



### *Washington State's nursing workforce in the context of COVID-19: Do we have a nursing workforce to meet the challenge?*



By Sofia Aragon, JD, BSN, RN, Executive Director, Washington Center for Nursing

With the UW Center for Health Workforce Studies, the WCN is releasing a series of reports about the characteristics of the state's supply of nurses. The first to be released is entitled [Washington State's 2019 Registered Nurse Workforce](#). Soon to follow

are similar reports on Licensed Practical Nurses (LPNs) and Advanced Registered Nurse Practitioners (ARNPs). In the midst of COVID-19, what questions do these survey results raise in terms of the nursing workforce's ability to respond to emergencies?

As the state's nursing workforce center, we have a privileged position in the nursing community. Our network of nursing organizations such as the WA State Nurses Association, the Northwest Organization of Nurse Leaders, the Council on Nursing Education in WA State, nursing unions, nurse practitioners, ethnic nurses associations, school nurses, public health nurses, the state board of nursing, and others provide the WCN with a bird's eye view of how nurses are responding to COVID-19.

The crisis in our state began in a long-term care facility called Life Care in Kirkland, WA. The Centers for Disease Control published a [Morbidity and Mortality Weekly](#) edition on March 18th in response to events at this facility. According to the 2019 RN report, only 9.6% of the state's registered nurses (RNs) work in long-term care. The state of WA passed legislation to increase the number of RNs working in long-term care facilities on a 24-hour basis. However, long-term care organizations have struggled to recruit the necessary RNs. In a [2018 survey of RNs](#) done by UW and WCN, long-term care nurses reported tending to feel more overwhelmed at work, with hospitals at a distant second.

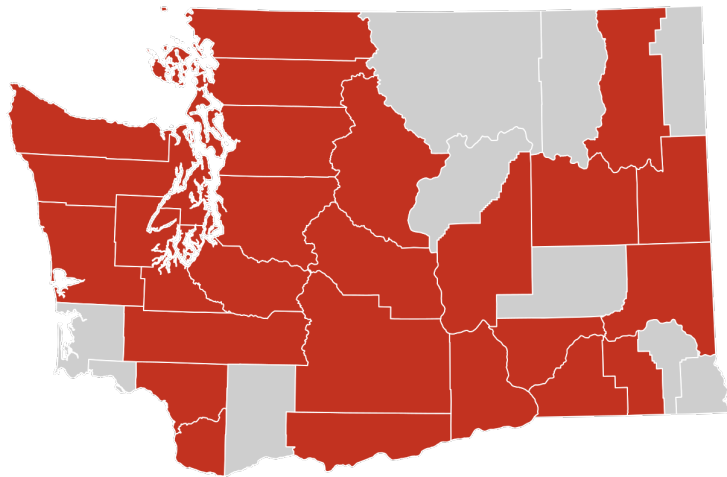
LPNs have long been both critical staff and leaders in the long-term care system. While we await the results of a survey of LPNs, we expect to see a trend we've been

seeing for over a decade: a steady decrease in the numbers of LPNs of about 1,000 per year. WCN is committed to further studying and elevating the role of the LPN workforce moving forward.

Meanwhile, the public hears of efforts to conserve hospital resources for those with the most acute care needs. Fifty-six percent of WA's RN workforce are employed in hospitals. Despite being the major employer, hospitals are having to boost recruiting efforts. This raises the question of surge capacity. The American College of Emergency Physicians (ACEP) defines surge capacity as the ability to manage a sudden influx of patients. It depends on a well-functioning incident management system and the variables of space, supplies, staff, and any special considerations such as contaminated or contagious patients. Surge capacity needs to be measurable (ACEP, 2017). Reports of COVID-19 response not only highlights challenges in meeting patient care needs but also system gaps that put nursing staff at risk. A sad example is the shortage of protective personal equipment and tests for the virus.

A balance of population health and community-based strategies, as well as a strong acute care system, are needed to effectively manage a pandemic response. Alarming, only 1% of RNs work in public health. Public health is the science of keeping our communities and populations healthy. Most relevant to the current situation, public health nursing keeps communities and populations healthy through disease prevention and response, disaster response, and emergency preparedness. Persistent and severe funding gaps in the public health system are now apparent to lawmakers, resulting in \$225 million in emergency expenditures for COVID-19 response during the 2020 legislative session.

Only 5.5% of RNs work in community health, the majority of whom are school nurses. While schools are closed in response to COVID-19, there continues to be medical and health needs for children in school-based



childcare. In addition, school nurses are proactively planning for school re-opening and the development of policies to improve school health as a result of the COVID-19 experience. Examples are:

- Coordinating with the National Centers for Disease Control and Prevention on adopting consistent public health messaging to students, parents, and staff
- Checklists and protocols for daily self-screening of staff prior to returning, guidance for staff over the age of 60 with or without underlying health conditions
- Nutrition-related safeguards and precautions. Examples are shared utensils for salad bars, sneeze guards, hand sanitizing stations available at cafeteria entrances
- Messaging on social distancing and other safeguards when restarting extracurricular activities such as sports, drama clubs, and other activities
- Guidance for teachers and specialists (occupational therapy, physical therapy, paraprofessionals, music teachers, PE teachers and others) to be cognizant of students who may be reporting or exhibiting symptoms during the school day

With health care facilities giving their undivided attention to COVID-19 response, nurse educators and nursing students are faced with the sudden halt of clinical practice sites, which threatens timely graduation and licensure of graduates, further exacerbating immediate nursing workforce needs to respond to the pandemic. The state's board of nursing, the Nursing Care Quality Assurance Commission, is working with nursing education to encourage nursing students to register as nurse technicians. This enables nursing students to assist with

nursing duties up to their level of education and documented skill level, under the supervision of a qualified RN. After graduation, students are also encouraged to apply for emergency interim permits allowing the applicant to work as a nurse during the declared emergency.

In an increasingly global community, assessing the capacity of the nursing workforce becomes complex. COVID-19 response is one example of the need for a nursing workforce that is responsive to health challenges both at times of peace and at times of emergency. Having sufficient numbers of nurses is only part of the solution. The nursing workforce must also be equipped to handle the range of challenges presented.

COVID-19 has demonstrated nursing's role in a variety of areas that directly impact the quality of prevention and response efforts:

- Strengthening infection control and prevention in long term-care and other facilities
- Care of persons with chronic underlying medical conditions
- Identifying and potentially excluding infected staff members and visitors and identifying exceptions
- Management of supply chain issues that impact the availability of personal protective equipment
- Taking steps now to develop or strengthen population strategies such as consistent adoption of policies to address health needs of populations like the elderly or children in the school environment
- Implementing health technology such as telemedicine to provide care and conserve the use of PPE and predominantly facility-based services
- Regulatory strategies to address disruption in nursing education and allowing properly credentialed out-of-state nurses to work in WA to increase response capacity

As the largest profession, RNs are positioned to work with experts and communities to develop and initiate effective responses, evaluate the effectiveness of strategies, and to provide public education on the importance of adopting effective measures into daily living. In addition to sufficient numbers of nurses, supporting their role to take action to plan for, prevent, and address situations like COVID-19 response is an indicator of a nursing workforce that can meet health challenges facing communities.

Reference: American College of Emergency Physicians. (2017). Health Care System Surge Capacity Recognition, Preparedness, and Response. Retrieved from <https://www.acep.org/patient-care/policy-statements/health-care-system-surge-capacity-recognition-preparedness-and-response/>

# Emerging Leaders in Nursing

## An Interview with Jingyi (Cindy) Dong, BSN, DNP Candidate

Speaking with men and women who are driven by a passion to help others be and live healthy lives is always inspiring. But some of the nurses we talk with don't just jump into the challenges of nursing with fortitude—they are also driven to lead and mentor others along the way—ultimately forging systematic changes in health care that benefit every person living in Washington State.

Jingyi (Cindy) Dong, a UW Bachelor of Science in Nursing (BSN) graduate working towards her Doctor of Nursing Practice (DNP) degree also at the UW, exemplifies this energy.

Cindy has been employed as a nurse at a Swedish Family Medicine clinic for the past two and a half years. In addition to returning to school to study for her DNP, in 2017, Cindy co-founded the Pacific-Northwest Chinese Nurses Association (PCNA, [contact.pcna@gmail.com](mailto:contact.pcna@gmail.com)), which now supports around 200 members.

WCN recently sat down with Cindy to get her experience. Here is what she had to say.

**WCN:** What inspired you to pursue a career in nursing?

**Cindy Dong:** My dad is a doctor and my mom is a nurse, and as a child, they did an amazing job of sharing with me the spirit and essence of nursing. My mother is my role model. She helped infuse in me the conviction that there are three phases to medicine; “To cure sometimes, to relieve often, to comfort always.” In medicine, there are often limitations to how far we can go in curing someone. To do our best, we should be humble. Nursing offers opportunities to fill in some of the voids in care including offering relief to patients. But this idea of “to com-



Left: Cindy Dong, Right: WCN ED, Sofia Aragon, Rose DeGacia, Cindy Dong

fort always” is what really drew me to nursing.

**WCN:** You were fortunate to have a nursing role model in your mother, what did she show you?

**Cindy Dong:** My mother showed me that there are many different paths in nursing and to keep advancing throughout your career. My mother was a floor nurse, then a scrub nurse, then a legal nurse, and finally became nursing faculty before she retired.

**WCN:** What are some challenges or difficulties you've had to overcome to become a nurse?

**Cindy Dong:** I came to America on my own when I was only fourteen. It was a decision I made to study abroad, and I attended a private boarding school in Virginia. Of course, it was a challenge overcoming the language and cultural barriers in America. In China, I was expected to be obedient and that was no longer valued in America. It took me some time, but I finally learned to speak my ideas and thoughts and be more open and not afraid to make mistakes in front of other people. This new trait was extremely important once I became a nurse because nursing is not

about being obedient; it is about speaking up and advocating for my patients.

**WCN:** What do your parents think about what you have accomplished so far?

**Cindy Dong:** They are very proud of me now. But it took a while. When I first told them I wanted to be a nurse in America, they were not happy. In fact, my grandma cried in disappointment when I told her I was accepted into UW's BSN program. During my freshman year in college, I took a lot of pre-nursing science, biology and chemistry classes, but I told my parents at the time that I was taking business classes. They did not want me to be a nurse at all because their assumption was that nursing was a very hard, very low paying job, because that is the way it is in China. But in America it is different. Nurses still work very hard, but the pay is much better, and nursing is a well-respected profession here.

**WCN:** Why do you think diversity is important in the nursing workforce?

**Cindy Dong:** I really didn't consider the concept of diversity in nursing until working toward my BSN when I joined the Nurse Camp Leadership Team. Nurse Camp is a program for high school students interested in nursing careers. The



high school students who participated in the camp were from very diverse and underrepresented communities. So, while inspiring them to go into nursing, I also became aware of the fact that we need more diversity in nursing. It was a very reciprocal teaching moment for me. Opening my eyes and looking back at my BSN classmates I realized, wow, it is very white. I began to understand how a minority patient could feel more connected to a minority nurse. At vulnerable moments, I can see how a patient could have a deeper bond of trust with a nurse who is the same ethnicity. And in turn, how a nurse with the same ethnicity or cultural background could potentially give a patient more effective care.

After my Nurse Camp experience and graduating from the UW with my BSN, I wanted to take that diversity promotion idea into a broader scale. That is when I co-founded the PCNA.

**WCN:** You are currently working on your UW DNP capstone project. Can you share with our readers more about your project?

**Cindy Dong:** The goal of my project is to understand the supports and barriers for Chinese-American nurses in becoming nurse educators.

Wanting to support diversity in nursing, I am hoping to address diversity issues in nursing faculty by identifying both supports and barriers specifically for Chinese-American nurses.

The method is survey. I will be surveying Chinese-American nurses to get their perspective on what factors encourage or discourage them to go into nursing education.

Studies show that minority nursing students tend to have a higher attrition rate because they tend to feel less supported, isolated, or less valued compared to their Caucasian peers.

Studies also show that having higher ethnic and cultural representation in nursing faculty, in turn, tends to attract a higher rate of minority students and keep them there. The goal ultimately is to increase the success rates of minority nursing students, making sure they graduate and make it into the nursing workforce.

**WCN:** Thank you for sharing your experience with us today. What's next for you?

**Cindy Dong:** After graduating with my DNP, my next step is to get a job as an Advanced Registered Nurse Practitioner (ARNP). Moving forward, I am interested in working in immigrant health or in a rural health primary care setting. My big dream is to someday open my own clinic in a rural area, hopefully somewhere in Washington.

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**2020**  
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THE MIDWIFE

## A Return to Wisdom



By Victoria C. Fletcher, RN, MSN, ARNP, FACNM & Brenda Little

**M**idwifery. This profession is not new, not by a long shot. One could ask: How long have women been giving birth? And like the origins of midwifery, you can only travel down the path of historical evidence so far before hitting a fog of speculation. Perhaps, it began when humans first started living in tribes and creating roles for individuals that strengthened the survival of the community. It is hard to say. But one thing is for certain, the knowledge and skills of midwives have been a source of wisdom, comfort, and often survival, for expecting mothers and their babies throughout history, and that legacy continues today.

According to the American College of Nurse-Midwives, in 2014, nurse-midwives (CNMs) and certified midwives (CMs) provided primary care for 8.3% of total births in the U.S. This may not sound like a lot, and it's not, especially when compared to countries such as

Japan, the UK, and the Netherlands where midwives provide primary care for around two-thirds of all pregnancies and births. However, midwifery is seeing a resurgence in the U.S., both as a profession and as an option for mothers-to-be (Murphy, n.d.). Beyond the historical imagery of this revered profession, the reasons why are both practical and profound. But, to understand why, we must first take a brief look at the American history of midwifery.

Historically, midwives attended the vast majority of births in the U.S. But, not unlike other areas in our country's history, oppression, racism, sexism, and ignorance altered the course of this traditionally woman's role in our communities when, in the mid-1800s, medicine became a more formalized, white male dominated profession. The advancement of the practice of medicine at this time favored men and downplayed the role of lay

midwives (women) in the birthing process. By the early 1900s, reports began circulating criticizing the training of obstetricians and traditional birth attendants, recommending a two-tiered approach for better training: 1) hospitalization for all deliveries and 2) the steady elimination of midwifery altogether.

To exacerbate the situation, in 1915, a well-known obstetrician and academic, Dr. Joseph DeLee, published influential textbooks expounding the idea that pregnancy and birth, if viewed correctly, were simply a pathologic process. The approach he touted was an aggressive approach to childbirth that used techniques that only medical doctors could use, and then only in a hospital setting. The approach included the liberal use of sedatives, forceps, and episiotomies (“Joseph DeLee,” n.d.), all of which are no longer routinely recommended for normal vaginal deliveries. Unfortunately, this transition did not equate to healthier pregnancies and safer births. As stated in, “The History of Midwifery” by Judith P. Rooks CNM., “A scholar who conducted an intensive study concluded that the 41 percent increase in infant

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*The midwifery approach is a viable option to decrease maternal mortality. Studies have demonstrated that midwifery care improves the health outcomes for mothers and babies.*

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mortality due to birth injuries between 1915 and 1929 was due to obstetrical interference in birth.” This perspective virtually eliminated the use of midwives among middle- and upper-class citizens, resulting in midwives attending to births of mainly the poor and in communities of color, especially in the southern United States. The tradition of midwife-attended births for these populations continued well into the 1980s at which time midwifery education moved primarily into colleges and

universities, mostly under the auspices of the discipline of professional nursing.

It wasn’t until the 1970s and the Feminist movement when women started standing up for rights over their bodies, that we saw a renewed interest in the specific care and knowledge midwives bring to the experience of pregnancy and birth. For mothers-to-be, it is the perspective of childbirth as a natural physiologic process, the one-on-one knowledge, care, and education a midwife can offer that is so appealing. After all, midwives were among those responsible for urging mothers to breast-feed when hospitals were encouraging the primary use of formula; advocating for babies and new mothers to stay in the same room after birth instead of having babies held in a separate nursery; contributing invaluable



acumen to the development of childbirth education; and are responsible for the concept of family-centered maternity care, which included allowing fathers in the delivery room. Today, midwives provide care for women throughout their life span.

The U.S. maternal mortality rate has significantly increased from 1987 to 2016 and data indicates that more than half of these deaths are preventable (O’Neill Hayes & McNeil, 2019). The midwifery approach is a viable option to decrease maternal mortality. Studies have demonstrated that midwifery care improves the health outcomes for mothers and babies. Having a midwife there to support women during and into motherhood is a comforting option for many reasons, and so more and more expectant mothers are choosing it. The training and education of midwives now strives to incorporate the current evidenced-based practices while at the same time honoring the traditions that promote a baby-friendly, family-friendly, culturally appropriate approach to pregnancy and childbirth.

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# The Exciting Work of the WCN Diversity Committee

Racial and ethnic minorities are under-represented throughout nursing. There are also significant disparities in the burden of illness among the U.S. population. These two facts are linked: One of the factors producing health disparities is a healthcare workforce that doesn't reflect the population; a more representative healthcare workforce can help reduce health disparities. In addition, the under-representation of minorities in nursing is inconsistent with our professional values. A more diverse workforce and more inclusive work environments benefit all of us, not just minority persons.

Part of WCN's work includes promoting diversity in Washington's nursing workforce. To make a difference, WCN created a Diversity Committee to help inform strategies and programs that work to address these issues and effect change. Over the last couple of years, the committee has been busy advancing this exciting work.

Our Diversity Committee is currently working on a program called *So You Want to Be a Professor*. This program, which is in its second year, aims to introduce practicing nurses and prelicensure and graduating nursing students to a career in nursing education. Piloted in 2019 in Western Washington, the program will be expanding to Central Washington this year and plans to expand to Eastern Washington in 2021. The workshop informs participants of the responsibilities and duties of a nursing educator; the required degrees, qualifications, and preparation for educators and teaches basics on how to apply for jobs in a college and university setting, attain tenure, and other aspects of navigating a career in the academic world.

In 2016 and 2017, the WCN Diversity Committee hosted Implicit Bias Trainings in both Eastern and Western Washington for nursing educators and professionals. The trainings were run by Dr. Kenya Beard, EdD, AGACNP-BC, NP-C, CNE, ANEF, founding Director for the Center of Multicultural Education and Health Disparities, and As-



sociate Professor at City University of New York School of Professional Studies. These trainings focused on the instrumental role of nurses in eliminating health disparities and assuring health equity; examining how implicit bias gets in the way of culturally responsive care; and providing health care professionals with tools to address implicit bias to create culturally responsive environments.

The committee also helped create WCN's Diversity Initiative Mentorship Program in the Yakima Valley. This pilot program paired newly graduated minority RNs with experienced RNs to support minority nursing students as they transitioned into professionals. The goals of the program included helping these nurses develop organizational skills, understand interpersonal conflicts at work, and to give them the opportunity to reflect on new experiences.

To help higher education institutions cultivate a nursing workforce that better reflects the residents of our state, the committee advised the creation of a [Diversity Toolkit for Higher Education](#) now available on the WCN website. This toolkit provides information and strategies that help higher educational institutions build thoughtful, targeted, and sustainable programs that increase the recruitment and retention of underrepresented students in their nursing programs.

(WCN Diversity Committee Members on the next page.)



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**Frankie Manning**, Mary Mahoney Professional Nurses Organization Outreach Coordinator

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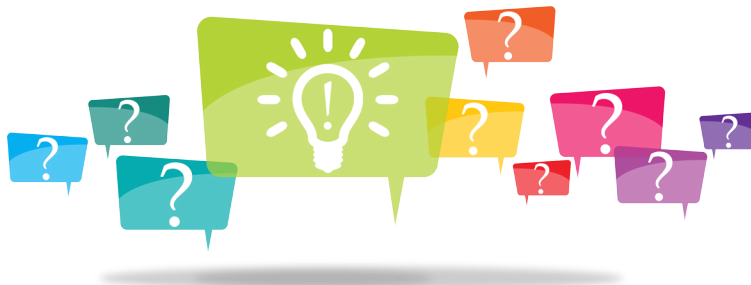
**For more information about any of these programs or for any questions, please feel free to contact us at [info@wcnnursing.org](mailto:info@wcnnursing.org)**

## Continuing Conversations...

### The Power of Nurses: Addressing SDOH, Asking the Tough Questions

**S**ocial determinants of health (SDOH), the conditions in which people are born, grow, live, work, play and age have more influence on our health than clinical care. For example, if you are born into a poor family living in a poor neighborhood, you might not have access to as many grocery stores and fresh produce as someone else. Or, you might skip preventive doctor appointments for yourself or your child because you can't take time off work. Differences like this stem from the distribution of money, power and resources, which result in health disparities.

The idea of SDOH is not new, in fact, it has been around for over 50 years. And while at first glance this may not sound like something nurses can influence, data says otherwise: Nurses can screen for SDOH within their institutions and partner with community-based organizations to help get patients what they need – improving health outcomes. Because of this, health care institutions are increasingly putting practices in place that support nurses in tackling SDOH.



Like with any preventive measure, we will achieve lower costs and better health outcomes if we can help patients address SDOH deficiencies. But how do we do this? It's the Wild, Wild West when it comes to SDOH screening tools; there are as many out there with as

many customizations for different populations as you can think of. There isn't one perfect tool that can be used across all institutions and all populations. Even if there was one, the elephant in the room is that nurses may still be reluctant to screen for SDOH if it's only going to open a Pandora's Box of problems they can't immediately help their patients address.

Currently, nurses might ask a specific set of scripted questions with every new patient. Or, they might ask a patient about their diet if they have uncontrolled diabetes or what their transportation options are if they frequently miss appointments. However, continuing conversations surrounding SDOH can be challenging. For example, questions related to someone's housing status, joblessness, past trauma or incarceration his-

tory are personal and may not be received well. This is especially true if these questions do not seem immediately relevant to the patient's primary complaint.

Does it do more harm than good to shine a light on someone's homelessness, joblessness, or isolation if a nurse does not have the time or resources to address their patient's health obstacles? The answer is yes and no.

If a nurse asks poorly written questions without having built trust with the patient, it could come off as robotic at best and rude at worst – making a patient further guarded. And, if a patient is misled to believe that all their problems will be solved, this sentiment could worsen if the nurse cannot solve the problem. In an ideal world, nurses would have the time and resources to work with social workers and community partners to help their patients find access to more stable housing, healthier foods, transportation, and so on. But the world is often far from ideal. However, if done well, screening in and of itself can be therapeutic for both the patient and nurse. After all, “social support” is one of the SDOH. If a patient connects with their provider and their provider shows sincere interest in what's going on in their life, that empathy can be healing.

Nurses, as the most trusted profession, are known for their caring spirit. While they may not have all the tools needed to tackle the challenges patients reveal, they can use their position to start a conversation about SDOH. It may be uncomfortable – for patients and nurses both – but acknowledging what patients are going through validates their experience and provides a more holistic view of how they might approach healthy living. This is a critical step to addressing SDOH. As nurses venture into this frontier, they should know that there is a risk they will stumble. However, if they focus on what they do best – developing trust with their patients – SDOH screening will become second nature and only deepen the relationship, thereby starting down the path of improved health.

One of WCN's key missions is to build health equity – to make sure everyone in Washington gets what they need to thrive. WCN is capturing the unique assets of nurses and synergy of this work around the state to see where we should go next. As we continue the conversation around SDOH, we will share the insights and resources we discover that help nurses address SDOH in patient care.

For additional reading, check out our [Advancing Health Equity](#) article in WCN News' 2019 4th quarter newsletter.

### UPDATE...

The National Academy of Medicine (NAM) is currently working on updating, The Future of Nursing: Leading Change, Advancing Health report for 2020-2030. In response to their 2010-2020 report, the Robert Wood Johnson Foundation (RWJF) created Action Coalitions in nine states, including Washington, to advance recommendations laid out in NAM's original report.

This last summer (2019), Washington's Nursing Action Coalition (WNAC) and WCN made recommendations to NAM's 2020-2030 report recommending that the report:

- 1) State an explicit goal of increasing diversity in the nursing workforce, including data disaggregation in academic progression and graduate degree attainment.
- 2) That recommendations on nursing leadership include advancing health equity through addressing the social determinants of health.

WNAC and WCN also recommended that national organizations such as NAM, RWJF, and AARP Center to Champion Nursing in America have a role in:

- 1) Convening states to share challenges and successes in achieving Future of Nursing goals.
- 2) Providing grant funding for research and increased capacity for implementation.
- 3) Publishing state exemplar experiences.

NAM's report is due to be released at the end of 2020 and WNAC and WCN will continue to work closely with NAM's recommendations to advance nursing in Washington State.



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