

**123<sup>rd</sup> Meeting of the National Advisory Council on Nurse Education and Practice**  
November 18-19, 2010

**Participants**

**Council Members**

Julie Sochalski, PhD, FAAN, RN, Chair, NACNEP  
Lakisha Smith, MPH, Executive Secretary, NACNEP  
Mary Lou Brunell, RN, MSN  
Ellyn Elizabeth Cavanagh, PhD, MN, CPNP  
Karen Cox, PhD, RN, FAAN  
Shirlee Drayton-Brooks, PhD, RN, CRNP, APRN, BC, CRRN  
Karen Neil Drenkard, PhD, RN, CNAA, CPHQ  
M. Jean Gilbert, PhD  
Bettie J. Glenn, EdD, RN  
Susan Hassmiller, PhD, RN, FAAN  
Jeanette Ives Erickson, MS, RN, FAAN  
Diana R. Jolles, CNM, MSN (via phone)  
Cydne Marckmann, MN, ARNP  
Gerardo Melendez-Torres  
Ann Minnick, PhD, RN, FAAN  
John J. Nagelhout, PhD, CRNA, FAAN  
Brandon N. Respress, PhD, RN, MSN, MPH, CPNP  
Monica Rochman, BSN, RN  
Rhonda A. Scott, PhD, RN  
Diane J. Skiba, PhD, FAAN, FACMI  
Linda Speranza, PhD, MS, MEd, ARNP-C  
Joyce Elaine Beebe Thompson, DrPH, RN, CNM, FAAN, FACNM

**Presenters**

Julie Sochalski, PhD, FAAN, RN  
Director, Division of Nursing, BHPr, HRSA  
Lakisha Smith, MPH  
Chief Operations Director, Division of Nursing, BHPr, HRSA  
Karen Drenkard, PhD, RN, CNAA, CPHQ  
Acting Executive Committee Chair, NACNEP  
Mary Wakefield, PhD, FAAN, RN  
Administrator, HRSA  
Marilyn S. Mobley, PhD  
Vice President for Inclusion, Diversity, and Equal Opportunity, Case Western Reserve  
University  
Thomas LaVeist, PhD  
Director, Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of  
Public Health  
Susan Hassmiller, PhD, FAAN, RN  
Senior Advisor for Nursing, Robert Wood Johnson Foundation

LCDR Aisha Mix, MPH, MSN, RN, CCM

Acting Branch Chief, Nursing Diversity and Development Branch, Division of Nursing,  
BHPr, HRSA

Antonia Villarruel, PhD, RN, FAAN

Associate Dean for Research and Global Affairs, University of Michigan

E. Michele Richardson, MS, BSN, RN

Senior Advisor, BHPr, HRSA

**Thursday, November 18, 2010**

### **Welcome and Review of Agenda**

Julie Sochalski, PhD, FAAN, RN

Dr. Sochalski called to order the 123<sup>rd</sup> meeting of the National Advisory Council on Nurse Education and Practice (NACNEP) at 8:32 am. Dr. Sochalski welcomed the Council members, speakers, HRSA staff, and guests. The focus of the meeting is diversity in nurse education and practice. NACNEP released a report on the same topic 10 years ago.

### **HRSA Update**

Mary Wakefield, PhD, RN

Dr. Wakefield thanked the members for their service on the Council as well as their work in the field of nursing. She noted that it is a turbulent but exciting time to be involved in informing health policy—there are both opportunities and challenges.

HRSA operates about 80 programs and has an annual budget of \$7.6 billion. Major HRSA programs include:

*Community Health Centers* – There are approximately 1,100 sites, which serve 19 million people.

*Ryan White HIV/AIDS Program* – There are 900 grantees providing care to half a million people impacted by HIV.

**Purpose of the Meeting:** To address diversity in nurse education and practice.

### **Objectives**

#### *November Meeting*

1. Articulate the definitions, goals, and implications of diversification of the nursing workforce.
2. Summarize the current data trends and existing information on diversity in the nursing workforce, including nursing students.
3. Examine existing policies, practices, and legal constraints that influence or limit the recruitment of diverse students into the profession of nursing.

#### *April Meeting*

4. Identify the key elements of successful programs in nursing education that have increased the recruitment and graduation of diverse individuals.
5. Identify the key elements of success in innovative models that have improved the retention, professional development, and promotion of diverse individuals within the nursing profession.

*Maternal and Child Health* – Block grants to States ensure that the Nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs, have access to quality health care.

*Workforce Programs* – The Bureau of Health Professions and the Bureau of Clinician Recruitment and Service work to strengthen the health care workforce, in conjunction with the National Health Service Corps.

*Office of Rural Health Policy* – Works at the Federal, State and local levels, and with the private sector to seek solutions to rural health care problems.

HRSA's ten regional offices extend the reach of HRSA.

HRSA has sought out opportunities to draw attention to nursing and recognizes the need for nurses to engage in conversations about health care. The Administration recognizes the importance of nurses. The First Lady participated in a conference call focusing on nursing that took place in September. Approximately 5,000 participants took part on the call.

### ***Impact of ARRA and ACA on HRSA Portfolio***

The American Recovery and Reinvestment Act (ARRA) provided \$2.5 billion to HRSA. Community health centers received \$2 billion to expand services. Funding was also provided to strengthen the health care workforce. In addition, there are many provisions in the Affordable Care Act (ACA) that will impact HRSA's work. Community health centers have been provided \$11 billion to expand services. Funding for the National Health Service Corp has been expanded providing support for nurse practitioners and nurse midwives. The Nurse Faculty Loan Repayment program was also expanded and the size of the loans available has been increased. Primary care training has also been expanded. The ACA also includes support for nurse-managed health clinics and for a home visitation program that will target children with special needs and families living in high-risk communities. The ACA also provided for the creation of the National Center for Health Workforce Analysis. The Center supports health workforce data collection and analysis and the development of information describing the health professions workforce and the analysis of workforce-related issues in order to provide necessary information for decision-making regarding future directions in health professions and nursing programs in response to societal and professional needs. The Center is directed by Edward Salsberg.

### **Discussion**

Ms. Brunell stated that the State Nursing Workforce Centers look forward to collaborating with the National Center for Health Workforce Analysis.

Dr. Hassmiller asked if there were any efforts related to nursing across Federal agencies. Dr. Wakefield stated that issues related to the health care workforce are addressed across Federal agencies. One example is HRSA's work with the Substance Abuse and Mental Health Services Administration (SAMHSA) on behavioral health workforce issues. HRSA also works with the Centers for Medicare and Medicaid Services (CMS) on issues relating to reimbursement. There is also a great deal of collaboration across HHS.

### **Framing the Focus of the Meeting**

Julie Sochalski, PhD, FAAN, RN  
Karen Drenkard, PhD, RN, CNAA, CPHQ

Dr. Sochalski stated that the topic of diversity aligns well with the strategic goals of HHS, HRSA, and BHP. In preparation for the meeting, the Executive Committee developed objectives and sought to better define what topics would be addressed in the report. Dr. Scott conducted a survey of NACNEP members to identify specific elements related to diversity that would be covered in the report. The top three elements identified by the survey were race/ethnicity, culture, and socioeconomics.

#### **Member Survey: Diversity Categories**

- Race/ethnicity
- Culture
- Socioeconomics
- Language/literacy
- Age
- Gender
- Education
- Physical/mental ability/disability
- Religion
- Sexual Orientation

Dr. Drenkard stated that progress has been made since NACNEP's first report on diversity, which was released 10 years ago. It is important to explore the recommended strategies that were not effective so that they are not repeated. Data are available that demonstrate how diversity is important for clinical outcomes. With the increased access to care that will result from the ACA, it is imperative that a diverse health care workforce is available to meet the demand for care.

### **Beyond Health Care Disparities: Diversity Workforce Matters**

Marilyn S. Mobley, PhD

*We are all tied together in a single garment of destiny...An inescapable network of mutuality...I can never be what I ought to be until you are allowed to be what you ought to be.*

Martin Luther King, Jr.

Dr. Mobley provided the perspective of a professional working for many years to address the issue of diversity in academic and other settings. The issue of diversity is being watered down—everything is included. Diversity should be focused on priority areas. Just talking about diversity does not address it—action and change is required. Diversity must be addressed at multiple levels. Not only must the focus on the recruitment/hiring side but also on the workplace—what happens once an employee is hired (retention, advancement, a non-hostile environment). Inclusion, not diversity is the end goal. Once a part of an institution or organization, people must be involved in all aspects, including decision making.

#### **Supporting Diversity: Key Elements**

- Recruitment to workforce
- Relationship with peers in workforce
- Support to meet full potential
- Mentors and role models
- Opportunity to thrive

For employers, there is a business case for increasing diversity and inclusivity. Greater diversity among employees can attract a more diverse customer base. Resolving tensions in the workplace can increase productivity.

A diverse health care workforce is essential to effectively address the health-related challenges facing American today. Health disparities are preventable differences across racial, ethnic, sexual orientation, and socioeconomic groups. Disparities often begin early in life. Research indicates that health care providers of color are more likely to serve in minority communities.

With this issue, it is necessary to move beyond citing the facts to exploring the nuanced complexities behind the facts.

- Move past demographic realities and look at what other issues need to be addressed.
- Structural issues are at the root of the problem.
- Follow up is necessary (i.e., has the problem been addressed?).

Revising the terminology can help to reframe the issue in a more effective way. For example, the term cultural competency implies a minimal acceptable level—something like a checklist. A better term is cultural intelligence, which implies the ability to apply knowledge, ask the right questions, and respectfully engage in dialog.

### *Issues Specific to Nursing*

- Look at the big picture – how to attract people to the profession, including people of color.
- Promote leadership, advocacy, and civic engagement.
- Retain people long enough for them to develop leadership skills.
- Encourage and support staff in becoming agents of change.
- How will nursing handle the issues that go beyond demographics and disparities (e.g., language)?
- Racial tension is often seen as a patient/provider issue but there are often peer-to-peer racial tensions in the health care workplace.

#### **Key Questions for Providers**

- Who am I?
- What is my work?
- How will I contribute?

#### **Steps to Promote Diversity**

- Inclusive thinking
- Mindful learning
- Transformative dialog

### *Steps to Address the Issue*

- Create a safe space for people to discuss issues of diversity.
- Design new methods of inquiry to deconstruct disparities so that they can be addressed in a meaningful way.
- Engage communities from a social justice framework.
- Consider nuances—the story behind the data.
- Consider the inequalities facing some communities.
- Create more opportunities for providers to develop cultural competency.

- Address micro-aggressions and subtle and unconscious biases (micro-affirmations can counteract micro-aggressions).
- Consider classification, seniority, content of work (i.e., how does this impact the work climate).
- Provide support to those “in the door” (e.g., coaches, mentors, etc.).

## Discussion

Dr. Sochalski asked how to frame future goals in terms of inclusivity. Dr. Mobley stated that diversity is the mix and inclusion is making the mix work—a diverse workforce does no good if the diverse individuals are not included in decision making. “Inclusion” means including everyone in the discussion—making opportunities available to the diverse mix of employees.

Dr. Gilbert asked about approaches that can be applied during nursing education that could help to address workplace racial tensions. Dr. Mobley stated that there needs to be opportunities for people to understand the impact of privilege. There is a significant body of research on privilege (Peggy McIntosh). The issue of privilege should be incorporated into cultural competency training.

**Value of Storytelling**

Providing a personal perspective can help people understand where that individual has come from and the challenges he or she has faced. When employees tell what they have gone through to get to where they are, their co-workers have a better understanding of this individual.

Dr. Respress stated that the training nurses receive is very categorical—students are given standard approaches for dealing with various racial/ethnic groups. This standardized approach is not helpful. Dr. Mobley replied that there is always a fear that giving people too much information will lead to stereotyping. Cultural competency requires that you ask questions, not make decisions based on data. Dr. Respress added that it is imperative to look at health disparity outcome data as the measure of progress in this area. Dr. Respress stated that she takes the questions of, “Who am I?, What am I?, What is my work?,” with her every day. Her goal is that her patients are as healthy as possible.

Dr. Glenn stated that members should consider the meeting to be a safe environment where all issues can be discussed. It is also necessary to consider some of the terminology used in nursing that may be preventing progress in this area.

Dr. Ives Erickson stated that subtle, unconscious bias and the role played by opinions must be considered. Dr. Mobley stated that people are entitled to their opinions—appreciative inquiry and dialog requires a safe space where people feel free to say whatever they want. This will require a thick skin on the part of some participants. Dr. Mobley explained that people do not need to share common opinions but they need to be able to explain why they think a certain way and how they arrived at their conclusions.

Dr. Drenkard stated that ways to link inclusion to outcome measures should be explored. It is necessary to look at what is happening in practice. If inclusion is not achieved in practice, recruitment efforts are futile as those recruited will not remain in the workforce.

## **A Conversation on Diversity in the Health Care Workforce**

Thomas LaVeist, PhD

Cultural competency is a relatively new concept, emerging in the 1990s. There are only 42 journal articles on the topic and at this point in time, the literature focuses primarily on think pieces and essays. Researchers have yet to address issues of implementations. It is necessary to start building an evidence base around the topic of cultural competency and explore ways to measure cultural competency.

In his research, Dr. LaVeist is exploring issues of cultural competency and diversity. One tool that has been developed is the COA360°. The COA360° is a multidimensional cultural competency tool that evaluates the readiness of a health care organization, or unit within an organization, to meet the needs of a rapidly diversifying U.S. population. Developed and scientifically validated by Johns Hopkins researchers, its advantage is that it provides a “360-degree view” of the institution from the perspective of its administrators, health care providers, non-provider staff, and patients, rather than focusing on a single health care provider, as is the case with most cultural competency tools. The COA360° helps health care organizations learn how to allocate resources to maintain quality, increase patient satisfaction, and improve patient outcomes.

Dr. LaVeist also conducted a study of eight safety net hospitals. The selected hospitals all had patient caseloads made up primarily of people of color. All were identified as high performing hospitals. The study sought to identify the best practices that contributed to the hospital’s performance.

The common element across the hospitals was leadership. The attitude of the administrators was critical. They set the tone for the entire organization. Dr. LaVeist provided an example of a hiring technique used by one of the hospitals. A candidate for a high-level position was driven to and from the airport by one of the hospital’s security guards. At the end of the day, the CEO asked the guard if the candidate had spoken with him during the airport trips. The candidate had not, and was consequently not hired. In the organization, engaging people at all levels is part of the culture. The CEO did not want a candidate who did not actively seek to communicate with others.

A recent study by Dr. LaVeist explored published literature to outline the methods for economic analysis of the “business case” for increasing the racial/ethnic diversity of the health care workforce. The benefits of a diverse health workforce, listed below, were presented by Dr. LaVeist.

- Enhance geographic distribution of providers.
- Enhance the level of cultural competency in health care and improve patient/health professional encounters.
- Improve minority patients’ access to and utilization of health services and, consequently, their health outcomes.
- Increase access to care in underserved white communities.

- Increase number of consumers seeking health promotion/disease prevention, reduce costly chronic health problems.
- Expand the breadth and scope of research topics studied and increase participation of minorities in clinical research.
- Indirect societal benefits including economic development in minority communities and civic involvement improve quality of life in communities.
- Improve overall quality of care through higher levels of patient satisfaction and trust.

Admission criteria also may play a role in limiting the diversity of the health care workforce. GPA and test scores may not be the most effective criteria for determining the applicant's future success in the health care workforce. Dr. LaVeist provided an example of a Native American individual who lived on a reservation and became deeply interested in public health. He worked in his community on various health-related projects and eventually decided to pursue a master's degree in Public Health. While his GPA and test scores may not have been as high as those of other applicants, the admissions committee had not doubt that this individual would be both a successful student and health professional. More research on the relationship between standardized test scores and professional success is necessary.

Dr. LaVeist concluded that the Council should focus on ways of impacting policy, such as setting guidelines (e.g., admission criteria, core competencies), and not simply recommend more studies and reports.

## **Discussion**

Ms. Brunell stated that with the nursing shortage and efforts to increase the availability of nursing education (i.e., teach more students), schools do not have the capacity to thoroughly review applicants. They rely on GPA and test scores. Schools need to dedicate more resources to admissions. Dr. LaVeist stated that test scores and GPA will reveal some things about a person but interviews or other methods may be more effective. If better selection criteria are used on the front end (i.e., admission to schools), it may be easier to train providers to be culturally competent.

Dr. Drayton-Brooks stated that it is necessary to explore the story behind the data and leadership in academic settings. Dr. LaVeist stated that often there is little commitment behind cultural competence efforts—the standard approaches are either to hire a person to be responsible for cultural competence in the organization or establish a committee.

Dr. Respress stated that low graduation rates (less than 50%) are also a consideration and when considering diversity. It is necessary to look at the individuals who are not completing their education. Dr. LaVeist said it is important to know why students do not complete their education (e.g., economic issues). It would also be necessary to look at variations across schools (high performing vs. low performing).

Dr. Minnick stated that data on completion rates do not present an accurate picture. Many schools count anyone who states they want to major in nursing, not those that actually enter the school of nursing.

Ms. Brunell stated that Mississippi has studied the issue of why student left nursing programs and implemented programs to address the problems. These programs could serve as models.

Dr. Sochalski asked about increasing the number of providers in underserved communities. Are programs that do this increasing the overall number of providers or is there displacement? Dr. LaVeist stated that incentives are necessary to get people to practice in some areas. However, if there is an increase in the overall number of providers, market forces will come into play and providers will be drawn to the underserved areas.

Dr. LaVeist suggested that nursing needs to identify core competencies for cultural competency. The American Association of Colleges of Nursing (AACN) and the Association of Schools of Public Health (ASPH) have established a taskforce on this issue. Nurses should be leading the discussion about cultural competency by virtue of the role they play in the provision of care.

Dr. Glenn stated that nursing schools have core competencies on cultural competence. This is an example of nursing not being involved in the dialog.

Dr. Minnick stated that cultural competency has been part of the accreditation standards for at least a decade. Many think that nursing has already addressed the issues. Dr. LaVeist added that addressing cultural competency should be a cross-disciplinary process. Nurses should be at the table because others can learn from their experience. Dr. Hassmiller added that data exist demonstrating that nurses are often excluded from discussions.

### **What Do the Data Say?**

Julie Sochalski, PhD, FAAN, RN  
Karen Drenkard, PhD, RN, CNAA, CPHQ

Dr. Sochalski presented a summary of findings on demographics and diversity in nursing from the 2008 National Sample Survey of Registered Nurses (NSSRN). Council members discussed these findings and identified a number of ongoing and emerging issues affecting the composition of the future workforce, such as:

- Aging workforce;
- Unemployment among nurses and the possible impact on enrollment in nursing schools;
- Role of community colleges in educating nurses;
- Second career nursing students; and
- Number of males in the nursing workforce (and percentage of men in top jobs).

### **Data Requested by the Council**

- Make NSSRN data available
- Include information in the report about the race/ethnicity of faculty (Note: AACN has data on faculty)
- Explore what other data are available (National League of Nursing, American Association of Community Colleges, National Council of State Boards of Nursing, Interagency Council on Nursing Data and Statistics, regional education boards)

***Issues that Need Further Exploration*** (i.e., are the data masking the story)

- Nurses of color are underrepresented in higher education.

- There are low numbers of minorities in programs that prepare advanced practice nurses (APRNs).
- Explore differences across geographic areas (and how the nursing workforce reflects the demographics of the region).
- Employment of APRNs (where are they practicing?).
- How to “grow your own” within a geographic region (e.g., best practices).
- Data of foreign educated nurses and where they practice.
- Data on Native Americans and Alaska Natives are lacking.
- Standardized data collection tools across organizations (note: the Florida Center for Nursing has developed three national data sets exploring both supply and demand).

### **The Initiative on the Future of Nursing**

Susan Hassmiller, PhD, RN, FAAN

In 2008, the Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a 2-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, with the purpose of producing a report to make recommendations for an action-oriented blueprint for the future of nursing. The report, titled *The Future of Nursing: Leading Change, Advancing Health*, was released in October 2010. Since its release, the report has generated widespread interest. The IOM website crashed within minutes of the report’s release and over 7,300 copies of the report were downloaded in the 10 days following the release.

The report includes recommendations related to four key messages.

- 1.) Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- 2.) Nurses should be able to practice to the full extent of their education and training.
- 3.) Nurses should be full partners with physicians and others in redesigning U.S. health care.
- 4.) Effective workforce planning and policy making require better data collection and an information infrastructure.

Recommendations call for expanded loan and grant programs for second degree nursing students and expanded funding for programs offering accelerated graduate degrees for nurses. In addition, the report includes a recommendation that that by 2010, 80 percent of all nurses should have a baccalaureate degree or higher. Other recommendations address the need for a minimum data set to assess the health care workforce.

RWJF and IOM are working closely with various stakeholders—such as nursing groups, community colleges, and physician groups—to promote the findings of the report and develop strategies to implement the recommendations. Regional Action Coalitions have been established in five pilot States (NJ, NY, MI, MS, and CA). These states will be working to capture best practices, track lessons learned, and identify replicable models. RWJF plans to establish Regional Action Coalitions in other States.

RWJF is also holding the National Summit on Advancing Health through Nursing. The summit takes place November 30 – December 1. It will bring together 500 stakeholders to discuss implementation of the recommendations and will be webcast live. The live webcasts have spawned Regional Awareness Meetings, at which participants view the webcast and then engage in discussion.

## Discussion

Mr. Melendez-Torres stated that there is evidence indicating that BSN degrees are not cost effective. Given this, how will RWJF build support for the report? Dr. Hassmiller responded that all the recommendations in the report are based on evidence and that the report was developed by a multi-disciplinary committee—not just nurses. RWJF is reaching out to stakeholders to gain their support for the recommendations.

Dr. Drayton-Brooks asked for clarification on the recommendation relating to residency programs. Requiring a residency is not consistent with the APRN Consensus Model, a document signed by 40 nursing organization that outlines all the requirements for APRN roles. Dr. Hassmiller stated that the recommendation does not provide specific details on the residency program requirements. The Committee did recognize that residency programs are an important transition tool and important for quality and safety. Ms. Richardson added that both internships and residency programs are fundable under Title VIII.

Dr. Drenkard noted that many of the issues raised in the IOM report are addressed in the Council's eighth annual report, *Addressing New Challenges Facing Nursing Education: Solutions for a Transforming Health Care Environment*. Ms. Marckmann added that the report discussed models to strengthen the bridge from ADN to BSN and spoke to the role of community colleges, especially in rural areas. Other models, such as online education, were also discussed.

Dr. Thompson asked if the report by the Carnegie Foundation, *Educating Nurses: A Call for Radical Transformation*, was considered in the development of the IOM report. Faculty must be prepared to teach future nurses, especially in terms of diversity. Dr. Hassmiller stated that the report was considered but that the IOM report focuses on more than education.

Dr. Respress stated that while there are calls to establish the BSN as the entry-level degree, Federal funding seems to be focused at the ADN level (e.g., Department of Education [ED] and Department of Labor [DOL] funding). It is a difficult issue because few ADNs progress to higher degrees but many of the nurses with ADN degrees are minorities. It creates a conflict between diversity and progression.

### Advantages of BSN Degree

Council members identified some of the advantages of the BSN degree.

- Prepares nurses to be decision makers and leaders
- Increased patient complexity and the use of technology require advanced critical thinking skills.
- Some settings (e.g., MAGNET hospitals) will only hire BSNs
- ADNs take longer to train and have higher attrition rates (quality, economic, and safety factor)
- For some roles (e.g., public health nurse), the necessary competencies are only available at the BSN level

Ms. Brunell stated that she serves on Florida's Workforce Investment Board. Participation in such bodies is an opportunity to raise the issue. She added that many community colleges in Florida are now offering 4-year degrees.

Dr. Thompson stated that socioeconomic factors play a major role. Many students go to a community college because it is affordable. Dr. Hassmiller stated that to prepare nurses at the BSN level will require multiple approaches—stipends, scholarships, 4-year community colleges, online education, simulation labs, etc.

Ms. Rochman asked if the IOM report considered the role/value of private-sector, online schools. Dr. Hassmiller stated that this is not addressed in the report as there is no evidence relating to these schools.

### **Public Comment**

#### ***Suzanne Begeny***

Director, Government Affairs  
American Association of Colleges of Nursing (AACN)

Ms. Begeny stated that AACN will make its data available to the Council. Data on both faculty and students are available.

AACN has programs to help nursing students develop their leadership and advocacy skills. Each year, AACN holds a 3-day policy summit for students.

AACN revised its cultural competencies for both baccalaureate and graduate students in 2008 and 2010.

AACN will work with RWJF/IOM to implement the recommendations of the report. However, there is a lot of uncertainty given the current economic situation. Title VIII funds could be severely reduced. This would impact the implementation of the recommendations.

#### ***Heather Clark***

American College of Nurse Midwives

Ms. Clark stated that ACNM is committed to increasing the diversity of its members. Currently, approximately four percent of midwives are minority.

Dr. Sochalski adjourned the meeting at 4:01 pm.

### **Friday, November 19, 2010**

Dr. Sochalski called the meeting to order at 8:46 am.

### **Group Discussion**

Council members engaged in a discussion of the presentations from the previous day. To initiate the dialog, they identified key issues for consideration.

### ***Definitions***

- Inclusivity vs. diversity (need for definitions)
- Inclusive thinking, mindful learning, and transformative dialog
- How to get people to understand the concept of “privilege”

### **Next Steps**

- Develop definitions (diversity, inclusivity, cultural intelligence, privilege)
- Explore models such as COA360°
- Obtain data from DOL on the diversity of the workforce
- Obtain data on regional differences in the workforce

### ***Workplace Issues***

- Identify ways to increase inclusivity
- Implications of a diverse workforce (i.e., is it inclusive)
- Role of leadership as a catalyst
- Engagement of individuals at all level (e.g., security guard example)
- Explore relationships across racial groups in the workplace (e.g., what are the issues, are there models that promote better working relationships)
- Leaders and board members need to be held accountable. Board members should reflect the diversity of the population served.

### ***Faculty***

- Research is necessary on the role of faculty and their attitudes (e.g., bias and racism). Faculty attitudes can have a significant impact on admissions and retention. Instructors do not understand the impact of their attitudes and actions.
- To change the culture, need to change preparation of faculty

### ***Pipeline/Admissions***

- Explore policies that limit recruitment and interfere with retention
- Admission process (e.g., what are the best criteria)
- Legal issues related to recruitment (e.g., quotas, affirmative action)
- Explore areas where there can be a rapid impact (e.g., LPN is a diverse workforce, explore ways to move LPNs to BSNs and beyond)
- Explore why some racial/ethnic groups (e.g., Asians) are not pursuing careers in nursing

### ***Education***

- If classes for nursing students are to become larger, there must be appropriate accommodations to ensure success (e.g., mentors)

### ***Data***

- Need for better data, especially related to faculty outcomes (e.g., impact of loan repayment programs, diversity of faculty)
- Issues that mask the data
- Measuring success (i.e., how will we know that we have achieved the goal)

- Link outcomes to health disparities

### ***Stakeholders***

- Role of foundations and other funders in increasing diversity

### **Other Discussion**

Dr. Ives Erickson stated that the Council's sixth annual report, *Meeting the Challenges of the New Millennium*, covers similar issues. A gap analysis focusing on progress in meeting the report's recommendations may be useful. In particular, the third recommendation addresses leadership.

### **Presentation on Nursing: Nurse Workforce Diversity Program**

LCDR Aisha Mix, MPH, MSN, RN, CCM

The purpose of the Nurse Workforce Diversity (NWD) program is to increase nursing education opportunities for individuals from disadvantaged backgrounds. The program provides stipends and scholarships, pre-entry preparation, and retention activities for minority nursing students, pre-nursing students, and students in elementary and secondary schools. Disadvantaged status is defined by various factors, such as financial resources and educational background but does not include race/ethnicity. The program is funded at \$16 million.

The ACA made slight changes to the program. It includes stipends for bridge programs and accelerated degree programs (i.e., second career). While the program has traditionally been a pipeline program, advanced education preparation was also added. These new components will be explored in the 2011 funding cycle.

There are currently 47 grantees covering 27 states and Puerto Rico. Grantees include historically black colleges and universities, tribal colleges, and community colleges. This year, the NWD program received 91 applications, of which 67 were approved for funding and 21 were ultimately funded.

The average award is approximately \$300,000. However, there is no funding cap. Most grantees request the "average" amount, which makes it difficult to gauge whether this reflects the level of need for educational support.

The program supports students through scholarships and stipends—the average scholarship amount is \$2,000 and the average stipend is \$1,000. There are currently over 11,600 students participating in the program, with 968 students graduating in the most recent year. Schools are required to have strategies in place to support the retention of students. These strategies include individual educational plans, mentoring, and peer support.

The program also supports pre-entry preparation. Most grantees are focusing on middle and high school students.

Grantees also must address faculty issues such as cultural competency and diversity. For example, schools cannot effectively provide mentoring opportunities to minority students if there are no minority faculty. Some schools have developed partnerships with nurses in the community to provide mentors to students. The National League for Nursing has developed a toolkit on diversity that includes information on educating faculty.

A challenge experienced by some grantees in administering the program is the impact of the stipend on students' financial aid packages. The stipend can compromise financial aid from other sources. A similar challenge occurs when students reduce the number of hours they work at outside jobs in order to focus on their studies. This can result in the loss of health insurance.

Areas for future consideration identified by LCDR Mix are listed below.

- Further evaluation of the impact of the program
- Explore ways to increase support for students
- Standardize outcome objectives across grantees
- Promote collaboration with other BHP and HRSA grantees
- Longevity of grants (i.e., with 3-year project period in pipeline program, it is hard to track students over time)
- Incorporate more STEM preparation
- Balance racial/ethnic diversity and economic status
- Role of faculty preparation and sensitivity

## **Discussion**

Dr. Respress stated that in terms of disadvantaged students, once a White student with lower socioeconomic status receives support and enters school, that student is no longer disadvantaged. It is different for racial/ethnic minority students. This relates to privilege. If grantees are being successful with their pipeline programs, why are these students not getting into programs? LCDR Mix stated that it is necessary to increase students' level of competitiveness for entering programs. There is still work to be done in the area of preparation. Grantees are required to identify educational barriers along the continuum and must complete an individualized needs assessment for each student and take steps to address those needs.

Dr. Respress asked why the program does not collect data related to the diversity of the grantee institution. LCDR Mix stated there are considerations relating to the reporting burden. The program is interested in learning how the grants are increasing diversity within the grantee institutions.

Dr. Cavanaugh asked how many of the students served by the grantees are males. LCDR Mix stated ten (10) percent are male but they still have to come from a disadvantaged background.

Dr. Cavanaugh asked how many of the students served by the grantees are from rural areas. LCDR Mix stated that these data are not collected.

Dr. Glenn stated that when the faculty is not diverse, it sends the message that diversity is not important and there are no role models for students. The grantees need to be held accountable.

Ms. Marckmann asked if grantees track students with 504 plans. LCDR Mix stated that these data are not collected.

Dr. Speranza stated that her organization has a NWD grant that serves African American, Hispanic, and Asian students. When it was unable to find Hispanic faculty to serve as mentors, the organization collaborated with a Hispanic nursing organization.

Dr. Drenkard asked if the NWD program collaborates with ED or DOL. LCDR Mix stated that many grantees apply for ED and DOL support and also work with other programs on campus supported by these agencies. The program has also learned that some of the institutions receiving NWD funding also get other grants from HRSA but are not collaborating. It is necessary to do a better job at identifying opportunities for collaboration.

Dr. Cavanaugh stated that an individualized education program (IEP) covers students until they are 21 years of age. This could shift the cost to the educational system. LCDR Mix stated that this varies by State and that some grantees are doing this.

### **Diversity in Nursing: Progress and Promises**

Antonia Villarruel, PhD, RN, FAAN

Dr. Villarruel stated that she served as the co-chair of NACNEP when the Council released its report on diversity 10 years ago. The report developed recommendations in three areas: education; leadership; and practice/workforce and cultural competency. Specific recommendations in these areas are listed below.

- Enhance efforts to increase the recruitment and retention of minority students.
- Promote minority nurse leadership development.
- Promote the preparation of all nurses to provide culturally competent care.

There has been progress in the past 10 years. This includes:

- Commitment by government, professional nursing organization, schools, and foundations;
- Development of infrastructures for diversity efforts;
- Implementation of many policy action items; and
- Promotion of cultural competence

#### **Areas Requiring More Attention**

- Impact of efforts to increase diversity in the nursing workforce is small.
- Accountability for and evaluation of programmatic outcomes is problematic (e.g., data are difficult to get).
- Minority nurse leaders are not used to their full potential in diversity efforts.
- Policy goals need to be

Dr. Villarruel identified areas where more work is necessary. These are listed below.

## ***Education***

- Identify successful models that support the recruitment, admission, retention, and graduation of minorities. Support the replication, dissemination, and scale up of these models.
- Track, monitor, and evaluate programs funded specifically to address minority outcomes.
- Promote efforts to sustain successful programs beyond external funding.
- Identify factors that impact sustainability.
- Develop strategic partnerships with minority communities to facilitate interest in nursing and educate all nurses in addressing community health needs.
- Develop relationships with high schools to facilitate access to opportunities in nursing.
- Identify best practices in articulation programs between ADN and BSN.
- Increase mobility of ADN graduates to BSN and higher.
- Do a better job of recruiting minorities to advanced nursing programs.

### **Underrepresentation in Advanced Nursing**

- African Americans (54.7%) and Latinos (55.1%) are more likely to enter nursing through ADN programs.
- Minority nurses are underrepresented in APRN roles (6.3% African American, 3.5% Latino)

## ***Leadership***

- Develop and sustain successful leadership and mentorship programs for minority nurses.
- Engage minority nurse leaders in meaningful ways to lead, develop, and disseminate successful leadership programs.

## ***Practice and Cultural Competency***

- Cultural competence standards are not included in NCLEX.
- Examine the effects and benefits of the nursing workforce reducing/eliminating disparities in care, access to care, outcomes of care, and cost.

Dr. Villarruel provided an example of how the nursing community can work together to move forward with the issue of diversity. The National Coalition of Ethnic Minority Nurse Associations (NCEMNA) was formed approximately 14 years ago as a result of the Leadership Summits held by the Division of Nursing. NCEMNA's mission is to serve as a unified force advocating for equity and justice in nursing and health for ethnic minority populations. NCEMNA is made up of the following organizations.

- Asian American /Pacific Islander Nurses Association, Inc. (AAPINA);
- National Alaska Native American Indian Nurses Association, Inc. (NANAINA);
- National Association of Hispanic Nurses, Inc. (NAHN);
- National Black Nurses Association, Inc. (NBNA); and
- Philippine Nurses Association of America, Inc. (PNAA).

NCEMNA was awarded a 5-year, \$2.4 million grant by National Institutes of General Medical Science (NIGMS) for the Nurse Scientist Stimulation Program. This program is designed to:

- Create a network of ethnic minority nurse scientists;
- Develop mechanisms to support ethnic minority researchers at all career levels; and
- Engage ethnic minority students to consider nursing research as a career trajectory.

Dr. Villarruel provided an example of how minority researchers are often discouraged from conducting research within their own communities. In one instance, a student's advisor told her there was no need to study dental caries in Hispanic children.

Another model program is the Oregon Center for Nursing's Nursing Workforce Diversity Initiative. The Center has developed a database on nursing student admissions that collects data from 21 ADN and BSN programs to accurately track and report admissions and enrollment trends. The data indicate that applicants from underrepresented ethnic/racial groups who met qualifications for nursing schools were admitted at rates similar to Caucasian students. The Center also works with the Oregon Community Foundation to nurture cultural competence in both nursing education and practice.

## **Discussion**

Dr. Drayton-Brooks asked about competency-based assessment. There are competencies for higher education but are they appropriate at the baccalaureate level or ADN level. Dr. Villarruel stated that it is necessary to look at if they are implemented and how they are implemented. For example, language (e.g., speaking Spanish) is included in the standards but not being implemented.

Dr. Sochalski asked about the barriers to leadership. Dr. Villarruel stated that nurses are not being tapped to be leaders and nurses do not recognize the value of leadership—they do not seek out leadership opportunities. Nurses need to be trained on how to be an effective leader (e.g., how to serve as a board member). It can be difficult being the only one at the table representing nursing.

## **Bureau of Health Professions Update on Diversity Mission**

E. Michele Richardson, MS, BSN, RN

Ms. Richardson shared her personal story of growing up in a single-parent household. She moved from public school to a more demanding parochial school. In this school, the guidance counselor told all the minority students that they should plan to become a secretary. After high school, Ms. Richardson attended community college. With an ADN degree she entered the workplace and observed that there were few minorities. She benefited from the involvement of mentors and also served as a mentor to others.

Ms. Richardson has developed key theoretical framing questions for the Bureau's efforts to address diversity.

- What does diversity mean to the Bureau? (e.g., definition)
- What to accomplish in the short and long term?
- What data are available?

- What is the Bureau’s strategic plan?
- How will the Bureau address the “my group” mentality?
- Is it possible to develop a diversity strategy for all minority groups?
- What evaluation efforts will be necessary to assess the effectiveness of current health professions programs (e.g., HCOP, COE, NWD)?
- How to assess health professions training with respect to minorities and determine if there is an impact on access to care?
- What has been the effect of evidence-based models for recruitment and retention of a diverse health workforce?
- Have we made progress toward a more diverse workforce in the past 10 years?
- How to improve health equity by developing a talented minority health professions workforce?

### ***Priorities for the Bureau***

- Enhance efforts to increase recruitment and retention of minority faculty and students
- Increase mentor opportunities for people in rural areas
- Promote leadership in practice and policy
- Showcase evidence-based models
- All FY2012 grantees should embrace inclusivity

### ***Next Steps***

- Bring stakeholders together to identify challenges (interprofessional discussions, grassroots strategic planning)
- Interagency workgroups (e.g., ED, DOL)
- Support private-sector initiatives (e.g. CVS pharmacy program for minority students)
- Promote nurse/family partnerships
- Specify what workforce data are needed

### **Discussion**

Dr. Drenkard asked if it is possible to increase the number of racial/ethnic minorities from all socioeconomic levels in Division of Nursing programs. Ms. Richardson said that the legislative language is limiting in terms of supporting racial/ethnic minorities—it focuses on disadvantaged students.

Dr. Minnick stated that it is necessary to focus on the needs of disadvantaged minorities first (before minorities that are not disadvantaged). Ms. Richardson stated that there needs to be better ways to measure disadvantage. For example, at the doctoral level, what constitutes a disadvantaged background?

Dr. Respress asked why the terminology was used in the legislation. Historically, in this country individuals coming from disadvantaged background have been racial/ethnic minorities. Was the intention to support minorities even though the term disadvantaged was used? Ms. Richards said it would be necessary to look at the Congressional Record to determine the intention.

Ms. Brunell stated that she worked in Kentucky early in her career and part of the orientation process was to help employees understand the culture in Appalachia. This is a severely disadvantaged area but the people are not racial/ethnic minorities.

## **General Discussion**

### **April 2011 Meeting**

Council members discussed possible topics for the April meeting. Other aspects of the meeting were also discussed.

The writing committee will use information obtained from the presentations from the November 2010 meeting and propose diversity definitions and verbiage regarding this topic for the 11<sup>th</sup> report based on the discussions at the November 2010 meeting.

### **Meeting Format**

Council members suggested ways to structure the meeting to better optimize the limited time.

- Link presenters to specific meeting objectives.
- Present speakers in a panel—short 10-15 minute presentations responding to specific questions.
- Request that organizations submit a “one pager” answering specific questions.

### **Meeting Summary**

Council members suggested more effective ways to capture meeting discussions in the meeting summary.

- Organize the summary by objectives, not simply as a sequential reporting of the discussion.
- Produce a verbatim transcript to capture the rich dialog that takes place during meetings.

### **Report Structure**

Council members discussed aspects of the report on diversity.

- Include narrative to support the data in the report—tell the stories behind the data.
- Include quotes from presenters at the November 2010 and April 2011 meetings.

### **Topics/Presenters for April 2011 Meeting**

- National Coalition of Ethnic Minority Nurse Associations
- National Center for Health Workforce Analysis (Edward Salsberg) – minimum data set
- Oregon Center for Nursing, Nursing Workforce Diversity Initiative
- Nursing Workforce Centers. (Jennifer Nooney)
- ED and DOL programs (types of programs, how they measure outcomes)
- Presentations by successful programs (drivers of cultural change) and “failed” programs (identify challenges, why objectives were not met)
- Presentations by “successful workplaces” surveyed by Dr. LaVeist
- Mississippi programs designed to address student attrition
- Efforts to promote diversity/inclusivity in different settings (e.g., hospital, university)
- Cultural facilitators and barriers to the effectiveness of diverse workforces
- COA360° (cultural competency tool)
- Negative impact of financial aid (e.g., jeopardizing other financial support, stipend vs. scholarship, etc.)
- Effectiveness of educational programs – number of graduates vs. dollars spent
- Pipeline programs in middle and high school (Betty Hafner)
- Legislative expert to discuss how the Council can make effective recommendations

### ***Definition of Terms***

The writing committee will develop definitions of key terms (e.g., diversity, inclusivity, cultural intelligence). Preliminary drafts will be circulated to Council members for comment. The definitions will be finalized at the April 2011 meeting.

### ***Data Requested by Council Members***

(To be provided prior to April 2011 meeting)

- AACN data (faculty)
- NLN data from schools (admission, retention, etc.)
- Information from State Nursing Workforce Centers on the minimum data set
- Qualitative and quantitative data on successful programs
- Comparative data on recruitment, retention, and leadership, 2000 and 2010

Dr. Minnick emphasized that the Council needs to identify what data are necessary and request that these data are collected—not just work with available data. Dr. Minnick volunteered to work to identify these data. A workgroup was formed with Dr. Sochalski, Dr. Brunnel, and Dr. Respress.

### ***Other Resources Requested by Council Members***

- Gap analysis of NACNEP's 2000 report
- Past reports on diversity (e.g., IOM, Sullivan)
- Evaluation of NWD program
- Congressional Record on NWD program (1998)
- National League for Nursing Toolkit
- Information about other successful diversity and/or pipeline programs
  - STEM
  - ANA/SAMHSA Minority Nurse program (faculty preparation)
  - RWJF Nurse Executive Fellows program
- IOM/NACNEP recommendations crosswalk
- Information on American Organization of Nurse Executives' (AONE) work in these areas

### **Council Business**

#### ***Next Meeting***

The next meeting will take place the week of April 11-15, 2011.

#### ***Membership***

Dr. Sochalski asked Council members to identify potential members and encourage them to submit nominations.

## **Public Comment**

*Melinda Mercer Ray*

National League of Nursing (NLN)

Ms. Mercer Ray stated that the NLN is happy to share information on their efforts to promote diversity.

## **Adjournment**

Dr. Sochalski adjourned the 123<sup>rd</sup> meeting of NACNEP at 2:00 pm.