Building Health Equity and Community Capital: Community College RN to BSN Programs Addressing Rural Health Professional Shortages
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Rural regions across the United States disproportionately face health workforce shortages. Approximately 20% of the U.S. population lives in rural regions, but more than half of all areas designated as having a health practitioner shortage or being medically underserved by the Health Resources and Services Administration are rural. Health inequities are further exacerbated by educational inequities, particularly the inaccessibility of health and medical training programs for rural communities. As demand for Bachelor of Science in Nursing (BSN) degrees grows, community colleges established to serve rural regions that lack access to other higher education institutions present an innovative solution: community college RN to BSN programs intended to continue training registered nurses (RNs) while also providing access to BSN degrees.

Utilizing the community capitals framework, this white paper analyzed political, human, and financial capitals to understand the role of community colleges in conferring BSN degrees. Through case studies of two states, Colorado and Arizona, this white paper examined how community colleges successfully transform political, human, and financial capitals into additional community assets aligned with addressing nursing shortages. This white paper is intended to advance understanding among policymakers, community colleges, and scholars on the utility and appropriateness of RN to BSN programs by exploring the political climate required for such legislation to pass, the suitable conditions for community college RN to BSN degrees to meet workforce demand, and the additional research needed to understand the landscape of community college baccalaureate degrees.
One in five U.S. residents live in rural communities, but according to the Health Resources and Services Administration (HRSA, 2020), more than half (61%) of Health Professional Shortage Areas (HPSAs) are rural. The lack of health professionals in rural areas hinders essential access to preventative chronic condition care for rural residents (Rosenblatt, 2000). Rural postsecondary institutions are well-positioned to train the local health workforce with individuals that are more likely to practice in rural regions (MacQueen et al., 2017). Some rural community colleges have met this need through Registered Nurse to Bachelor of Science in Nursing (RN to BSN) programs, which provide a pathway from the Associate’s in Nursing (ADN) to the Bachelor’s of Science in Nursing (BSN) degrees.

This paper analyzes the role of community college RN to BSN programs in rural health workforce shortages to answer two questions: 1) How do community college RN to BSN programs address nursing shortages? and 2) How does the political context affect the passage of legislation in support of these programs? To answer these questions, this paper examines how RN to BSN programs impact health in the regions they serve by analyzing the effects on political, human, and financial community capitals, or assets in which communities can invest to generate new resources that further strengthen social, economic, and health security (Flora et al., 2016). As regional public institutions, community colleges often operate in locations where residents may lack access to four-year institutions (McClure, et al., 2021). Community colleges enroll 46% of the nation’s postsecondary population and the largest share of adult learners (Biswas & Kelly, 2011). For every 10 additional miles required to travel to the nearest four-year institution, individuals are 3.6% more likely to attend a community college (Floyd & Skolnik, 2019). As such, some community colleges serving rural regions without access to four-year BSN programs are seeking approval for RN to BSN programs to create accessible opportunities and respond to local workforce demands.
Rural Nurse Shortages and the Demand for BSN-Educated Nurses

Rural communities are home to more than half of all federally-designated areas with shortages of both primary care providers and registered nurses according to the HRSA (HRSA, 2020). With fewer health providers and the need to travel longer distances to care, rural residents have limited access to necessary health services for chronic and preventative care, leading to increased healthcare costs and poorer health outcomes.

In addition, the role of nursing has evolved to require an understanding of population health, case management, and quality metrics, all obtained through baccalaureate education. Patients treated by BSN-educated nurses tend to have lower mortality rates, hospital stays, and complication rates (Robert Wood Johnson Foundation, 2011). Following the National Academy of Medicine’s call to increase the number of nurses with bachelor’s degrees, interest groups, post-secondary institutions, and policymakers began pushing for more BSN-educated nurses. The American Association of Colleges of Nursing (2018) found that 88% of employers prefer, and 46% require, a BSN degree.

Population health and case management are necessary for rural care to address racial and socioeconomic disparities that were already present but exacerbated by the COVID-19 emergency (Centers for Disease Control and Prevention, 2021). More than one in five rural residents are people of color and that number is increasing rapidly (Junod, 2020). As communities increasingly declare racism as a public health emergency and grapple with the health and economic impacts of the COVID-19 crisis, the additional training BSN degrees provide will be crucial for nurses providing critical preventative and chronic care to rural residents of color (American Public Health Association, 2021).
Community College Baccalaureate Degrees

Rural community colleges are uniquely positioned to fulfill regional workforce needs. As educational and anchor institutions, community colleges serve as the primary training ground for most health workers. This includes more than 57% of nurses who began their education at two-year institutions who are now meeting the needs of local hospitals and clinics (Ashford, 2017). To promote health and educational equity, community colleges identified a unique opportunity that only they could fill: community college RN to BSN programs.

Community college baccalaureate (CCB) degrees serve three functions: fulfilling a specific, unmet need in key educational and labor markets, providing opportunities for place-bound students, and providing cost-effective access to higher education (Holley, 2013; Hagan, 2018). Among CCB degrees, RN to BSN programs are often singled out to address state and local health workforce shortages. Educating nurses is often costly to postsecondary institutions during the first two years of technical training, and more than half of all U.S. nurses complete ADN programs at community colleges (Hagan, 2018). The second two years of a BSN degree, which include courses on public health, communication, critical thinking and leadership skills, require less inputs and are less costly to provide, representing a minimal investment for states seeking to increase the credentials of their rural nursing workforce.

Criticisms of CCB degrees largely derive from four-year institutions’ concerns that community colleges are encroaching on their market, including specific concerns about mission creep, degree duplication, cost escalation, and resource constraints of community colleges (Carroll & Glasper, 2018). RN to BSN programs face the same skepticism, but four-year institutions tend to be even more territorial over BSN degrees. For this reason, several states—including California, Hawaii, Idaho, Michigan, Minnesota, North Dakota, Ohio, Oklahoma, Oregon, South Carolina and Wyoming—have enacted legislation limiting community colleges to confer specific four-year degrees but exclude BSN degrees from that list (Love & Palmer, 2020; Fulton, 2020). Between 2016 and 2019, at least 16 states proposed legislation allowing community colleges to confer baccalaureate degrees, and nine states enacted policies (Fulton, 2020). As of 2019, 12 states allowed RN to BSN programs, as Figure 1 shows.
Theory of Change: Facilitating Community Capitals

To better inform decisions about the conferral of baccalaureate degrees by community colleges, it is necessary to understand the context in which these degrees are successful at improving health outcomes and, by extension, strengthening rural communities. One approach to doing this is through the community capitals framework, which focuses on the interaction between different community assets to foster new individual and collective resources. The community capitals framework provides an “organizational frame for understanding diversity and changes in rural communities” (Flora et al., 2016). This paper analyzes interacting community capitals in states that have enacted legislation on community college RN to BSN degrees. The seven community capitals—assets subject to investment that can be leveraged to generate new resources and strengthen community social, economic, and health security—include natural, cultural, human, social, political, financial, and built, as shown in Figure 2 (Flora et al., 2016).
## Figure 2. Community Capital Definitions

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<th>Community Capital</th>
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<tr>
<td>Natural</td>
<td>Resources used to strengthen cultural and social capital or convert into financial capital</td>
</tr>
<tr>
<td>Cultural</td>
<td>Understanding and explanations of the surrounding world and what a community views as possible to change</td>
</tr>
<tr>
<td>Human</td>
<td>Health, formal education, skills, knowledge, and leadership of each individual and their potential to earn a living and strengthen their families, themselves, and the community</td>
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<tr>
<td>Social</td>
<td>Mutual trust and reciprocity found in relationships within the community that allow individuals to move beyond self-interest and consider the community as a whole</td>
</tr>
<tr>
<td>Political</td>
<td>Resources invested by the community (public capital) and by the individual or group (private capital) that are easily monetized and converted into other resources or assets</td>
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<tr>
<td>Financial</td>
<td>Organization, connection, voice and power that citizens use to convert shared norms and values into rules, regulations, and resource distribution</td>
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<tr>
<td>Built</td>
<td>Permanent, physical infrastructure that ensures the ability to build and sustain other community capitals if used productively</td>
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This paper highlights political, human, and financial community capitals that, if leveraged, can lead to more equitable health outcomes in rural communities. Political capital is the ability of a community to use connections, organizations, and power to convert norms or values into standards that then become regulations or resources. This paper critically examines the context in which community college RN to BSN degrees emerged, the problems it intended to solve, and its reinforcement or challenge of the status quo (Young & Diem, 2016). Human capital represents the shares of educated, healthy, and skilled workers and their resiliency during periods of economic uncertainty (Flora et. al, 2016). This paper analyzed education as a form of human capital, including how training and retention of adults in rural communities can foster other community capitals, such as financial capital. Financial capital includes savings, income generation, fees, loans and credits, philanthropy, and tax exemptions that stimulate regional economic growth by connecting business resources to communities (Beaulieu, 2014). This paper examines how community colleges increase the financial capital within a community through lower tuition and higher earnings potential as a result of RN to BSN programs. While health is an aspect of human capital, it is inextricably linked to each of the community capitals (Flora et al., 2016). Areas with extreme poverty—where the poverty rate is 40% or greater of the population—were concentrated in rural areas in the 2018 American Communities Survey. People living in poverty often have fewer employment and educational opportunities, hampering their ability to foster other community capitals, such as human or financial capital. As the single largest social determinant of health, poverty leads to poorer health outcomes for rural residents (World Health Organization, 2020). This paper analyzes how leveraging existing community capitals to create RN to BSN programs and investing in RN to BSN graduates can improve the health outcomes of rural residents within the communities they serve.
Method

This paper used two case studies comparing rural community colleges at the state and institutional level to analyze the contributions of community college RN to BSN programs to community capitals. More specifically, the paper examines Colorado Mountain College (CMC), which has had a RN to BSN program in Colorado since 2010, and East Arizona College (EAC), which only recently gained the ability to offer a RN to BSN program in Arizona. Both CMC and EAC serve rural counties designated as HPSAs. Colorado and Arizona both debated whether and where RN to BSN degrees should be offered, and each implemented a unique approach to allowing CCB degrees that illuminates the criteria in which states will consider and implement RN to BSN degrees. The experiences of each community college within their distinct legislative landscape provide insight into the context in which community college RN to BSN programs can most effectively serve students and meet workforce needs.

These case studies examine the environment in which policy was implemented and how it shaped policy outcomes, namely which community colleges are allowed, or not, to confer BSN degrees (Maxwell, 2020). The ability of a community to leverage its connections to decision-makers within the environment in which policy is formed is a measure of political capital. Political capital is analyzed through the stakeholders involved, including policymakers, institutional leaders at both the community college and university level, and employers. Political context and workforce shortages shape which community colleges are permitted to offer baccalaureate degrees and specifically RN and BSN degrees. This white paper examined lobbying efforts by community colleges and four-year institutions and ongoing debates among postsecondary institutional leaders, policymakers and employers over the necessity and value of CCB degrees to describe context in which each community college operates.

Community college RN to BSN degrees often provide access to postsecondary education and professional development for students who otherwise cannot attend a university. In addition, community colleges are often able to provide BSN degrees at a lower cost to students than degrees offered by four-year institutions, which supports human capital development. Graduates can obtain increases in life earnings, which builds the financial capital within the larger community. CMC and EAC offer competing examples of how communities were able to organize and strengthen political, human and financial capitals to address clear educational and workforce needs. Each case is discussed in turn.
Colorado was the tenth state to allow community colleges to confer four-year degrees in 2010, and CMC became the first Colorado community college to do so. As a dual-mission institution, CMC operates across traditional two-year and four-year college designations (Merisotis & Besnette Hauser, 2021). The college offers a mix of programs that meet the needs of as many students as possible. CMC is a public community college in central and western Colorado with 11 campuses serving 12,000 square miles of rural communities. CMC offers five baccalaureate degrees, including a BSN program. The district’s BSN degree is offered at four campuses—Breckenridge, Salida, Glenwood Springs, and Steamboat Springs—each of which is located in a county that is designated as an HPSAs. The only college or university operating in the communities its 11 campuses serve, CMC provides affordable access to rural students that otherwise are underserved by higher education in their local community.
Colorado Mountain College

Political Capital: Expanding Institution by Institution

Proposals to establish CCB degrees tend to result in two opposing positions: 1) those who support the expanded degree offerings to meet student needs; and 2) those who maintain a clear delineation between the missions of community colleges and four-year institutions. Colorado’s experience expanding the role of select community colleges to include the provision of baccalaureate degrees has not been without conflict and illustrates the ability of state actors to leverage and organize community capitals.

Colorado allowed CMC to offer up to five baccalaureate programs in 2010 through Senate Bill 10-101. The Colorado Department of Higher Education (CDHE), tasked with implementing policies to maximize higher education opportunities, initially opposed the legislation, suggesting that CMC wait until the higher education strategic plan was completed later that year (Engdahl, 2010). In speaking to the Colorado Senate Education Committee—which included five of the bill’s sponsors—CMC President Stan Jensen disagreed, noting that the bill focused on degrees meeting a demonstrated workforce need. This testimony, alongside early support from the Senate Education Committee, illustrates the political capital that CMC was able to build throughout the legislative process to ensure the bill’s passage. The bill was ultimately enacted, allowing CMC to confer BSN degrees. As the only institution operating in the Mountain region, CMC was uniquely positioned to address local workforce demands.

Once approved, CMC’s five baccalaureate programs effectively addressed local workforce needs. In response, Colorado passed additional legislation, House Bill 18-1086: Community College Bachelor Science Degree Nursing, in 2018 with bipartisan support. As a result, more than 300 community college students are enrolled in RN to BSN programs at six additional community colleges. Colorado’s experience with both laws demonstrates the political capital that communities were able to garner to transform its norms and values into rules that built other capitals within rural communities.
Human Capital: Training Diverse, Rural Nurses

Community colleges provide technical training and serve as an important stakeholder in the human capital of a region. CMC developed performance objectives to address disparities between Latino and non-Latino enrollment, retention, and completion in 2013 (Besnette Hauser, 2021). By 2020, Latino students had the highest completion performance among all groups and had grown to nearly 28% of enrolled students. The college was designated a Hispanic Service Institution in 2021 as a result of their continuing efforts to provide historically underserved students with the opportunity to build human capital—and thus financial capital—that will strengthen their local communities.

CMC’s RN to BSN program boasts a high success rate with every student employed after graduation in 2021. With a BSN degree, nurses are more competitive in the job market and more likely to meet employer requirements. Twelve students graduated from CMC’s Breckenridge campus in 2021, and most years, every student passes the National Council Licensure Examination, certification necessary to practice nursing (Toomer, 2021). This growth in human capital also leads to growth in financial capital. Earnings, one opportunity to build financial capital, are typically higher for BSN nurses than ADN nurses. Nurses that complete an RN to BSN degree within five years of finishing their ADN degree see an increase between 2.6% and 5.1% in lifetime earnings (Spetz & Bates, 2013).

States allowing community college RN to BSN degrees produce more nurses than non-adoption states (Daun-Barnett, 2011). Community colleges with RN to BSN degrees have high graduation rates, high alumni employment rates in communities that often face shortages of nurses. Each CMC campus serves a county designated as an HPSA. CMC’s RN to BSN programs strengthen the local health workforce, increase access to health services, and build financial capital within CMC’s service area.
Financial Capital: Minimizing Debt and Increasing Earnings

CMC’s history demonstrates the college’s ability to contribute to financial capital within the communities it serves. The college district was founded by ranchers, property owners and business leaders in 1967 to address the lack of postsecondary opportunities in Colorado’s mountain region. As a local district, CMC collects local taxes and lowers the tuition for students living within the tax district (Colorado Department of Higher Education, 2020). This allows the college to operate multiple campuses and uniquely serve smaller, rural markets (Griffin, 2021). Students who live within CMC’s tax district pay $130 per credit hour for tuition, which is $100 less than Colorado residents outside the CMC district pay at the in-state tuition rate. CMC also offers a $1,000 scholarship to all graduating in-district high school seniors.

Six community colleges in Colorado are authorized to confer baccalaureate degrees under House Bill 18-1086.

Among the eight postsecondary institutions offering RN to BSN programs in Colorado (Figure 2), CMC was the most affordable by between $100 and $450 compared to other institutions in Colorado for its baccalaureate degree by per-credit tuition and among the most affordable in the country according to the Colorado Department of Higher Education and the U.S. Department of Education. As an institution established to serve its immediate community, CMC provides a cost-effective alternative within the communities that CMC serves for local nurses to pursue their BSN degree. Affordable RN to BSN programs offered by regional community colleges build the financial capital of its students and the broader community and fosters equity among marginalized students that disproportionately carry the burden of student debt (Murakami, 2021).
Arizona became the twenty-fourth state to allow CCB degrees in 2021. Historically, Arizona has not allowed community colleges to confer RN and BSN degrees. Therefore, EAC, located in Thatcher, Arizona, established transfer agreements with state universities to serve students who could not leave the region to pursue a BSN degree. New legislation in 2021 allows community colleges to confer CCB degrees—including RN to BSN degrees—but sets varying rules for rural- and urban-serving institutions. EAC’s campus in Graham County is geographically remote. Graham County is rural with Census-designated distant and rural fringe counties surrounding Thatcher and Safford. The county has been designated as medically underserved since April 2018. Thatcher and Safford are designated as low-income HPSAs, and several local Indian Health Service and Tribal Health organizations are also designated as HPSAs.
Political Capital: Distinguishing Rural and Urban Institutions

For nearly four decades, Arizona has considered whether community colleges should be allowed to confer baccalaureate degrees. Average tuition and fees have tripled at public four-year institutions since 1990, and community colleges still present a more affordable option for many students (College Board, 2019). Arizona was one of the first states to propose legislation on the topic in 1997 but was unable to foster the political capital necessary for it to pass until 2021.

Arizona’s first attempt to allow CCB degrees came in 1997 as Rio Salado College, a community college located in the urban community of Tempe, sought approval to confer baccalaureate degrees. Linda Thor, then president of Rio Salado College, framed the degrees as applied baccalaureate degrees that would meet a predetermined workforce demand. Senate Bill 1109 proposed authorizing all 19 of the state’s community colleges to offer CCB degrees. Even with the support of leadership from Rio Salado College, the bill was defeated in the House Education Committee after four-year institutions—which deemed the bill “well-intentioned but misguided” and in need of further study—lobbied against the legislation (Thor, 2018).

Previous attempts in Arizona had emerged from urban community colleges, but Eastern Arizona College gradually built political capital within its community during the 2020 and 2021 session as a rural institution seeking approval to confer baccalaureate degrees. Representative Becky Nutt, who represents EAC’s rural home-base of Safford, proposed House Bill 2790 in 2020 and House Bill 2523 in 2021. Opponents of CCB degrees, including the Board of Regents (the state’s governing body for higher education) and four-year institutions lobbied against the 2020 legislation, which passed through the House but failed to get the necessary votes in the Senate Education Committee. Whereas Colorado’s RN to BSN bill had several cosponsors within the Senate Education Committee, Arizona House Bill 2790’s had none. This lack of political capital led to the bill ultimately failing.

In May 2021, however, Arizona passed legislation that built on previous attempts to allow all community colleges within the state to confer baccalaureate degrees but set separate requirements across rural and urban institutions. A community college located in a county with less than 750,000 residents can offer accredited four-year baccalaureate degrees after demonstrating workforce need and student demand. Urban community colleges may do the same but are only allowed to offer CCB degrees if they are less than 5% of the institution’s total degree and certificate offerings and if tuition per credit hour does not exceed 150% of its tuition for any other district program. EAC President Todd Haynie worked alongside Rep. Nutt to advocate both in the legislature and in the media to communicate the potential impacts of CCB degrees for EAC’s local community (Johnson, 2021). Arizona Governor Doug Ducey signed the legislation in May 2021 (Ducey, 2021).
Human Capital: Moving from Transfer to CCB Degrees

Prior to this legislation being adopted, EAC had created transfer agreements with six four-year institutions to meet its students where they are located (Beaulieu, 2014). The only RN to BSN agreement at EAC is with Arizona State University, which offers a concurrent enrollment program allowing students to complete their ADN while simultaneously completing their BSN at Arizona State University. The program currently offers hybrid classes including online and face-to-face classes at EAC, fulfilling the need for BSN degrees, but at a higher price point than future CCB degrees under the 2021 law. Providing this program at EAC through online and in-person instruction increases human capital, such as the education, skills, and acumen of nurses within the local community, allowing nurses to better serve and continue to treat patients where they are located.
Financial Capital: Addressing Barriers for RN to BSN Students

EAC became the first member of Arizona’s Junior College System in 1962, opening state funding for the junior college’s maintenance and operating costs. Even so, investment by the local community is critical to build financial capital. Community colleges in Arizona have uniquely shifted from relying on state appropriations to local appropriations. Arizona provided 7.9% of revenue for community college districts in 2010, but provided just 2.9% in 2019. Arizona eliminated state funding for its two largest community colleges in 2016, resulting in an increase in the proportion of local funding to 50% of total funding for community colleges. This made Arizona the only state with more funding from local than state sources for community colleges (Laderman, 2020). Individual grant programs still exist, but there is a larger burden on local governments to fund community colleges to avoid increasing tuition and fees amid eroding affordability.

EAC and Arizona State University’s concurrent enrollment RN to BSN program has a lower tuition rate than similar programs across the state. Students pay a tuition rate slightly over half of what full-time Arizona State University students pay for their traditional program (See Figure 3). The lower tuition, along with the potential increased earnings and wealth of RN to BSN graduates, helps build financial capital for individuals, and thus the larger community.

While the concurrent enrollment program allows students to pursue a BSN degree within their local community, it does not simultaneously build human and financial capital in the way that a CCB program does. The lower tuition rate is an important step to making the program accessible to students in the Gila Valley, but it is still more than three times higher than EAC’s ADN degree at approximately $84 per credit hour. If EAC begins offering an RN to BSN program under the new law, there is a greater potential for minimizing debt among students by offering a lower tuition rate.
Recommendations
The case studies of CMC in Colorado and EAC in Arizona suggest two criteria that both states used to determine where CCB degrees, including RN to BSN degrees, should be allowed:

01
There must be a clear workforce demand for the CCB programs offered, such as a shortage of nurses practicing in rural communities, that is not currently being met by other training programs within the state.

02
There must be a clear student demand for CCB programs that they cannot otherwise access—either due to geographic distance or due to cost—through current four-year institution program offerings.

Regionally-serving institutions that are the sole provider of postsecondary educational opportunity for the surrounding community meet the first of the two criteria. In addition, community colleges offering CCB degrees can also provide RN to BSN programs at a lower cost due to the lower cost inputs to provide the second two years education achieved with a BSN degree. Both CMC and EAC demonstrated that their programs would provide...
the remote mountains of Colorado and the Gila Valley in Arizona, respectively, with unique opportunities to build the human and financial capital of their local communities. As community colleges uniquely serving the surrounding rural community, both community colleges were well-positioned to identify workforce needs alongside employers, such as hospitals and clinics, and identify a solution to meet workforce needs that also addressed the geographic and financial needs of students.

Community colleges currently located in states that do not currently allow CCB or community college-conferred RN to BSN programs must first determine if they can meet the two criteria outlined above. Without meeting these criteria, CCB degrees run the risk of duplicating already-existing degree programs and overstepping the mission of community colleges to meet the unique workforce needs of the communities they serve. Examining these two criteria through the lens of the unique community capitals for each institution’s surrounding community—especially political, human and financial capital—provides an understanding of which capitals must be further fostered in order to ensure RN to BSN degrees successfully increase student access and address health disparities.

Policymakers, especially state legislators determining whether to continue or allow CCB degrees, must identify whether these criteria have or can be met by community colleges within their state. While Colorado pre-identified CMC as qualified to meet these criteria, Arizona placed the onus on community colleges to complete a study to determine the educational and workforce niche that a CCB degree would fulfill. Policymakers must also determine what approach is most appropriate for their state: a limited pilot to assess CCB feasibility like Colorado, or a blanket policy that sets varying restrictions on CCB degree conferral based on rural and urban geographies like Arizona. There are clear benefits to both approaches. Colorado was able to identify a system of 11 campuses, all who met the criteria above, to pilot the conferral of CCB degrees before committing to statewide action, and later expanded the authority to six other community colleges across the state. Arizona, on the other hand, was able to take action across the state to reach as many students as possible but recognized the increased benefit of rural community colleges in meeting unique student and workforce demands. There is no one-size-fits-all approach that will work in every state, and community capitals provide a valuable framework to explore which approach will yield the best success for students.

In addition, more data are needed to understand the development of RN to BSN programs. While several analyses of individual programs exist, there is no comprehensive list of states or institutions currently offering RN to BSN programs. The creation of a comprehensive dataset will create value through more relevant and accurate research and policy analysis (Kelchen et al., 2019). By incorporating measures of the different community capitals, a dataset of RN to BSN programs would provide insight into how their outcomes—better trained nurses—affect health equity within rural communities.

Recommendations
Conclusion

Community college RN to BSN programs present a promising approach for rural community colleges to build community capital and improve health equity in communities that are medically underserved and experience health professional shortages. RN to BSN legislation and programs are unique and, depending on the identified workforce training needs of a community, they could provide a solution to registered nurse shortages in rural areas. States like Arizona, however, have faced decades-long battles to make the case for CCB degrees, and in response, two-year institutions have established distance learning and transfer agreements with large state universities. States and community colleges must first consider whether there is a justified need for community college RN to BSN programs that universities cannot fill and whether community colleges can support an influx of BSN students. Researchers must better understand the landscape of community college baccalaureate degrees and the potential costs and benefits associated with other efforts to address the push for BSN-educated nurses.
References


References


in the Community College.


Endnotes

1The National Center for Education Statistics defines rural areas into two subtypes based on place size and location relative to a metropolitan area: fringe and remote (NCES 2006). The Health Resources and Services Administration (HRSA) defines two shortage area designations focused on the total number of health-care providers available in a geographic area. Health Professional Shortage Areas (HPSAs) are based on the population to provider ratio, the percentage of the population below 100% of the Federal Poverty Level, and travel time to the nearest source of care (HRSA 2020). Medically Underserved Areas (MUAs) are based on the ratio of providers to 1,000 residents, the percentage of the population below 100% of the Federal Poverty Level, the percentage of the population over 65 years old, and the infant mortality rate.