low price. Because CEPs are offered in a variety of formats and timeframes, they are very flexible, and participants can tailor their courses to address specific developmental needs in their practice. While there may be little connection between different CEP offerings and little (if any) outcome measurement (Estrada, 1980; Ioannidis, 2012) to document registrants’ achievement in a meaningful way, CEPs remain very attractive to AD nurses who are not able to (or do not choose) to return to school for an academic degree.

On the other hand, continuing education programs have very different purposes and outcomes than traditional coursework and curriculum. For instance, an academic program has an identified sequence of courses and expected outcomes for enrollees, whereas nurses taking continuing education programs are free to take any series of offerings they desire, regardless of how

these offerings relate to their practice area (as long as they can document the required number of contact hours). At the individual nurse level, changes in attitude, perceptions, knowledge, and skills have been documented following CEPs (Gijbels, O'Connell, Dalton-O'Connor, & O'Donovan, 2010; Wood, 1998), and changes in confidence, communication, and view of practice have been documented following completion programs (Crooks et al., 2005; Delaney & Piscopo, 2007; Haffer & Raingruber, 1998; Lillibridge & Fox, 2005; Osterman et al., 2009; Zuzelo, 2001). It is important to note, however, that the effect of learning (whether in CEPs or in academic programs) on nurses' actual practice has not been documented<sup>4</sup> (Ellis & Nolan, 2005; Gijbels et al., 2010; Griscti & Jacono, 2006; Wood, 1998). Clearly, more research is needed to better understand the potential of each of these educational paths.

Furthermore, there is a complex set of factors that influence the outcomes of educational programs, including both CEPs (Ellis & Nolan, 2005) and academic programs. In addition to the difficulties of documenting the effect of this education on nurses' actual practice, it is also important to understand the system or organizational influences on if and how what is learned is put into practice. For example, if the practice environment is not receptive to the changes that result from participation in CEPs or the completion of the academic program,

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<sup>4</sup>There is a great deal of interest in testing nursing competencies (knowledge, skills, and abilities) via simulation experiences. While this is an important area for investigation, it is important to note that there is also no evidence linking performance in simulated experiences with practice in complex and evolving situations beyond beginning skill levels.

nurses become disempowered, and the new knowledge does not impact the care provided in that setting (Ellis & Nolan, 2005). Perhaps an increased emphasis on knowledge translation, change theory, and communication skills in complex environments would augment both CEPs and academic education. Further investigation into how unit and organizational systems can best support changes resulting from continued education in the nursing workforce is also imperative.

One significant difference between BSN completion programs and CEPs is that the former give AD nurses the opportunity to develop a sense of becoming professionals by fostering confidence and professional identity (Crooks et al., 2005; Delaney & Piscopo, 2007; Haffer & Raingruber, 1998; Megginson, 2008), but these differences have yet to be empirically demonstrated via valid and reliable measures (Ridley, 2008). Research has shown that AD nurses in BSN completion programs have opportunities to gain knowledge through exposure to theory and research, which improves their communication and construction of arguments (Crooks et al., 2005; Delaney & Piscopo, 2007; Haffer & Raingruber, 1998; Osterman et al., 2009; Zuzelo, 2001), and that AD nurses practice nursing differently by using research and better communication skills learned in BSN completion programs (Lillibridge & Fox, 2005; Zuzelo, 2001). Moreover, Delaney and Piscopo (2007) conducted a qualitative study of 12 AD and diploma graduates to understand the lived experience of transitioning from AD to BSN. Their findings demonstrated that graduates of completion programs could identify a direct benefit for their patients and reported adopting a more holistic view of

patient care. Yet the extent to which these skills (using research and communication) could be learned in CEPs has not been investigated.

As the discipline focuses on increasing the education of the nursing workforce, it is timely to re-examine “what difference does it make.” Returning to Gadamer’s notion of the fusion of horizons (2004), it becomes apparent that understanding the experiences of AD nurses (their perspective or vantage point) is imperative in creating a preferred future. Participants in this study shared experiences that raised questions about the extent to which completion programs would increase their knowledge or practice. In part, this perspective is understandable in that one typically returns to school to become something different (Keeling & Hersh, 2011). If one is not seeking a new position, then what does returning to school provide? Perhaps this understanding underpins how frequently returning to school is equated with leaving the bedside to become a teacher or manager (Delaney & Piscopo, 2004; Lillibridge & Fox, 2005; Orsolini-Hain & Waters, 2009). Similarly, perhaps it is timely to critically examine the structure, requirements, and outcomes of current BSN completion programs. Identifying ways for AD nurses with high levels of practice (as shown in this study) to take advanced level coursework in lieu of baccalaureate level courses may be more attractive to potential students and have a greater impact on their practice in the long-term. Can completion programs be designed to be more flexible, episodic, and reflective of specialty practice expertise acquired over a career?

A fusion of horizons is created through dialogue or conversations (Gadamer, 2004) and leads to a richer, shared understanding of the experience. Through dialogue that is open to challenging inherited perspectives and to new possibilities, Gadamer contended, the original horizon is surpassed and integrated into a broader, more informed understanding. Conversations across the discipline—among leaders, national organizations, and bedside nurses (both with and without baccalaureate degrees)—could create a fusion of these horizons, and all may see more possibilities for increasing the education of the nursing workforce. Indeed, when horizons fuse, something arises that did not exist before (Gadamer, 2001).

In summary, participants in this study consistently questioned “what difference does it make” to have a BSN. Many have been able to advance to staff positions identified as “BSN preferred” without returning for a BSN. Although some recognized that they “probably [were] not prepared” for the roles they assumed, they described practicing successfully. Consistent with Orsolini-Hain’s (2012) findings, participants received mixed messages about the importance of pursuing a BSN and seeing the BSN as important only if they wanted to change position or leave the bedside for another type of role (i.e., teaching or management). For some, the BSN provided security, although this was tempered by the perceived barriers of returning to school. Participants did describe continuing to learn to advance their practice through continuing education programs and often viewed this as an alternative and more relevant path than returning to school for an academic degree. The experiences shared by

participants in this study provide an opportunity for the discipline to question the ways in which AD nurses complete their BSN and to provide insight into innovative possibilities for the future.

### **Summary**

The themes explicated in this chapter are consistent with the literature and a previous hermeneutic study of AD nurses in an urban area of the western United States showing that students select AD programs because they are perceived to be faster and/or are closer to the student's home. In the absence of clear differentiation of different types of preparation, practicing participants questioned "what difference does it make," and many currently work in positions described as "BSN preferred." The experiences shared by participants also highlight the added challenges faced by nurses and organizations in rural settings. These findings raise important questions for the nursing discipline to consider in terms of (a) the desirability of AD programs to students considering a nursing degree (getting in and getting out expediently), (b) the benefits to individual AD nurses of completing the BSN, and (c) the costs to AD nurses and their practice unit. While the literature has described outcomes of BSN education for AD nurses, there is little to suggest a causative relationship between education (whether academic or continuing education) and practice. To meet the IOM (2010) challenge of 80% by 2020, rigorous research investigating the most effective structures and processes for advancing the education of the AD workforce is imperative.

## CHAPTER 5 DISCUSSION AND CONCLUSIONS

The IOM (2010) and the Carnegie Foundation (Benner et al., 2010) conducted research with the conclusion the United States needs a more educated nursing workforce. The IOM (2010) called for an 80% BSN-prepared nursing workforce by 2020, and the Carnegie Foundation (Benner et al., 2010) called for a BSN to be the education needed to enter into practice for RNs and further to obtain a master's of science in nursing in 10 years after initial licensure. These recommendations mirror the nursing literature showing growing evidence that (a) the complexity of health care is increasing (IOM, 2000, 2001); (b) the RN is most likely to be in a position to identify risk, prevent errors, and recognize deteriorating conditions in hospitalized patients (Benner et al., 2010; IOM, 2010); (c) the patient care given by nurses with a BSN or greater generates better patient outcomes (Aiken et al., 2003; Friese et al., 2008); and (d) the United States does not have adequate numbers of baccalaureate-prepared nurses to achieve the expected improvement in patient outcomes (USDHHA HRSA, 2010).

Currently, 50% of the RN workforce in the United States holds a BSN or higher degree. This percentage drops to 40% overall in Michigan and to under 30% in rural areas in the state. In the rural North-Central Region of Michigan, only 29% of the RN workforce holds a baccalaureate or higher degree in nursing. While it will be a challenge to meet the IOM goal of an 80% BSN-educated nursing workforce by 2020 nationally, in rural areas such as North-Central Michigan it will be an even greater challenge, as rural areas have fewer baccalaureate-prepared nurses and fewer academic institutions offering a BSN.

There are three educational pathways that lead to licensure as an RN: diploma, AD, or baccalaureate degree. The majority of graduating RNs today come through ADN programs. In 2010 (NCSBN, 2011), 58% of the graduates taking the NCLEX-RN were from AD programs. Unfortunately, only one in five of these AD nurses returns for a BSN or higher degree (USDHHS HRSA, 2010). AD nurses comprise a large pool of RNs with the capability of increasing their educational preparation to a BSN, which will meet the demands of the increasing complexity of health care and the goal of an 80% BSN-prepared workforce (IOM, 2010).

The purpose of this study, undertaken in the context of national calls to rapidly advance the education preparation of the nursing workforce, was to understand and interpret the meaning of being an AD nurse, the meaning attaining a BSN would have for the ADN nurse, and the barriers that prevent those nurse' return to school for a BSN. Extending the research conducted by Orsolini-Hain (2008) by situating this investigation in a rural setting, 11 AD nurses who lived and worked in the North-Central Region of Michigan were interviewed to accomplish this purpose. The specific aims of the study were to:

1. Understand and interpret the meaning being an AD nurse holds for participants in rural North-Central Michigan.
2. Understand and interpret what it would mean for these AD nurses from a rural area to attain a BSN, and the barriers that prevent this from happening.



In Chapter 4, the presentation and analysis of interview data were reported. Chapter 5 contains a (a) summary of the study, (b) discussion of findings, (c) strengths and limitations, (d) implications for education and practice, (e) recommendation for further research, and (f) conclusions.

### **Summary of the Study**

Participants in this study were recruited from a population of rural AD nurses who work within the North-Central Region of Michigan using convenience sampling after exempt research status was given from the Indiana University Institutional Review Board. The criteria for inclusion were AD nurses without a baccalaureate degree in nursing or another field and with at least eight years of experience practicing as an RN. An invitation to participate in the study (Appendix C) was sent to all AD nurses in rural Michigan, and those who met the criteria were selected randomly from the responses to this invitation. Because of the low response rate to the email solicitation, further recruiting was conducted via snowball sampling by asking existing participants to put forward names of other potential participants.

Interviews were conducted at a time and place convenient to each participant. Before the interview began, the investigator explained the purpose and aims of the research, reviewed the Study Information Sheet (Appendix D) with participants, and collected demographic information (Appendix E).

Unstructured interviews were used to obtain participants' narrative accounts of their experiences (regarding how rural AD nurses are engaged in and understand

themselves related to their education). Participants were given one \$25 grocery gift card as a token of appreciation for participating in the study.

The digitally-recorded interviews were transcribed by a professional transcriptionist. Deidentified copies of the transcriptions were used for data analysis by a research team comprised of experienced hermeneutic phenomenological investigators, nursing educators, and students. Using hermeneutic phenomenology, two themes emerged from the analysis of the 11 interviews and are reported here.

### **Discussion of Findings**

The discipline of nursing is preparing to meet the challenges of a rapidly evolving healthcare system and respond to multiple calls for increased educational preparation of the nursing workforce (Benner et al., 2010; IOM, 2010). Understanding the meaning of increasing education for AD nurses and the meaning of returning to school or not can powerfully enhance and refine disciplinary efforts to address the low percentage of baccalaureate-prepared nurses. The stories shared in this study suggest that increasing the educational preparation of the nursing workforce is a complex endeavor. It was anticipated participants would be able to share specifically what was needed to help them increase their education and those factors that may serve as a “tipping point” in their decision making about returning to school. However, participants shared accounts revealing the complex nature of having a family, working, committing to an RN-to-BSN completion program, covering shifts so they (or others) could

return to school, and understanding how further education would influence their nursing practice.

The findings of this study revealed that returning to school does not appear for participants as an obvious or a natural response to national calls for improving practice. The assumptions AD nurses made about increasing their education were readily apparent. For instance, in many cases they chose an ADN program because it was a fast way to accomplish the goal of becoming an RN and to begin practice, even though the time to complete their degree exceeded the anticipated two years. These participants did not see the BSN as contributing to their nursing practice, so if they were satisfied with their current position and wished to continue to provide direct patient care they did not investigate (or in many cases even consider) options for continuing their education. Furthermore, pursuing additional (academic) education was seen as unnecessary and was understood merely as a strategy to ensure they had flexibility or “security” in the future (particularly when moving to a new organization or to a traveling nurse position) or to attain a managerial or teaching position away from the bedside.

The mode of delivery did not entice these participants to return to school to complete their BSN. No participants spoke of pursuing opportunities to complete their baccalaureate degree in face-to-face, online, or by any other means as feasible options. When participants did consider furthering their education to prepare for advancement to roles in which a BSN was “preferred” by the organization, they described attending CEPs. In addition to providing

knowledge seen as relevant to practice, participants averred that CEPs did not require “papers” and “classrooms,” but offered opportunities for dialogue (“picking each other’s brains”) about current practice issues. While academic programs may provide these experiences as well, the participants in this study saw completion programs largely theoretical and distanced from actual nursing practice. Not only must disciplinary attention be focused on addressing this assumption, it may also be prudent to investigate how the structure and processes of CEPs might be adopted by academic BSN completion programs. For example, CEPs typically allow registrants to select offerings that are most timely and relevant to their practice; they are completed on-demand, in intermittent timeframes, and at times convenient for working nurses.

Lastly, it is important to consider the mixed messages that AD nurses continue to perceive from their organizations and leaders. In this study, many of the participants currently held positions for which their organization believed them to not be fully capable (i.e., BSN preferred). Clearly, some participants described practice abilities that went far beyond what one would expect of a nurse prepared with an ADN. For others, the common practice of hiring AD nurses into positions in which BSN preparation was preferred reinforced the notion that a BSN was not really necessary and would not impact their practice in the position in a significant way. Efforts to differentiate nursing practice have been advocated and debated in the discipline for decades (ANA, 1965, 2000; Haase, 1990; Orsolini-Hain & Waters, 2009; Rines, 1977) with no lasting effect. If AD nurses are to be encouraged and supported to return to school, then the

nursing discipline, academia, healthcare organizations, and state legislators must clearly articulate the value the BSN brings to the practice area, support those seeking this preparation (while in school and with a salary that reflects this added value upon graduation), and create environments conducive to taking advantage of what these nurses have learned upon completing the program. Hiring practices also must be scrutinized so the mixed messages so commonly perceived by AD nurses can be avoided.

In rural parts of the country, like North-Central Michigan, the difficulties of increasing the education of the nursing workforce are significant. Because this region has the lowest percentages of BSN-prepared nurses in Michigan, there are more AD nurses needing to return for a BSN (over half of the AD nurses in this area would need to return to school to meet the 80% goal set by the IOM). Organizationally, participants in this study pointed out the “manpower drag” created by having many AD nurses from the same unit or from the same organization returning to school at the same time. Yet individually, it takes a commitment to drive long distances to a university center or to invest in computer and Internet services required to support online programs. In the North-Central Region of Michigan, these difficulties are exacerbated because there is not consistent availability of high-speed Internet access, making online coursework difficult. For these reasons, education in rural areas lags behind regions that have more resources (Blustein, 2011). Devising intentional ways of reaching AD nurses in these rural areas with flexible and meaningful RN-to-BSN completion

programs that can be completed without adversely affecting the RN workforce in the area is imperative to meeting the IOM goal.

The profession of nursing in Michigan (academia, administrators, healthcare organizations, and bedside nurses) should come together and have conversations on how flexible and meaningful RN-to-BSN programs can be conducted in this state, including rural areas. Michigan nursing organizations (Coalition of Michigan Organizations of Nursing, 2011; MDCH, 2012) have worked on having a conversation but the most recent publications do not show progression in nursing education as other states, such as Oregon and Indiana, have accomplished (Hendricks et al., 2012; Tanner et al., 2008). It is time for Michigan's nurses to come forth with their own plan for academic progression of RNs to increase the education of its nursing workforce.

### **Strengths and Limitations**

Strengths of this research study include the use of open-ended questions that allowed AD nurses to describe the meaning of attaining a BSN from their individual perspectives and in ways that made sense to them. This study also took place in a unique region that has not been researched before, AD nurses working in a rural setting. This is important because rural participants often are overlooked in nursing education research, yet they are critical to addressing regional needs to increase the education of nurses. Importantly, the investigator is a nurse living and working in this rural area asking questions of rural AD nurses. Furthermore, the study is timely, and national attention is focused on significantly increasing the number of BSN-prepared nurses in the workforce.

Limitations of this study include its focus on one area of a state in the rural Midwest. The findings may not represent the experiences of all AD nurses in the region or in other rural areas. Another limitation is the potential power inequities between the investigator (a doctoral student) and the participants. Because the educational level of nurses has been debated hotly over the past decades, it is possible that participants shared only those experiences they believed the investigator would find acceptable or appropriate.

### **Implications for Education and Practice**

These findings are important because nationally only one in five AD nurses returns for a BSN (USDHHS HRSA, 2010). If the nursing discipline is to meet the challenge of having an 80% BSN-prepared workforce in the next eight years, it will be imperative to devise effective strategies for addressing education assumptions and creating direct entry and completion programs that are readily available and accessible across the country, including in rural areas of the country such as North-Central Michigan. Specifically, completion programs need to be reviewed for access, flexibility, and outcomes. Implications that effect access and flexibility include prior strategies, state curricula, and new strategies for completion programs. Also, outcomes of completion programs need to be evaluated to help define what is gained by returning for a BSN. Clarity is needed from the nursing discipline so AD nurses (and others in the field such as administrators, legislators, and other health professionals) know how BSN education affects their practice and what value it will bring to patients and organizations.

Prior strategies for promoting BSN completion by AD nurses include legislative mandates and direction, offering on-site or online education, bringing BSN degree programs to community colleges, and statewide curriculum programs with articulation agreements for seamless transfer and academic progression. Legislative mandates for entry-to-practice education in nursing or continuing to a BSN (RN-to-BSN) within a certain timeframe have not been sought widely or enacted. Likewise, mandates by employers have not been consistent. Although, in the North-Central Region of Michigan there is one healthcare facility that enacted a policy that all AD nurses hired in 2009 and after will have a BSN within 10 years for continued employment (J. Fischer, personal communication, June 3, 2009). Further, Indiana University Health will require a BSN within five years of hire beginning in 2013 for continued employment (L. Q. Everett & E. C. Brown, personal communication, October 3, 2012). It may be that until a BSN is required to practice as an RN nationally or until healthcare facilities demand it, the numbers of AD-prepared nurses will remain essentially unchanged. There is a mismatch between what the national calls are asking for and what is being practiced currently regarding the education of the nursing workforce. In this study, most of the participants had RN positions that were designated as “BSN preferred.” Discourse analysis is needed to bring attention to this mixed message of saying more education is needed then giving BSN preferred positions to RNs with less education without mandating they return to school. We say we value BSN education but our healthcare organizations are not willing to change to take advantage of the knowledge, skills, and attitudes of



nurses who attain this education. The extent to which each of these strategies are effective in meeting the IOM mandate for a more highly educated workforce has not been explored adequately in either academic or practice settings.

State curricula such as the OCNE have made strides forward with increasing the rate of their ADN graduates returning for a BSN (Munkvold et al., 2012). The OCNE model has been able to triple the number ADN graduates attaining a BSN from the national average (USDHHS HRSA, 2010) by going beyond articulation agreements. They offer dual admission, align prerequisites, and eliminate redundancy in curriculum (Munkvold et al., 2012). Adopting statewide curriculum programs is a promising strategy that should continue to be investigated, developed, and adopted by more states in the United States. In addition to students' learning outcomes, the effects on practice, time-to-degree, and "stop-out" time prior to continuing on for the baccalaureate degree should be investigated.

Additionally, access to BSN completion courses has been well documented as a factor facilitating AD nurses' return to school. Despite this, increasing availability of on-site, online, and BSN completion degree programs offered locally at community colleges have not impacted significantly the numbers of AD nurses attaining a BSN. Clearly, further research evaluating these strategies is needed as they are developed and implemented over time. In this study, the participants did not see any option as feasible for them to return for more education. These participants need to visualize themselves returning to

school and understand the value before taking the opportunity of the different ways to access completion programs.

Completion programs with high levels of access and flexibility that can be completed without travel are imperative. Such programs could assist healthcare organizations in rural areas (where a higher percentage of AD nurses practice) to support larger numbers of staff nurses to return to school concurrently without disrupting staffing. Additionally, such programs would keep nurses in their home communities, which may contribute to them remaining in these areas after program completion (AACC, 2011b; Bernier, 2003; Blustein, 2011; Fulcher, 2002; Larowe, 1978). RNs in rural areas understand the culture of living and working in those regions and are the best sources for providing and improving local patient care (Nilsen et al., 2012). Nurses with BSNs are needed in these rural areas because they are familiar with the specific needs of the local patients and are trusted and valued members of their communities. In the rural North-Central Region of Michigan, RNs need to understand the value this education has for their continued practice at the bedside and be able to visualize themselves returning to school.

New strategies for completion programs need to be developed to help retain rural nurses in their communities. Partnerships with academia and healthcare service industries could create new ways to deliver education. Fitzgerald and Townsend (2012) report on a pilot study where university faculty delivered nursing continuing education to hospital employed RNs by providing four classes. The classes were developed after surveying the RNs to understand

what kind of continuing education programs would be relevant to their practice. Certificates were earned once the classes were complete. Osterman et al. (2009) found that nurses taking advantage of continuing education opportunities are more apt to continue in academia. Making a more intentional link between continuing education and academic credit would be an excellent opportunity to introduce AD nurses to online education, university nurse educators, and the possibility of returning to attain a BSN.

Furthermore, it is timely to investigate specifically the learning needs of AD nurses relative to their practice, and the needs of healthcare organizations so that together site-specific BSN programs could be devised and implemented. Why not survey a pool of AD nurses to find out what is relevant to their practice and let them design their own BSN program depending on their own interests and needs? AD nurses would likely understand the value added of the BSN if they were taking courses highly relevant to their practice and they could apply the information right away to improve patient outcomes.

Similarly, the cost of higher education is being addressed by many online, free course programs in which students work with other students from around the world. Why not take this a step further and offer an online academic course for free? Stanford University (Beckett, 2012) beginning in the fall of 2011 began offering free online courses that were a huge success drawing “more than 350,000 participants from around the world” (para. 1). This is a great way to “try” a class without the barriers of admission and committing to one program. Offering one or a certain number of free courses also may break down the barrier

of initial cost of a course and may motivate some AD nurses to return to school sooner. Some healthcare facility tuition assistance programs require the student to pay for the course upfront, complete it, and only give reimbursement after a satisfactory grade is attained. In this model, having the first course free may provide incentive to help motivate students to begin.

Another barrier discussed in rural areas is Internet connection for online completion programs. Dial-up Internet connections still are prevalent in rural areas. A way to break this barrier is for healthcare organizations to offer space in their institutions for students to access the Internet and to study. Healthcare organizations have the capability of providing high-speed Internet access for a minimal cost, relieving the students' issue of lack of high-speed Internet service, thus enhancing the opportunity for online courses. Other options may be to provide data plans and Internet boosters through cell phone companies to overcome the barrier of Internet service issues.

Nursing faculty also need to be included in the conversation of encouraging students to return to school. Altmann (2012) surveyed nurses initially educated at the ADN level and found that only 52% of faculty encouraged these participants to return to school. Munkvold et al. (2012) reported students felt encouraged by 88% of their faculty in the OCNE program. With the success of the OCNE tripling (from the national average) the number of RNs to further their education, this must be investigated further. Nursing faculty need to positively promote returning for a BSN because this appears to influence more RNs to return. We need to say "when you return to school" instead of "if you

return to school.” Similarly, students need to envision themselves returning to school for a BSN. Having the conversation with them at the beginning of their ADN program (beginning sooner than later) has implications for them returning to school sooner. Studies also are needed to document the implicit and explicit ways students are encouraged to return to school from ADN and BSN faculty. Giving them intentional exposure to university education is another way for them to visualize returning to school. Having them take the first course from faculty of a BSN program before graduating from their ADN program may create this exposure.

This study also revealed some insights into alternatives to the RN-to-BSN programs that are common today. For instance, it may be useful to incorporate structures, processes, and teaching methodologies of continuing education into BSN completion programs. Since the format for selecting content in continuing education programs appears relevant to AD nurses’ current practice, perhaps academic programs also could adopt those strategies and offer an array of modules or units, available at any time from which students could select. When a certain number of these modules have been completed, a pre-specified number of credit hours toward the baccalaureate degree would be earned. A state nursing consortium in Indiana (Hendricks et al., 2012) offers year-round online courses in seven week terms with flexibility in sequencing the courses. This consortium also gives credit for previous experience and professional achievements and courses are accessed from any of the eight campuses by a variety of nursing faculty. While there is no outcome data yet, this is a promising

model for increasing flexibility and access and has “shorter timeframes” to complete courses. The Indiana State University consortium (Hendricks et al., 2012) for nursing education is comparable to the recommendation in this study of having coursework similar to continuing education program courses.

Similarly, perhaps AD nurses returning to school also could take courses at the masters’ level in their specialty while getting a BSN. This would have the added benefit of further knowledge development specific to the AD nurses’ areas of practice while also encouraging them to continue on to even higher levels of preparation. Offering this type of coursework outside of the typical academic calendar or business hours would provide greater flexibility to these students and may be a further incentive.

Requiring coursework toward a degree also requires the discipline take a critical look at completion programs to determine the extent to which these programs provide the “value added” that academe and healthcare organizations assume. Aiken and colleagues (2003) did find increasing the education of the nursing workforce does produce better patient outcomes but it is not clear why this is so. In the 2003 study by Aiken et al., the type of BSN education (generic or completion) nurses attained was not differentiated. It is important to know what it is about education that makes the difference in patient outcomes and also this knowledge will inform nursing curricula.

Nursing education has remained largely unchanged in structure and process for decades, and most programs (of all types) continue to focus on content transmission and skill acquisition (Ironsides, 2001). Merely “filling in” the

courses from the BSN curriculum that nurses with an ADN have not taken previously is insufficient to meet the challenges of improving health care and improving safety in practice, while at the same time meeting AD nurses' interests in furthering their practice knowledge. Across higher education, faculty and administrators increasingly are being criticized for ill-preparing students for the jobs they will fill following graduation (Keeling & Hersh, 2011). A good place for the nursing discipline to begin this self-critique is by investigating RN-to-BSN completion programs and the extent to which these programs directly affect the practice of these students. This also would provide insight into how the differences achieved by completing programs could be highlighted to incentivize further student matriculation.

Ridley (2008) suggested it is important to empirically demonstrate the impact of nursing education with valid and reliable measures. This would help determine how education ties into nursing practice, especially quality and safety measures related to patient care. Evaluating RN-to-BSN programs for quality and safety content by making the outcomes related to patient care transparent would help AD nurses and others understand how this education affects practice and the quality and safety of care. Furthermore, reviewing past strategies for increasing the education of the RN workforce, while at the same time evaluating the content and outcomes of RN-to-BSN programs, would generate important knowledge for making future pedagogical decisions.

The appropriate level of nursing education needed to enter practice and provide safe patient care is a dated issue spanning more than 50 years, and the

contention regarding entry-into-practice remains today. Conversations are needed between the nursing discipline, academia, healthcare organizations, policy makers, legislators, and bedside nurses to devise workable solutions that provide the best-prepared nurses in the shortest amount of time possible with the least disruption to the nursing workforce. Such conversations also need to address increasing the education of the nursing workforce beyond the baccalaureate level (Benner et al., 2010). The IOM (2010) called for the nursing profession to double its current number of doctoral prepared nurses. Strategies are needed to make preparation at the master's or doctoral levels (PhD or DNP) a viable option for AD nurses. Much could be learned by studying initiatives in other healthcare disciplines (e.g., pharmacy and physical therapy) that have effectively moved entry level preparation to the doctorate in a time-span of only 10 years (American Physical Therapy Association, 2012; Purdue University, College of Pharmacy, 2012).

### **Recommendations for Further Research**

Because of the importance of promoting patient safety via increasing the education level of the nursing workforce, it is important that robust programs of research continue to investigate this phenomenon over time. Further investigation into the effects of different strategies for prompting AD nurses to return to school, as well as the completion rate of students once matriculated, the net impact on the number of students seeking BSN completion, and the number of BSN graduates returning to practice areas or staying at the bedside is important. Investigation also is needed into how organizational healthcare



systems can support change through the education their RN workforce is receiving. Having environments that are conducive to change will empower the nurses to use their new knowledge and, in turn, improve patient care. A national, coordinated evaluation of state-wide initiatives (such as OCNE or the baccalaureate offered in community colleges) also is critical to identify best practices in advancing the knowledge of the nursing workforce. Finally, looking at other rural areas and devising ways to study the net impact of selected strategies of increasing the nursing education workforce specific to this population is needed. Understanding the unique needs of this population and the healthcare organizations in which they work will impact rural communities.

### **Conclusions**

Increasing the education of the nation's and Michigan's RN workforce is a critical issue. It is time all stakeholders are involved to help achieve the IOM goal of an 80% baccalaureate-prepared nursing workforce by 2020. Conversations across the nursing discipline, academia, national organizations, and bedside nurses (both with and without a baccalaureate degree) are needed to devise and evaluate the impact of proposed strategies on outcomes such as the number of nurses completing the baccalaureate program, the time-to-degree, the influence of this education on patient safety, and the cost/benefit ratio to individuals and organizations. Innovative strategies to promote the access and flexibility of completion programs must be developed and studied. A critical look at the discourse of the discipline and the healthcare system at large to highlight implicit and explicit ways AD nurses are discouraged from returning to school is

important. Support from organizations to overcome the mixed messages given about the need for more education and the difficulty nurses have using new approaches learned in academic programs in practice settings are needed also.

In rural areas such as North-Central Michigan, collaborative conversations are particularly important because ADN programs educate the majority of the nurses in the region. While the nation considers ways to increase the education of the nursing workforce, care must be taken that the unique challenges of AD nurses living in rural areas, such as North-Central Michigan, are not overlooked.

Appendix A IRB APPROVALS



**INDIANA UNIVERSITY**

OFFICE OF RESEARCH ADMINISTRATION

**To:** PAMELA M IRONSIDE  
NURSING

**From:** IU Human Subjects Office  
Office of Research Administration – Indiana University

**Date:** December 06, 2011

**RE: EXEMPTION GRANTED**

Protocol Title: Understanding RN Workforce Education in the Rural North-Central Region of Michigan

Protocol #: 1110007216

Funding Agency/Sponsor: None

IRB: IRB-01, IRB00000220

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Your study named above was accepted on December 02, 2011 as meeting the criteria of exempt research as described in the Federal regulations at 45 CFR 46.101(b), paragraph(s) (2) . This approval does not replace any departmental or other approvals that may be required.

As the principal investigator (or faculty sponsor in the case of a student protocol) of this study, you assume the following responsibilities:

**Amendments:** Any proposed changes to the research study must be reported to the IRB prior to implementation. To request approval, please complete an Amendment form and submit it, along with any revised study documents, to [irb@iu.edu](mailto:irb@iu.edu). Only after approval has been granted by the IRB can these changes be implemented.

**Completion:** Although a continuing review is not required for an exempt study, you are required to notify the IRB when this project is completed. In some cases, you will receive a request for current project status from our office. If we are unsuccessful at in our attempts to confirm the status of the project, we will consider the project closed. It is your responsibility to inform us of any address changes to ensure our records are kept current.

Per federal regulations, there is no requirement for the use of an informed consent document or study information sheet for exempt research, although one may be used if it is felt to be appropriate for the research being conducted. As such, these documents are returned without an IRB-approval stamp. Please note that if your submission included an informed consent statement or a study information sheet, the IRB requires the investigational team to use these documents.

You should retain a copy of this letter and any associated approved study documents for your records. Please refer to the project title and number in future correspondence with our office. Additional information is available on our website at <http://researchadmin.iu.edu/HumanSubjects/index.html>.

If you have any questions, please contact our office at the below address.

Thank you.



**INDIANA UNIVERSITY**

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**OFFICE OF RESEARCH ADMINISTRATION**

**To:** PAMELA M IRONSIDE  
NURSING

**From:** IU Human Subjects Office  
Office of Research Administration – Indiana University

**Date:** January 30, 2012

**RE:** NOTICE OF EXPEDITED APPROVAL – AMENDMENT

Protocol Title: Understanding RN Workforce Education in the Rural  
North-Central Region of Michigan

Protocol#: 1110007216

Funding Agency/Sponsor: None

IRB: IRB-01, IRB00000220

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An amendment to your above-referenced protocol was approved by the Institutional Review Board on January 30, 2012. The protocol meets the requirements for expedited review pursuant to §46.11 O(b)(2). The changes described in the amendment can now be implemented, unless any departmental or other approvals are required.

If you submitted a revised informed consent document a copy of the approved stamped document is enclosed and must now be used.

You should retain a copy of this letter and any associated approved study documents for your records. All documentation related to this protocol must be maintained in your files for audit purposes for at least three years after closure of the research; however, please note that research studies subject to HIPAA may have different requirements regarding file storage after closure. Additional information is available on our website at

<http://researchadmin.iu.edu/HumanSubjects/index.html>. If you have any questions, please contact our office at the below address.

Thank you.

## APPENDIX B EMAIL RECRUITMENT SCRIPT

**To:**

**Subject:** Attention RNs of Northern MI

You are invited to participate in a research study designed to explore the meaning of being an RN with an associate degree. To be eligible for this study you must have an Associate Degree in nursing, have practiced for at least 8 years, and live in northern Michigan. Participation includes one face-to-face interview with an investigator. There will be a small monetary gift for participating in this study. An information sheet describing the study in detail is attached.

The study is being conducted by Pamela M. Ironside, PhD, RN, FAAN, advisor to Susan Owens, Doctoral Candidate at Indiana University. It is partially funded by a scholarship from the National League for Nursing/Jonas Center for Nursing Excellence Scholars program.

I hope you'll consider participating in this study! As national attention focuses on health care reform and transforming nursing education, it is imperative that the experiences of veteran AD nurses are understood. To arrange a convenient time for a confidential interview, please contact Susan Owens by replying to this email or by phone \_\_\_\_\_.

Thank you,

Susan Owens, PhD(c), RN

## APPENDIX C STUDY INFORMATION SHEET

IRB STUDY #1110007216

### INDIANA UNIVERSITY STUDY INFORMATION SHEET FOR

#### Understanding RN Workforce Education in the Rural North-Central Region of Michigan

You are invited to participate in a research study designed to explore the meaning of being an RN with an associate degree. You were selected as a possible participant because you have an Associate Degree in Nursing, have practiced for at least 8 years, and live in the North-Central Region of Michigan. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Pamela M. Ironside PhD, RN, FAAN, advisor to Susan Owens, Doctoral Candidate at Indiana University, RN. It is partially funded by a scholarship from the National League for Nursing/Jonas Center for Nursing Excellence Scholars program.

#### **STUDY PURPOSE**

The purpose of this study is to understand the meaning of being an associate degree nurse living in a rural area and what would it mean to get a BSN. This study will consist of the completion of a demographic data sheet and an audio-recorded interview.

#### **PROCEDURES FOR THE STUDY:**

If you agree to be in the study, you will do the following things:

You will be asked to complete a demographic data sheet. The study consists of an audio-recorded interview, lasting about 60 minutes at a location chosen by you. Susan Owens, Doctoral Candidate at Indiana University will conduct the interviews. You will be asked to relate your experiences and your thinking about being an associate degree nurse. It is possible that you would be contacted by phone following the interview for clarification or review of the interview text. If so, you will receive no more than one additional call. If you would prefer not to be re-contacted, please indicate by placing your initials here\_\_\_\_\_.

#### **CONFIDENTIALITY**

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and databases in which results may be stored. The audio-recorded interviews will be transcribed by the investigator (or designee) and then destroyed. Any identifying information from the interview will be removed or changed to a pseudonym on the written text. The transcripts will be shared with a research team consisting of the investigator, faculty members



experienced in hermeneutical or other qualitative research methods, and a transcriptionist. Transcripts will be identified with numbered codes only to maintain your anonymity. No personal identifiers will be detectable in any reports or publications from this study.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the Indiana University Institutional Review Board or its designees, the study sponsor, National League for Nursing/Jones Center for Nursing Excellence Scholarship, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP) who may need to access your research records.

## **PAYMENT**

You will receive payment for taking part in this study. After your interview you will be given a Meijer's \$25 grocery card.

## **CONTACTS FOR QUESTIONS OR PROBLEMS**

For questions about the study, contact the investigator Susan Owens at \_\_\_\_ or Dr. Pamela Ironside at \_\_\_\_.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

## **VOLUNTARY NATURE OF STUDY**

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with the investigators or Indiana University.

### **Are there any risks?**

It is possible that through discussion and recollection of your experiences, upsetting memories or thoughts could occur.

### **Are there any benefits?**

It is possible that you could experience a sense of satisfaction as a result of sharing your experiences, but otherwise there is no direct personal benefit to you.

## APPENDIX D DEMOGRAPHIC SURVEY

1. What is your current age? \_\_\_\_\_
  
2. How long have you been employed as an RN? \_\_\_\_\_
  
3. Where was your Associate Degree in Nursing program located?  
\_\_\_\_\_
  
4. What year did you graduate from your Associate Degree in Nursing program?  
\_\_\_\_\_
  
5. How many years did it take you to obtain your Associate Degree in Nursing,  
from the start of your first pre-requisite course to graduation? \_\_\_\_\_
  
6. Have you ever been an LPN? \_\_\_\_\_

APPENDIX E CONFIDENTIALITY AGREEMENT/TRANSCRIPTION SERVICES

I, Linda J. Morris, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Susan Owens related to her doctoral study on Understanding RN Workforce Education in the Rural North-Central Region of Michigan. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual or specific organization that may be inadvertently revealed during the transcription of audio-recorded interviews, or in any associated documents;
2. To not make copies of any recordings or computerized files of the transcribed interview texts, unless specifically requested to do so by Susan Owens;
3. To store all study-related recordings and materials in a safe, secure location as long as they are in my possession;
4. To destroy all recordings, electronic files and study-related documents as directed by Susan Owens from my computer hard drive and any backup devices in a complete and timely manner.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the recordings and/or files to which I will have access.

Transcriber's name (printed) Linda J. Morris

Transcriber's signature \_\_\_\_\_ )

Date January 12, 2012

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## CURRICULUM VITAE

**NAME:** Susan J. Owens

### **EDUCATION:**

<u>Degree Granting Institution</u>	<u>Degree</u>	<u>Date Awarded</u>
Hope College	B.S.N.	1984
Northern Michigan University	M.S.N.	1994
Grand Valley State University	F.N.P.	2001
Indiana University, Indianapolis, IN	Ph.D.	2012

### **ACADEMIC APPOINTMENTS:**

<u>Place</u>	<u>Title/Rank</u>	<u>Dates</u>
Kirtland Community College	Nursing Faculty	1994–2009
Ferris State University	Assistant Professor	2009–2012

### **CLINICAL APPOINTMENTS:**

<u>Place</u>	<u>Title/Rank</u>	<u>Dates</u>
Grand Traverse Community Hospital	Staff Nurse-Medical/ Surgical	1984–1985
Grand Traverse Community Hospital	Staff Nurse-Emergency	1985–1990
Mercy Health Services North-Grayling	Level III Staff Nurse-Emergency	1990–1995
Mercy Health Services North-Grayling	Clinical Coordinator Emergency	1995–1997
District Health Department #10	Nurse Practitioner	2002–present

### **PROFESSIONAL SOCIETIES:**

<u>Name</u>	<u>Dates</u>
American Nurses Association	1984–present
Michigan Nurses Association	1984–2005
Emergency Nurses Association	1988–2002
Registered Nurses Association in Michigan	2005–present
Sigma Theta Tau-Alpha Chapter	2008–present
Midwest Regional Research Association	2008–present



## **HONORS:**

2002 Michigan Campus Compact Contributions to Community Service-Learning  
2005 Trends in Occupational Studies Outstanding Educator Award

## **SERVICE:**

### Committee Service

Kirtland Community College representative for Michigan Nursing Faculty Summit, 2006–2008

Instructional Council, Kirtland Community College, 2003–2005, 2008

Ferris State University, College of Allied Health, Health and Safety Committee, August 2009–present, Chair, August 2011–2012

Ferris State University, School of Nursing, Clinical Task Force, 2009–2010

Ferris State University, University Professional Development, November 2010–present

Ferris State University, Academic Scholar Award Committee, 2012–present

Ferris State University, School of Nursing, Faculty Advisor, BSN Class of August 2012, 2010–present

Ferris State University, College of Pharmacy, Physical Assessment committee, 2010–2011

Ferris State University, School of Nursing Advisor to the Wellness Clinic 2011–2012

Ferris State University, School of Nursing, Ferris State Student Nurses Association Advisor 2011–2012

### Professional Service

Committee member for: Nichols, P (2000). *The effect of music intervention for the patient experiencing a minor procedure in the emergency department*. Thesis for degree of MSN, Grand Valley State University.

Committee member for: Weaver, B (2003). *The effect of therapeutic touch for the cardiovascular rehabilitation client*. Thesis for degree of MSN, Saginaw Valley State University.

RN-AIM Representative to the Michigan Association of School Nurses (MASN)–2008

Preceptor for MSN Nursing Education students, Fall 2006, Fall 2007, Fall 2008

Preceptor for MSN Nursing Education student, Spring 2011

## **Presentations**

“One Next Step: Using Stakeholder Management Theory to Increase the BSN Workforce.” Kirtland Community College, Grayling, MI; May 13, 2008.

“Your Next Step: Moving Beyond Your PN Certificate.” Kirtland Community College, Roscommon, MI, July 2, 2009.

“Head to Toe: Interprofessional Diabetes Education for Tomorrow’s Providers.” Ferris State University, Big Rapids, MI, November 19, 2009.

“How Did We Get Here & Why Do We Care?” Advanced Clinical Workshop, Ferris State University, Big Rapids, MI, May 17, 2010 and September 17, 2010.

“Building Blocks for Clinical Education” and “Continuing Education and Support” Basic Clinical Workshop, Ferris State University, Big Rapids, MI, August 23, 2010.

Dreifuerst, K. T., Owens, S. J. and Esch, M. “Exploring the Clinical Reasoning Skills of Pre-licensure and New-to-Practice Registered Nurses: Implications for Nursing Education Reform.” Midwest Nursing Research Society, Columbus, OH, March 26, 2011.

“Student Evaluation” Basic Clinical Workshop, Ferris State University, Big Rapids, MI, September 16, 2011.

“Understanding RN Workforce Education of the North-Central Region of Michigan” Institute for Heideggerian Hermeneutical Methodologies, Indiana University, Indianapolis, IN, June 13, 2012.

## **Posters**

Hillman, W., Pavelek, N., Owens, S., Girard, K., Mogle, B., & Smith, J. *QSEN Competencies. Let’s Talk about Nursing*, Kirtland Community College, Grayling, MI, May 13, 2009.

Owens, S. J., Singleterry, L., Colley, S. L., Morton, A. M., Teschendorf, M. E., *Bridging between classroom and clinical: Developing an advanced clinical teaching workshop*. Enhancing Nursing Undergraduate Teaching and Learning in the Clinical Setting: What do we know and how do we move forward? Robert Wood Johnson Foundation, Washington, D.C., October 20, 2010.

Owens, S. J., Singleterry, L., Colley, S. L., Morton, A. M., Teschendorf, M. *Bridging between classroom and clinical: Developing an advanced clinical teaching workshop*. Sigma Theta Tau International Spring Event. Kappa Epsilon Chapter, Grand Rapids, MI, March 29, 2011.

## **Community Service**

Health Director for Grayling Co-op Preschool 2006–2008

Coordinator for Nursing Service Learning at Kirtland Community College 2003–2009

Community representative for Think Tank, Crawford County Economic Development Partnership 2009–2010

Counselor at Camp Midicha, American Diabetes Association, June 2009

**RESEARCH:**

Owens, S. (1994). *The effect of triage nurse intervention for non-urgent emergency patients waiting for care*. Thesis for degree of MSN, Northern Michigan University.

Dreifuerst, K. T., Owens, S. J., & Esch, M. (2012). *Exploring the clinical reasoning skills of pre-licensure and new-to-practice registered nurses: Implications for nursing education reform*.

Owens, S. J. (2012). *Understanding the RN workforce education in the Rural North-Central Region of Michigan*. Dissertation, Indiana University.