Sustaining Nursing Programs in the Face of Budget Cuts and Faculty Shortages

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When asked what their major problems are, many nursing deans would state that they are very concerned about budget cuts and faculty shortages. Yet, there is little, if anything in the literature describing how administrators are dealing with these problems. This article describes three strategies that we employed to address these issues. The first strategy, our home hospital program, involves qualified hospital staff serving as clinical instructors. The second strategy, a collaborative on-line doctor of nursing practice program, reduces the number of courses our faculty must teach, while ensuring adequate numbers of students. Lastly, differential fees is a strategy whereby students enrolled in high-cost educational programs (e.g., nursing) pay greater fees but reap supportive benefits that increase their success in the program. These strategies have allowed us to enhance our educational programs despite budget cuts and faculty shortages. (Index words: Faculty shortage; Funding; Nursing faculty; Clinical partnership; Collaborative program; Differential fees) J Prof Nurs 30:5–9, 2014.

DURING THE LAST 4 years, most of the public universities across the country have faced major budgetary cuts. This has direct influence on the future health care workforce and the ability to educate health care providers, especially those in high-cost programs such as nursing. Consequently, the future registered nurse (RN) workforce is in peril. For example, California has one of the lowest RN:population ratios (857:100,000; U.S. Department of Health and Human Services Health Resources and Services Administration, 2010) in the country and typically produces more than 6,000 new RNs each year (Bargagliotti, 2009) but is also experiencing one of the largest state budget deficits in the U.S. As one of the larger producers of RNs in the country, a decrease in production in California will have consequences for the surrounding states who import nurses from California, notably Nevada (with the lowest RN:population ratio of 688:100,000).

Concurrently, there is a severe shortage of nursing faculty that affects the ability to educate future nurses, especially at a time when an increased need for RNs is expected—a fact well-documented in numerous publications and summarized in the American Association of Colleges of Nursing, Nursing Shortage Fact Sheet (American Association of Colleges of Nursing, 2012). In response, leaders of nursing education institutions have developed numerous strategies to combat the nursing faculty shortage (Reinhard & Hassmiller, 2011).

Such strategies have been systematically reviewed and fall into four categories: advocacy (mass media, workforce data, and policy); educational partnerships (school-to-school, multisector); academic innovations (nontraditional faculty, technology, and new curricula); and funding (public, philanthropy, and health care industry; Allan & Aldebron, 2008). In addition, the doctor of nursing practice (DNP) has been offered as a partial answer to the nursing faculty shortage (Danzey et al., 2011). Although a reasonable approach, Kelly (2010) doubts that this will solve

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http://dx.doi.org/10.1016/j.profnurs.2013.07.002

the problem primarily because these clinically oriented nurses can earn more by remaining in the current roles rather than assuming academic positions. She believes that money is the "driving force of the faculty shortage" (p. 269). Lastly, we have previously described our successful efforts to increase nursing faculty salaries at the University of Nevada, Las Vegas (UNLV; Yucha & Witt, 2009), but still suffer from a faculty shortage. Perhaps, this is because UNLV offers the only nursing doctor of philosophy (PhD) program in the state and, therefore, must import doctorally prepared faculty from other states at a time when faculty are hesitant to relocate. With the exception of the dedicated education unit mode, the literature describing partnerships approaches to clinical education is limited (Teel, MacIntyre, Murray, & Rock, 2011); and even these papers do not describe the financial model supporting the dedicated education unit in sufficient detail to be useful to others.

In this article, we describe three strategies that we have used to address both budget cuts and faculty shortages. While others are using similar strategies, the published literature does not contain specific and detailed information about how these activities increase income and conserve faculty effort. For example, De Geest et al. (2012)) describe two models of funding academic service partnerships. They highlight the need for a common vision, shared leadership, communication, visible senior leadership, commitment, and trust but also report that they did not find any detailed descriptions of the financial framework that supports these partnerships. In this article, we provide very specific information about these approaches. These strategies are sustainable, replicable, and relatively easy to implement by individual institutions. The first, known as the home hospital program, is an educational partnership between two universities and private hospitals in southern Nevada and is described below.

Home Hospital Program

The Home Hospital Partnership is an innovative clinical teaching model that offers multiple benefits to students, the hospital community, and UNLV (Yucha, Kowalski, & Cross, 2009). Rather than rotate through numerous clinical sites, students stay within the same hospital for most of their clinical experiences. This limits the time spent in orientation and allows them to become familiar with the setting so that they can focus on patient care. Hospitals then have the same students at their facility over multiple semesters, and students are likely to accept nurse apprentice positions and eventually apply for employment at these hospitals. To aid this partnership, the university assists in clinical instruction, policies and procedures, and learning opportunities for students.

Financial Model

As in most nursing programs, one clinical credit is equal to 3 hours per week or 45 hours per semester. We believe that clinical instructors need approximately 1.5 times the students' clinical time for making patient assignments and grading care plans. The school pays the hospital $2,500 per clinical credit taught by hospital staff.

However, this program should be started slowly. An additional group of students should be added to the home hospital program each semester. This allows the hospital administration and nursing managers to plan for and staff the program. Table 1 shows the progression of implementation over four semesters, the courses and credits involved, and the cost of the program to UNLV.

When the program is in full operation, UNLV pays the hospital $116,250 to provide 16.5 credits of clinical instruction each semester for three semesters. Without this program, the university would need to hire two faculty members to cover these clinical credits, but this cost is actually less than the 12-month salary and benefits for one faculty member. Therefore, UNLV saves money and receives help with clinical instruction.

Challenges

This program has been tried at four different hospitals and works better where there is administrative support for the program, an adequate supply of Master of Science-prepared staff, and an organizational commitment to education. When the chief nursing officer is able to use the funds for nursing staff development or other initiatives, he or she is far more likely to support this program.

In Nevada, the state board of nursing requires that clinical instructors have a bachelor of science in nursing (BSN) and an MS in nursing or a health-related field. Some hospitals may not have a sufficient number of MS-prepared staff who are willing and able to implement this program, especially within specialties.

It has also been difficult in some cases to find time to orient the home hospital clinical instructors to our curriculum, expectations, and policies/procedures related to students. To address this, each clinical instructor is assigned a full-time faculty member who oversees the clinical course. This faculty member is responsible for providing guidance and support to the clinical instructor.

Collaborative DNP Program

There are two public universities in Nevada; one is located in Las Vegas and the other in Reno, approximately 8 hours away from one another via car. In response to the American Association of Colleges of Nursing position statement (American Association of Colleges of Nursing, 2004), both schools were hoping to start DNP programs. Yet, it was recognized that proposing two competing programs in a state with a small population would not be financially responsible. Therefore, a plan was created to offer an on-line collaborative program wherein courses would be shared between the two universities.

In 2009, when we were ready to propose the program to the Nevada Board of Regents, Nevada was suffering from a nationwide recession. Therefore, we proposed the program as a self-sustaining program, whereby no state funds were required because the tuition/fees would cover all of the costs.

In brief, the Nevada DNP program is a 39-credit postmaster's degree program with two tracks, nurse executive and advanced practice. Because there is one 3-