

SB08 - 188 Meeting Minutes  
Pilot Program Implementation Committee Meeting  
November 13, 2008

**Member Attendance:**

*\*Absent*

Colorado Hospital Association

**Kathy Harris**

Banner Health  
Regional Vice President, Clinical Services  
Banner Health

*\*Carolyn Sanders - CoChair*

University of Colorado Hospital  
Associate CNO

Colorado Nurses Association

**Fran Ricker - CoChair**

Colorado Nurses Association  
Executive Director

**Eve Hoygaard**

Colorado Nurses Association  
President

Service Employees International Union

*\*Bernie Patterson, SEIU*

**Judy Hutchinson, SEIU**

Nurse Alliance of SEIU

Colorado Organization of Nurse Leaders

*\*Colleen Casper*

Clinical & Executive Partnerships

**Kelly Johnson**

Children's Hospital  
Vice President and CNO

Colorado Council of Nurse Educators

**Linda Stroup**

MSCD  
Assistant Professor, Department of Nursing

**Nancy Smith**

Dean and Professor  
University of Colorado at Colorado Spring

Colorado Department of Public Health and Environment

*\*Ned Calonge*

Chief Medical Officer

Colorado Center for Nursing Excellence

*\*Sharon Pappas*

Porter Adventist Hospital  
Chief Operating Officer/Chief Nursing Officer

Governor's Appointees

*\*Lysa ErkenBrack*

Grand Junction

*\*Lydia Handberry*

Swedish Medical Center

Interested Parties and Observers

**Janet Houser PhD EdS MN - Researcher**

Regis University  
Associate Dean

*\*Linda Hattenbach, RN*

Sr. Nursing Policy Coordinator  
Nursing Alliance of SEIU

**Lola Fehr - Administrator**

Colorado Center for Nursing Excellence

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**October 2, 2008 Meeting Minutes** - approved by consensus

**PROCESS**

**Budget**

The budget needs to be sent as a report to the Colorado Trust and DORA.

Two pages were handed out-- the original Proposed Budget and the Proposal to Serve as Project Administrator, both prepared by Lola Fehr, dated August 5, 2008. The Proposal sheet included an explanation of what the \$20,000 administrative services line item on the Proposed Budget contained.

Discussion:

A question was raised as to whether the discretionary amount at the bottom of the Proposed Budget could be used for early implementation of the research planning process. This would include purchasing the initial instrumentation, evaluation costs, and site recruitment. Fran said she would check the legislation for any restrictions. It was suggested that these expenses be added as a line item for research planning expenses on the proposed budget if there were no restrictions. As it is, the budget looks top heavy for administrative services and this would help balance it more. The amount decided upon for this line item, Research planning, was \$7000 to cover the items listed above. See discussion below for mileage & overnight expenses, too.

Consensus: Agreed to add the expense for Research Planning, \$7000, as a line item to the proposed budget and increase amount for Research Consultant from \$2,000 to \$5000 as 20 hours didn't seem like enough hours for what would be required.

Further discussion:

It was suggested that \$15-20,000 of the discretionary amount could be used for compensating hospital or staff for their time in participating in the study. This would avoid having to ask for that amount from funding sources.

Question was brought up about how much site recruitment would cost. The IRS mileage reimbursement is at \$.58/mile currently and there could be overnight expenses as well. If ten sites were required, 16 sites may need to be visited but a phone call would tell us whether or not a visit was required. If 10 sites were selected at about \$500 each, it would cost \$5000.

When a question was asked about whether gifting was necessary, Dr. Houser said that you usually get 30% participation without incentives or reimbursement and 80% participation with their use. A greater range of nurses would participate which is what the committee hopes to reach—not just the ones who would participate regardless.

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Could leftover money be given to an education fund which would allow nurses to determine where monies are used? This will be discussed at the next meeting with sampling.

**3-4 Hospital Issues**

Senator Boyd recommended that Fran speak with Kristen Forestall, one of the bill drafters, who said that the committee is not constrained by this number. Three to four hospitals need to be considered but the sample can be more.

**Funding Sources**

Colorado Trust sent questions and asked for responses concerning this study. Fran Ricker, Carolyn Sanders, and Dr. Houser answered the questions and submitted them to the Colorado Trust so that the application for funding is again being considered. The administrative and research project budgets need to be submitted to them as well.

Let it be noted that Fran Ricker did a great job of working to get this far with the Colorado Trust because they originally turned the request down. Fran also mentioned that the Colorado Center for Nursing Excellence did a lot of work helping her to get this positive response from the Colorado Trust. However, the Colorado Trust will not fund the entire project so additional funding needs to be solicited.

(Most of the agencies discussed in previous meetings will have an interest in the outcomes of the study but it needs to be determined if they would have vested interest in the findings and avoid requesting money from those that would.)

Criteria for avoiding vested interest or the appearance of conflicts of interest in other funding sources:

Not affiliated to groups listed below under vested interest groups  
Should represent all nurses and advocate for the profession

Groups That Could Have (Or Be Perceived as Having) Vested Interest in the Study:

- Hospital organizations (CHA & others)
- Unions
- Nurse leaders/administrators
- CNA-ANA & other nursing organizations
- Anyone affiliated with magnet hospital or ANCC

Discussion: What about the Rose Foundation? It is funded separately from hospital budget and is considered a public or community foundation, not a private one

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Honor Society of Nursing could be approached for funding after the study has been designed so that they aren't perceived as influencing the study.

Should the National Council of State Boards of Nursing be considered? It's regulatory and for the public protection; not an organization that can be joined.

Nursing alumni associations don't have much extra money.

Groups That Could Be Contacted for the Qualitative Phase:

Sigma Theta Tau International  
Colorado Nurses Foundation  
National Council of State Boards of Nursing  
Friends of Nursing  
Johnson & Johnson

**Timepoints**

This section covers changes in the original proposed timeline for research design (see separate page for revised timeline):

Sampling strategy would have been done by now but other issues had to be checked first.

Today's meeting – finish the qualitative design, review the variable list, and revisit the test blueprint

Next meeting, Dec. 4 (4 hrs) – talk about sampling strategy for quantitative study, review instruments

Dec. 18 meeting (6-8 hrs) – select instruments, draft protocol for data collection and training of data collectors

Jan. 8 – first draft of research proposal – everything should be decided

Jan. 22 – second draft of research proposal

Feb. 2 – deadline for Sigma Theta Tau applications

Feb. 6 – submit pilot program proposal

Will full day meeting be needed on Dec. 18? Half day would probably be better and could be possible if a subgroup drafts the protocol at a meeting between Dec. 4 and 18 and brings it to Dec. 18 meeting for approval by rest of committee. Subgroup would be comprised of volunteers from the committee (no limit on size) and Phyllis. Colorado Center for Nursing Excellence will

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send out a notice recruiting volunteers for the subgroup. Dr. Houser will check dates when Phyllis is available and send them to the Center. Keep in mind that this is very technical and difficult.

The next two meetings are extremely critical and there is concern about recent absenteeism. Is it due to work conflicts or meeting problems? Center will call to remind others that the next meeting is very important to attend.

Janet Houser & Joyce Verran will be evaluating instruments and selecting those most likely to fit the study. It was suggested that they send copies of the ones they like best before the next meeting so committee members can have time to evaluate them. Dr. Houser said that this might be difficult because of proprietary issues and they might only be available in paper copy. Then they could be faxed.

It was suggested that Janet Stephens from the CHA be contacted for feedback concerning the sampling strategy.

### **Press Release**

The press release prepared by Regis was approved. To make it complete, though, Fran and Carolyn's qualifications are needed and it would be nice to have some quotes from committee members. They will be using it with their usual contacts but will send to business journals, too. It was recommended that it also be sent to AARP and Modern Health Care and nursing organizations that alert their people to legal issues.

There were other changes recommended to revise the press release for nursing contacts:

- Add that it is a collaborative effort between nurses and administrators in 2<sup>nd</sup> paragraph.
- Add names of all organizations represented as it will add strength.

Timing of release:

The Center will send out the press release with changes noted above before Thanksgiving to meet early deadlines for some publications but will also send it out again in January to keep it in the minds of people. If anyone has any additional changes, send them to Lola by Friday, November 21.

### **RESEARCH PLANNING**

The medical librarian has done one literature search for background on this project and will also do one to determine instruments which might be appropriate to use with the study as well.

Discussion on Weston Model (see today's handout – second to last page):

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This is important as the qualitative phases will be based on this model and the committee needs to be comfortable with it.

A question was raised about what the differences are between the terms in Columns 2 and 3 of the first tier, or Content, of the model. Dr. Houser said that the terminology is what Weston used but they can be changed. It was decided to change the terms after the words, “Decisions about...” to Patients (Column 1), Unit (Column 2), and Organization (Column 3).

The second tier of the model (identification, development, selection, and implementation) has stages of nursing involvement and it was mentioned that nurses are less involved as you progress down the four stages.

The third tier of the model, Level of Involvement section looks linear but isn't—these levels are incorporated into the top two tiers. How should that be reflected in the model?

Consensus: Committee members should experiment with the layout, or representation, of the model and get back to Dr. Houser on this.

**QUALITATIVE** (see page after press release in handouts)

These are the variables for descriptive part of data collection. After a discussion which included the point that it is better to have more variables that might not be applicable to all organizations than to find out you don't have a variable you need for the study, the following changes were made (see discussion following):

Under Nurse Level section:

- Add pier diem to full time/part time/agency/traveler line
- Add Year passed NCLEX

Under Unit Level section:

- Change Specialty to Specialty Type
- Change Bed size to Bed Count
- Change Manager to Leadership Title (what position do they report to)
- Change Delivery method to Delivery model

Add these variables:

- Staff meetings
- % of students
- % of new graduates
- % time set aside for administrative functions

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- Advance practice support position available
- Administrative support (unit clerical & secretarial)
- Paid time for professional activities
- Unit level structures for involvement

Under Hospital Level section:

- Change Certified (under Bed Count) to Licensed/Staffed
- Remove Margin
- Change Administrative Profile to Organizational Chart
- Add Rapid response team or equivalent

Discussion:

Is the variable Magnet/Non-Magnet/Magnet Aspiring needed under Hospital Level Variables because the next variable, Organizational structures for involvement, may be redundant? Yes, it is needed so the information can be correlated with other data.

Should informal be added to Unit Level Variables?  
No, this is descriptive and will be in the instrument.

Margin (under Hospital Level Variables) needs to be defined—patient margin, bottom line margin, etc. Why is it included? One definition is that margin is allocating appropriate resources for nursing practice and it's not necessarily the money that is important. Magnet hospitals need to report the amount per nurse. Smaller hospitals don't have this information easily available.

Dr. Houser said that this could be added as a question so it was dropped from the variables list.

Average admissions/transfers/discharges (under Unit Level) are measured differently by agencies reporting them. It will be important to have operational definitions that hospitals can follow when answering the survey. Definitions shouldn't be so difficult that they will be a burden to the participating hospitals.

If these are the descriptors the committee wants, the subgroup will define the terms. Each subgroup committee member should bring the definition their facilities use for each and then compare these to the definitions from NDNQI and NWF and the Board of Health. Janet Stephens, CHA, was also asked to furnish definitions.

Licensed bed count (under Unit Level Variables) might not be as important because smaller hospitals will show a higher correlation compared to a larger hospital.

It's not harmful to collect in case it is needed; more concerned about omissions to this list of variables.

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Delivery method (under Unit Level Variables) – what is meant by this term?

It was changed to delivery model. Again it is not harmful to collect as it gives more information in case it is needed.

A question was raised whether or not it would matter if a hospital can't answer a question. It won't matter in the descriptive variables but it will be more important in the research variables.

Critical care, emergency, outpatient, and operating room units are difficult to define as a unit because of their function.

Let's discuss this in the sampling strategy.

Who answers the survey questions for each level?

This will be laid out later in data collection protocol.

Should percent of participation be added as a variable here?

No, it would be a research variable.

**TEST BLUEPRINT** (see next page in handouts after Qualitative variables)

This is our critical research variable; it needs to represent what the study is trying to discover.

This needs to be kept to a minimum or it will be difficult to find an instrument to measure it.

Need to have 5-7 experts evaluate if the blueprint matches our content validity.

Only changes to it were to change the line for Types of Decisions...across the board to match the previous changes made to the Weston model—change second column from 'nursing practice' to 'patient', change third column from 'work methods' to 'unit', and change fourth column from 'work environment' to 'organization'.

Also organizational alignment was clarified as support from organization and leadership alignment as support from nurse leaders.

**OUTCOME VARIABLES** (next page in handouts after Test Blueprint for Involvement)

This is a first draft to be reviewed and operational definitions are also needed for these variables. Some of these variables are not required for reporting until next year—how will this information be used to compare with hospitals that don't collect information for these variables? The hospitals may collect that data even though they aren't required to report it and could give the study what they have. They may not have it, though, and that will be dealt with later.

Will hospitals know what questions they will be answering if they sign up to participate? People will visit to give them details. There is a concern that some organizations may opt out of participating in the study if they are required to answer all the questions.

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It would be good to know what is collected by the various agencies represented by the committee members and use those as a core group of variables and then find out other data that is collected. Committee members should bring what their facilities report to the next meeting. Kathy Harris will report on what federal reports require, perhaps Donna Kasuda could bring the state requirements, and Ned Calonge could provide what the Department of Health requires and what information is the standard, or benchmark, on infection control. Then the final list for outcome variables can be compiled from all this information.

**MEASUREMENT STRATEGY** (4 pages found in handouts after Outcome Variables) – this will be discussed at next meeting

**QUALITATIVE DESIGN** (5 pages found in handouts after Measurement Strategy)

This is the highly unstructured part of the study which is emergent and addresses the 3 aims and 2 questions outlined. Qualitative design follows the subjects and not the other way around. Quantitative design worries about validity and tries to explain, not describe.

There are some decisions to be made. Population of interest is found in the legislation on page 6 of Senate Bill 08-199 and is “a registered nurse who is engaged in direct patient care in an inpatient hospital unit setting for at least fifty percent of his or her working hours”.

Estimate sample size is driven by the concept of saturation—point at which you hear nothing new. This size could be anywhere from 7 to 70. This can be estimated and saturation can't be reached with less than 10 sites with a research study this complex.

Dr. Houser suggested a possible implementation model using the sampling strategies below. She suggested three phases:

- One-on-one leadership interviews – ask them to give us names (more than 1) of others to contact
- Form focus groups with staff – have nurses bring their friends who might be interested
- Observe shared governance models as a means of triangulation

Random sampling is irrelevant as a sampling strategy for this type of study. However, there are various strategies which could be used in the qualitative design:

- Purposive sampling – use this approach to select the facilities for study
- Snowball or network sampling - involves dependent samples which is deadly for quantitative studies but not for qualitative studies; Dr. Houser recommends this for the focus groups

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- Theoretical sampling – not appropriate for this study as we aren't developing theory

Discussion:

How do we capture non-involved subjects? Staff nurses could identify.

How do we make first contact? Ask nurse leaders for names

How do we get an organization without structure to participate? How do we get facilities to participate? How do we identify organizations? One suggestion was to go to Colorado Organization of Nurse Leaders and ask for names of official nurse leaders or informal leaders in nursing from throughout the state. It was also commented that not all CNOs actively participate in CONL so an alternate strategy may be needed.

### **Inclusion criteria**

The inclusion criteria should not be too restrictive—want to ensure that all types of organizations are included (good, bad, and in-between). Study could include more than one organization per category (geography, bed size, functionality) magnet hospitals (objective vs. subjective), hospitals rated highly and reported in press.

Would it be beneficial to go to the six regions of the state after advertising the project and asking nurses or leaders to participate in a meeting?

The next meeting will cover research design and how to find the sample (these groups) and how to make it diverse geographically as well as recruitment protocol and guidelines for dissemination to other interested groups.

Dr. Houser will send out a draft of focus group and leader interview guides.

Jerry Spicer will be contacted to see about sending out a newsletter to all members about this study.

**FEEDBACK** – All felt that a lot was accomplished at this meeting.

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Next Meeting: Thursday, December 4, 2008 from 8:30 am to 12:30 pm

**Minutes taken and written by:** Lynette Christensen

**Minutes reviewed by CoChairs:** Fran Ricker & Carolyn Sanders

**Administration for SB08-188:** Colorado Center for Nursing Excellence

**Administrative Coordinator:** Wendy Krzeczowski