

122nd Meeting of the National Advisory Council on Nurse Education and Practice
April 22-23, 2010

Participants

Council Members

E. Michele Richardson, MS, BSN, RN, Chair, NACNEP
Lakisha Smith, MPH, Executive Secretary, NACNEP
Karen Cox, PhD, RN, FAAN
Shirlee Drayton-Brooks, PhD, RN, CRNP, APRN, BC, CRRN
M. Jean Gilbert, PhD
Bettie J. Glenn, EdD, RN
Diana R. Jolles, CNM, MSN (via phone)
Maureen R. Keefe, RN, PhD, FAAN
Cydne Marckmann, MN, ARNP
Ann Minnick, PhD, RN, FAAN
John J. Nagelhout, PhD, CRNA, FAAN
Brandon N. Respress, PhD, RN, MSN, MPH, CPNP
Rhonda A. Scott, PhD, RN
Diane J. Skiba, PhD, FAAN, FACMI
Joyce Thompson, DrPH, RN, CNM, FAAN FACNM

Presenters

E. Michele Richardson, MS, BSN, RN
Director, Division of Nursing, BHPr, HRSA
Lakisha Smith, MPH
Division of Nursing, BHPr, HRSA
Maureen Keefe, RN, PhD, FAAN
Executive Committee Chair, NACNEP
M. Christina Johnson, CNN, MS
Director of Professional Practice and Health Policy, American College of Nurse-Midwives
Linda Olson Keller, DNP, RN, FAAN
Section Public Health Nursing Chair, American Public Health Association
Michelle Beauchesne, DNSc, RN, CPNP, FNAP, FAANP,
President, National Association of Pediatric Nurse Practitioners
Patti Rager Zuzelo, EdD, RN, ACNS-BC, ANP-BC, CRNP
President, National Association of Clinical Nurse Specialists
Ginger Rogers, ARNP, DNP, GNP-BC
GNP-MAP Project Coordinator, University of Nebraska Medical Center, College of Nursing

Thursday, April 22, 2010

Welcome, Introductions, and Review of Agenda

E. Michele Richardson, MS, BSN, RN

Ms. Richardson called to order the 122nd meeting of the National Advisory Council on Nurse Education and Practice (NACNEP) at 8:43 am. Ms. Richardson welcomed the Council members, speakers, HRSA staff, and guests and thanked the Council members for their ongoing work.

Ms. Richardson provided an overview of the 122nd meeting. While health care reform will have a significant impact on nurses and nursing programs, she noted that it is too early to discuss reform as there is still a lot of interpretation and clarification that must occur before implementation can begin. She reviewed HRSA's current priorities, which are:

- Establishment of interprofessional collaboration;
- Professional competencies; and
- Collection of strong workforce data (e.g., through partnerships with national nursing organizations).

Purpose of the Meeting: To address issues relating to the role of nursing in primary care and implications for workforce.

Objectives

1. Delineate the variety of roles nurses play in primary care including health promotion, screening, public education, illness prevention, primary care and management of stable chronic conditions when an expanded, comprehensive definition is used.
2. Review and evaluate the data related to educational preparation and supply of primary care nurses and advanced practice registered nurses (APRNs).
3. Describe factors that facilitate and sustain primary care practice by qualified, competent APRNs.
4. Identify the financial and regulatory barriers to effective, accessible primary care delivered by nurses and recommended strategies for resolution.
5. Review and recommend community-based, nurse-directed models for primary care delivery that are cost effective and produce quality outcomes.

The 122nd meeting builds on the previous meeting, which focused on advanced practice models. At the 121st meeting, members determined that it would be helpful to learn about other nurses, especially those involved in the provision of primary care. In addition to the presentations during the meeting, NACNEP requested that organizations submit information about their activities in this area. Approximately eight responses have been received.

Finally, Ms. Richardson congratulated Dr. Irene Sandvold of the Division of Nursing, who was recognized with a lifetime achievement award from the National Organization of Nurse Practitioner Faculties (NONPF).

Framing the Focus of the Meeting

Maureen R. Keefe, RN, PhD, FAAN

Dr. Keefe reviewed the details of the all advisory council meeting that took place on April 21. The meeting was the third time an all advisory council meeting has been held.

During the second meeting, participants drafted a statement that was sent to Congress. The statement had a significant impact on the health care reform process.

Dr. Keefe and Dr. Drenkard participated in the planning process for the third all advisory council meeting. The planning committee determined that a focus on professional competencies would allow for collaboration with foundations and national organizations and is an important issue for all the advisory councils—requiring the councils to work together towards a consensus.

As the advisory councils move forward, the chair of the NACNEP executive committee will represent NACNEP in the process.

Dr. Keefe asked NACNEP members to provide feedback on the all advisory council meetings.

Dr. Glenn stated that it is both an opportunity to interact with other disciplines and for nursing to educate other disciplines about professional competencies.

Dr. Thompson stated that there needs to be a single definition for competencies and competence. The definitions provided at the meeting were not complete. There needs to be a shared language as many people use the terms but have a different understanding as to what they mean.

Dr. Drayton-Brooks stated that the meeting was beneficial and that some interesting models on team-based competencies were provided. There is a clear need for ongoing evaluation work. None of the models presented included a well-designed evaluation of the model.

Dr. Minnick stated that working in small groups with the members of other councils was beneficial. Participants learned about writing educational objectives and evaluating competencies. To make competencies become a reality, an approach similar to the Clinical and Translational Science Awards (CTSAs) is needed. When making grant awards, HRSA should include the requirement that no funds will be provided unless the grantee includes an interdisciplinary and rigorous evaluation component.

Dr. Thompson stated that there must be an emphasis on interprofessional collaboration. There are different perspectives on what constitutes interprofessional collaboration—it is across major professions, not the subspecialties within a profession.

Dr. Drayton-Brooks stated that there is a need for infrastructure enhancements to achieve a collaborative team approach to care, particularly in areas that are rural, isolated, have fewer providers, and limited resources.

Ms. Richardson reported that Title VIII has been reauthorized. The Division of Nursing will be re-evaluating the Title VIII programs to determine if they are still meeting the Nation's needs. In particular, the components of the grants and the evaluation sections

need to be considered (e.g., what type of evaluation is appropriate). Ms. Richardson recommended that the Council members provide feedback when a summary of modifications are implemented in the next several months.

Dr. Thompson asked if the Division gives specific guidance on the key components of an evaluation. The Division could provide technical assistance in this area.

Dr. Minnick stated that there is a lot of variation across the evaluation components included in proposals. It might be more effective (and cost-effective) if the Division developed standards evaluations for its programs. People try to conduct evaluations without the necessary expertise and tools. With guidance, grantees might produce a better product.

Ms. Richardson stated that the Division is entering into partnerships that will impact the grant programs. The Division is working with the National League for Nursing (NLN) to conduct sessions for nurses on how to write grants and there has been a lot of demand for this activity. In addition, the Division has recognized a need to work with nursing faculty in the areas of grant writing and managing grants. Nurse educators need technical assistance in this area.

Ms. Richardson stated that the Division is currently reviewing the performance measures used by grantees. For example, for nurse-managed centers, the Division is exploring the UDS measures used by FQHCs, as these may be appropriate.

Nurse Specialty Organization Presentations

The Role of Midwives in Primary Care

M. Christina Johnson, CNN, MS

Certified Nurse Midwives (CNMs) have a long tradition of reaching out to underserved communities. The characteristics of midwifery make this outreach especially appropriate. These characteristics include:

- Use of scientific evidence in clinical practice;
- Shared decision making;
- Communication and counseling;
- Public health promotion, disease prevention, and health education;
- Work with vulnerable populations; and
- Collaboration with other health care team members.

Certified Nurse Midwives

- Education programs accredited by Accreditation Commission for Midwifery Education (ACME)
- Take primary care courses alongside other graduate nursing students
- National exam administered by American Midwifery Certification Board (AMCB)
- Licensed independent providers with prescriptive authority in all 50 States

Midwives are defined as primary care providers under Federal law and play an important role in the provision of primary care to women—for many women, especially underserved women, they are the initial point of contact. Midwifery services are a

mandatory benefit under Medicaid. The American College of Nurse-Midwives (ACNM) defines the components of primary care as: 1) integrated, accessible health care services; 2) addresses the majority of health care needs; 3) sustained partnership with patients; and 4) care provided in the context of family and community. Midwives practice in a variety of settings including: hospitals and birth centers; home care; migrant health centers; health care for the homeless programs; public housing primary care programs; and urban Indian and tribal health centers. For example, in 2006 there were over 370 CNMs working in FQHCs and they provided over 800,000 encounters.

In the 1990s, there was a significant increase in nurse midwifery education and practice. The total number of midwives ever certified is currently over 11,000. CNMs are predominantly white, female, and the average age is 50. Students are also predominantly white and female, with an average age of 36. CNMs have been certified, on average, for 15 years. It is important to note that this is an aging workforce, with many facing retirement in the near future.

Midwifery education programs increased from 28 in 1990 to 50 in 1997. Currently, there are 40 accredited programs, with the vast majority of programs (37) residing in colleges of nursing. In 2008, there were over 800 applicants to midwifery programs, approximately 1300 students enrolled in programs, and just under 300 CNMs received their certification. However, it is important to note that it is a challenge to provide clinical practice sites for students, which can limit the number of students prepared by programs. Clinical placement sites often go to funded medical residencies as hospitals cannot bill for CNM training of students or residents.

The 2007 AMCB Task Analysis Survey revealed that over 96 percent of midwives have master's or doctoral degrees and 93 percent had prior experience as an RN. Over 50 percent are employed by a medical center, hospital, or physician group. Twenty-three (23) percent held dual certification as a Family Nurse Practitioner, Women's Health Care Nurse Practitioner, or Adult Nurse Practitioner. Eighty-one (81) percent practice in large urban areas.

Of those surveyed, 47 percent reported providing primary care services, which means a large number of CNMs who are prepared to provide primary care are not practicing. However, it was noted that rural CNMs were not well represented in the study and they are more likely to be providing primary care services. Another reason is that CNMs may prefer to focus on attending births. In addition, in some practice settings, such as health care systems, the role of CNMs may be limited due to institutional policies.

According to the ACNM Core Data Survey, characteristics of CNMs that reported primary care as their main responsibility included full-time employment, working in physician- or midwife-owned practices, and master's level preparation (non-doctoral degree holders).

In addition to the aging workers, there are multiple workforce issues that may impact the supply of CNMs in the future. There is high burn out and job dissatisfaction—in one

survey respondents reported working 49-99 hours per week. There is also a lack of racial/ethnic diversity in the field.

There are also practice barriers and the Federal, State, and institutional level. Medicare/ Medicaid Conditions of Practice (CoPs) limit the ability of CNMs to obtain clinical privileges. In addition, under Medicare, CNMs cannot perform some key primary care functions such as:

- Certify patients for home health services or hospice care;
- Perform physical exams authorizing Workers Compensation claims; and
- Order respiratory services.

State regulations, which vary from State to State, also serve as barriers. Barriers include:

- Requirements for signed written collaborative agreements;
- Prohibitive supervisory language;
- Statutory exclusion of primary care from defined scope of midwifery practice; and
- Varying Medicaid reimbursement rates (e.g., less pay for equal services).

In addition, some States require that CNMs have a master's degree in nursing and there is often a lack of "grandfathering" clauses when regulations change. This makes it difficult for CNMs to practice in another State.

At the institutional level, barriers include:

- Admitting/discharge privileges denied;
- Services billed under physician's name (which can also create problems in the coordination of care)
- Lost birth certificate and outcome data;
- Prohibitive professional liability costs;
- Lack of voting rights on medical staff; and
- Lengthy credentialing procedures with no due process.

Strategies for Resolution

- Amend Medicare/Medicaid CoPs to require hospitals to privilege providers to the full extent of licensure
- Equitable reimbursement rates
- Increase funding sources, site for training
- Tort reform
- Research

The practice restrictions and inadequate reimbursement rates can serve to make practicing as a CNM unappealing and also result in fewer students pursuing midwifery as a career.

The Patient Protection and Affordable Care Act addresses many of these issues and many of these provisions were included in health care reform. Important provisions included in the Act are:

- Equitable reimbursement for CNM services under Medicare Part B, increasing from rates from 65 percent to 100 percent;
- Encourage Medicaid plans and third-party payers to adopt equitable reimbursement policies for midwifery services;
- Recognize freestanding birth centers under Medicaid;

- Improve access to women’s preventive health services;
- Ensure women direct access to the CNM/CM of their choice;
- Take steps to address the health care workforce needs of the Nation; and
- End gender discrimination and exclusion based on pre-existing conditions.

A model of CNM-based care is Centering Pregnancy. The model is based on health care assessment, education, and support—essentially providing a medical home for women during their pregnancy and beyond. The model focuses on group prenatal care provided by a midwife and a co-facilitator. This approach results in the patients spending more time with providers and others—learning with and from each other. The model has worked well with low-income women and has resulted in a reduction in preterm births and increased satisfaction and breast feeding rates. It has also improved knowledge about and readiness for birth and parenting skill.

Programs that have implemented other innovative and effective models include Maryland General Women’s Health Associates (midwives provide and refer patients to a wide range of primary care services) and DC Developing Families Centers, a collaboration between three nonprofit service providers that builds on clients’ strengths and promotes empowerment. Through the collaboration, the program meets the primary health care, social service and child development needs of underserved individuals and families. These innovative models improve community health by utilizing interdisciplinary team members to the full scope of their licensure. To fully implement these models requires appropriate regulation, equitable reimbursement, credentialing, and training must be mandated in order to ensure an adequate workforce.

The Role of Public Health Nursing in Primary Care: Workforce Implications

Linda Olson Keller, DNP, RN, FAAN

The National Association of County and City Health Officials (NACCHO) estimates that every health department employs at least one public health nurse. Public health nurses play an important role in responding to the problems in communities. Most public health nurses participate in primary medical care, even though most health department do not provide primary care (only 11 percent of health departments provide primary care). Some of the roles public health nurses play include assessments for developmental delays and early intervention, care coordination for people with special needs and chronic illness (83 percent of public health nurses perform case management on a regular basis), injury prevention, parenting programs (to prevent maltreatment of children), directly observed therapy (e.g., TB), and health screenings in schools and worksites. Practice settings include: clinics; correctional facilities; daycare centers; group homes; private homes; hospitals; schools; homeless shelters; and worksites.

Public health nurses specialize in community-level work. This type of work often goes way beyond health care and relies on many partners within the community. For example, public health nurses in Bloomington, MN had a long-time relationship with families in an apartment complex. When the nurses learned that rents were randomly increased and that the units were unsafe because necessary repairs were not completed, they contacted a tenant advocacy organization. The tenants were reluctant to engage with the advocacy organization—there was no existing relationship. The public health nurses used their existing ties to tenants to introduce the advocacy organization. As a result, the necessary bridges were built and the advocacy organization was able to make the building owner comply with the law. The situation would have never come to light, nor been resolved, without the involvement of the public health nurses.

Factors to Facilitate the Provision of Primary Care by Public Health Nurses

- Baccalaureate standard for entry into practice
- Ongoing stable funding for health departments
- Competitive salaries commensurate with responsibilities
- Interventions grounded in and responsive to community needs
- Consideration of health determinants
- Experience in health promotion and prevention
- Long-term trusting relationships in the community (i.e., with patients)
- Established network of community partners
- Commitment to social justice and eliminating health disparities

A baccalaureate degree in nursing is the educational credential for entry into public health nursing. However, there are some States that do not follow this standard. Public health nurses make up the largest component (more than 25 percent) of the public health workforce. It is estimated that approximately 50,000-60,000 registered nurses working in public health, which is about two (2) percent of the RNs in the United States.

The public health nursing workforce is in a state of flux. A 2004 survey showed a reduction in the number of RNs working in the community and public health settings by approximately five (5) percent. At the same time, there has been a reduction and/or elimination of public health nurse positions due to budget cuts in local and State health departments. Currently, health departments report a shortage of public health nurses. In an Association of State and Territorial Health Officials (ASTHO) survey, the majority of States reported public health nursing as the field that will be most affected by workforce shortages in the future.

Barriers to increasing the supply of public health nurses include:

- Deteriorating public health nursing leadership infrastructure (e.g., many States lack a Director of Public Health Nursing and/or a Chief Nurse Position);
- Public health nurse workforce shortage;
- Inadequate supply of BSN graduates results in hiring of AD grads;
- Lack of clinical sites that provide meaningful public health nurse experiences;
- and

- Lack of accurate data on the public health network workforce.

There are viable ways to address these issues. For example, the leadership issue could be addressed through mentoring programs and by providing administrative training and experience in management areas to those on leadership tracks. The shortage of graduates could be addressed by providing loan forgiveness programs for ADN to BSN completion programs in shortage/underserved areas. The Doctorate of Nursing Practice (DNP) has resulted in many public health nursing master's programs being disbanded. This gap needs to be filled.

There are efforts in place to address the need for clinical training sites for public health nurses. In Minnesota, a regional project is designed to link schools with health departments—facilitating a relationship between faculty and health departments. Through this linkage, students can be provided meaningful training experiences.

Finally, it is important to note that more data is necessary to thoroughly understand the workforce issue. Partnerships are necessary to collect the data that will provide the necessary information to guide workforce and education decisions.

Educating Nurses to Care for Our Nation's Children

Michelle Beauchesne, DNSc, RN, CPNP, FNAP, FAANP,

In 2008, there were 73.9 million children ages 0-17 in the United States, with about 20 million of these children suffering from at least one chronic health condition. These conditions include: allergies; asthma; attention-deficit disorder; depression, anxiety, or other emotional problems; and migraines or frequent headaches. Obesity is also a major concern in children's health.

The National Association of Pediatric Nurse Practitioners (NAPNAP) is a professional nursing organization for pediatric nurse practitioners (PNP) and other advanced practice nurses who care for children. NAPNAP's mission is to promote optimal health for children and adolescents through leadership practice, advocacy, education, and research. NAPNAP has over 7,000 members in 47 chapters with 14 special interest groups. The NAPNAP Foundation supports nursing research and clinical practice efforts that contribute to the improvement of the quality of life for children and their families. The foundation's major initiatives address mental health and obesity.

PNPs are APRNs who are dedicated to improving children's health. Practice settings include pediatric offices and clinics, acute care settings, and specialty areas. Almost 50 percent of PNPs work in primary care. Nurses whose sole practice is pediatrics represented only 7.3 percent of the RN workforce in 2004.

NAPNAP supports educational models that prepare nurses with requisite skills and competencies to provide safe, comprehensive, quality care for children and their families. In particular, NAPNAP believes that nursing

IOM Competencies

Patient-centered care
Teamwork and collaboration
Evidence-based practice
Quality improvement
Safety
Informatics

curricula focused on content areas should be replaced to focus on shared health care competencies, as recommended by IOM. To this end, NAPNAP led the unification of several documents in 2007 to develop *Pediatric Nursing: Scope and Standards of Practice*, which was published in collaboration with the American Nurses Association (ANA). It addresses pediatric nursing practice at all levels and in all settings and consists of 16 standards grounded in the perspectives and priorities of pediatric nursing, with a comprehensive scope discussion for understanding and using these standards.

In addition, nursing students must understand evidence-based practice and how to use research to make choices—making the connection between research and practice.

Opportunities are needed that:

- Allow nursing students at all levels to integrate evidence-based research in coursework; and
- Engage students in comparative effectiveness research, which compares treatments and strategies to improve health.

Partnerships must be fostered to create an infrastructure to prepare students for interprofessional work. Partnerships can take the form of consortia of nursing schools and can result in the sharing of resources and expertise aimed at preparing nurses with shared skills and competencies.

An important issue for PNPs and all APRNs is the ability to practice to the full scope of practice. Regulation and limitations on the scope of practice can serve to dissuade potential students—they may not be able to do the type of work they want to do and therefore opt for a different career course. APRN education can be expanded by decreasing existing barriers due to variations in scope of practice from State to State. It also opens up opportunities for innovation and distance education.

NAPNAP supports the model of a health care home. Key components include:

- Collaborate with teams of other health professionals;
- Deliver family-centered, comprehensive, culturally sensitive, compassionate care; and
- Focus on the overall well-being of children and families

To move forward in all the areas mentioned above, NAPNAP recommends:

- Focus on educating pediatric health care providers to function as primary care providers for children;
- Remove barriers to providing health care to children;
- Recognize the significant and necessary role PNPs play in contributing quality health care to children.

Discussion with Speakers

Dr. Keefe asked about the role of school nurses and school-based clinics. Dr. Olsen Keller stated that the National Association of School Nurses has been an advocate in supporting ratio standards (i.e., number of students per nurse). The situation varies

from State to State and community to community—some schools hire their own nurses while others are hired through the health department. Public health nurses and school nurses have similar role. Dr. Beauchesne added that sometimes there is little coordination between school nurses and school-based clinics—they need to work together.

Dr. Drayton-Brooks asked for clarification on instances in which State licensing boards have rejected applicants because their degree is not in nursing. Ms. Johnson stated that while CNMs receive the required education, if they change States they need to prove that the curriculum includes the necessary content. These are barriers that hold up credentialing and privileges. Dr. Beauchesne added that it is necessary to educate individual boards of nursing and to emphasize that it is a graduate degree. Also, if regulations change, there should be grandfathering.

Dr. Minnick asked if the use of technology could be an effective substitute for clinical sites for public health nurses (e.g., create a virtual community). Dr. Olsen Keller stated that it is necessary to create ways for students to have quality experiences with standards, competencies, and technology.

Dr. Glenn stated that it could be useful to demonstrate that primary care is more comprehensive than is generally considered and the role nurses play in primary care, including their potential as team leaders.

Dr. Thompson stated that it is helpful to tell the story about what really happens in practice. Nurses are already doing the things necessary to meet the criteria for a medical home—they just need to be put in a different structure. Nursing has a chronic public image problem in communicating the scope of services provided. There needs to be more research on existing practice models that are not called “medical homes” but meet the criteria. Many are in rural areas that do not have the resources to conduct the evaluation to demonstrate their outcomes.

Dr. Keefe asked what definition of primary care is used in public health nursing. Dr. Olsen Keller stated that there are several definitions and that she could provide them to the Council. Dr. Beauchesne encouraged the use of simple language and inclusiveness—people should not be put in silos. People should not have to struggle to fit within the definition.

Dr. Cox stated that it is important to include social justice and social determinants in the discussion.

Dr. Cox asked how the nurse/family partnership model could be tested. Dr. Olsen Keller stated that there are several States using the nurse/family partnership model, some of which are based in the health department. However, a whole new system should not be created to do so. Evaluating and adopting models can be very controversial and political—it comes down to money.

Dr. Minnick stated that it would be difficult for public health nurses to do summer internships (as suggested by Dr. Olsen Keller) since many programs run throughout the entire year—there is no summer break. She asked if residencies would be a viable alternative. Dr. Olsen Keller stated that any experience that gets a nurse into a health department is important. Health departments are so overburdened, incentives are necessary to get them to take students. It is necessary to explore how to engage students in public health. It is problematic that public health nurses are not included in advanced practice (they do not meet the requirements of the Consensus Model [CM]). Public health nurses seem more connected to the public health field than to nursing.

Ms. Johnson stated that it is also necessary to address the other end of the pipeline—to get young people interested in nursing careers before they get to college.

Ms. Richardson stated that there is Title VIII funding to support public health nursing at both the baccalaureate level and the master's level. Another opportunity is that there are many new graduates that cannot find positions in hospitals—they could be directed to public health careers. Internships are important since hospitals do not want to hire new graduates because they lack experience.

Dr. Respress stated that Ms. Johnson noted the lack of diversity among CNMs and asked for suggestions on increasing diversity. Dr. Beauchesne stated that Federal scholarships are limited to family nurse practitioners and PNs do not qualify for these funds. In addition, there is a lack of paid preceptorships in nursing. Finally, it is necessary to create programs that encourage young people to pursue careers in nursing. Outreach is necessary to schools and youth organizations. Dr. Olsen Keller stated that for public health nurses it is necessary to consider AD graduates and accelerated students—this is where you will find students with different backgrounds. Ms. Johnson stated that ACNM has developed presentations that members can take to the community to promote careers in midwifery. In addition, national organizations need to show a diverse face, such as having people of color on their board of directors.

Dr. Respress stated that Case Western has a community engagement program that sends students into the community. While technology is a good approach, there is no substitute for sending students into the community. Mentoring (e.g., faculty/student) is also important. Funding is not always necessary for activities like these.

Work Group Discussion

Council members considered some of the possible areas for recommendations identified at the November 2009 meeting. In crafting recommendations, it was suggested that the Council use the language from the health care reform legislation so that the recommendations align with reform efforts.

The Council considered the definition of primary care that was selected at the November 2009 meeting. The Council opted to use the Institute of Medicine (IOM) definition of primary care:

Primary care is the provision of ***integrated, accessible health care services*** by ***clinicians*** who are ***accountable*** for addressing a large ***majority of personal health care needs***, developing a ***sustained partnership*** with ***patients***, and practicing in the ***context of family and community***.

Dr. Thompson suggested that the term “primary health care” should be used in place of primary care. Dr. Minnick suggested that few modifications should be made to the definition—the Council should stay with something that has been accepted.

Possible Areas for Recommendations (identified at November 2009 meeting)

- Education and Training (preparation of primary care providers, faculty shortage, models for residencies/fellowships, and funding)
- Workforce/Pipeline Issues (data to project future needs, diversity of primary care workforce)
- Regulation/Reimbursement (financial, regulatory, and economic barriers)
- Broad role of Nurse in Primary Care (beyond APRNs)

Discussion

Education and Training

Dr. Dayton-Brooks stated that a recommendation should call for more funding for training, clinical sites, faculty, and program enhancements.

Dr. Drayton-Brooks stated that the Council should use the term fellowship instead of residency as residency implies that students are not prepared to enter the workforce. Dr. Minnick added that there are over 600 nurse residency program already and it may not be possible to change the terminology. The term fellowship could be reserved for training received after an advanced degree.

Dr. Keefe added that there has been discussion of “super producers” in terms of educational programs (large demo sites) designed to graduate a large number of students. Models will be necessary.

Dr. Scott stated that once students are attracted to the career of nursing, the challenge is to get them interested in pursuing a career in primary care.

Dr. Respress stated that data indicate that there are high numbers of students accepted into nursing programs but many do not graduate. The Federal Government needs to hold the schools it funds accountable (i.e., students who receive financial support should graduate from the program). Schools should also be required to explain why there is a lack of diversity in the students they educate. Dr. Minnick added that it is necessary to look at this issue closely as many State schools start counting students in their first year and many of these students do not even make it into nursing programs. In most States, if students do not graduate, the program is scrutinized. High attrition rates can also result in a loss of accreditation.

Ms. Richardson stated that the health care reform legislation addresses quality and accountability. It is necessary to look at how to do this within the context of Title VIII. For example, the Nursing Workforce Diversity Program by statute specifies an attrition rate and programs can lose their funding if they exceed it. However, there is a year lag time for the data.

Dr. Minnick stated the it is necessary to look at the outcome of programs (i.e., the impact) and not just the numbers (e.g., students trained, etc).

Recruiting to the Profession

Dr. Scott stated that recruitment to the profession (of young people) needs to be addressed in the Council's report.

Dr. Gilbert stated that it is necessary to make a career in nursing attractive so that it appeals to students.

Dr. Scott added that it is also necessary to make primary care attractive to nurses—many may change specialties but they do not change from a specialty to primary care.

Workforce Supply and Demand

The Council discussed how health care reform will impact demand for and access to care. Dr. Scott suggested that there will be less demand for emergency care since these patients will now have access to primary care. Ms. Jolles suggested that patients will continue to use emergency departments due to limited clinic hours and appointment backlogs (i.e., for convenience).

Models of Care

Dr. Drayton-Brooks stated that the nurse managed clinics and the barriers they face needs to be addressed (e.g., not being able to participate in CMS demonstration projects).

Dr. Skiba stated that the Council should explore new models of consumer engagement, such as how technology will be used to partners with patients. Meaningful use should also be addressed as it relates to the engagement of consumers.

Dr. Thompson stated that the concept of developing community partnerships and how to do it should be integrated throughout the Council's report. Nurses are very good at developing community partnerships.

Dr. Drayton-Brooks stated that the role of nurses in accountable care organizations is not clear. It may be an opportunity for nurses to become leaders.

Evaluation

Dr. Drayton-Brooks stated that that there may be opportunities for comparative effectiveness demonstration project in terms of the use of technology and consumer engagement.

Dr. Minnick added that it is necessary to build in a comparative effectiveness component when looking at potential models such as the centering pregnancies model. Something might work but it may not be the most effective approach and offer the most bang for the buck.

Regulation/Reimbursement

Ms. Marckmann stated that regulation might be the most important area for recommendations. The barriers are huge and mostly at the State level. The Federal Government is in a position to move the issue forward through Medicare/Medicaid reimbursement.

Dr. Keefe added that differing State regulations are becoming problematic in many areas such as disaster relief and telehealth.

Dr. Thompson stated that the focus should be to standardize Medicaid/Medicare guidelines to allow for the full scope of practice (practice at the highest level of preparation). In addition, State Boards of Nursing must lift the barriers for practicing a full range of primary care services.

Dr. Minnick added that there are various types of reimbursement mechanisms—which could vary depending on level of preparation. However, standardized guidelines could have unintended consequences—the Council needs to be clear on what should be standardized (i.e., practicing to the full extent of training).

However, Dr. Drayton-Brooks added that the Consensus Model defines APRNs.

Ms. Johnson added that organizations representing APRNs are working together at the request of the White House to develop a list of Federal regulatory barriers to APRN care.

Dr. Minnick stated that with the push back from States on health care reform, the timing may not be good for making recommendations at the State level.

Dr. Thompson suggested that the Council might consider a recommendation calling for collaboration across HRSA advisory councils on the issue of reimbursement. It would demonstrate that NACNEP is will to work collaboratively on this issue.

Public Comment

Kathleen Gallo

Senior Vice President and Chief Learning Officer
North Shore-LIJ Health System

Dr. Gallo stated that her organization is beginning to strategize on developing an accountable care organization that will encompass the organization's 40,000

employees. There are wonderful opportunities for nurses to be part of the model. She suggested that the Council build the business case for regulation and reimbursement around the benefits for the patient and the community—not what it does for the provider. Otherwise, it seems self serving.

Janet Selway

American College of Nurse Practitioners (ACNP)

Ms. Selway stated that there is confusing nomenclature around the term “primary care.” Using terms like primary care, primary health care, primary provider is unclear as it does not mean that the provider is actually engaging in primary care and prevention. The IOM definition should be considered because it uses the inclusive term “clinicians,” which includes APRNs.

There is also confusion about the term “advanced practice nurse.” Some mid-level providers consider it pejorative. However, it is clearly defined in the Consensus Model.

Cynthia Haney

American Nurses Association (ANA)

Ms. Haney suggested that the Council use the same language that is included in the health care reform legislation, which includes a discussion of practicing to the full scope of training. The health care reform legislation also focuses on quality, value-based care, and the economic value of nursing.

In crafting recommendations, making arguments within the context of the patient and the community and how nurses can serve the patient/community will be better received and create more common ground when partnering with other groups. The Council should look at why certain models of care permit nurses to better serve these populations. The case needs to be made that the resources (i.e., highly trained nurses) are already in place, except for regulatory and reimbursement barriers. These barriers keep nurses from helping patients.

Ms. Richardson adjourned the meeting at 4:05 pm.

Friday, April 23, 2010

Ms. Richardson called to order at 8:36 am.

Division of Nursing/Title VIII Update

Ms. Richardson thanked the Council for their ongoing hard work and their level of commitment and stated that being

Strategic Goals
<ul style="list-style-type: none">• Increase access to quality care through improved composition, distribution, and retention of the nursing workforce through financial assistance.• Identify and use data, program performance measures, and outcomes to make informed decisions on nursing workforce issues.• Increase cultural competence in the nursing workforce.• Increase diversity in the nursing workforce.

chair of NACNEP has been a very enriching experience.

It is an exciting time for Title VIII, which was reauthorized until 2014. The Division needs to look at the programs, which were initiated more than 40 years ago, to see what changes need to be made.

The Division of Nursing is the key Federal focus for nursing education and practice. It provides leadership to assure supply and distribution of qualified nursing personnel to meet the health needs of the Nation. While the Division administers the Title VIII programs, it also carries out other functions vital to supporting the nursing workforce. For example, the Office of Workforce Policy and Performance Management is the Division's analytical think tank that is focused on improving the available data on the nursing workforce. The Office also oversees the National Sample Survey of Registered Nurses and the Division's performance measures for grantees.

Major Activities

Title VIII Nursing Workforce Development Programs: These programs provide the

Estimated Registered Nurse Population, 2008

- Over 3.1 million RNs
- Over 2.5 million work in nursing
- 93.4 percent are women
- 62.2 percent work in hospitals
- 63.2 percent work full time
- 34.2 percent had a baccalaureate as an initial degree
- 83.2 percent are white
- Average annual earnings: \$66,956
- The share of nurses under age 40 grew to 29.5 percent of all RNs, increasing by nearly 18 percent from 2004
- Among nurses under 50 years old, 90 percent or more are employed in nursing positions.

largest source of Federal funding that assists students, schools of nursing, and health systems in their efforts to recruit, educate, and retain registered nurses. Last year, the program assisted at least 70,000 students in obtaining their nursing education through individual student support and support for programs.

National Sample Survey of Registered Nurses (NSSRN): The survey is conducted every four years at the cost of \$5 million, which comes out of grant funds. The last survey was conducted in

March 2008, with the final report expected by September 2010. The 2008 survey had a response rate of 62.4 percent. The survey explores the number and distribution of nurses by type of employment and location of practice; full-time vs. part-time employment; compensation levels; and activity status of RNs with advanced training or graduate degrees in nursing.

Advanced Nursing Education Preparation: There has been a marked growth in the numbers of RNs with master's or doctoral degrees in nursing or a related field (46.9 percent). There were an estimated 28,369 RNs with a doctoral degree in nursing or a nursing-related field in 2008.

American Recovery and Reinvestment Act (ARRA):

- \$200 million for National Health Service Corps (June 2009)

- \$13.4 million for the Nurse Education Loan Repayment and Nurse Faculty Loan Program (August 2009)
- \$2.7 million for the Nursing Workforce Diversity Program (September 2009)
- \$50 million for equipment for health professions training programs (received 685 proposals)

The Division of Nursing supports a wide range of programs.

Advanced Education Nursing (AEN) Program: Provides infrastructure grants to schools of nursing to increase advanced education nurses trained to practice as primary care providers and/or nursing faculty. The program funds 160 schools of nursing and in 2008, the AEN program supported the training of 5,649 graduate-level nursing students and there were 1,785 graduates. Twenty (20) of the funded programs focus on preparation of nurse educators at the master's and doctoral level.

Advanced Education Nursing Traineeship (AENT) Program: Provides support to full-time and part-time master's, doctoral, and post-master's students. Assistance is provided to primary or acute care nurse practitioners, nurse-midwives, nurse anesthetists, clinical nurse specialists, nurse administrators, nurse educators, public health nurses, and other advanced level nursing specialties. In FY 2009, 270 schools of nursing were funded. In 2008, the program supported 6,675 graduate nursing students and produced 2,550 graduates. Approximately 200 graduates were prepared in nurse educator specialty programs.

Nurse Anesthetist Traineeship (NAT) Program: Provides Federal support to nursing students enrolled in nurse anesthetist programs. Traineeships are awarded to schools to assist nurse anesthetist students with the cost of tuition, books program fees, and stipends. In FY 2009, 83 programs were funded and the programs supported 2,145 nurse anesthetist students and produced 1,368 graduates in 2008.

Nurse Faculty Loan (NFLP) Program: Supports student loans within individual schools of nursing to produce qualified nurse faculty. Loan recipients must agree to teach at a school of nursing in exchange for partial loan cancellation. In 2009, 99 awards were made to schools of nursing, with an additional 65 awards made through ARRA funds (\$5.3 million). In FY 2008, 793 graduate-level nursing students received loan support, with 223 graduates.

Integrated Technology into Nursing Education and Practice (ITNEP) Program: supports the incorporation of technology, including simulations, informatics, and telehealth. In Fy2009, seven cooperative agreements were funded.

NEPR Supported Programs (Total: 117)

- Expand Baccalaureate Enrollment
- Internship/Residency
- New Technology/Distance Learning
- Nurse Managed Centers
- Care for Underserved/High-risk Populations
- Quality Improvement and Skills to Practice
- Cultural Competency
- Career Ladder
- Enhancing Patient Care Delivery Systems

Nursing Workforce Diversity (NWD) Program: includes scholarships and stipends; pre-entry preparation; and retention activities. In 2009, 47 grants were funded. In 2008, over 11,600 students were supported.

Nurse Education, Practice, and Retention (NEPR) Program: There are currently nine focus areas under NEPR, which will be merged into two programs.

Nursing Education Loan Repayment Program (NELRP): Provides loan support to assist RNs repay up to 85 percent of incurred qualified nursing educational expenses. In FY 2009, 3,785 applications were approved and 561 awards were made to individual recipients.

Nursing Scholarship (NSP) Program: Scholarships are made to eligible individuals who agree to serve as a nurse in health care facility with a critical shortage of nurses for a minimum of two years in return for scholarship support at schools of nursing. In 2009, 189 awards were made to eligible recipients.

Discussion

Dr. Respress asked about the NEPR funding profile and whether each area has a specific dollar amount. Ms. Richardson replied that it is a competitive process.

Dr. Drayton-Brooks stated that schools have problems submitting grants through Grants.gov and asked whether there have been any improvements to the system. Ms. Richardson replied that project officers reach out and work closely with current grantees to help them with their applications. The Division also does technical assistance workshops with Grants.gov for new grantees. It is important to note that Grants.gov is overseen by the Federal Government and not HRSA. One of the challenges is last minute submissions, when the system is overburdened. Grantees and applicants that experience trouble submitting applications need to document the process. There is a waiver process for those that miss the deadline. In addition, the Division of Nursing has a listserv for professional organizations that is used to disseminate grant-related information. The Division also has an eRoom for important documents.

Questions from the Public

Kathleen Gallo

Senior Vice President and Chief Learning Officer
North Shore-LIJ Health System

Dr. Gallo asked about what organizations are eligible to apply for education programs targeting middle school students. Ms. Richardson stated that 95 percent of grantees are schools of nursing but that community-based organizations can apply. There are three components to the program: pre-entry; stipends and scholarships; and retention for students in nursing programs. Community-based programs have difficulty in meeting the retention requirements as they require an established relationship with the school of nursing. In May, the Division of Nursing will be holding a forum with NWD grantees to discuss what is happening in the field.

Janet Selway

American College of Nurse Practitioners (ACNP)

Ms. Selway asked about funding for nursing across all HRSA programs. Ms. Richardson reported that the Division is working with other Divisions in HRSA to track Title VIII funding across the Agency, including NHSC.

Cynthia Haney

American Nurses Association (ANA)

Ms. Haney suggested that HRSA post best practices on its Web site so that others can access the information. Ms. Richardson replied that some grants have had very successful outcomes. HRSA has just re-launched its Web site.

The Role of Clinical Nurse Specialist in Primary Care

Patti Rager Zuzelo, EdD, RN, ACNS-BC, ANP-BC, CRNP

There exists some confusion about the uniqueness of the clinical nurse specialist (CNS). Three spheres of influence provide the framework for CNS competencies. The spheres of influence include:

- Client direct care;
- Nurses and nursing practice; and
- Organization and systems.

CNS specialty practice competencies are defined by the specialty organizations.

CNS Specialization

Population
Type of problem
Setting
Type of care
Disease/pathology

The CNS practice description includes:

- Clinical nursing expertise in diagnoses and treatment to prevent, remediate, or alleviate illness and promote health with a defined specialty population;
- Care provided either directly or by influencing nurses, nursing personnel, or systems; and
- CNSs work toward achieving quality, cost-effective outcomes using evidence-based care standards and programs of care.

Prevention and early detection of illness are important skills, especially in primary care. For example, CNSs can play an important role in prenatal homecare to prevent low birth weight babies. Diabetes management is also another area where CNSs play an important role.

CNSs are experts in evidence-based practice. In addition to their specialty, CNSs are trained in evidence-based assessments and treatments; human and organizational factors; health promotion activities; development of best practices, standards, and policies; and public policy and resources.

The CNS educational process supports future involvement in primary care. CNSs are initially prepared in MSN or DNP programs that include pathophysiology, pharmacology, and physical assessment courses. Students must perform 500 hours of precepted clinical experience, which includes specialization and skill acquisition specific to the CNS role.

There are multiple financial and regulatory barriers at the Federal level to CNS participation in primary care.

- Home health certification: APRNs are not permitted to certify patients for home health services
- CNSs are not permitted to certify patients for hospice
- Inequitable reimbursement rates
- Medicare supervision requirements
- Lack of reimbursement for supervision and training of medical students and residents in teaching facilities
- Eligibility for CNSs in Medicaid fee-for-service program

Other barriers also limit the scope of practice.

- CNSs have prescriptive privileges in 38 States
- Inconsistencies across States (e.g., some States require licensure as an APRN while others require certification, CNSs are recognized by title but the scope of practice is as an RN)

Certification is also an issue for CNSs. If national certification of a CNSs is required, the lack of certifying examinations presents a significant barrier to practice. Exams are not available for all specialties and some CNSs might have to take exams that are not directly aligned with their specialty (e.g., a women's health specialists would take the adult health exam).

The medical home model is well aligned with CNS practice. The whole person orientation is very congruent with the diverse areas of expertise inherent in the CNS specialty practice as is the emphasis on team work and quality and safety.

Practitioners in the 'Medical Director' Role in Nursing Homes

Ginger Rogers, ARNP, DNP, GNP-BC

The position of gerontological nurse practitioners as "Health Care Director" in nursing homes is a model that may help to meet the growing need for geriatric care. The health care director would support the Medical Director's role. CMS requires that facilities designate a physician to serve as medical director and this individual is responsible for implementation of resident care policies and the coordination of medical care in the facility. The role of the medical director came about in the early 1970s after a salmonella outbreak in a nursing home in Maryland result in the death of 36 residents and highlighted the need for medical care in these facilities.

There are many challenges facing nursing homes that point to the need to augment the role of the medical director. These include: physician shortages; increasing demands in terms of resident care; and the increasing complexity of care. For example, there is currently a shortage of approximately 12,000 geriatricians; by 2030 the shortage will be about 28,000. By 2025 there is projected to be a shortage of 100,000 physicians. This coupled with the growing number of elderly who may eventually need to be cared for in a nursing home points to serious limitations in terms of the capacity to meet care-related needs. At the same time, there are questions about the future of nursing home medical

practice and how to best recruit, staff, and train physicians to provide sufficient quality care for nursing home patients.

There are currently 16,100 nursing homes in the United States. Forty-seven (47) percent of the residents are over 85 years old and more than 50 percent enter the nursing home for sub-acute or rehab services.

A possible solution is gerontological nurse practitioners as “Health Care Directors” to provide direct clinical care and treatment intervention in the nursing home in collaboration and coordination with the physician medical director as well as the other providers. Nurse practitioners are well qualified to assume this role. NPs diagnose and treat a wide range of health problems. They have a unique approach and stress both care and cure. Besides clinical care, NPs focus on health promotion, disease prevention, health education and counseling. Research indicates that gerontological APRNs can provide quality care. In particular, studies have shown:

- Improved prevention and assessment;
- Improved management of symptoms, chronic illness, geriatric syndromes (e.g., delirium, falls), and medications;
- Shorter lengths of hospital stays and fewer hospital re-admissions; and
- Higher patient and family satisfaction.

To move this proposal forward requires that support of local, state, and national organizations. A logical next step would be to conduct a pilot project. This would require Congressional action to modify the Social Security Act, allowing for the creation of a position of “Health Care Director,” to be filled by a gerontological nurse practitioner.

Discussion

Dr. Drayton-Brooks asked that if CNS programs are closing around that country, what are the implications for faculty, especially those that are not practitioners. Dr. Zuzelo stated that there are a number of reasons for the declining enrollment in CNS programs. Many of the barriers that were discussed make the programs unattractive. For example, in Pennsylvania, CNSs would have to work off an RN license. In other settings, a CNS with a specialty is seen as expendable, which is unsettling to nurses in that role. At the same time, many organizations are recognizing the value of CNSs, which can be related to magnet status, with the focus on a set of criteria designed to measure the strength and quality of nursing. In terms of faculty issues, there is a taskforce of the National Association of Clinical Nurse Specialists along with AACN and NLN, which is exploring the LACE process. Typically, CNSs have a great deal of clinical experience. While CNSs programs have had faculty representing a variety of backgrounds, many are not eligible to sit for exams due to the criteria. A core exam would help to address this. Some faculty do not meet the criteria to be certified (e.g., do not have 500 hours of precepted clinical experience).

Dr. Keefe asked if there are data on the number of CNSs practicing and where they are practicing. Dr. Zuzelo replied that data are available.

Dr. Minnick stated that the demand for CNSs changes with the economy. Given the rise of the DNP, which emphasizes many of the same things as CNS training, will this attract students that may have previously entered CNS programs? Similarly, a career as an NP is often seen as providing more flexibility and more enjoyable. Is this a concern for the National Association of Clinical Nurse Specialists? Dr. Zuzelo stated that the organization has issued a statement of neutrality on the DNP. AACN is very supportive of the DNP and the master's essentials do not include the CNS. There are many programs in institutions that cannot offer doctoral degrees (it is not in their charter).

Dr. Keefe asked about the trends in gerontological nursing. Dr. Rogers stated that the numbers are either flat or decreasing. Licensure will soon merge geriatrics and adult specialization. This will require some changes in the curricula.

Dr. Keefe stated that the concept of the teaching nursing home, as well as the teaching community health center, is appealing. When considering the severe shortage of physicians available to serve older adults in nursing homes, would it be possible to have either a medical director or a gerontological nurse practitioner? Homes could also contract with a gerontological nurse practitioner. Dr. Rogers stated that the team concept of a medical director and gerontological nurse practitioner is important. This team has to navigate between approximately 40 clinicians and the relationship with all these providers can be challenging—you need to have a strong medical director. If there was only a nurse practitioner in charge, there would be a ripple effect in terms of all the regulations that would need to be changed, such as admission to hospice.

Dr. Glenn stated that gerontology would be a good fit with the health care home model with a nurse leader. Given the barriers, what recommendations could the Council make? Dr. Rogers stated that discussions are taking place among national organizations to identify ways to meet needs. The Council could monitor these discussions. Nurse practitioners can bill independently so they are recognized as independent providers. It is the relationships that are getting in the way.

Dr. Drayton stated that in nursing homes, when patients become acute they are transferred to the hospital. Would gerontological nurse practitioners be able to care for these patients in the nursing home? Dr. Rogers stated that many physicians prefer to see patients in the emergency room as it is easier in many ways (e.g., to get test results). Better preventive care in the nursing home would hopefully prevent the need for hospital care. Much of the gerontological nurse practitioner curriculum is geared toward preventive and palliative care. If the model goes forward, the curriculum would need to be modified—focusing on administration.

Dr. Thompson asked if an adult health certification would be sufficient for an NP to practice in a nursing home or if it would be better to focus on CNSs with a specialty in gerontology. Dr. Rogers stated that specific training in geriatrics is important. An NP with a focus on adult care practicing in a geriatric environment might be a difficult fit. A CNS with a specialty in gerontology would be a good fit.

Dr. Respress stated that the Division of Nursing funds clinical nurse ladders within hospitals that do not require master's degrees—this seems in direct competition with CNSs. It is necessary to convey that CNSs have much more expertise as a result of their training than nurses who have gained their expertise in the workplace. Dr. Zuzelo stated that across most settings, CNSs are recognized as APRNs. Clinical ladders recognize certain behaviors. Any nurse working in her specialty long enough will develop expertise. CNS education gives a background in evidence-based practice, outcomes, health literacy, etc. All these things that CNSs get through formal education make a difference.

Public Comment

Kathleen Wilson

American Medical Directors Association (AMDA)

In considering the role of the medical director it is important to look at how they relate to the director of nursing. An important issue is what happens when patients go from the nursing home to the hospital—nurse practitioners can play a role. AMDA has submitted comments to the Council.

Carole Jennings

American Academy of Nurse Practitioners (AANP)

Dr. Jennings asked whether hospitals, especially in magnet hospitals, are paying CNSs commensurate with their training and expertise. Dr. Zuzelo stated that CNSs are paid at the same level as NPs—demand often exceeds the supply of CNSs. Dr. Minnick added that people with master's degrees in different fields (e.g., administration) make more.

Janice Brewington

National League for Nursing (NLN)

Competencies for geriatrics need to be identified—this is critical.

Janet Selway

American College of Nurse Practitioners

There is value in partnerships between CNSs, NPs, and others—they all must deal with the 15-minute appointment. With the projected physician shortage, the CNS role is valuable. They may not be appropriate as primary care providers but can play a role as consultants.

Christina Johnson

American College of Nurse-Midwives

The barriers must be taken down. Especially with gerontology, someone must be responsible for the coordination of care and that most often is the APRN. We must send the message that there is a shortage of providers, there is an existing, prepared workforce, and there is documented evidence of their effectiveness.

Chandra Burnside

American Association of Colleges of Nursing (AACN)

There has been a lot of collaboration across organizations in terms of APRNs and primary care and there is an ongoing need to break down the barriers. Continued support for Title VIII is necessary.

NACNEP Business

Next Meeting

Next meeting: November 18-19

In the future, HRSA will try to schedule 2-3 meetings in advance so that Council members have as much notice as possible.

Meeting Attendance

Ms. Richards asked members to let HRSA know if they cannot make it to a meeting. If a member does need to cancel, please let HRSA know as soon as possible.

Members were reminded that they should schedule their travel so that they can participate in the entire meeting. If necessary, members can stay an additional night so that they do not have to leave the meeting early.

New Members

Five new NACNEP members have been approved and they will attend the next meeting (November 2010). New members will arrive at the meeting a day early for orientation. New members will also be partnered with experienced members for mentoring. HRSA will announce the new members in the near future.

Currently, HRSA is preparing more nominations. Five members will be cycling off the Council in September 2010. These members can extend their participation. Members cycling off include: Dr. Cox; Ms. Jolles; Ms. Marckmann; Dr. Keefe; and Dr. Minnick. All other current members will cycle off in 2011.

Executive Committee

A new executive committee will be elected at the April 2011 meeting. Members should be thinking of the role they would like to play in the Council. To ensure continuity, Dr. Keefe will remain Chair of the executive committee until the elections in 2011.

Working with the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD)

Ms. Richardson made a presentation to ACTPCMD and will attend their meetings in the future. The Committee is interested in working with NACNEP in the future. The Committee is currently working on a report on primary care.

Tenth Report Update

The topic of this report is the role of nursing in primary care and implications for workforce. The writing committee includes: Ms. Jolles; Dr. Cavanagh; Dr. Cox; Dr. Drayton-Brooks; Dr. Respress; and Ms. Marckmann. The first draft is anticipated by June.

Topics for November 2010 Meeting

The topic selected for the November 2010 meeting is diversity in nursing education and practice. While the possibility of combining the topic of diversity with other topics, such as quality or access, was discussed, Council members thought that the topic was too significant and should not be watered down. Issues to consider in addressing the topic of diversity are listed below.

- The IOM report *Unequal Treatment* identifies diversity as an important factor in increasing quality and safety.
- With health care reform, more people of color will have access to health care. It is necessary to ensure that this care is culturally competent.
- The U.S. population is growing more diverse and the nursing workforce does not reflect the patients being served. There must be a serious discussion with schools of nursing to create entrance criteria beyond GPA so that they can recruit a more diverse student body.
- Diversity and cultural competence are separate issues.
- Diversity is also an issue in academic preparation—both faculty and researchers.

The Council also strongly considered addressing the topic of quality and safety, including the role of research, which may be an appropriate topic for a future meeting. Issues to consider related to quality, safety, and research are listed below.

- The nursing research workforce is shrinking and there are very few people qualified to do comparative effectiveness evaluations. Additional researchers are needed (i.e., more must be trained) and current researchers may need some re-tooling so that

Suggested NACNEP Meeting Topics (from April 2009 Meeting)

- Competency-based education in nursing
- Online education: trends and demand
- Independent nursing reimbursement, evaluation of current coding system
- Evaluation of APRN scope of practice
- Diversity in practice
- Impact of health care reform on nursing
- Role of nursing workforce in primary care environment, including mental health (addressed at November 2009/April 2010 meeting)
- Nursing models of patient care delivery
- Models of cultural competency curricula
- National Health Service Corps
- Nursing research workforce (comparative effectiveness)
- Role of nursing in chronic care/aging
- Faculty sharing models
- Role of nurses in health IT
- Nursing management workforce
- Nurses leading quality and safety

they are able to re-focus their efforts.

- There are unmet needs in the area of basic science research—there are not enough researchers in nursing.
- The topic of research should also address the collection of data to identify workforce needs.
- More information is needed on the role of the National Institute of Nursing Research and how it supports nursing.
- Quality and safety are becoming increasingly important as facilities will not be reimbursed for mistakes and patient satisfaction becomes more important.
- Nursing has always been at the forefront of quality and safety—this is an opportunity and a responsibility.
- The use of technology is being driven by quality and safety issues.

Meeting Format

Dr. Keefe asked Council members to recommend speakers, model programs, data sets, and other potential presentations for the November 2010 meeting. It was suggested that presentations be limited to two per day, as this will allow members more time for discussion. Ms. Richardson stated that there could be more panel discussion. In addition, organizations can be invited to submit resources documents.

Dr. Respress suggested that a broad range of presenters be considered—not just nurses and nursing organizations. Possible presenters could include sociologists, economists, anthropologists, and students.

Development of Recommendations

Based on the discussions of the previous day, the executive committee identified several categories for recommendations. In discussing the potential recommendations, Council members were reminded that they have to be very specific in directing recommendations to the appropriate party—those with authority to act on the recommendations (e.g., Congress, Secretary of HHS, HRSA).

1. Recruitment of RN's into primary care
 - Recruitment of individuals into the profession of nursing
 - Recruitment of individuals into primary care nursing

Proposed Report Format

Introduction:

- Definition of Primary Health Care
- Roles of Nursing in the primary health care

Content embedded within report and recommendations:

Recruitment of RN's into primary care

- Recruitment of individuals into the profession of nursing
- Recruitment of individuals into primary care nursing

Workforce supply and demand

- The workforce analysis commission collect data supply and demand be detailed by service and geographic location

Technology

- Partnership with clients
- Community and consumer engagement
- Demonstration project in comparative effectiveness in consumer demands

2. Education and Training
 - Need for clinical sites
 - Quality and accountability
 - Interprofessional competencies
 - Fellowships
3. Models of Care
 - Nurse managed clinics
 - Nurse/family partnerships
 - School-based clinics
 - Comparative effectiveness
 - Role of nurses in accountable care organizations
 - Access issues/convenience
4. Workforce supply and demand
 - The Workforce Analysis Commission data on supply and demand should be detailed by service and geographic location
5. Technology
 - Partnership with clients
 - Community and consumer engagement
 - Demonstration project in comparative effectiveness in consumer demands
6. Regulation and Reimbursement
 - Remove regulatory and reimbursement barriers to allow RNs and APRNs to actualize their full potential to provide primary health care.

Final Draft Recommendations

Education and Training

- Leverage Federal, State and local governmental and private foundation resources to build primary health care educational program capacity and increase clinical training sites that support interprofessional team competencies and innovative technology. Develop, implement and evaluate primary care residencies and fellowships for nurses in teaching health centers and other community-based settings to meet increased consumer demand for primary care. Develop, implement and evaluate mechanisms to prepare faculty for educating primary health care providers.

Discussion

- Emphasize the need for faculty development. Building primary care educational program capacity requires faculty.

Innovative Models of Care Incorporating Technology

- Utilize Federal, State, local government and private funding to expand current successful models of primary care services such as; nurse managed clinics, nurse/family partnership, and school-based nursing clinics and evaluate outcomes using comparative effectiveness. Support the development and testing of innovative models to meet the primary care needs of specific

Discussion

- Clarify the role of nurses in accountable care organizations and medical homes in the narrative of the report.
- Practice by nurses within nursing homes should be addressed and successful models for nursing homes should be identified. This is important since nursing homes do not fall under the IOM definition of primary care.
- Look at systems that allow providers to communicate across settings (e.g., hospital to nursing home) and the implication of technology for the workforce.
- Explore how to expand capacity to engage patients in care. How can they partner with providers?

Regulation and Reimbursement

- Increase consumer access to primary care provided by registered nurses and advance practice nurses by removing Federal (e.g., Medicaid and Medicare) and State regulatory and reimbursement barriers. Ensure all Federal reimbursement policies are provider neutral.

Discussion

- In framing this issue, the focus should be on how it will impact patients (e.g., more access to care, better care) and not what it will do for nurses.
- Include examples of regulatory barriers in the narrative of the report and if available, include the list of barriers compiled by national nursing organizations as an appendix.
- In the report, it will be important to separate regulation and reimbursement—they are two separate issues.
- It must be clear in the narrative of the report that the issue is equal pay for equal work.
- The National Committee on Vital Statistics has terms that are provider neutral. These were used when they addressed the issue of e-prescribing.

Other Issues to Address in the Report

- For all of the recommendations, it is necessary to ensure that the funding provided results in the desired outcomes. It is necessary to ensure quality, evaluation, and accountability. It is important in education and training but there also must be mechanisms for models of care and regulation.
- Include information on workforce supply and demand in the narrative. The Workforce Analysis Commission will be collecting data.

Adjournment

Ms. Richardson adjourned the 122nd meeting of NACNEP at 2:30 pm.