COMMONWEALTH OF MASSACHUSETTS

CIVIL SERVICE COMMISSION
100 Cambridge Street: Suite 200
Boston, MA 02114
(617) 979-1900

LORRAINE STRONG,
Appellant

v.

DEPARTMENT OF PUBLIC HEALTH,
Respondent

Docket Number: C-23-090

DECISION

Pursuant to 801 CMR 1.01 (11) (c), I, in my capacity as Chair of the Civil Service Commission (Commission), assigned the Commission's General Counsel to serve as presiding officer over an evidentiary hearing into whether the Appellant should be reclassified from Registered Nurse IV (RN-IV) to RN-V.

The Presiding Officer released to the Commission the attached Tentative Decision and advised the parties that they had thirty days in which to provide any written objections to the Commission. No objections were received.

After careful review and consideration, the Commission voted to affirm and adopt the Tentative Decision of the Presiding Officer, thus making the attached the Final Decision of the Commission.

Accordingly, the Appellant's appeal under Docket No. C-23-090 is ***allowed***. In accordance with G.L. c. 30, § 49, her position as RN Supervisor shall be reclassified, effective April 10, 2023, from RN-IV to RN-V, with commensurate compensation retroactive to that date, and the change documented appropriately in the personnel file applicable to this position and in her EPRS forms.

By vote of the Civil Service Commission (Bowman, Chair; Dooley, Markey and McConney, Commissioners [Stein -absent]) on August 22, 2024.

Civil Service Commission

/s/ Christopher C. Bowman
Christopher C. Bowman
Chair

Either party may file a motion for reconsideration within ten days of the receipt of this Commission order or decision. Under the pertinent provisions of the Code of Mass. Regulations, 801 CMR 1.01(7)(l), the motion must identify a clerical or mechanical error in this order or decision or a significant factor the Agency or the Presiding Officer may have overlooked in deciding the case. A motion for reconsideration does not toll the statutorily prescribed thirty-day time limit for seeking judicial review of this Commission order or decision.

Under the provisions of G.L. c. 31, § 44, any party aggrieved by this Commission order or decision may initiate proceedings for judicial review under G.L. c. 30A, § 14 in the superior court within thirty (30) days after receipt of this order or decision. Commencement of such proceeding shall not, unless specifically ordered by the court, operate as a stay of this Commission order or decision. After initiating proceedings for judicial review in Superior Court, the plaintiff, or his / her attorney, is required to serve a copy of the summons and complaint upon the Boston office of the Attorney General of the Commonwealth, with a copy to the Civil Service Commission, in the time and in the manner prescribed by Mass. R. Civ. P. 4(d).

Notice to:
Lorraine Strong (Appellant)
David Markowitz, Esq. (for Respondent)

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v.

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Respondent

Docket Number:	C-23-090
Appearance for Appellant:	Lorraine Strong, *pro se*
Appearance for Respondent:	David Markowitz, Esq. Deputy General Counsel Department of Public Health 250 Washington St., 2nd Floor Boston, MA 02108
Presiding Officer:	Robert L. Quinan, Jr., Esq.[1]

SUMMARY OF TENTATIVE DECISION

The Commission should allow the appeal of Ms. Lorraine Strong, an employee of Western Massachusetts Hospital, to be reclassified from a Registered Nurse (RN) IV to RN-V. Despite the imprecision of the outdated Classification Specification for the RN series, Ms. Strong has proved by a preponderance of the evidence that she has regularly spent a majority of her working time performing the level-distinguishing duties of an RN-V (functional title: Nurse Manager). Although the Respondent recently appointed her to an RN-V position, the Appellant is entitled to a reclassification retroactive to the date she filed her appeal with the Human Resources Division.

[1] The Commission acknowledges the assistance of Law Clerk Daniel Taylor in the drafting of this Tentative Decision. As the duly appointed Presiding Officer, I am filing this initial decision with the Commission today. Pursuant to 801 Code Mass. Regs. 1.01(11)(b) and (c), the parties shall have 30 days from today to file any written objections to this Tentative Decision.

TENTATIVE DECISION

On July 5, 2023, the Appellant, Lorraine Strong ("Appellant" or "Strong"), pursuant to G.L. c. 30, § 49, timely appealed to the Civil Service Commission ("Commission") contesting the June 5, 2023 decision of the state's Human Resources Division (HRD) to affirm the April 7, 2023 decision of the Massachusetts Department of Public Health ("Department" or "DPH") denying her request for reclassification from the position of Registered Nurse IV ("RN-IV") to Registered Nurse V ("RN-V"). A pre-hearing conference was held via Webex on October 2, 2023. I held a full hearing in person (with one witness testifying via Webex) at the Springfield State Office Building on December 1, 2023.[2] The hearing was recorded, and a copy was electronically shared with both parties.[3] The Commission also retained a copy of the hearing recording. For the reasons stated below, I recommend that Ms. Strong's appeal be allowed.

FINDINGS OF FACT:

Twenty-eight exhibits were offered into evidence at or after the hearing: eleven by the Appellant, fifteen by the Department, and two jointly (submitted post-hearing). Both parties chose to file post-hearing briefs. Based on these exhibits, pleadings, and the testimony of the following witnesses:

Called by the Department:

- Alexandra Owens, Classification & Compensation Advisor, Executive Office of Health & Human Services
- Anthony DiStefano, Chief Executive Officer, Western Massachusetts Hospital, DPH

[2] The Standard Adjudicatory Rules of Practice and Procedure, 801 CMR § 1.00, *et seq.*, apply to adjudications before the Commission, with G.L. c. 31 or any Commission rules, taking precedence.

[3] Should there be an appeal of the Commission's final decision, the plaintiff in the action for judicial review shall be responsible for transcribing the evidentiary hearing recordings for the court's use if the plaintiff intends to argue that the Commission's decision lacks substantial supporting evidence, overlooked material facts, or is unreasonable, arbitrary or capricious.

Called by the Appellant:

- Susan Zak, Registered Nurse IV
- Carol McGuill, Registered Nurse IV
- Lorraine Strong, Appellant

and taking administrative notice of all papers filed in the case, plus pertinent rules, statutes, regulations, case law and policies, and drawing reasonable inferences from the credible evidence, I make the following findings of fact:

Appellant's Background

1. The Appellant, Lorraine Strong, is a licensed registered nurse. She holds associate degrees in nursing and medical laboratory technology, a bachelor's degree in nursing, and several related certifications in behavior modification, Alzheimer's treatment, and intravenous care. She has also received several awards from professional associations in the healthcare industry. (Resp. Ex. 4)

2. The Appellant has approximately 30 years of experience as a medical professional and has worked as a nurse in a supervisory capacity since 2003. Since 2014, the Appellant has been employed as a Registered Nurse Supervisor or Nurse Manager, overseeing the Pulmonary Care Unit at Western Massachusetts Hospital ("Hospital" or "WMH"). At the time of the filing of this appeal, she was classified as an RN-IV. (Testimony of Appellant; Resp. Ex. 4)

About WMH and the Appellant's Job Duties

3. WMH is an 87-bed hospital owned and operated by the Commonwealth of Massachusetts via the Department of Public Health. WMH provides acute and chronic care to a variety of patients, but with a particular focus on long-term inpatient care, cardiac and pulmonary disease, neurological disorders and degenerative disease, and end-stage terminal illness. (Administrative Notice [Western Massachusetts Hospital website]; Testimony of Appellant; Testimony of DiStefano)

4. WMH nursing staff are assigned to one of three shifts. The Appellant and all other RN Supervisors are assigned to the first shift, from 7 a.m. to 3 p.m. The second and third shifts are overseen by "house supervisors." Generally speaking, the position of RN Supervisor is more interdisciplinary than that of the house supervisors, because more staff in other departments and positions are present during the first shift than second and third shifts. House supervisors, unlike the Appellant, do not serve on any Hospital policy-setting committees. (Resp. Ex. 6; Testimony of DiStefano; Testimony of Zak; Testimony of Appellant)

5. In her capacity as an RN Supervisor, the Appellant manages WMH's Pulmonary Care Unit, a 21-bed unit divided into three pods. This is "the most acute and busiest [unit] in the Hospital."[4] The Appellant manages payroll and time and attendance for approximately 40 staff, including respiratory therapists, and reports directly to WMH's Chief Nursing Officer ("CNO") (classified as an RN-VI). Her position also involves daily monitoring of collaborative work between registered nurses, certified nursing assistants, unit clerks, respiratory therapists, and housekeeping. Many of the Appellant's oversight responsibilities extend to the second and third shifts, requiring her to be responsive to staff and patients at all times of day (e.g., to respond to patient/family complaints, recommend ordering of equipment, reassign staff). In particular, the Appellant "complete[s] the nursing assignments and allocate[s] the nurses on all three shifts." She oversees patient treatment schedules and compliance with many different required reports over all three shifts. (App. Exhs. 2, 3 and 5; Resp. Exh. 3; Testimony of DiStefano; Testimony of Appellant)

6. WMH's RN Supervisors regularly inspect their units for compliance with state and federal regulations (for approximately 30-60 minutes each day), collect and analyze incident data for

[4] The patient census in the unit the Appellant manages was 50% higher in 2022 than in 2014. (App. Ex. 2)

submission to the Hospital's Quality Assurance unit, and allocate resources and staff between shifts based on patient needs. Additionally, while WMH employs a clinical educator responsible for overseeing the training of its nursing staff (and particularly new hires), the RN Supervisors are typically responsible for administering rather frequent and extensive training on an informal basis, particularly after nursing staff have completed the hospital's formal orientation sessions. For example, the Appellant is a CPR instructor for the Hospital. There are also occasions when the Appellant fills in for the nursing educator, who is classified as an RN V. (App. Exs. 2 and 6; Resp. Ex. 6; Testimony of Appellant; Testimony of McGuill; Testimony of Zak)

7. WMH's RN Supervisors also regularly staff committees devoted to reviewing and revising hospital policy and participate in the hiring of new staff (both RN V or higher-level functions). The latter duty varies in frequency and duration, but each requires several hours each month (i.e., each takes up about an hour in an average week). (Resp. Ex. 6; Testimony of Appellant; Testimony of McGuill; Testimony of Zak)

Appellant's Request for Reclassification and DPH Review

8. On March 30, 2022, the Appellant emailed the Office of Human Resources within the Executive Office of Health and Human Services ("EOHHS"), seeking guidance on the procedure for requesting reclassification of her position from RN-IV to RN-V. She did this after a peer, who likewise managed the Pulmonary Care Unit at another state hospital, advised her that there was no material difference in responsibilities or duties between that Nurse Manager position, classified as an RN-V title, and the RN-IV position the Appellant held at WMH. After the Appellant received guidance on the reclassification process, she filed an appeal with EOHHS that same day. As is standard in reclassification appeals, EOHHS's HR office then asked the Appellant to complete a so-called interview guide. (Resp. Ex. 1; Testimony of Appellant)

9. In her interview guide dated May 9 and May 17, 2022, the Appellant described her appeal as being grounded in a significant expansion of her duties overseeing the Pulmonary Care Unit over the last eight years. This expansion included managing an enlargement of the unit's average census from 14 to 21 and overseeing the implementation of a pod system. In this period, there was also an increase in abstract reviews, evaluations, admissions, and transfers, and an increase in the number of care plans. The Appellant also took on responsibilities related to the implementation of Covid-19 policies, a new out-of-bed program, evaluation of patient data, quality assurance and performance improvement, and specialized training and education within the unit. (Resp. Ex. 3; Testimony of Appellant)

10. The Appellant's official job description, or Form 30, that pre-dated her appeal was dated June 27, 2019. In her interview guide, the Appellant provided the following estimate of her working time based on the responsibilities set forth in that Form 30:

1. **20%** Supervises and directs nursing staff and patient care activities on assigned unit for all shifts.
2. **5%** Ensures the development of individualized care plans for each patient.
3. **5%** Generates nursing assignments and prepares time schedules to ensure adequate nursing coverage 24 hours per day, seven days per week as defined by the hospital staffing system.
4. **5%** Provides staff, patients, and significant others instruction and educational case conferences to ensure continuity of care and compliance with facility standards and regulations.
5. **10%** Ensures the implementation of patient's individual treatment plans, and confers with appropriate health care professionals.
6. **20%** Evaluates nursing activities on all shifts by reviewing patient charts, observing care, and visiting patients and significant others to ensure that nursing care is carried out as directed, and treatment is administered in accordance with physician's instructions.
7. **2.5%** Investigates complaints by patients and others, and attempts to resolve such complaints.

8. **2.5%** Be the primary source for abstract review and off-site evaluations.

9. **5%** Perform duties of charge nurse as necessary. (IDT and Quarterly meeting preparation and attendance).

10. **2.5%** Coordinates the transfer of patients to other health care facilities for emergency and routine services as needed.

11. **2.5%** Requisitions supplies and equipment to ensure established inventory levels, and recommends to the nursing administration the purchase of new equipment to improve and/or maintain the quality of patient care.

12. **5%** Participates in performance evaluation of unit nursing services personnel on the assigned shift and recommends disciplinary action as needed.

13. **10%** Attends and participates in staff meetings and facility committees as needed.

14. **2.5%** Serves as the primary replacement for the Employee Health Nurse.

15. **2.5%** Participates in a schedule to work as the House Supervisor on weekends, holidays, on other shifts and as administratively required.[5]

16. Provides monthly meetings.

17. Performs other job-related duties as needed.

(Resp. Ex. 3; Resp. Ex. 11)

11. In her interview guide, the Appellant described recent changes to her job duties as follows:

- Payroll – SSTA – review and approval of 40 staff (Mon/Wed/Fri 3x/week).
- Monitoring of Time and Attendance Issues (3x or more per week)
- Coverage of weekends/holidays/other units/staffing/EHN/others as needed
- Mock Code Management – scheduling and oversight (monthly)
- META – new EMR system – Super User – Documentation review (daily)
- Unit Clerk – oversight and supervision (daily) – Meetings and Minutes (monthly)
- CPR Instructor for WMH staff (as needed/scheduled)
- Oversight of the Respiratory Therapy personnel (daily)
- Covid-19 new regulations and requirements and infection prevention practices
- Employee Health Nurse – coverage and support (FMLA/Covid-19 issues)

(Resp. Ex. 3)

[5] When the Appellant works a weekend/holiday shift, approximately once per month, she is responsible for overseeing the overall functioning of Hospital nursing services, across all units. (Resp. Ex. 4)

12. In other documentation relevant to this appeal, evidence establishes that the Appellant "[c]onducts daily environment of care checks" to ensure that the Pulmonary Care Unit remains compliant with state and federal patient care standards. The Appellant instructs on—and ensures others' proper use of—the hospital's electronic health records systems. (App. Ex. 2)

13. EOHHS Classification and Compensation Advisor Alexandra Owens met with WMH's Chief Nursing Officer, Chief Executive Officer, and Chief Operating Officer to discuss the Appellant's interview guide. She found, based on the input of those individuals, that the descriptions of the Appellant's job duties were largely accurate, with some minor exceptions.[6] (Resp. Ex. 7; Testimony of Owens)

14. In a letter dated April 7, 2023, EOHHS denied the Appellant's request for reclassification. The letter stated that the Appellant did not perform the duties of an RN-V at least 51% of the time and, instead, her duties fit within those performed by an RN-IV. (Resp. Ex. 8)

15. The Appellant appealed this denial to the Commonwealth's Human Resources Division ("HRD"), per G.L. c. 30, § 49, in an email dated April 10, 2023. (Resp. Ex. 9)

16. In a letter dated June 5, 2023, HRD affirmed the denial of Appellant's request by EOHHS. Therein, HRD agreed (without further explanation) that the duties being performed by the Appellant did not "warrant the reallocation of [her] position." (Resp. Ex. 10)

Classification Specifications

17. The Classification Specification for the Registered Nurse series was developed in 1984,

[6] The management team with whom Owens conferred reportedly objected to the Appellant's characterization of her supervisory duties as "24/7," but it is clear from the record that the Appellant does exercise supervision over all three shifts in her unit: overseeing staffing (including payroll and overtime), providing coverage, collecting data and analyzing incident reports, and responding to patient and family complaints at all times of day, including weekends. (Resp. Ex. 7; Testimony of Owens; Testimony of DiStefano; Testimony of Appellant)

revised in November 1985, and given final approval by HRD effective July 1, 1987. This specifications document summarizes the series as follows:

> Incumbents of positions in this series render primary care to patients; provide psycho-social support; establish plans of patient care; investigate and act upon complaints by patients and others; admit and discharge patients; confer with other healthcare professionals; orient new personnel; and perform related duties as required.
>
> The basic purpose of this work is to provide primary nursing care to patients in in-patient or out-patient hospital units, clinics, infirmaries, or similar institutions.

(Resp. Ex. 12)

18. The Classification Specification for the RN series describes the duties common to all levels in the series as follows:

1. Provides primary nursing care to patients by assessing health status of patients, recording related health data, administering standard nursing treatment, evaluating patient's conditions and adjusting care in conjunction with other providers.
2. Provides psychosocial support to patients.
3. Establishes a plan of patient care with both short and long term goals through consultations with other staff and superiors and through an analysis of data and symptoms.
4. Investigates complaints by patients and others regarding such matters as methods of treatment, room assignments, etc., and attempts to resolve such complaints.
5. Admits and discharges patients; provides and coordinates health teaching to maintain optimum level of health and function.
6. Identifies, evaluates and responds to changes in patients' conditions and reports findings to appropriate health care personnel.
7. Performs related duties such as responding to health and safety issues and initiating appropriate action; and preparing and maintaining pertinent documentation in accordance with regulatory and departmental standards.
8. Attends seminars, workshops, conferences and staff meetings to maintain professional proficiencies and/or licensure.

(Resp. Ex. 12)

19. The Classification Specification for the RN series further describes the additional duties of each level in the series as follows:

Registered Nurse II:
Incumbents of positions at this level or higher also:

1. Perform duties of charge nurse on a ward or unit for a single shift on a regular basis.
2. May instruct ward or unit personnel in nursing techniques, procedures, and equipment.

Registered Nurse III:
Incumbents of positions at this level or higher may also:

1. Oversee the nursing care of patients on assigned ward or unit for all shifts by insuring the development of an individual care plan for each patient, by marking nursing assignments, and by providing staff instruction and educational conferences to insure continuity of care and compliance with facility standards and regulations.
2. Evaluate nursing activities on all shifts by reviewing patient charts, observing nursing care, and visiting patients to insure that nursing care is carried out as directed, and treatment is administered in accordance with physician's instructions.
3. Coordinate the implementation of clients' individual treatment service plans, as determined by an interdisciplinary team, by conferring with appropriate health care professionals in a hospital or institution; may serve as an interdisciplinary team leader.
4. Coordinate the clinical and administrative activities of clinics by utilizing available resources, including personnel, equipment, etc., in order to make appropriate referrals and initiate necessary follow-up care.
5. Provide nursing services, such as infection control and employee health, on an institution-wide basis.
6. Coordinate the clinical and administrative activities of community-based facilities, such as halfway houses, community residences and intermediate care facilities.

Registered Nurse IV:
Incumbents at this level or higher also:

1. Direct the nursing activities for two or more wards or full-time programs for all shifts.
2. Authorize overtime for shift personnel and transportation of patients to other hospitals.
3. Authorize transportation of patients to other health care facilities in emergency situations.

Registered Nurse V:
Incumbents of positions at this level or higher may also:

1. Inspect physical facilities to ensure compliance with Federal and State laws

and regulations.

2. Oversee and implement the quality assurance program and examine medical and other records relative to utilization reviews to ensure compliance with federal, state, and professional standards, regulations and laws designed to ensure and control quality of care.
3. Analyze statistical reports such as reports on patient census, personnel changes, accidents and time and attendance in order to recommend action concerning patient census deployment of personnel and effective use of available resources.

Registered Nurse VI:
Incumbents of positions at this level also:

1. Interview candidates for employment as nurses.
2. Recommend new equipment purchases.
3. Initiate and/or coordinate special research projects to maintain and upgrade quality of patient care.

(Resp. Ex. 12)

20. The Classification Specification for the RN series describes the supervision exercised by an RN-IV as follows:

> Incumbents of positions at this level exercise direct supervision (i.e., not through an intermediate supervisor) over 6 or more registered nurses, 6-15 licensed practical nurses, and 6-15 ancillary personnel such as ward clerks, mental health assistants, attendant nurses, orderlies, and/or volunteer personnel.

(Resp. Ex. 12)

21. The Classification Specification for the RN series describes the supervision exercised by an RN-V as follows:

> Incumbents of positions at this level exercise direct supervision (i.e., not through an intermediate supervisor) over 6-15, and indirect supervision over 16-25 registered nurses, licensed practical nurses and ancillary personnel.

(Resp. Ex. 12)

A New Form 30 for the WMH Nurse Manager and Nurse Strong's Promotion to RN-V

22. In September 2023, the Respondent DPH developed a new formal description of the responsibilities of a Nurse Manager at the various state hospitals. (Joint PH Ex. A) The Form 30

for the position of Nurse Manager at WMH (classified as an RN-V) describes the general duties of the position, then as now held by Ms. Strong, as follows:

- Ensure competent and **person-centered nursing care** within a designated unit(s), overseeing patient care, personnel, and unit management under a performance improvement and **quality assurance** framework.
- Direct, guide, and evaluate nursing personnel, **fostering effective working relationships with multidisciplinary teams**.
- Coordinate care with assigned evening and/or night supervisors, ensuring **24-hour accountability** for patient care, personnel, and unit operations.
- Collaborate on the **development, implementation, and evaluation of policies and procedures** for patient care, based on established standards.
- Evaluate the provision of safe and effective patient care through communication, observation, and **continuous performance improvement**.
- Encourage nursing staff to leverage strengths and address weaknesses for high-quality patient care, providing timely, constructive feedback.
- **Participate in committees for policy development**, performance reviews, and **hiring processes**, contributing to professional development and unit success.
- Facilitate the implementation of **evidence-based practice** to improve patient care.
- Maintain clinical competence, serving as a role model for nursing staff and **ensuring ongoing education** to meet professional needs.
- Collaborate with other healthcare professionals to promote optimal care, treatment, and interventions for all patients.
- Participate in the **development of staffing patterns**, department orientation programs, and unit-based educational opportunities.
- **Monitor compliance with external regulatory/accrediting body standards**, ensuring delivery of care aligns with established benchmarks.

(Joint post-hearing exhibit B, emphasis added[7]).

23. A month after the Commission's December 2023 evidentiary hearing, the Respondent formally posted notice that it was seeking to fill the Nurse Manager positions at WMH with

[7] As will be elaborated upon below, the emphases I have supplied above via boldface text either reflect significant differences in nurse leadership as practiced today, versus how the duties of nurse supervisors were conceived in 1984 when the RN Classification Specification was created, or else highlight key aspects of Nurse Manager Strong's responsibilities in recent years that correspond with an RN-V level of responsibility.

individuals classified as RN-Vs. (Joint PH Ex. A) After the Appellant applied and was interviewed, she was "promoted", effective April 21, 2024, into the position of Nurse Manager in charge of WMH's Pulmonary Care Unit, a position (but not necessarily title) she had in fact held continuously since 2014.[8] There is no indication that the Appellant's functional responsibilities have changed since this personnel action took effect (per Commission post-hearing exhibit 1).

Evolution of Nursing as a Profession Since 1985[9]

24. In 1986, Congress established the National Center for Nursing Research (later renamed the National Institute of Nursing Research or NINR) within the National Institutes of Health. The NINR agency coordinates and supports nursing research across the country, with a focus on promoting multilevel approaches, cross-disciplinary collaboration, and community engagement. (Administrative Notice of NINR webpages regarding NINR's history and mission)

25. "During the 1990s, nursing practice underwent a clinical revolution in response to societal, medical, scientific, and technologic advances." J.M. Stolley et al., "The Evolution of Nursing," J. Neuromusculoskelet. Syst. 2000 Spring; 8(1): 10–15. According to the NINR, RN responsibilities have significantly expanded in the past 40 years with heightened importance accorded to patient

[8] The Appellant testified that when she first joined WMH in 2014 she was given the title of Nurse Manager. A reorganization a few years later, however, resulted in all day-shift unit heads being accorded the title of RN Supervisor, which was not intended by hospital management as any form of demotion. (Testimony of Appellant)

[9] In her testimony before the Commission, Alexandra Owens, a Classification and Compensation Advisor for EOHHS, stated that she did not know why the Classification Specification for the RN series had not been updated since 1985. She also stated that technology, nursing, and the provision of care had changed in this period, but it was her opinion that "the duties they [RNs] are performing are still in line with the existing specifications." (Testimony of Owens). The following paragraphs (nos. 24-30) examine this assumption. What follows do not constitute formal findings of fact but rather observations based on a literature review. The parties are invited to supplement, comment upon, or object to the contents of this section. (*See* footnote 1, *supra*.) Intended to be illuminating only, my recommended decision does not turn on these observations.

safety and advanced nursing practice, which applies science and technology to improve health care delivery. Among the most important ways in which the nursing profession has evolved since the mid-1980s: (1) technological advancements; (2) evidence-based practice; (3) interdisciplinary collaboration; (4) patient-centered care; and (5) a growing emphasis on cultural competence in nursing education and practice. (Administrative Notice of NINR publication on the evolution of nursing practice since 1985)

26. Several transformative technologies routinely employed in the nursing profession today simply were not available 35 or 40 years ago. For example:

> [1.] Electronic Health Records (EHRs): Electronic health records have revolutionized the way nurses document patient care, track health information, and communicate with other healthcare professionals. EHRs provide a centralized platform for storing patient data, facilitating seamless information sharing, improving care coordination, and enhancing patient safety.
>
> [2.] Point-of-Care Technology: Point-of-care technology encompasses various devices and tools that enable nurses to perform diagnostic tests, obtain real-time patient data, and make immediate clinical decisions at the bedside. Examples include handheld devices for measuring vital signs, portable ultrasound machines, and wireless monitoring systems, which enhance efficiency, accuracy, and timeliness of patient care.
>
> [3.] Remote Patient Monitoring Systems: Remote patient monitoring systems allow nurses to monitor patients' vital signs, symptoms, and adherence to treatment protocols from a distance. These systems use wearable sensors, mobile devices, and cloud-based platforms to collect and transmit patient data in real-time, enabling early detection of changes in health status and timely intervention to prevent complications or hospital readmissions.

(*Id*.; Stolley, et al., *supra*.) It falls to Nurse Managers such as the Appellant to oversee the integration and utilization of technology within their units or wards to improve efficiency, communication, and patient care delivery. Apart from serving as an EHR "super user" and instructor, as Nurse Manager Strong does, nurse managers in general may be expected to implement technology-based clinical decision support systems and other technological solutions to enhance workflow and clinical outcomes. (*Id*.; App. Ex. 2) Nurse Manager Strong used

technology, for example, to implement a pod system in the Pulmonary Care Unit she manages at WMH. (Testimony of Appellant; App. Ex. 4)

27. The concept of patient-centered care began gaining traction in U.S. hospitals in the late 20th century. One notable milestone in the promotion of patient-centered care was the publication of the Institute of Medicine's landmark report "Crossing the Quality Chasm: A New Health System for the 21st Century" in 2001. This report highlighted the need for nurse managers to champion a patient-centered approach to healthcare delivery and called for fundamental changes in the organization and delivery of healthcare services to improve patient outcomes, safety, and satisfaction.

28. Evidence-based practice (EBP) concepts began appearing in the medical literature in the mid-1990s, but the nursing community did not really embrace the practice until the 2000s. In nursing, EBP is a systematic approach that integrates clinical expertise with scientific knowledge to improve practice and patient outcomes. For example, a primary tenet in EBP implementation in nursing focuses on meeting a patient's needs and weighing carefully each patient's experiences and preferences. (Evidence-based practice in nursing article; Stolley, et al., *supra*.)

29. In 2010, following Congressional passage of the Affordable Care Act, the national Institute of Medicine partnered with the Robert Wood Johnson Foundation to release a report entitled "The Future of Nursing: Leading Change, Advancing Health."[10] The report included the following recommendations:

> **Recommendation 1: Remove scope-of-practice barriers.** *Advanced practice registered nurses should be able to practice to the full extent of their education and*

[10] I take administrative notice of this official report, cited as: "The Future of Nursing: Leading Change, Advancing Health." Institute of Medicine (US) Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. Washington (DC): National Academies Press (2011).

training.

Recommendation 2: Expand opportunities for nurses to lead and diffuse collaborative improvement efforts. *Private and public funders, health care organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team to conduct research and to redesign and improve practice environments and health systems. These entities should also provide opportunities for nurses to diffuse successful practices.*

. . .

Recommendation 6: Ensure that nurses engage in lifelong learning. *Accrediting bodies, schools of nursing, health care organizations, and continuing competency educators from multiple health professions should collaborate to ensure that nurses and nursing students and faculty continue their education and engage in lifelong learning to gain the competencies needed to provide care for diverse populations across the lifespan.*

Recommendation 7: Prepare and enable nurses to lead change to advance health. *Nurses, nursing education programs, and nursing associations should prepare the nursing workforce to assume leadership positions across all levels, while public, private, and governmental health care decision makers should ensure that leadership positions are available to and filled by nurses.*

Twenty-first century nurse managers are expected to champion innovation, lead change management initiatives, and foster a culture of continuous improvement within their units or wards.

30. In May 2021, the Committee on the Future of Nursing 2020-2030 released a follow-up report entitled "The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity."[11] The report included the following recommendations:

. . .

Recommendation 2: By 2023, state and federal government agencies, health care and public health organizations, payers, and foundations should initiate substantive actions to enable the nursing workforce to address social determinants of health and

[11] Again, as an official government report, I take administrative notice of "The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity." National Academy of Medicine Committee on the Future of Nursing 2020–2030; Flaubert JL, Le Menestrel S, Williams DR, et al., editors. Washington (DC): National Academies Press (May 11, 2021).

health equity more comprehensively, regardless of practice setting.

> **Recommendation 3:** By 2021, nursing education programs, employers, nursing leaders, licensing boards, and nursing organizations should initiate the implementation of structures, systems, and evidence-based interventions to promote nurses' health and well-being, especially as they take on new roles to advance health equity.
>
> **Recommendation 4:** All organizations, including state and federal entities and employing organizations, should enable nurses to practice to the full extent of their education and training by removing barriers that prevent them from more fully addressing social needs and social determinants of health and improving health care access, quality, and value. . . .
>
> **Recommendation 6:** All public and private health care systems should incorporate nursing expertise in designing, generating, analyzing, and applying data to support initiatives focused on social determinants of health and health equity using diverse digital platforms, artificial intelligence, and other innovative technologies. . . .

In general, today's Nurse Managers are much more involved than their counterparts thirty or forty years ago in setting organizational goals, developing policies and protocols, and allocating resources to ensure efficient and effective patient care delivery. Through committee and interdisciplinary team efforts and special projects, the Appellant has made high-level contributions to WMH, in line with the above recommendations. (See App. Exhs. 2, 3, 10, and 11)

LEGAL STANDARD

Section 49 of G.L. c. 30 provides:

> A manager or an employee of the commonwealth objecting to any provision of the classification affecting the manager or employee's office or position may appeal in writing to the personnel administrator. Any . . . employee or group of employees further aggrieved after appeal to the personnel administrator may appeal to the civil service commission. Said commission shall hear all appeals as if said appeals were originally entered before it. If said commission finds that the office or position of the person appealing warrants a different position . . . it shall be effective as of the day of the appeal.

Generally speaking, "the bar for proving that one's position is misclassified is set very high." Shields v. Department of Revenue, 21 MCSR 263, 266 (2008). To prevail in a

reclassification, an appellant must prove, by a preponderance of evidence, that they perform a majority of the functions of the classification title they seek and that they perform those functions a majority of the time. See, e.g., Thompson v. Division of Insurance and HRD, 29 MCSR 565 (2016). Stated differently, in order to justify a reclassification, an employee must establish that they are performing duties encompassed within the higher-level position the majority (i.e., at least 50% or more) of the time. See, e.g., Pellegrino v. Department of State Police, 18 MCSR 261 (2005) (at least 51%). Further, "[w]here duties are equally applicable to both the lower and higher titles, although they may be described slightly differently for each title, those types of overlapping duties are not distinguishing duties of the higher title." Saunders v. Dep't. of Labor Standards, 32 MSCR 413, 415 (2019).

ANALYSIS

A holistic view of the evidence in this case compels the conclusion that Ms. Strong, as the Nurse Manager in charge of one of the four major units at WMH, had been misclassified as an RN-IV prior to her recent promotion. Although the HRD-approved Classification Specification document for the job titles in question traditionally has served as the touchstone for reclassification appeals, when that document has not been updated in many decades, proper adjudication may depend on supplementation with any (more recent) formal job description for the sought-after titles and other competent evidence of incumbents' actual duties. Here the marked evolution of the nursing profession in general, and nurse leadership in particular, over the past four decades necessitates the examination of material beyond the four corners of the Classification Specification for the RN Series approved by HRD nearly 40 years ago.

In general, the process of determining what proportion of their working time an appellant seeking reclassification regularly spends performing certain duties is necessarily limited in its

precision; normally, it requires the appellant to estimate the composition of a "typical" workday or work week, which may be ill-suited to capturing important, though only occasional, monthly, or annual obligations. Likewise, the interview guide—which serves as another pivotal document in a reclassification review—often is heavily influenced by the specific duties set forth in an appellant's Form 30, which may also be several years out of date. In this case, the Appellant's request for reclassification followed a recent expansion of her assigned unit and the implementation of several new policies (including policies related to Covid-19, which were conceived and implemented entirely after the most recent, pre-appeal update to the Appellant's Form 30 in June 2019).

Some of the descriptions of regular duties contained within the 2019 Form 30 and the Appellant's interview guide are also somewhat vague (e.g., "Supervises and directs nursing staff and patient care activities on assigned unit for all shifts"), not mapping precisely onto the duties described by any title in the RN series Classification Specification. Accordingly, I also look to other parts of the record before me, including supporting documentation (e.g., organizational charts, examples of work produced by WMH's RN Supervisors[12]) and the testimony of Zak, McGuill, and the Appellant, to clarify the particulars of these more general descriptions.

By the same token, in light of the fact that the RN series Classification Specification document was last revised in 1985, I give less weight to some of the illustrative examples presented therein. The Commission has generally permitted the use of classification specifications of

[12] The Appellant submitted in evidence over 200 pages of documentation reflecting or illustrating the responsibilities of WMH RN Supervisors/Managers that give insight into the high-level oversight they maintain over patient care plans, admissions and discharges, utilization review activities, incident and accident reports, quality assurance initiatives, performance improvement plans, accreditation maintenance, internal policies and procedures, education and training responsibilities, and other topics. (App. Exhs. 3-11)

considerable age, so long as the duties described therein are consistent with those still actually being performed. See, e.g., Bhupendra Naik v. MassDOT, C-20-123 (2021) (finding classification specifications from 1989 to be consistent with duties performed in 2019). However, past Commission decisions have admonished employers to reconsider reliance on classification specifications that do not properly encompass the functional titles which are at issue in reclassification disputes. See, e.g., Christine Poland v. Department of Revenue, C-08-110 (2008) (finding the EDP series ill-suited for the "Account Analyst" position); Denise Snyder v. Department of Revenue, C-10-37 (2010) (denying the Appellant's request for reclassification but acknowledging that her duties were poorly described by the CSES series).

Having last been revised 37 years before this Appellant's request for reclassification, the RN series is among the oldest classification specifications the Commission has ever examined. Furthermore, nursing as a profession has undergone significant changes over the last four decades, including the establishment of a National Institute for Nursing Research, and the release of several landmark reports calling for sweeping changes in education requirements, the scope of duties, and clinical practices, and the embrace of (ever-more-complex) technology. The profession also places far more emphasis than it once did on patient-centered care, evidence-based practice, interdisciplinary cooperation, and cultural competence. In short, the Classification Specification for the RN series makes little (or no) allowance for the considerable work done in the last four decades to improve the skills of nurses and revolutionize the ways in which they provide quality patient care.

Respondent DPH appears to acknowledge this, at least implicitly, in its current Form 30 for the position of Nurse Manager, now classified as an RN-V. The duties described therein are consistent with the abovementioned changes to nursing that have taken place in the past several

decades. They also map perfectly onto the responsibilities the Appellant has discharged ever since commencing her reclassification quest. Revert back to Finding no. 22 above and observe how at least half a dozen of the concepts or responsibilities appearing in boldface in my synopsis of DPH's 2023 RN-V Form 30—all matters central to the Appellant's functions as head of the WMH Pulmonary Care Unit—are missing entirely from the 1985 RN Classification Specification lists of distinguishing duties either for all RNs or nurses at the RN IV and lower levels. As such, rather than a blinkered reading of the Classification Specification that might be construed to require an RN-V, for example, to be specifically involved in overseeing the entire hospital's quality assurance *program* or managing *permanent* increases or decreases in the patient census, I recommend a broader reading of the level-distinguishing duties described by the Classification Specification, emphasizing the spirit rather than strictly the text thereof. Those central duties at the RN-V level include: (1) inspecting physical facilities to ensure compliance with laws and regulations, (2) ensuring quality of care by implementing quality assurance initiatives and regular examination of records, and (3) analyzing data from multiple sources to ensure effective allocation of staff and use of resources. (Resp. Exh. 12) This reading is consistent not only with the duties described in related Form 30s, but also with the Appellant's core duties as an RN Supervisor/Manager: performance improvement, promoting quality of care, allocation of staff, oversight of a multi-disciplinary team, collaborative development and implementation of policy, and ensuring compliance with industry regulations. Quite apart from the bottom-line result that such modest interpretational flexibility yields (a positional reallocation), I give weight to the fact that the Appellant's peer at another state hospital, who also manages that hospital's Pulmonary Care Unit, and who does not have materially greater responsibilities than the Appellant, has for several years

at least been classified as an RN-V.[13]

It is true that a not insignificant portion of the Appellant's duties fall within the duties of an RN-IV or lower. For example, the development of individual care plans is a responsibility of RN-IIIs, and exercising the duties of a charge nurse as needed, or providing coverage for a house supervisor, also fall within the duties of an RN-II or III. Coordinating the implementation of individual treatment plans is likewise a duty of RN-IIIs, and providing informal instruction to nursing staff, depending on how elaborate the training becomes, might be considered a duty of RN-IIIs.[14] Altogether, these duties comprise approximately 30% of the Appellant's working time.

As to the duties which fall more clearly under the description of an RN-V, the Appellant spends between 30 and 60 minutes each day inspecting her unit to ensure safety and compliance with state and federal regulations; unquestionably a level-distinguishing duty of RN-Vs, and equivalent to approximately 10% of the Appellant's working time. She also spends an estimated 5% of her time participating in performance evaluations, and an additional 5% assigning staff across shifts based on patient needs; that is, analyzing reports to effectively deploy resources and ensure quality of care. The Appellant also regularly spends approximately two hours in an average week (i.e., 5% of her working time) engaged in the hiring of new staff and recommending the

[13] I reject the Respondent's argument that an RN-V designation was justified for the Appellant's peer at the other state hospital in 2022, but not the Appellant at that time, because the former is not formally assigned to a particular shift; rather, I find that the Appellant has always discharged equivalent "24/7" responsibilities despite being nominally assigned to the day shift. I also find there to be a qualitatively *very* significant difference in the level of responsibility assumed by the Appellant as compared to the "house supervisors" who oversee the second and third shifts at WMH, even though the latter, like the Appellant before April 2024, also had been designated as RN-IVs. (See App. Ex. 2)

[14] I note, however, that the "[a]bility to plan and conduct training or instruction in nursing" is a level-distinguishing qualification for an RN-V per the 1980s Classification Specification. (Resp. Ex. 12 at 10) The Appellant clearly met and delivered on this qualification at the time of her appeal.

purchase of new equipment. Per the 1980s Classification Specification, these are in fact level-distinguishing duties of an RN-VI but may be considered overlapping with the duties of an RN-V to ensure quality of care and the effective allocation of staff. Certainly, it is not the duty of a level lower than RN-V. In sum, these duties make up a good 25% of the Appellant's working time.

Most of the remaining duties described in the Appellant's interview guide and elaborated upon in testimony before the Commission are more difficult to categorize, as they deal primarily with the nature of the Appellant's supervisory authority. I am unwilling to say that a general statement of duties such as "supervises and directs nursing staff and patient care activities" falls squarely within one level or another within the RN series. Indeed, such a statement might encompass the duties of any supervisory job therein, given its considerable breadth. That said, a review of the Appellant's more specific duties, based on extensive documentary evidence, suggests a prodigious amount of the high-level oversight that typifies the RN-V position (as the third-level supervisory job in the series). (*See generally* App. Exhs. 2-11) To that end, I also credit the testimony of the Appellant, as well as that of her peers McGuill and Zak, all of whom described the position of RN Supervisor as dealing with, primarily, allocation of staff and resources, monitoring of compliance with law and policy, and ensuring quality of care.[15] Added to the more easily-identifiable level-distinguishing duties of an RN-V, as specified in the 1980s-era Classification Specification,[16] the upper-level supervisory responsibilities that Nurse Manager Strong discharges on a daily basis easily carry her over the 50% threshold for an RN-V designation.

[15] This testimony was lent particular credence by its consistency with the Form 30 description of WMH's Nurse Manager duties, summarized in Finding no. 22 and discussed in more detail above.

[16] For example, I credit the Appellant with the RN-V-level-distinguishing "knowledge of the methods used to evaluate nursing practices" (Resp. Ex. 12 at 11) as she in fact routinely evaluates, competently, the many nurses who directly or indirectly report to her.

And the proof is in the pudding: Without any material expansion or alteration of her functional responsibilities, the Appellant has now been "promoted" to an RN-V.

To give particular examples, in both her former capacity as an RN Supervisor, and now as a Nurse Manager, the Appellant is and has been responsible for investigating reports of accidents, fashioning and proffering said reports to quality assurance staff, and taking or recommending action to prevent further accidents of the same nature. She recommends new equipment purchases for her Unit, a level VI distinguishing duty. Likewise, she has always (at least since first seeking reclassification) been responsible for evaluating nursing activities on all shifts via the review of reports and data, to ensure that care is being properly administered (again, fulfilling an RN-V duty by ensuring quality of care and the effective allocation of resources and staff). Given that the Appellant oversees approximately 40 staff on a regular basis (a number far more consistent with the supervision exercised by an RN-V than that exercised by an RN-IV), and holds administrative responsibilities like overseeing payroll and use of FMLA banks, I find that she is not, and has not been, engaged solely in the oversight of ward-level nursing activities, as might be expected of an RN-III or IV. That all of WMH's RN Supervisors/Managers regularly engage in the review and revision of hospital policy further supports my bottom-line finding.

Consequently, given the weight of documentary and testamentary evidence present in the record,[17] I find that the Appellant has proven by a preponderance of the evidence that she had been improperly classified as an RN-IV prior to April 21, 2024, and ought to have been classified as an

[17] One final note: There is no question but that the Appellant satisfied upon hire the minimum entrance requirements for an RN-V as laid out in the 1980s-era Classification Specification. *Compare* Resp. Ex. 4 (Appellant's pre-appeal résumé) *with* Resp. Ex. 12 (RN Class. Spec. at 13).

RN-V at the time she initiated her reclassification appeal.[18]

CONCLUSION

For all of the above reasons, I recommend that the appeal of Lorraine Strong under Docket No. C-23-090 be ***allowed***. In accordance with G.L. c. 30, § 49, her (pre-May 2024) position as RN Supervisor shall be reclassified, effective April 10, 2023, from RN-IV to RN-V, with commensurate compensation retroactive to that date, and the change documented appropriately in the personnel file applicable to this position and in her EPRS forms.

Civil Service Commission

/s/ Robert L. Quinan, Jr.
Robert L. Quinan, Jr., Esq.,
General Counsel and assigned Presiding Officer

Date: June 12, 2024

Notice to:
Lorraine Strong (Appellant)
David Markowitz, Esq. (for Respondent)

[18] Chapter 30 of the General Laws authorizes this Commission to order compensatory relief to an appellant who successfully establishes that her position "warrants a different position allocation"; relief that is retroactive to "the date of appeal to the personnel administrator [or, more specifically, HRD's Classification and Compensation Unit]." G.L. c. 30, § 49; *see also* G.L. c. 30, § 57. In this case, the operative "date of appeal" is April 10, 2023. (Resp. Ex. 9)