NURSE RETENTION AND WORKFORCE DIVERSITY— Two Key Issues in New York City's Nursing Crisis

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The New York Academy of Medicine
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PREFACE

This report is based on a project conducted by the New York Academy of Medicine (NYAM) Office of Policy Development with funding from the New York City Department of Health and Mental Hygiene, through an allocation from the New York City Council for Fiscal Year 2006. During the period in which this project was carried out, I served as Director of the NYAM Office of Policy Development and as project director.

To assist with this project, NYAM convened a Nurse Retention Advisory Committee and a Task Force on Nursing Workforce Diversity The members of both groups provided important guidance for the project, both collectively (each group met once during the course of this project) and through individual consultation and input. In particular, the chairs of these two bodies—Connie Vance, EdD, RN, FAAN, who chaired the Nurse Retention Advisory Committee and C. Alicia Georges, EdD, RN, FAAN, who chaired the Nursing Workforce Diversity Task Force—gave freely and enthusiastically of their time and expertise. Both groups represented a diverse range of perspectives. Responsibility for the report's findings and recommendations should not be imputed to the committees or their individual members, but the project would not have been possible without the overall guidance, expertise, advice and support for the common goal of achieving a strong, stable, energized and diverse nursing workforce that they provided.

Other NYAM staff also played major roles in this project. Peri Rosenfeld, PhD and Richard Adams, PhD, both of whom were affiliated with the NYAM Division of Health Policy, designed and carried out research on nursing workforce trends based on data from the National Sample Survey of Registered Nurses. Dr. Rosenfeld also provided expert knowledge of issues related to retention of older nurses. In addition, Laura van Wyk, MA, who served as Executive Assistant for the Office of Policy Development during most of the project period, provided invaluable support.

Mary Ellen McCann, MS, RN and Daniel Doniger, MPH, MS, RN, both served as consultants to this project. Mary Ellen McCann conducted the interviews with nurse executives and other health care leaders which are discussed in this report and which yielded much important information. Daniel Doniger provided invaluable background research and analysis of issues related to workplace safety and benefits portability. Both displayed immense flexibility and enthusiasm, as well as considerable expertise and ability, in their work on this project.

Jeremiah A. Barondess, MD, who was NYAM President during this project, and Patricia Volland, MSW, MBA, NYAM Senior Vice-President, were instrumental in securing funding for the project. Dr. Barondess provided ongoing input and guidance to the project. His continued recognition of the critical role that nursing plays in health care delivery, and thus his support of this project, is deeply appreciated.

Jean Moore, MSN, of the Center for Health Workforce Studies at the University of Albany provided access to and analysis of nursing workforce data, along with ongoing, expert consultation. She, along with CHWS staff members Robert Martiniano, MPA, MPH and Sandra McGinnis, PhD were extremely and quickly responsive to requests (and occasional pleas) for assistance throughout the course of this project.

The Jonas Center for Nursing Excellence helped immeasurably in developing this report and disseminating the work of the project. However, thanks to Marilyn DeLuca, PhD, RN, CNA, the Center's Executive Director, its role went far beyond this. The Center developed this partnership into an opportunity to involve broader audiences in examining the nursing shortage in New York and designing responses to it. The establishment of the Center is a welcome and much-needed development for New York's nurses and for the diverse range of groups and individuals with an interest in the nursing workforce. As a convener and a common ground for those groups and individuals, it offers the hope of actually applying what we have learned through projects and reports such as this.

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EXECUTIVE SUMMARY

New York City, like the rest of the United States, is in the midst of a significant shortage of registered nurses (RNs), one which is projected to last well into the future. Eliminating or reducing the nursing shortage requires attention both to recruiting new nurses into the profession and retaining nurses in practice. Substantial efforts have focused on increasing recruitment. These have met with some success. However, recruitment alone cannot adequately address the shortage. Despite growth in enrollment, nursing schools face constraints on further expansion due to insufficient numbers of faculty, access to clinical sites, and other factors. In addition, many licensed RNs are not currently practicing nursing—in 2004, 16.6% of NYC-area RNs were not employed in nursing. Improving retention must be given high priority in efforts to confront the nursing shortage.

At the same time, ensuring an adequate nursing workforce involves more than focusing on the numbers of RNs in practice. Addressing the health care needs of New Yorkers also requires attention to other aspects of the nursing workforce, including educational preparation, experience, areas of specialization and geographical distribution. An area of particular concern is the racial and ethnic diversity of the nursing workforce—a critical issue in providing culturally and linguistically appropriate care for New York's diverse populations and for ensuring equal access to entry into the health professions for New Yorkers of all ethnic, national and racial backgrounds.

This report is the result of a project carried out by the New York Academy of Medicine (NYAM) Office of Policy Development, with funding from the NYC Department of Health and Mental Hygiene, to examine priorities for improving nurse retention and ensuring workforce diversity. The Jonas Center for Nursing Excellence has partnered with NYAM to disseminate these findings and to continue advancing a multifaceted approach to addressing the nursing crisis.

This project was assisted by an Advisory Committee of nursing and other health care leaders who provided guidance in examining retention issues and a Task Force of experts on nursing workforce diversity. The project also drew on current data from a number of sources and a series of interviews with nurse executives and other informants.

Key findings include:

- A large number of recent and current efforts have focused on improving retention. However, with some exceptions, these efforts are generally fragmented, with few mechanisms for evaluating their impact or for generalizing successful efforts.
- Improving nurses' workplace and practice environments is critical to encouraging retention. Several NYC-area hospitals have successfully sought designation as Magnet facilities and others are seeking Magnet designation. A basic element of achieving supportive practice environments is to treat nurses with respect—as one nurse executive put it, to "treat them like human beings."
- Different strategies and approaches are needed to address varying needs among nurses. Some employers have implemented residency-type programs of up to a year to assist new nurses in their transition into practice. Many have implemented 12-hour shifts, often in response to demand from their staff. Thus far, few employers appear to be focusing on the needs of older nurses, for whom longer shifts may be undesirable or unfeasible, and who often face increasing demands of caring for aging family members.
- While New York's nursing workforce is more racially and ethnically diverse than that of the U.S. as a whole, aggregate figures mask ongoing problems in access to entry to the profession for minorities and immigrants.
- In addition, the distribution of minority and immigrant nurses is uneven throughout the five boroughs and among institutions. Minority and immigrant nurses widely perceive being less welcome, and having fewer opportunities for advancement, in some facilities than in others. And these nurses remain underrepresented in executive, management, advanced practice and educator roles.
- The percentage of Hispanic nurses in NYC—less than 4%—while higher than the national average of 1.8%, is woefully small in a city that is approximately 27% Hispanic.

RECOMMENDATIONS:

- **Establish a coordinated, long-range, strategic approach to nursing workforce planning, including recruitment, retention and diversity**. This effort must involve all stakeholders. Serious consideration should be given to establishing a nursing workforce center on a local, regional or, more likely, statewide basis, similar to centers already established in over 30 states.
- **Improve data sources and collection.** Current data sources are inadequate, particularly for analysis of nursing workforce trends at the county or city levels. Initiating a survey of all registered nurses at the time of licensure renewal would provide an important and much-needed source of reliable nursing workforce data.
- **Move toward a profession-based approach to nurse retention.** Efforts to improve nurse retention should include the goal of career-long commitment to nursing as a profession, and not necessarily to a specific position, institution or type of facility or employer. While initiatives to improve retention must include efforts to retain nurses in hospital staff nurse positions, they should not be limited to such efforts.
- **Target improvements in practice environments and work-life** that emphasize respect, acknowledgement of contributions to patient care, ongoing professional development, and balance between nurses' work lives and outside commitments. Such efforts must take into account varying needs among nurses, including new graduates and older nurses.
- **Expand partnerships between practice and education, including enhanced opportunities for educational mobility**. Such partnerships can result in more seamless transition for new nurses entering practice, increased education and satisfaction for experienced nurses, and a source of clinical faculty to help expand nursing school capacity.
- **Develop benefits policies that reward years of commitment to the profession**, including portability of pensions and other benefits.
- **Establish ensuring racial and ethnic diversity of New York's nursing workforce as a major, ongoing priority.** Such diversity is critical to providing culturally competent and appropriate care and to ensuring equal opportunities for entry into the nursing profession.
- **Target increased representation of minority and immigrant nurses in leadership, advanced practice and faculty roles.**
- **Address the continued, significant underrepresentation of Hispanics among New York nurses** through targeted recruitment efforts, assisting Latin American immigrant health professionals with preparation for entry into the U.S. nursing workforce and efforts to ensure patient access to linguistically appropriate health care services.
- **Broadly replicate successful efforts by nursing schools and others to increase retention of minority nursing students.** Such efforts include providing mentorship and tutoring for high school, pre-nursing and nursing students enrolled in prerequisite and nursing school courses.
- **Initiate mechanisms to investigate and respond to ongoing concerns about racism and discrimination against minority and immigrant nurses.** Health care institutions, nursing schools, professional organizations and unions must share responsibility for openly discussing and addressing these concerns.
- **Develop and implement principles of ethical recruitment of nurses from other countries.** International recruitment should be guided by a commitment to integrating immigrant nurses into the workforce, ensuring equal opportunities, protecting them from deceptive recruitment practices, and balancing the needs of U.S. health care facilities with consideration for impact on source countries' health care systems.

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INTRODUCTION

By all accounts, the United States is in the midst of a significant shortage of registered nurses (RNs), one which is projected to last well into the future. Nationally, hospitals report an average vacancy rate of approximately 8.5% (American Hospital Association, 2006). While shortages of hospital staff nurses have received the greatest amount of national attention, shortages persist in other settings and roles as well—including a shortage of nursing faculty, which in turn constrains nursing schools' ability to expand their enrollment in order to help alleviate the shortage. The Bureau of Labor Statistics (BLS) predicts that more than 1.2 million new nurses will be needed by 2014 (Hecker, 2005). As of 2005, the RN vacancy rate in New York City hospitals averaged approximately 6.7% (GNYHA, 2006)--lower than the national level, but still substantial. Approximately 17% of actively licensed RNs in the New York City Primary Metropolitan Statistical Area (consisting of Bronx, Brooklyn, New York, Queens, Richmond, Westchester, Rockland and Putnam counties) were not employed in nursing in 2004, according to that year's National Sample Survey of Registered Nurses. In New York State, a total of 19.1% of actively licensed nurses were not employed in nursing in 2004.

A number of factors are cited as contributing to the shortage, including a growing demand for nursing services fueled by an aging population, a growing prevalence of chronic disease, a need for a increasing intensity of nursing services across patient care settings, continued growth of health care technology, along with a rapidly aging nursing workforce whose anticipated rate of retirement will further decrease the supply of RNs (Buerhaus, Donelan, Ulrich, Norman and Dittus, 2006; Heinrich 2001). The critical role that nurses play in all segments of the health care system has drawn considerable focus to the implications of the shortage. In light of a significant and growing body of research demonstrating the impact of nurse staffing on patient care outcomes, quality and safety (Hassmiller & Cozine, 2006; Agency for Healthcare Research & Quality, 2004; Page, 2002), the need to confront this long-range nursing shortage is particularly compelling.

While the U.S. has experienced shortages before, the confluence of all of the above factors is widely characterized as making this shortage different from others. While previous shortages have often dissipated suddenly, the current shortage has already persisted longer than its predecessors. Hospitals and other health care organizations describe a growing need for RNs, and in fact some have continued to create new positions.

The shortage is most commonly described in terms of the supply of RNs who are currently either working or seeking employment, balanced against demand—i.e., the numbers of positions that employers seek to fill (HRSA, 2005). Employer demand is influenced by a number of factors. While population need is one factor, other variables shape demand, including economic conditions, payor reimbursement rates, and other factors that help to shape managerial decision-making. All of this makes it difficult to be fully confident in any precise figures that are used to describe the state of the shortage now or in the future. But it is clear that the shortage presents a significant problem for the health care system and for the goal of ensuring access to high quality health care services.

Recruitment and Retention

Eliminating or reducing the nursing shortage requires attention both to recruiting new nurses into the profession and retaining nurses in practice. Substantial efforts have focused on increasing recruitment. These have met with some success—nursing school enrollments, which had steadily declined leading into the beginning of the shortage, have increased, and most nursing schools have had to reject large numbers of qualified students because the schools lack sufficient faculty or clinical sites to accommodate much larger numbers of additional students (American Association of Colleges of Nursing, 2005). Particularly given the constraints on expanding recruitment, improving retention must be given high priority. In order to address policy issues and options for improving nurse retention in New York City, the New York Academy of Medicine (NYAM), with funding from the NYC Department of Health and Mental Hygiene, examined factors contributing to nurses leaving the profession and current efforts to improve retention.

The project was guided by an Advisory Committee of nursing and health care leaders convened by NYAM (see Appendix I). The Advisory Committee, chaired by Dr. Connie Vance of the College of New Rochelle, met in February 2006 to provide initial ideas and focus for the project and assisted in providing and locating further information. Committee members continued to provide input into the project following the meeting.

The project also drew from other sources of data, including New York City –area data from the National Sample Survey of Registered Nurses for 1996, 2000 and 2004; data collected by the New York State Education Department survey of RNs in 2002; and data collected by the Center for Health Workforce Studies at the University of Albany.

In preparing this report, NYAM staff and consultants also collected data from several informants. These included semi-structured interviews with 15 nurse executive in a variety of facilities throughout the five boroughs. NYAM staff also drew information from other informants, including staff nurses, hospital executives, union leaders, educators and researchers.

The primary focus of this project was on nurse retention in New York City hospitals and home health agencies. Additional work on nurse retention should include other settings in which nurses practice, including nursing homes, public health services and schools

Workforce Diversity

Ensuring an adequate nursing workforce involves more than focusing on the numbers of RNs in practice—as important as this question is. Addressing the health care needs of New Yorkers also requires attention to other aspects of the nursing workforce, including educational preparation, experience levels, areas of specialization and geographical distribution. An area of particular concern is the racial and ethnic diversity of the nursing workforce—a critical issue in providing culturally and linguistically appropriate care for New York's diverse population and for ensuring equal access to the entry into the health professions for New Yorkers of all ethnic, national and racial backgrounds. Accordingly, as part of its project on the nursing workforce, NYAM also examined issues related to nursing workforce diversity in New York City. This work was guided by a Task Force on Nursing Workforce Diversity, chaired by Dr. C. Alicia Georges of Lehman College, which met in March 2006 to provide guidance to this project. (See Appendix II). These findings are addressed in Part Two of this report.

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PART 1. IMPROVING NURSE RETENTION

I. BACKGROUND

Traditionally, nursing has included many RNs who no longer practice their profession. Nationally, the percentage of RNs who are licensed but are not practicing has ranged between 16 to 19% in data from the National Sample Survey of Registered Nurses collected in 1992, 1996, 2000 and 2004. These data reflect nurses who have retained active licensure and does not include those who have allowed their licenses to lapse. Licensed RNs who are not employed in nursing cite several reasons for not practicing. The 2000 and 2004 NSSRN asked non-practicing RNs their primary reasons for not being employed in nursing. (Respondents could provide multiple reasons). In 2004, RNs in the New York City PMSA most commonly cited retirement as a reason for not being employed in nursing (31.8%), followed by taking care of family and home (30.1%), burnout/ stressful work environment (26.1%), physical demands of the job (22.7%), career change (21.5%) and inadequate staffing (20.1%). (Several other responses were each cited by smaller percentages of respondents).

These figures generally reflect the types of reasons cited in the literature and by professional and trade organizations for nurses leaving the profession or for stating an intent to leave in the near future (Heinrich, 2001).

- An aging nursing workforce includes large numbers who are approaching retirement age—notwithstanding the fact that many RNs leave the workforce before reaching traditional retirement age. The physical and emotional demands of nursing practice, particularly for hospital staff nurses, prove increasingly difficult for many nurses as they age. In many instances, years of job mobility mayhave eliminated the availability of a full pension at retirement, thus removing a potential incentive for remaining in the workforce longer.

- Family caregiving demands may pull younger nurses from the workforce in order to care for children; they may also pull older nurses from the workforce in order to care for aging family members.

- Working and practice conditions contribute to many nurses' decisions to leave the nursing workforce. Areas of concern include:

Retention of RNs in the workforce has a direct impact, of course, on overall RN supply. But loss of RNs from the workforce must also be understood as having an impact that goes beyond a numerical one.

◊ Loss of experienced RNs represents a loss of skill and expertise that is honed through years of nursing experience, as well as loss of a source of mentorship and training for new nurses and for other clinical staff.

◊ Loss of RNs from the nursing workforce (regardless of length of experience) squanders the significant investment of financial and human resources that go into educating nursing students. In particular, the loss of newer RNs—including those who leave in the first year or two of practice—undercuts the successes achieved by ongoing recruitment efforts.

◊ Replacement of nursing staff—whether an RN has left to take a new position, or has left nursing practice entirely—represents significant costs for hospitals and other health care organizations.

◊ Significant turnover is a source of instability in health care organizations and reinforces the idea that nursing is an inherently difficult or unsatisfying profession.

II. NATIONAL EFFORTS TO ADDRESS NURSE RETENTION

The Nurse Reinvestment Act

The Nurse Reinvestment Act (P.L. 107-205), enacted in 2002, authorized new federal programs to enhance the nursing workforce, and expanded federal nursing workforce programs' traditional emphases on recruitment and advanced practice, to include programs oriented to enhance retention. Total funding (including recruitment, retention, faculty loan forgiveness and other programs) for Fiscal Year 2007 stands at approximately $150 million.

The Magnet Recognition Program

Both nationally and locally, considerable attention has been focused on improving nurses' practice (or workplace) environments as a principal strategy for improving retention. The 1983 Magnet Hospital Study (McClure, et al., 1983), and the Magnet Recognition Program developed by the American Nurses Credentialing Center (ANCC) based on that study's findings, have largely supplied the criteria by which such supportive environments are defined and evaluated.

The original Magnet study, commissioned by the American Academy of Nursing, examined the characteristics of hospitals that enjoyed reputations as good places to work and which, despite a large-scale nursing shortage at that time, were successful in attracting and retaining nursing staff. (Kramer & Schmalenberg, 2005). Based in part on the Magnet study's findings, in 1991 ANCC launched a Magnet Hospital Program (now known as the Magnet Recognition Program) to certify hospitals which meet the program's criteria as markers of excellence in nursing care. The Magnet program's criteria also reflect the American Nurses Association's *Scope and Standards for Nursing Service Administrators.* (ANA, 2003). The Magnet program lists its objectives as:

- Recognize nursing services that use the Scope and Standards for Nurse Administrators (ANA, 2003) to build programs of nursing excellence for the delivery of nursing care to patients
- Promote quality in a milieu that supports professional nursing practice
- Provide a vehicle for the dissemination of successful nursing practices and strategies among health care organizations using the services of registered professional nurses
- Promote positive patient outcomes

(ANCC, 2006).

Applicant facilities are evaluated based on their implementation of 14 "Forces of Magnetism," which include the 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 the hospital, nurses as teachers, image of nursing, interdisciplinary relationships, and professional development. (Drenknard, 2005). Research has linked Magnet status with higher rates of nurse satisfaction (Brady-Schwartz, 2005) and improved patient outcomes. (Aiken, 2002)).

State Nursing Workforce Centers

Over the past 15 years, the number of state nursing workforce centers has grown from one—the North Carolina Center for Nursing, initiated in 1991—to over 30. These centers focus on collecting and analyzing data related to the nursing workforce, long-range strategic planning for addressing recruitment, retention and other workforce-related issues, developing and improving capacity for forecasting supply and demand and for nursing workforce policy development. In some states, nursing workforce centers also spearhead the development of state and regional recruitment and outreach programs. A consortium of state nursing workforce centers has organized three national conferences (the most recent of which was held in Jersey City, NJ in April 2006) and has recently begun focusing on collaborative and strategic efforts among centers, with the following goals:

- Assure standardized core nursing supply and demand data sets;
- Achieve consensus on the key elements in forecasting nursing supply and demand.
- Promote dynamic and strategically driven processes for nursing workforce long-range planning.

- Disseminate successful practices related to contemporary nursing workforce issues.
- Share resources related to creating and sustaining statewide nursing workforce entities.
- Provide a collective force for developing and disseminating state nursing workforce policy initiatives.

("Taking the Long View, A National Forum of State Nursing Workforce Centers," 2006).

These centers take a variety of forms. Some, such as the North Carolina Center for Nursing, are independent state agencies. Several are public-private partnerships, sometimes initiated by state legislative action and funded primarily through foundation support. Others operate entirely as private, grant-funded organizations. Generally, all of the state nursing workforce centers bring together a variety of relevant groups and individuals with varying perspectives and priorities related to nursing workforce issues.

Regulatory approaches

Several nursing organizations, including nursing unions, have pressed for legislative solutions to workplace problems, including nurse staffing levels, use of mandatory overtime, workplace violence and other health and safety concerns including risk of musculoskeletal injury from patient lifting. Based on the proposition that poor working conditions contribute to turnover and to nurses leaving the profession, proposals to regulate working and practice conditions are often framed as retention strategies. (ANA, 2006; AFT Health Care, 2004; Heinrich, 2001).

III. STATE AND LOCAL EFFORTS

The nursing shortage and issues related to it, including nurse retention, have been examined several times over the past few years. Among significant efforts to describe the shortage in New York, in 2001 the Healthcare Association of New York State (HANYS, 2001) surveyed staff nurses in several New York State hospitals to measure their level of engagement and outlined Best Practices surveyed hospitals were employing to increase staff nurse engagement. The New York State Board of Regents Blue Ribbon Task Force on the Future of Nursing issued a 2001 outlining reasons and potential solutions for the nursing shortage. In 2003, the New York State Education Department issued a report on the nursing shortage that included analysis of a 2002 statewide sample survey of RNs (New York State Education Department, 2003). In 2005, the Subcommittee on Nursing Shortages of New York State Senate Higher Education Committee issued its final report. (Subcommittee on Nursing Shortages, 2005).

Within New York City, a number of health care institutions, systems and nursing schools are involved in efforts to address the nursing shortage, some of them specifically targeting nurse retention. Some efforts are underway that span different institutions and systems. The Greater New York Hospital Association (GNYHA) Nurse Leadership group has served as a focal point for discussion among nurse executives and educators regarding priorities and joint initiatives. The recently initiated Jonas Center for Nursing Excellence, which focuses on nursing practice and the nursing workforce, is funding collaborative projects initiated jointly by nursing schools and hospitals (and home health agencies) as part of the Center's first round of grant-making. And the Brooklyn Nursing Partnership has recently been formed as a collaborative effort involving local hospitals, nursing schools, community organizations and policy-makers to address nursing shortage and workforce issues in that borough.

Nursing organizations have pursued legislative strategies to address working and practice conditions (The New York State Board of Regents Blue Ribbon Task Force on the Future of Nursing, 2001) including overtime, staffing, workplace safety and other areas. Nursing unions have also sought to address many of these issues through contract negotiations or collaborative efforts with employers.

IV. ISSUES IN NURSE RETENTION IN NEW YORK CITY

A number of prominent themes emerge from the data collected during the course of this project.

Developing and Sustaining Supportive Practice Environments

The Magnet Recognition Program

Four New York City hospitals have been accredited as Magnet facilities: the Hospital for Special Surgery, which was designated in 2002; Mount Sinai Hospital, designated in 2004; New York University Medical Center and Elmhurst Hospital Center, both of which were designated in 2005. (In addition to these four New York City facilities, Huntington Hospital and Good Samaritan, both in Suffolk County, were designated as Magnet facilities in 2004 and 2006, respectively, and St. Francis Hospital in Nassau County was designated in 2006).

Magnet status is widely viewed as an indicator of quality nursing care. Although not all observers may agree on how strong an indicator it is—i.e., whether it constitutes the "gold standard," as the Magnet program has marketed the designation, or simply indicates high quality, there appears to be general agreement that the designation is meaningful. Most Magnet facilities include their Magnet designation as a marketing and recruitment tool. Several nurse executives in Magnet and non-Magnet facilities indicated that they believe that Magnet designation attracts applicants for nursing positions, who see it as an indicator of good nursing care and a supportive environment. In fact, enhanced ability to attract new staff was cited by some nurse executives as a major reason to seek Magnet status.

Some nurse executives emphasized that achieving Magnet status does not in and of itself change the practice environment or organizational culture; rather, it recognizes what a facility has already achieved in these areas. Others, however, suggested that the process of preparing for and later seeking magnet status—generally referred to as embarking on the "Magnet journey"—can spark major changes within the facility and its practice environment. McClure (2006), an author of the original magnet study, notes that this is a subject of ongoing discussion among nurses involved in Magnet accreditation.

"Treat them like human beings"

Some of the major elements of the Magnet program and, more broadly, of the characteristics of supportive practice environments, appear to boil down to a need to treat nursing staff with respect. This was a common theme sounded by many nurse executives and other informants. One nurse executive stated that sustaining a supportive practice environment that encourages retention is not a complicated matter, explaining: "You have to treat them like human beings." Others characterized this as an application of basic principles of good management. Specifically, respondents consistently pointed to the importance of:

Supportive managers who are viewed by staff as a resource and who can respond to staff concerns and problems humanely and flexibly.

Visibility, open communications and transparency on the part of the Chief Nursing Officer and nurse managers. Some nurse executives emphasized the importance of regularly making rounds throughout the facility, of being approachable, and establishing open communications both in person and, increasingly, though e-mail.

Collegial relations and communications with physicians, which continue to be viewed as major factors in nursing staff satisfaction with their practice environment. The state of nurse-physician relationships appear to vary markedly between hospitals and to some extent between units. They also appear to vary among nurses. Some hospitals have instituted trainings to help staff nurses communicate effectively with physicians (for example, when calling an attending physician at night) and to avoid feeling intimidated. One nurse executive noted that this was helpful for newer nurses, while most experienced nurses found it unnecessary.

Participation in workplace decision-making. This can take many forms, from instituting shared governance models to soliciting staff input on uniform/dress code issues to working with architects and engineers to ensure that nurses' stations and

other workspaces accommodate staff needs and comfort. In some facilities, this has also meant evolving more collaborative relationships between nursing management and nurse unions.

Acknowledgement for good work and for contributions to patient care.
In different hospitals, this takes different forms—from formal "Nurse of the Year" banquets to awarding "good job" cards and gold stars, to simple verbal acknowledgement from managers, physicians or other colleagues. Some informants emphasized the effectiveness of small gestures (such as giving stars), while others characterized them as unprofessional and even insulting.

Transitioning from Student to Professional

Several informants noted particular concern with retention of nurses who have recently graduated from nursing school. The transition is a difficult one for many new nurses, who may be overwhelmed by the demands of caring for several acutely ill patients or who may encounter unwelcoming attitudes from other nurses. This "reality shock" has long been recognized and discussed (Kramer, 1974). Several nurse executives suggested that turnover among new graduates is especially high, with many leaving within the first three months.

Many hospitals provide extended periods of clinical orientation for new graduate nurses, which often vary depending on specific needs and circumstances. Others utilize extensive, more formalized, structured programs to support new nurses during their transition from student to professional. New York University Medical Center provides a year-long nurse residency program for all its new graduate nurses. (NYUMC currently hires only graduates of Bachelor of Science in Nursing [BSN] programs). (See Rosenfeld, Smith, Iervolino and Bowar-Ferres, 2004). The Visiting Nurse Service of New York (VNSNY) also offers an internship program for new graduates of BSN programs.

Other organizations focus on opportunities to prepare students for socialization into professional roles prior to graduation. Some have found that organized summer internship programs not only serve as a useful source of recruitment, but also help to familiarize students with the working and practice environment of that hospital, easing their transition following graduation and potentially increasing retention.

The Greater New York Hospital Association (GNYHA), with funding from the Jonas Center for Nursing Excellence, is developing a program whereby participating hospitals and nursing schools will restructure elements of the clinical component of nursing students' clinical education. As part of this program, students will go through a process of interviewing and "matching" with one or another hospital, which will serve as the site for the student's clinical rotations. Among other things, this program will seek to help socialize students into the work and practice environment of their "matched" hospital, with a goal of facilitating a more seamless transition into the professional nursing role following graduation.

This program may also help to identify changes in nursing students' clinical education that can help them to develop skills that are more congruent with hospitals' current demands and expectations. A common theme in many informant interviews was that experienced nurses and nurse managers believe that new nurses lack needed clinical skills and have unrealistic expectations regarding the scope of their responsibilities. The extent to which nursing education programs can balance preparing students for immediate workplace demands while continuing to focus on longer-range occupational, educational and professional needs is likely to require ongoing discussion.

Educational Mobility

Access to educational opportunities—particularly education leading to bachelor's and graduate degrees—was a consistent theme among nurse executives, educators and union leaders. Many hospitals and systems have sought to facilitate access to and enrollment in programs leading to a bachelor of science in nursing (BSN) degree for nursing staff who are educated at the associate degree in nursing (ADN) level. Some facilities and systems have sought to enhance access to

master's education for BSN-prepared nurses. A few hospitals have arranged for courses to be offered on-site. A private university currently offers graduate courses on-site at two Health and Hospitals Corporation facilities in Queens, with plans to expand these offerings to a private facility in Brooklyn. A union-administered benefits program has made arrangements with two City University of New York campuses to fund coursework leading to a masters degree in nursing for many of the union's nurse members. Another union has consistently negotiated tuition reimbursement as a hospital-supplied benefit in most of its contracts. (Tuition reimbursement is highly ranked as an important benefit in surveys of New York staff nurses. GNYHA, 2006; New York State Education Department, 2003). The chief nursing officer of one hospital noted that the availability of paid tuition for coursework at a nearby university is a benefit that is highly valued by that hospital's nursing staff.

The increasing demands of a complex health care environment—an aging, diverse patient population often presenting with multiple acute problems, growing use of patient care and information technology, increasingly sophisticated regulatory requirements and a growing focus on research and evidence-based practice—make nurses' access to higher levels of education a matter of growing importance. Although efforts by many nursing groups over the past 40 years to require baccalaureate nursing education for all registered nurses have been unsuccessful, proposals are currently being considered that would require nurses in New York State to obtain a baccalaureate degree within ten years of initial licensure (Keepnews, 2006).

Some informants suggest that many staff nurses who obtain graduate education, particularly when facilitated through their employing facilities or health care systems or through their union, do so in order to deepen their clinical skills and knowledge, or to move into higher-level clinical roles within their facilities or systems. It also bears consideration as a means of reducing the shortage of nursing faculty—thus helping to expand schools' capacity to educate new nurses. Some schools and hospitals have explored, or are currently developing, cooperative arrangements whereby master's-prepared nurses in participating hospitals receive academic appointments and can serve as clinical faculty. In particular, the Health and Hospitals Corporation has actively facilitated its hospitals' participation in such efforts, including taking steps to clear potential regulatory obstacles to their participation.

Work-Life, Economic Security and Benefits Issues

Flexibility and caregiving

While there has been considerable emphasis on nurses' practice environments as a factor in retention, other factors need to be taken into account as well, including the balance between work obligations and other priorities outside of work. Nurses with family caregiving responsibilities often face challenges in this respect. It is rare for hospitals to provide child care services, although one nurse executive indicated that her hospital will arrange for back-up child care when needed. As the nursing workforce continues to age, greater numbers of nurses are faced with responsibilities for caring for sick or frail parents. Preliminary research suggests that this is a growing concern for many New York nurses, and that without flexibility in work hours and other accommodation, many nurses find that these caregiving responsibilities threaten to pull them from the workforce (Rosenfeld, 2005.). Older nurses who leave the workforce to care for aging family members may be less likely than to return subsequently than, for example, nurses who leave to care for young children.

Salary

Nurses voice differing opinions regarding the importance of salary in retention. Research findings on this issue are equivocal; most recently, Kovner, Brewer, Wu, Cheng & Suzuki (2006) found that, among nurses they surveyed, salary was not closely related to nurse satisfaction. Among NYC-area non-practicing nurses responding to the 2004 NSSRN, 9.4% cited "low salaries" as a primary reason for not working nursing.

Some believe that overall, salary is not a major factor in nurses' decisions to leave, except when there are substantial salary differences between different hospitals or systems. While com-

parative salaries may play a role in some nurses' choice of employment, including a decision to leave one employer for another, it is not clear whether salary plays a role in nurses' decisions to remain in or leave the profession. In some surveys, nurses have ranked salary as less significant than factors relating to working and practice conditions. However, findings that examine salary as a comparative measure may be misleading; this ranking may speak more to the strength of nurses' concerns with these conditions than to a perceived lack of importance of salary. (Bergmann, 2006). Nationally, at least two health care unions, the American Federation of State, County and Municipal Employees (AFSCME) and the Service Employees International Union (SEIU), emphasize salary as a recruitment and retention issue, and SEIU has supported class-action litigation against hospitals in four cities for conspiring to depress nurses' wages (Greenhouse, 2006).

Benefits and portability

Benefits, including pension and health benefits, may also play a role in retention, at least for some nurses. In some large systems, such as HHC or the Veterans Health Administration, many believe that pension and health benefits contribute significantly to nurse retention—not only because of the relative richness of these systems' benefits packages, but because nurses (and other employees) can move freely within the system without any loss or disruption of benefits.

For many nurses, pension benefits have not been a source of great concern. Traditionally, nurses, like many women, paid relatively little attention to pension and economic security issues. For nurses, many of whom change jobs several times during the course of a career, mobility has often come at the expense of vesting or of building up a substantial retirement income.

Within nursing, there have been sporadic attempts to seek pension portability. Formulating strategies to achieve that goal have generally been made complicated by the variety of public and private employers for whom nurses work, and by the complex web of laws and regulations that apply to these entities. Pensions (and other benefits) may be portable. within some multihospital systems, or among some employers who bargain jointly with nurses' unions. In some industries, employer-funded pension plans are administered through a union pension fund, which allows portability between employers. However, these pension funds are generally found in industries which are completely or almost completely unionized, and in which employees are all represented by a single union. While most New York City hospitals are unionized, some prominent hospitals are not; further, within unionized hospitals, nurses are represented by several unions.

The nature of pensions has changed over the years as well. While many years ago, employer-provided, defined benefit pension plans (in which the employer agreed to pay a retiree a specified amount or a specified percentage of his or her salary) was the norm, this is no longer the case. Many employers today offer defined contribution plans (such as 401(k) plans), in which the employer contributes a percentage of the employee's salary, often requiring (or matching) a contribution from the employee as well. Defined contribution plans represent a more limited, less open-ended obligation for the employer (paying a percent of the employee's salary during his active employment, rather than being obligated to pay out a set amount for the rest of a retiree's life). Defined-contribution plans do not guarantee any particular level of support when an employee retires (among other things, the funds in the employee's account may grow or shrink depending on where and how the money has been invested). However, they are fully portable.

Recently, the New York State Nurses Association (NYSNA) sought legislation to include registered nurses among the positions considered to be "physically taxing" by the City of New York. This designation would entitle NYC-employed nurses to retire as early as age 50 with 25 years of service. The legislation (as A10273/S7238) passed both houses of the New York State legislature in 2006 but was vetoed by the Governor.

The role of pension and other benefits in nurse retention is not clear, and merits further examination. While portability of other benefits (including health, life and disability insurance) may not be as big a consideration as it is for pen-

sions, it should be noted that many part-time or per diem positions in nursing do not provide benefits. (The availability of benefits differs depending on employer policy and/or union contract, where applicable; availability of benefits for part-time positions often depends on the number of hours an employee is regularly scheduled to work). Lack of availability of such benefits may be a consideration for nurses for whom more flexible work hours are necessary or preferable (because of family obligations, school demands, age or other considerations)—for some of these nurses, access to benefits could provide an incentive to remain in nursing on less than a full-time basis rather than leaving altogether. Again, this is an area that requires further examination.

Flexible Scheduling

Ensuring availability of 12-hour shifts—most often referred to as "flexible scheduling"—was a consistent topic that arose in discussions of nurse retention. Longer shifts have become popular among a great many nurses, particularly because they mean reducing the length of the work week. For some nurses, this allows more time for family, educational or other demands outside the workplace. For others, it provides greater flexibility to work additional hours at another job. And for some, it may simply minimize the number of days devoted to tiring and stressful work.

What is consistently clear, however, is that there is great demand for 12-hour shifts. This demand is great enough that some nurse executives expressed concern that failing to offer such shifts may hinder their ability to retain and recruit staff. Availability of 12-hour shifts was ranked as a particularly important retention tool in the GNYHA 2005 staffing survey (GNYHA, 2006) has also been an issue in at least some union contract negotiations.

Some nurse executives express concern with potential scheduling complexities posed by 12-hour shifts, as well as potential costs. Some also express concern about impact on collegiality and cohesiveness among nursing staff. Some cited concerns about staff performance (and thus on patient safety) when working long shifts. Others noted the potential impact on older nurses, for whom 12-hour shifts may be undesirable or unfeasible (Hoffman & Scott, 2003). In fact, offering shifts of fewer than 8 hours has been suggested as a retention strategy for older nurses. Most nurse executives who discussed 12-hour shifts suggested that mixing 12- and 8-hour shifts on a single unit was not a tenable option, and some indicated that units on which nurses had requested 12-hour shifts were required to elect either 8- or 12-hour shifts for all nurses on the unit on an "all or nothing" basis.. In some hospitals, however, shifts of different lengths are employed in at least some units.

V. RECOMMENDATIONS

1. MOVE TOWARD A COORDINATED, LONG RANGE STRATEGIC APPROACH TO NURSE RECRUITMENT AND RETENTION

Efforts to address New York's nursing shortage, both by increasing recruitment and improving retention, are largely fragmented, focusing on specific employers or systems, or representing the perspectives of a specific groups—hospitals, educational institutions, nursing organizations and unions. (There are some important exceptions, including emerging partnerships between schools and health care facilities).

Successfully addressing the nursing shortage crisis will require broad efforts that go beyond individual initiatives, projects, and "best practices" approaches. These are important but insufficient. A coordinated and integrated effort is needed that can identify the kinds of broad changes that are needed—whether in practice environments, education, benefits structures or other areas; that can provide the evidence needed to design those changes, and develop strategies to implement them.

Further, in order to be successful, this effort needs to bring together a wide variety of groups and interests--from nursing, the health care industry, education, research, business and public policy. It also needs to take a long-range approach, optimally based on specific goals and timelines. Historically, attempts to address nursing shortages have been short-term and reactive, as enthusiasm for longer-term changes in education and practice dissipate when the shortage appears

to improve. This pattern has been problematic in the past and, if repeated, is a recipe for failure in addressing the current large-scale and ongoing shortage.

The specific form that a coordinated, long-range approach takes will require discussion among the many groups with an interest in resolving the nursing shortage. One option is the creation of a collaborative nursing workforce center on a city-wide, regional or, more likely, statewide basis. Such a center could draw on the experiences of nursing workforce centers in other states in developing long-term, strategic planning for addressing nursing workforce issues and policy development. The center could also serve as a point of coordination for current diffuse efforts.

2. IMPROVE DATA SOURCES AND COLLECTION

Current data sources on the New York nursing workforce are do not adequately support the level of inquiry and understanding needed for effective planning and policy development. The NSSRN is an important source of data, but using county-level data from the NSSRN presents significant methodological challenges. In addition, the availability of the data is unpredictable. The NYSED 2002 study yielded useful information, but it also presents challenges in analyzing county-level data and its utility as a one-time, four-year old study is limited. The current CHWS effort to survey nurses in participating hospitals offers the potential of more in-depth data about the hospital workforce. One proposal that has been raised as a means of improving nursing workforce data collection is to survey all nurses at the time of license renewal.

The Center for Health Workforce Studies possesses considerable expertise and experience in collecting and analyzing nursing data, but it faces constrained resources. It is notable that the major early priority for most state nursing workforce centers was to arrange for better and more available state nursing workforce data. A coordinated effort to address the nursing shortage could design and seek funding for more comprehensive data collection, building on the expertise that already exists in the form of CHWS and a cadre of workforce researchers in several academic institutions.

3. TARGET IMPROVEMENTS IN NURSES' PRACTICE ENVIRONMENTS & WORK LIFE

Improving working conditions, achieving supportive practice environments and providing for a sustainable work-life balance are key to improving nurse retention and long-term recruitment. A number of different strategies are required to achieve these objectives. Different areas of emphasis on the part of employers, unions, professional associations, educators and others should not obscure strong agreement on the importance of improving work/practice environments and work life, or to impede the formulation of common strategies in these areas. Establishing a common framework for recruitment and retention efforts—as identified in Recommendation 1 above—is of critical importance in this regard.

4. ADOPT A PROFESSION-BASED APPROACH TO NURSE RETENTION

Most efforts to improve nurse retention focus on keeping nurses employed within a specific institution or system. A focus on nurses' current places of employment is logical and, from the employer's perspective, understandable, particularly in view of the significant costs involved in replacing nurses who leave. But there is also a need for a broader view of retention—one that focuses on keeping nurses within the profession, not just within a facility or system. Some degree of mobility is to be expected and is even desirable, particularly inasmuch as it represents nurses availing themselves opportunities for promotion, specialization or movement into different sectors of the health care system. In fact, the potential for such mobility is an attractive feature of nursing.

Where dissatisfied nurses are able to find significantly better conditions at another facility, this can provide an incentive for employers to take steps toward improving their working/practice environments. The strong interest by large numbers of hospitals in seeking Magnet status suggests that many employers recognize the potential that recognition for achieving positive practice environments holds for enhancing recruitment and retention.

Efforts to improve nurse retention should include the goal of career-long commitment to nursing as a profession, and not necessarily to a specific job or employer. Such efforts should also recognize that movement into non-hospital settings and into roles other than staff nurse are important options for nurses. While initiatives to improve nurse retention must include efforts to retain nurses in hospital staff nurse positions, they should not be limited to such efforts.

5. DEVELOP PENSION AND BENEFITS POLICIES THAT REWARD YEARS OF COMMITMENT TO THE PROFESSION

Nurses who move between positions during the course of their career often face loss of full pension benefits; those who move to part-time or per diem positions may face loss of health insurance and other benefits. This is true even for nurses who make a career-long commitment to the profession but who change employers (and/or hours). Pension and benefits portability are available within government hospital or health systems and some private systems. Pension portability is also often available for nurses who move between facilities that jointly negotiate union contracts.

Industry-wide pension and other benefits policies could also promote a profession-based approach to nursing as well as signaling a broad, career-long commitment to nursing on the part of employers and, depending on the mechanisms through which such policies could be achieved, policy-makers as well. The diverse nature of the health care industry, which includes a range of public and private employers, and in which nurses (and other employees) are represented by many different unions (or by no union at all), greatly complicates the prospect of achieving consistent benefits policies and has stymied previous efforts to achieve pension portability. These remain areas that will require careful consideration and broadly collaborative efforts.

6. EXPAND PARTNERSHIPS BETWEEN EDUCATION AND SERVICE

Enhance opportunities for educational mobility

Nurses' demand for more education should be encouraged as much as possible. Hospitals and schools should be urged to continue to develop collaborative arrangements for on-site and on-line courses and for other flexible approaches to providing education to practicing RNs. Issues of cost and funding need to be considered carefully, and sources of external funding, including public funding, should be identified. Opportunities for advanced education should include doctoral studies for master's-prepared nurses. Educational opportunities should be structured such that nurses do not need to leave employment in order to pursue them. Most master's programs accommodate working nurses; increasingly, doctoral programs seek to do so as well.

Expand innovative partnerships

Efforts such as those being developed to utilize master's-prepared nursing staff as clinical faculty should be expanded wherever possible. These efforts can simultaneously address retention and recruitment, by developing and utilizing staff as new faculty without requiring or expecting them to leave their current positions. Partnerships such as these can also foster collaborative changes in both practice and education.

PART 2: NURSING WORKFORCE DIVERSITY — ISSUES AND PRIORITIES

I. BACKGROUND

As part of its larger project on the New York City nursing workforce, the New York Academy of Medicine (NYAM) examined issues related to nursing workforce diversity. To help provide guidance for this part of the project, NYAM convened a Task Force on Nursing Workforce Diversity. That Task Force met in person on March 24, 2006. Task Force members also provided guidance and input to NYAM staff to assist in preparing a report to outline current knowledge regarding workforce diversity, to outline issues of current concern, and formulate recommendations.

This report reflects initial efforts to address nursing workforce diversity issues in New York City. It should be understood that achieving clearer understanding of these issues (particularly as they apply to nursing in New York City) and identifying strategies for addressing those issues must be part of an ongoing, coordinated process. This report should be seen as a step toward that process.

It should also be emphasized that the Task Force served in an advisory capacity. The analysis and recommendations in this report should not be assumed to reflect the opinions of any individual Task Force member. However, the expertise and guidance of those members were invaluable in preparing this report.

Finally, it should be noted that while many types of diversity are important to a high-functioning, effective nursing workforce—including gender, sexual orientation, social class and others—these are outside the scope of this paper, which focuses specifically on racial and ethnic diversity.

II.. THE IMPORTANCE OF A DIVERSE NURSING WORKFORCE

An area of growing national concern

Over the past several years, increasing attention has focused on racial and ethnic diversity within the health care professions. In 2004, the Institute of Medicine released *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. (Smedley, Butler & Bristow, 2004). In the same year, the Sullivan Commission on Diversity in the Healthcare Workforce released its report, *Missing Persons: Minorities in the Health Professions*. Both reports detailed the need to increase racial and ethnic diversity within nursing, medicine and other health professions, and both outlined priorities for accomplishing this goal. Initiatives to address health care workforce diversity are ongoing through the Sullivan Alliance to Transform America's Health Professions, programs funded by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA), and programs funded by several philanthropic foundations, including the Jonas Center for Nursing Excellence.

While the population of the United States grows increasingly diverse, the health professions remain predominantly white and non-Hispanic. Nursing is no exception; according to the 2004 National Sample Survey of Registered Nurses (NSSRN), White, non-Hispanic nurses account for approximately 81.8% of RNs in the U.S. (HRSA, 2006).

In addressing the need for a more diverse health care workforce, the Sullivan Commission explained:

> The fact that the nation's health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans. Today's physicians, nurses, and dentists have too little resemblance to the diverse populations they serve, leaving many Americans feeling excluded by a system that seems distant and uncaring. In future years, our health professionals will have even less resemblance to the general population if minority enrollments in schools of medicine, dentistry, and nursing continue to decline and if health professions education remains mired in the past and—despite some improvements—inherently unequal and increasingly isolated from

> the demographic realities of mainstream America. Failure to reverse these trends could place the health of at least one-third of the nation's citizens at risk.

(Sullivan Commission, 2003, p.1).

Achieving a more diverse nursing workforce is important for several reasons. A diverse workforce can be better prepared to provide culturally appropriate care for a diverse patient population. A workforce that includes nurses who can communicate with patients whose primary language is other than English is better prepared to provide safe, quality care to those patients. Many believe that a diverse workforce can reduce health disparities (Brach & Frasirechter, 2000). In addition, a commitment to social justice and equity demands that access to entry into the health professions, including nursing, be open to individuals of all racial and ethnic backgrounds.

Nursing workforce diversity in New York City

While nationally, the nursing workforce remains overwhelmingly white and non-Hispanic, in New York City, the picture is different. Although precise figures are not available, the most recent data available—derived from the 2002 survey conducted by the New York State Education Department (New York State Education Department (2003)--suggest that approximately 56.5 percent of RNs in New York City are members of an ethnic minority group. The table below shows the composition of RNs in New York City:

It might be easy to glance at these figures and conclude that, with such a high percentage of minority nurses, nursing workforce diversity is not an issue for New York. Such a conclusion would be incorrect. These aggregate figures, as impressive as they may appear, provide an incomplete picture of the city's nursing workforce.

- The presence of large numbers of immigrant nurses, while an asset to the nursing workforce, make analysis of data on racial and ethnic diversity more complex. Significant barriers remain for many minority students in seeking entry into the nursing profession. And among minority populations, some groups—particularly Hispanics—remain markedly underrepresented in nursing.

REGISTERED NURSE WORKFORCE BY RACE AND ETHNICITY VS. POPULATION—
UNITED STATES, NEW YORK STATE AND NEW YORK CITY

	U.S Nurses[a]	U.S. Population[b]	NYS Nurses[c]	NYS Population[d]	NYC Nurses[e]	NYC Population[f]
White, non-Hispanic	88.4	67.9	70.1	62	43.5	5
Black, non-Hispanic	4.6	12.2	17.9	14.8	21.8	24.5
Hispanic	1.8	13.7	4	15.1	3.8	27
Asian	3.3	4.1	7.6	5.5	21.7	9.8
Native American	0.4	0.7	0.2	0.3	0.2	0.2
Other race	--	0.1	0.1	0.4	2.8	0.7
Two or more races	1.5	1.3	0.1	1.9	2	2.8

[a] Source: HRSA, preliminary findings from 2004 National Sample Survey of Registered Nurses. Figures are based on respondents who specified their racial/ethnic background and exclude the approximately 7.5 percent of respondents who did not so specify.
[b] Source: Annual Estimates of the Population by Sex, Race and Hispanic or Latino Origin for the United States: April 1, 2000 to July 1, 2004 (NC-EST2004-03). Population Division, U.S. Census Bureau. Release Date: June 9, 2005.
[c] Source: New York State Education Department (2003*). Registered Nurses in New York State, 2002 - Volume I: Demographic, Educational, and Workforce Characteristics*
[d] Source: U.S. Census Bureau, Population Division, 2000.
[e] Source: Brewer, C.S. and Servoss, T. *2002 Registered Nurses in New York State: County Level Nursing Data.*
[f] Source: U.S. Census Bureau, Population Division, 2000.

- The distribution of minority and immigrant nurses is uneven across the five boroughs and across health care institutions, such that some institutions are significantly less diverse than citywide figures suggest.

- There remain relatively few minority nurses in leadership positions in health care organizations and academic institutions, and minority nurses are significantly under-represented in management, advanced practice and faculty roles.

- Perceptions and reports of bias and discrimination in workplace settings persist among many minority and immigrant nurses.

II. CURRENT DATA SOURCES ARE INADEQUATE TO DESCRIBE NURSING WORKFORCE DIVERSITY

The growing diversity of the nursing workforce make the use of traditional survey approaches to measuring race and ethnicity progressively inadequate. For example, the National Sample Survey of RNs (NSSRN), conducted every four years by the Health Resources and Services Administration (HRSA), asks respondents to identify themselves as White, Non-Hispanic; Black, Non-Hispanic; Asian/Pacific Islander, Non-Hispanic; Hispanic/Latino; Native American/ Alaska Native, Non-Hispanic; or Two or More Races, Non-Hispanic (HRSA, 2006). This approach forces nurses of considerably different backgrounds into existing umbrella categories. Thus, for example, Japanese, Filipino, Indian, Taiwanese and Korean nurses (including those born abroad and those born in the U.S.), among others, are all grouped together as Asians, while Haitian, Trinidadian, Nigerian and U.S.-born African-American nurses, among others, are similarly grouped together as Black. The 2002 statewide sample survey of registered nurses conducted by the New York State Education Department (NYSED), uses similar racial/ethnic categories. County-level public use files collapse NSSRN data further into White and Non-white.

There are, of course, valid reasons for limiting these categories, particularly in conducting a sample survey. Expanding the numbers of categories might not only prove impractical, but could present methodological and potential confidentiality concerns. In fact, even with the use of aggregate categories, issues related to sample size pose important concerns for the use of county-level data for statistical analysis or for producing precise descriptive data.

These problems call for additional approaches to collecting and analyzing data on nursing workforce diversity that can yield more usable information. One proposal raised by some researchers, for example, is to survey all New York State registered nurses as they renew their licenses triennially. In addition, more qualitative research approaches may produce more detailed or nuanced information in some areas.

III. BARRIERS TO ENTRY INTO NURSING

Significant barriers remain for attracting minority and immigrant students into nursing. These barriers prevent many from entering nursing school and prevent many admitted students from successfully completing nursing school. Many applicants (and potential applicants) have received inadequate academic preparation, especially in mathematics, the sciences and English. The long-term solution to this problem lies in improving the quality of education available to minority students, children of immigrant families, and others who are disadvantaged by current educational opportunities beginning in primary grades and continuing through high school. However, some nursing schools have designed efforts to help students to strengthen their academic preparation, either through additional study prior to beginning nursing classes, through the availability of tutors and mentors, or some combination of these. One such program, the BEST (Becoming Excellent Students in Transition to Nursing) program at Hunter-Bellevue School of Nursing, provides mentorship and tutoring for high school, pre-nursing and nursing students to support their efforts in prerequisite and nursing school courses. The BEST program (http://www.hunter.cuny.edu/shp/nursing/BEST/) focuses on improving academic performance, learning more about culturally competent health care practices, engaging in

mentoring relationships within the New York City nursing community and developing leadership opportunities. Recently, the Lehman College Department of Nursing received a three year grant from the Jonas Center for Nursing Excellence to recruit Hispanic high school students and to retain and successfully graduate Hispanic baccalaureate nursing students.

In addition, while nursing school graduations in New York City reflect significant numbers of some minority populations, the distribution among schools is very uneven. In 2003-4, 43% of approximately 1,668 graduates of New York City nursing schools were Black. However, more than half of these students graduated from one of five schools; percentages of Black nursing graduates among all of the city's nursing schools varied from a low of 7% to a high of 90%. (IPEDS data, 2005). During this same period, 7% of nursing school graduates were Hispanic and 8% were Asian.

Many minority students may not regard nursing as a career option that is available to them. Outreach into minority communities through health fairs, visits to schools, and work with school counselors and community organizations may help to spark interest in nursing and assist students to focus early on seeking academic preparation for admission to nursing schools. However, the costs involved in attending nursing school—both the direct costs of tuition, books and supplies, and the indirect costs of decreased employment income while in school—remain a barrier for many minority, immigrant and low-income students.

IV. ADDRESSING DISPARITIES WITHIN NURSING

The large numbers of minority and immigrant nurses in New York City are unevenly distributed throughout the five boroughs and among health care institutions. Numbers of Black nurses, for instance, range from 36.8% in Brooklyn to 1.4% in Staten Island (NYSED, 2003). Specific figures regarding the distribution of minority and immigrant nurses in hospitals and other health care organizations are generally unavailable, but observational and anecdotal information suggest that significant numbers of minority nurses are concentrated in some institutions while larger numbers of white, non-Hispanic nurses are concentrated in others.

There are a number of factors that may contribute to this uneven distribution. For many nurses, geographic location, commuting time or convenience may play a role. For others, a desire to work in an institution or a system that serves large numbers of minority and underserved patients may also be a factor. In fact, *In the Nation's Compelling Interest* notes that "Racial and ethnic minority health-care clinicians are significantly more likely than their white peers to serve minority and medically underserved communities, thereby helping to improve problems of limited minority access to care." (p.29).

An important goal, however, is that the presence of large concentrations of minority nurses in settings that serve minority patients stem from those nurses' preferences, not from real or perceived limits on their career options. The perception that minority nurses are less welcome in some organizations, or that opportunities for advancement or more desirable assignments in some facilities or systems are limited, presents cause for significant concern. Members of the Task Force noted their own experiences and reports received from other nurses regarding racism and discrimination in hiring, assignment and promotion within New York health care facilities, as well as the overall reputations that some facilities hold with regard to the climate that minority and/or immigrant nurses encounter.

Minority nurses in the New York City area are significantly less likely than white nurses to be employed in managerial or advanced practice roles (32.6% vs. 45.2%; NSSRN data for Bronx, Brooklyn, New York, Putnam, Richmond, Rockland and Westchester counties, 2000). Minority nurses in leadership positions in health care facilities and academic institutions tend to be concentrated in those that serve largely minority populations. Minority nurses are significantly underrepresented in faculty roles. The lack of minority nurses in managerial, advanced practice and faculty roles limits the number and availability of

mentors and role models for minority students and constrains the level of cultural competence of many health care facilities and academic institutions. A smaller percentage of minority nurses holds masters or doctoral degrees (8.5% vs. 26.5%), limiting minority nurses' potential for career mobility within the profession.

A recent initiative by the New York University (NYU) College of Nursing focuses on training and mentorship to increase the numbers of Black nurses in leadership roles. NYU's Leadership Institute for Black Nurses, "seeks to empower nurses of African descent who seek career advancement in education, research and administration." ("NYU College of Nursing Launches Leadership Institute for Black Nurses," 2006). This initiative is noteworthy not only for its potential to increase the numbers of Black nurses in leadership positions, but also for its contribution to increasing visibility of the need to provide training and mentorship opportunities for emerging minority nurse leaders.

To date, there has been little systematic examination of minority and immigrant nurses' experiences and perceptions of bias and discrimination. Such research could help to measure and document these concerns s and could assist in designing interventions to address them.

Openly addressing and confronting issues of racism, and intervening in specific instances of discrimination, are essential to creating practice environments that truly support workforce diversity and that can adequately serve an increasingly diverse patient population. Examining and addressing these issues should be a priority for health care institutions and for professional nursing organizations and unions.

There are, of course, other issues related to workplace and practice environments that affect all nurses, including minority nurses. Minority nurses are no less affected by issues such as adequacy of nurse staffing, workplace safety or support from nurse managers than are other nurses. In fact, because larger percentages of minority and immigrant nurses work in staff nurse positions, they are arguably more affected as a group by these issues. Issues related to racism and discrimination, however, are also important aspects of the practice environment. Efforts aimed at assessing and improving nurses' practice environments should take these factors into account as well. In its *National Agenda for Nursing Workforce Racial/Ethnic Diversity*, HRSA's National Advisory Council on Nursing Education and Practice (2000) noted the need to "[c]reate and maintain workplace environments and employee support programs that promote and document recruitment, retention and advancement of minority nurses."

V. UNDERREPRESENTATION OF HISPANIC NURSES

Approximately 3.8% of New York City's registered nurses are Hispanic. In a city with a Hispanic population that currently stands at approximately 27% and which continues to grow rapidly, the under-representation of Hispanics in nursing is alarming. New York's Hispanic population includes large numbers of recent immigrants with limited proficiency in English and often with little knowledge of the complex U.S. health care system. There is a crying need for health care professionals who can communicate with Spanish-speaking patients and who can provide culturally appropriate care.

The reasons for such small numbers of Hispanic nurses are complex. Whereas percentages of Black and Asian nurses in part reflect large numbers of immigrant nurses, there has been little recruitment aimed at Latin American countries. Some analysts have suggested cultural factors that may serve as a barrier to recruitment of Hispanics into the nursing profession, such as the status of nursing in some Latin American countries. For new immigrants, proficiency in English may also be a factor.

New York City is home to many health professionals who have emigrated from Latin American countries but who, for one or another reason, are not licensed to practice in New York State. These include nurses, physicians and other professionals. While the actual number of these professionals is not known, they represent at least a limited pool of potential nurses. In Chicago, an initiative to assist Latin American immigrant nurses to become licensed as RNs has met with some suc-

cess; that initiative has expanded to include other immigrant groups as well. (Lebold and Walsh, 2006). In New York City, Lehman College is currently developing an initiative, funded by the new Jonas Center for Nursing Excellence, to help Latin American nurses to obtain licensure and to provide nursing education to Latin American physicians who are interested in seeking a career in nursing.

Absent large-scale recruitment of Hispanics into nursing, measures are also needed to ensure adequate communication between Spanish-speaking patients and health professionals. These include providing interpreter services for patients with limited English proficiency. Initiatives are also needed to expand the numbers of nurses with at least basic proficiency in Spanish. While this cannot substitute for increasing the availability of nurses with Spanish-language fluency or for the availability of professional interpreters, it can at least provide for basic patient-provider communication, especially for hospitalized patients.

VI. IMMIGRANT NURSES AND WORKFORCE DIVERSITY

New York, a city of immigrants, includes large numbers of nurses who have emigrated from other countries. Many of these nurses were educated abroad and recruited to work in the U.S. International recruitment has been a strategy for reducing nursing shortages for the past thirty years. New York's nursing workforce thus includes nurses who have been recently recruited to work here along with nurses who immigrated many years ago. While in years past, the great majority of internationally recruited nurses were from the Philippines, nurses now arrive from a broader group of countries, including India, Korea, China, Jamaica and Nigeria, among others.

Figures demonstrating the presence of large numbers of minority nurses in New York reflect the presence of many immigrant nurses—so that, for instance, the participation of Filipino nurses in the New York nursing workforce helps to account for the relatively high percentage of Asian nurses here. (By the same token, traditional racial/ethnic categories do not reflect the presence of some immigrant nurses, such as most Russian or Polish immigrants.) In addition, New York nurses include large numbers of immigrants who received their nursing education in the U.S. Mostly, these are individuals who arrived in the U.S. with their families, often as children or adolescents, and subsequently enrolled in area nursing schools. Data from the 2002 NYSED survey suggest that approximately 44.9% of New York RNs were born outside the U.S. However, approximately 23.8% of New York RNs were educated outside of the U.S.—meaning that approximately 21% of New York RNs are immigrants who received their nursing education in the U.S.

The presence of large numbers of internationally educated nurses poses some additional challenges as well. While internationally educated nurses must successfully sit for the same licensure examination required of all New York nurses (i.e., the National Council Licensure Examination, NCLEX), there is great variability among these immigrant nurses in terms of English proficiency, familiarity with U.S. medical and nursing terminology, relationships between health professionals, and other aspects of acculturation into U.S. society and the U.S. health care system. Many arrive with little preparation in colloquial English or for working with patients from a wide variety of ethnic and linguistic backgrounds. Some may also arrive with exaggerated expectations regarding benefits or working conditions, often as a result of misinformation received from recruitment agencies or other sources.

While wide-scale international recruitment has helped to ameliorate the effects of the current nursing shortage (as it has with previous shortages), there is increasing recognition that such recruitment comes at a cost to the health care systems of many source countries (Brush, Sochalski and Berger, 2004;Buchan and Sochalski, 2004).This is the case even with the Philippines, which traditionally has supplied the bulk of internationally educated nurses for New York and the rest of the U.S., but which is now experiencing shortages of its own in terms of adequate numbers of experienced and/or specialized nurses.

Internationally, the nursing profession has been working to establish principles to guide international recruitment, with the goals of protecting the health care infrastructures of source countries and ensuring ethical treatment of immigrant nurses. These include position statements and guidelines adopted by the Royal College of Nurses in the United Kingdom (Royal College of Nursing, 2003) and the International Council of Nurses (2002). In the U.S., there is increasing awareness and study of these issues, but thus far little action has been initiated toward adopting or acting on principles to guide ethical international recruitment policies.

VII. RECOGNIZING AND MAXIMIZING AVAILABLE RESOURCES

Greater coordination is needed to maximize available resources for increasing nursing workforce diversity in New York City, to identify and replicate successful efforts, and to identify needs and opportunities to press for additional resources.

Several New York City schools have received funding through HRSA's Nursing Workforce Diversity grant programs. In addition, the Jonas Center for Nursing Excellence, in its first round of grantmaking, is funding several local initiatives aimed at increasing workforce diversity. The recent move by the City University of New York (CUNY) to begin a doctoral program in nursing may provide greater opportunities to produce doctorally prepared nursing faculty, particularly in schools with high concentrations of minority students.

The New York City area includes active local chapters of national minority nursing organizations, including the National Black Nurses Association, the National Association of Hispanic Nurses, the Philippine Nurses Association of America and the Asian American/Pacific Islander Nurses Association,. Nationally, these organizations (along with the National Alaska Native American Indian Nurses Association) have formed a National Coalition of Ethnic Minority Nurses Associations (NCEMNA), through which they have identified areas of common interest and opportunities to support one another in membership development, research and other areas. In addition to these organizations, New York is also home to a newly formed Indian Nurses Association, and organizations for nurses from China, Korea, Nigeria and other countries. As a whole, these minority and immigrant nurses vary in terms of their levels of activity, numbers of members and their overall resources. NCEMNA provides a useful model that could be replicated on a local level, providing a stronger basis for collaboration, coordination and sharing of resources.

VIII. RECOMMENDATIONS

1. ESTABLISH ENSURING RACIAL AND ETHNIC DIVERSITY OF NEW YORK'S NURSING WORKFORCE AS A MAJOR, ONGOING PRIORITY

A diverse workforce is critical to achieving culturally and linguistically competent and appropriate health care services. It is necessary in order to ensure access to safe, quality care for all New Yorkers. It is also important, as a matter of social justice, to ensure access by minority and immigrant New Yorkers to entry into the nursing profession.

An ongoing effort is required to reduce barriers to effective recruitment and retention of minority nurses, to address problems related to bias and discrimination and to advance cultural and linguistic competency within New York's health care system. This requires ongoing coordination health care facilities and their trade organizations, nursing schools, professional associations, unions and policy-makers with the active engagement of minority nursing organizations. There is currently no structure in place for such a coordinated effort. These actors, working together with public and private funders, should seek to establish a means to develop and sustain ongoing efforts to advance nursing workforce diversity.

2. EXPAND RESEARCH—INCLUDING EFFORTS THAT GO BEYOND TRADITIONAL AGGREGATE RACIAL/ETHNIC CATEGORIES

The diversity of New York City's overall population and its nursing workforce cannot be adequately measured by the use of racial and ethnic categories that aggregate individuals of markedly different cultures, languages and countries of origin. Census-type approaches (such as a survey of all RNs at the time of re-registration), qualitative research, and other methods that can improve upon or supplement information currently available through existing survey approaches should be implemented.

3. TARGET INCREASED REPRESENTATION OF MINORITY AND IMMIGRANT NURSES IN LEADERSHIP, ADVANCED PRACTICE AND FACULTY ROLES

A diverse nursing workforce should include equal opportunities for professional and educational advancement. Representation of minority and immigrant nurses in a wide variety of roles, including those that require advanced educational preparation, would also demonstrate that nursing provides equal opportunities for career mobility for minority and immigrant nurses, and could thus serve to encourage greater recruitment from minority and immigrant populations.

4. INITIATE MECHANISMS TO INVESTIGATE AND RESPOND TO ONGOING CONCERNS ABOUT RACISM AND DISCRIMINATION AGAINST MINORITY AND IMMIGRANT NURSES.

Health care institutions, nursing schools, professional organizations and unions must share responsibility for openly discussing and addressing these concerns.

5. ADDRESS THE CONTINUED, SIGNIFICANT UNDERREPRESENTATION OF HISPANICS AMONG NEW YORK NURSES

New York City's Hispanic population is growing rapidly, while the percentage of Hispanic nurses in New York City—which has always been low—remains essentially stagnant. This is a major barrier to achieving cultural and linguistic competence in New York City's health care system. Targeted efforts to increasing recruitment of Hispanics into nursing are essential. These should include targeted outreach programs and efforts to address economic, cultural and legal barriers (including immigration status).

These efforts should also include initiatives to assist immigrant health professionals, including nurses from Latin American countries who have not yet passed the NCLEX, to prepare for careers as professional nurses in the U.S. In addition, widespread availability of interpreter services for patients with limited English proficiency is critical to ensuring access to safe, quality care for Spanish-speaking patients, particularly in the absence of adequate numbers of Spanish-speaking health professionals.

6. **BROADLY REPLICATE SUCCESSFUL EFFORTS BY NURSING SCHOOLS AND OTHERS TO INCREASE RETENTION OF MINORITY NURSING STUDENTS.**

As programs such as Hunter's B.E.S.T. and Lehman's programs to recruit more Hispanic nurses proceed, it will be important to evaluate their successes and determine how to replicate them throughout nursing programs in New York their successes and determine how to replicate them throughout nursing programs in New York and beyond.

7. DEVELOP AND IMPLEMENT PRINCIPLES OF ETHICAL RECRUITMENT OF NURSES FROM OTHER COUNTRIES.

Stakeholders and interested groups should be urged to take action on this. Many of the problems attached to international recruitment practices have been identified, and efforts in other countries provide models that can be followed in developing similar initiatives here.

REFERENCES:

AFT Health Care (2004). *Patient-to-Nurse Staffing Levels: Perspectives from Hospital Nurses.* Washington, DC: AFT.

Agency for Healthcare Research & Quality (2004). *Research in Action: Hospital Nurse Staffing and Quality of Care*. Accessed July 15, 2006 at http://www.ahrq.gov/research/nursestaffing/nursestaff.pdf.

Aiken, L. H. (2002). Superior outcomes for magnet hospitals: The evidence base. In M. L. McClure & A. S. Hinshaw (Eds*.), Magnet hospitals revisited: Attraction and retention of professional nurses* (pp. 61-81). Washington: American Nurses Publishing.

American Association of Colleges of Nursing. (2005). New data confirms shortage of nursing school faculty hinders efforts to address the nation's nursing shortage (press release). Retrieved July 16, 2005, from http://www.aacn.nche.edu/Media/NewsReleases/2005/Enrollments05.htm

American Hospital Association (2006). *The State of America's Hospitals—Taking the Pulse*. Chicago: AHA.

American Nurses Association (2004). *Scope and Standards for Nursing Service Administrators.* Silver Spring, MD: ANA

American Nurses Association (2006). Nursing Facts: Nursing Shortage. Accessed June 10, 2006 at http://www.ana.org/readroom/fsshortage.htm.

American Nurses Credentialing Center (2006). Objectives of the Magnet Recognition Program. Accessed 10/28/06 at http://www.nursingworld.org/ancc/magnet/index.html

Bergmann, B.R. (2006). *Curing the nursing shortage—the role of compensation. New England Journal of Medicine* 354(15):1648-9.

Brach, C. and Fraserirctor, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review 57(Supp.1),181-217.*

Brady-Schwartz, D.C. (2005). Further evidence on the Magnet Recognition Program. *Journal of Nursing Administration* 35(9): 397-403.

Brush B, Sochalski J and Berger A (2004).Imported Care: Recruiting Foreign Nurses to U.S. Health Care Facilities. *Health Affairs* 23 (3) 78-87.

Buchan J and Sochalski J (2004). The migration of nurses: trends and policies. *Bulletin of World Health Organization* 82 (8) 587-594.

Buerhaus. P.I, Donelan, K. Ulrich, B.T., Norman, L. & Dittus, N. (2006). State of the registered nurse workforce in the United States. Nursing Economics 24:1, 6-12.

Drenknard, K.N. (2005). Sustaining Magnet: Keeping the forces alive. *Nursing Administration Quarterly* 29(3): 214-222.

Greater New York Hospital Association (2006). *Survey of Staffing in GNYHA Member Hospitals, 2005.* New York, NY: GNYHA.

Greenhouse, S. (2006). Suit claims hospitals fixed nurses' pay. *New York Times,* June 21, 2006.

Hassmiller, S., & Cozine, M. (2006). Addressing the nurse shortage to improve the quality of patient care. *Health Affairs* 25(1), 268-274.

Health Resources Services Administration (2004). *What Is Behind HRSA's Projected Supply, Demand and Shortage of Registered Nurses?* Accessed June 27, 2006 at ftp://ftp.hrsa.gov/bhpr/workforce/behindshortage.pdf,

Healthcare Association of New York State (2001). *Health Care Recruitment and Retention Best Practices*. Albany: HANYS.

Hecker, D.E. (2005). Occupational employment projections to 2014. *Monthly Labor Review* November 2005: 70-101.

Heinirch, J. (2001). Multiple Factors Create Nurse Recruitment and Retention Problems. GAO-01-912T. Washington, DC: Government Accountability Office.

Hoffman, A., & Scott, L. (2003). Role stress and career satisfaction among registered nurses by work shift patterns. Journal of Nursing Administration, 33(6): 337-342.

International Council of Nurses (2002). *Position Statement: Ethical Nurse Recruitment.* ICN, Geneva, Switzerland.

Keepnews, D.M. (2006). A fresh approach to an old issue (Editorial). *Policy, Politics & Nursing Practice 7*(1): 4-5.

Kovner, C., Brewer, C., Wu, Y., Cheng, Y. and Suzuki, M. (2006). Factors associated with work satisfaction of registered nurses. *Journal of Nursing Scholarship* 38(1): 71-79.

Kramer, M. (1974), *Reality Shock - Why Nurses Leave Nursing*, St. Louis: Mosby.

Kramer, M. and Schmalenberg, C.E. (2005). Best quality patient care: A historical perspective on Magnet Hospitals. *Nursing Administration Quarterly* 29(3): 275-287.

Lebold, M.M. and Walsh, C.D. (2006). Innovations in Health Care Delivery: Response to Global Nurse Migration—An Education Example. *Policy, Politics &Nursing Practice,* 7 (3): 40S - 43S.

McClure, M., Poulin, M., Sovie, M. and Wandelt, M. (1983). *Magnet Hospitals: Attraction and Retention of Professional Nurses.* Kansas City, Mo: American Academy of Nursing.

McClure, M.L. (2005). Magnet Hospitals: Insights and Issues. *Nursing Administration Quarterly* 29 (3): 198-201.

National Advisory Council on Nursing Education and Practice (2000). *A National Agenda for Nursing Workforce Racial/Ethnic Diversity*. Accessed June 20, 2006 at http://bhpr.hrsa.gov/nursing/nacnep/diversity.htm .

New York State Board of Regents Blue Ribbon Task Force on the Future of Nursing (2001). The Future of Nursing in New York State: Addressing the Nursing Shortage. Accessed June 20, 2006 at http://www.op.nysed.gov/taskforcereport.htm.

New York State Education Department (2003). *Registered Nurses in New York State, 2002. Volume II: Organizational Climate Factors, Organizational Commitment, and the Culture of Retention.* Albany: University of the State of New York.

"NYU College of Nursing Launches Leadership Institute for Black Nurses," (2006). Accessed June 15, 2006 at http://www.nyu.edu/nyutoday/archives/19/09/PageOneStories/black-nurses.html,.

Page, A. (2004). *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington, DC: National Academies Press.

Rosenfeld, P. (2005). *Understanding Why Nurses Leave the Bedside: Does Informal Caregiving Affect Formal Caregiving?* Unpublished manuscript.

Rosenfeld, P., Smith, M.O., Iervolino, L. and Bowar-Ferres, S. (2004). Nurse residency program: A 5-year evaluation from the participants' perspective. *Journal of Nursing Administration* 34(4): 188-194.

Royal College of Nursing (2003). *Internationally recruited nurses : good practice guidance for health care employers and RCN negotiators*. London: RCN.

Subcommittee on Nursing Shortages of the New York State Senate Higher Education Committee (2005). *New York's Nurse Shortage Crisis.* Accessed June 1, 2006 at http://www.senate.state.ny.us/SenateReports.nsf/6DD2F2819E02BB6185256EBD004E2D20/A007460B44BB6C9B8525700400514036/$file/Nursing.pdf?OpenElement .

Sullivan Commission (2003). *Missing Persons: Ethnic Minorities in the Health Professions.* Accessed June 2, 2006 at http://www.aacn.nche.edu/Media/pdf/SullivanReport.pdf

Taking the Long View: A National Forum of State Nursing Workforce Centers. Accessed June 28, 2006 at http://www.nursingworkforcecenters.org/

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