

130th Meeting of the National Advisory Council on Nurse Education and Practice

**November 5 and 6, 2014
DHHS Parklawn Building
Rockville, Maryland**

The National Advisory Council on Nurse Education and Practice (NACNEP) was convened for its 130th meeting at 8:45 A.M. to 5:00 P.M. EST on both November 5th and 6th, 2014 at the Department of Health and Human Services Parklawn Building in Rockville, Maryland.

In accordance with the provisions of Public Law 92-463 the meeting was open to the public for the duration of this two day meeting.

Council Members Present

Carol S. Brewer, PhD., RN, FAAN
Mary Lou Brunell, MSN, RN
Mary Burman, PhD, RN, FAANP
Katherine Camacho Carr, PhD, ARNP, CNM, FACNM
Lenora Campbell, PhD, RN
Sally Solomon Cohen, PhD, RN, FAAN
Kathleen Gallo, PhD, MBA, RN, FAAN
Rosa Gonzalez-Guarda, PhD, MPH, RN, CPH
Susan Hassmiller, PhD, RN, FAAN
Doris Hill, PhD, RN, CNOR
Sandra Nichols, MD, FAANP
Sally Reel, PhD, RN, FNP, BC, FAAN, FAANP
Monica Rochman, PhD, RN
Linda Speranza, PhD, MS, MEd, ARNP-BC
Arti Patel Varanasi, PhD, MPH, CPH
David Vlahov, PhD, RN, FAAN
Margaret Wilmoth, PhD, MSS, RN, FAAN

Council Members Absent

Gerardo Melendez-Torres, RN
Marc Nivet, EdD
Barbara Tobias, MD

Presenters

Andrea Brassard, PhD, FNP-BC
Margaret Flinter, PhD, APRN
Kathleen Gallo, PhD, MBA, RN, FAAN
Tine Hansen-Turton, MGA, JD, FAAN, FCPP
Susan B. Hassmiller, PhD, RN, FAAN along with Regina Cunningham, PhD, RN, AOCN, FAAN and P.J. Brennan, MD

Cheri Lattimer, BSN, RN
Ellen-Marie Whelan, PhD, NP, FAAN

Welcome Remarks

HRSA's Administrator, Dr. Mary K. Wakefield, formally welcomed the council and set the stage for the expectations for this meeting regarding interprofessional nursing practice followed by a meeting on interprofessional nursing education in the spring of next year. She stressed the importance of the reliance on the level of expertise the council provides to inform the government and in particular nursing. Dr. Wakefield reminded the council that their expertise helps to ensure that the government's approach to the delivery of health care on behalf of the nation is the best approach. Dr. Wakefield then provided a reflection on some of the comments DHHS Secretary Burwell made recently at the Brookings Institution regarding health care transformation. Dr. Wakefield also discussed a newly announced initiative called Transforming Clinical Practice. This initiative is designed to support a partnership between the federal government and clinicians to help them to rethink and redesign their practice. The purpose of the initiative is to help us move from systems driven by quantity to systems that are driven by quality, focusing on health, patient outcomes and care coordination. Hoping that this reflection helped to provide some context to this meeting, Dr. Wakefield closed with asking the council to consider the question: "What is the role for nurses in this transformation that is underway in the U.S. health care delivery system?" Dr. Wakefield also reminded the council about the next upcoming marketplace enrollment starting November 15th, and extended an invitation for the council to extend their reach and encourage those in their communities to sign up.

Dr. Mary Beth Bigley, Director for the Division of Nursing and Public Health, provided some additional opening and welcome remarks to the council and public. She provided some historical background regarding the selection of the topic, and the set-up of this meeting as well as the one that will be held in the Spring of 2015. Following the background, Dr. Bigley provided a review of the agenda and asked the council to set tasks for the next two days ahead so that there will be a final product of recommendations on interprofessional nursing for the upcoming 13th report. Dr. Bigley asked the council as they are listening to the presentations to consider the information rendered across four domains: RN level, advance practice level, acute care, and finally primary care. She asked the council to consider the strengths, challenges and opportunities across these four domains. Dr. Bigley thanked the council for their ongoing efforts and commitment to nursing, and requested that they stay focused during the deliberations of this two-day meeting to come up with precise, practical and pragmatic recommendations.

Interprofessional Practice – What are the Challenges and Opportunities for Nursing Practice? – Presented by Andrea Brassard, PhD, FNP-BC

Dr. Andrea Brassard is the Director of Health Policy at the American Nurses Association (ANA).

Dr. Brassard's presentation included the fact that there are a lot of opportunities for interprofessional practice for nurses in access, quality and expanded care. Regarding the Affordable Care Act, she agreed with Dr. Wakefield's call for us to encourage those in our communities to enroll.

In regards to interprofessional nursing, Dr. Brassard identified opportunities in pharmacy, lab services, mental health, substance abuse, clinical nurse specialists in psychiatric nursing, ambulatory care, chronic care disease, collaborations with rehabilitation services (physical, occupational and speech therapists), preventative wellness and finally chronic disease management. Dr. Brassard stated that as nurses we need to keep in mind, that when we think about interprofessional practice patients and families come first, taking care of the whole person – body, mind and spirit. Dr. Brassard stated that all four APRN roles need to be included in the health exchanges.

Regarding challenges Dr. Brassard identified one regarding midwifery and the fact that midwives cannot practice unless they have hospital privileges. Another challenge was in the area of billing. Dr. Brassard urged the council to consider making a recommendation to CMS that they create a billing modifier in claims. This would also help us to acquire more accurate data that would better reflect the work of APRNs and RNs especially in ambulatory care. Usually the outcomes reflect the physician or practice as the provider, excluding the nurse's role in the care provided. The nurse in this case is invisible. Dr. Brassard stated that large national data sets (such as the Medical Expenditure Panel Survey or the Health Care Cost Institute) do not ask about APRN or RN care, and so perhaps the council could make a recommendation in that regard. When large national data sets migrate from paper to electronic, every provider should be identified, separating RNs from LPNs.

NACNEP council members offered several constructive comments post Dr. Brassard's presentation. The white paper from the Federal Trade Commission (FTC) was mentioned as well. The council was provided with a copy of that document.

Broad Perspective Specific to the Strengths of Interprofessional Practice and the Role of Nursing – Presented by Susan Hassmiller, PhD, RN, FAAN along with Regina Cunningham, PhD, RN, AOCN and P.J. Brennan, MD

Dr. Hassmiller, along with her colleagues from the University of Pennsylvania, gave a presentation about the work that the Robert Wood Johnson Foundation (RWJF) is doing around interprofessional practices and finding out what good models are out there. Dr. Regina Cunningham is the Chief Nurse Executive and Dr. P.J. Brennan is the Chief Medical Officer at the University of Pennsylvania. Dr. Hassmiller stated that the RWJF is very much involved in building capacity around the issue of interprofessional collaboration.

Dr. Hassmiller mentioned the Future of Nursing report that addressed building the capacity of the nursing workforce, so that we might be better positioned as the country's largest workforce to help transform health and health care in this country. The report emphasized that as the delivery of care becomes more complex across a wide range of settings, and the need to coordinate care among more providers becomes even more important. Developing well-functioning teams has become a crucial objective throughout the health care system.

Dr. Hassmiller then went on to describe the process of a survey that was conducted at approximately 18 sites through the Center for Applied Research (CFAR). The primary assessment was of chief medical officers (CMO) and chief nurse officers (CNO) described their

healthcare system as a team. The CMOs and CNOs had to describe how they delivered care, and what outcomes they thought they were achieving because of their interprofessional practice. Ultimately seven systems were chosen that demonstrated promising practices that the RWJF wanted to review further. The systems chosen were diverse geographically as well as the type (urban vs. rural or academic health center vs. community health center). Both Dr. Cunningham and Dr. Brennan were present online to discuss their particular organization's system at the University of Pennsylvania Health System. Dr. Hassmiller indicated that a white paper is currently being edited and there is also a plan to develop a tool kit and future site visits.

Dr. Hassmiller's presentation outlined six promising practices in interprofessional collaboration:

- Establish strategic alignment
- Demonstrate leadership commitment
- Create a level playing field
- Promote effective communication
- Use organizational structure
- Prepare people to work together.

After the presentation by Drs. Hassmiller, Cunningham and Brennan, there were questions from the NACNEP and an opportunity to clarify points made during the presentation.

Promising Practices and Models that Work – Presented by Margaret Flinter, PhD, APRN, c-FNP, FAAN, FAANP and Mary Blankson, APRN, DNP

Dr. Flinter gave her presentation next which focused on the role of Registered Nurses in primary care. She made the point that RNs in the broad landscape of primary care across the country have, in some ways, disappeared from view over the last couple of decades, particularly in primary care. This, however, is not necessarily the case in the nation's community health centers. If you look at the UDS report for 2013, there were 10,000 physicians, 5,000 NPs, but there were 13,000 RNs practicing in community health centers. She stated that those of us who are entrusted with leading these organizations recognize that not only do the patients need nurses, but the organization needs nurses. She said that we cannot manage the volume and complexity of patients that we have unless we bring everybody's skills on the team. And where we talked about volume versus value and quality versus quantity, here in this organization we really had to say to everybody that it's always going to have to be both. It's volume absolutely, as well as value. It's quantity absolutely, as well as quality. There are so many people who need our services.

Dr. Flinter went on to briefly describe community health centers generally and her organization in particular. She described the role of RNs in primary care as part of a model of care. Dr. Flinter stated that the core elements of this particular model began with the full integration of the primary care team and pods. The pod has become the functional unit of our community health centers. A standard pod has two primary care providers. It could be two nurse practitioners; it could be one physician and a nurse practitioner; it could be a physician assistant and a nurse practitioner or a physician. Each of those primary care providers are managing a panel of about 1,200 people, and are supported by a medical assistant. They also did an 'up skilling' of medical assistants to allow the RNs to practice to the full extent of their license. Each of those

two-person primary care provider teams are supported by an RN in the pod. The pod also includes a behavioral health clinician, which could be a social worker or a psychologist for example, so that those primary care providers have seamless access to a behavioral health component for their patients.

They also made a commitment to contributing new knowledge to the field of primary care and understanding that -- both in terms of helping our colleagues across the country, but also keeping a very fresh, highly vitalized and engaged staff. Dr. Flinter said that we have to engage in the work of research and innovation. The Weitzman Institute is a division of the Community Health Center. It is the home of the post-graduate training program, the nurse practitioner post-graduate training program, and the post-doctoral clinical psychology program. It's also the home of the quality institute and some of the innovations like Project ECHO, which is a case-based system learning approach to manage highly complex issues like chronic pain, opiate addiction, HIV, and hepatitis C in the community health center setting. They say that the slogan is to sometimes think locally and act globally. She think we're practicing locally in Connecticut, but they are trying to share our efforts globally. Dr. Flinter said they have taken the post-graduate nurse practitioner training program (Project ECHO) and the quality improvement work to multiple states around the country.

Drs. Flinter and Blankson then went on to describe two significant categories where nursing services are provided. The first is called independent nurse visits that are done understanding orders for patients -- those standing orders having been developed by Mary as a CNO in collaboration with the CMO. The second type of nurse visit is called the delegated nurse visits in which the primary care provider requests or orders a visit or a set of visits to happen with the RN who supports that team in which medications may be adjusted. Additional intensive education, motivational interviewing, and self-management goal setting can happen during. This is particularly critical to managing our large volume of patients with multiple chronic illnesses.

Another topic area mentioned was the critical role of RNs in care coordination, care management, and care planning which Mary Blankson provided further detail. Two other areas mentioned were nurses as leaders and participants in research in the health center. Through the Weitzman Institute, examples are 'Rewards to Quit' tobacco cessation ran by controlled trials, which is going on right now, and a care coordination study as well as a study on chronic pain. Dr. Flinter also brought up the topic of mentoring of RN students. She indicated that they are pretty focused on their intent to ensure that the next generation of RNs who are graduating from the university, graduate knowing that coming directly into primary care is a perfectly viable option. Dr. Flinter stated that she would like to see nursing students get the kind of experience within their undergraduate training to understand what the role of RNs are in primary care, rather than feeling that they have to go to the acute care setting before they can come into primary care. In summary, for the last 12 months, Dr. Flinter's organization, the Community Health Center has had approximately 25,000 visits that can be allocated specifically to the resource of the nurse for multiple different reasons.

After the presentation by Drs. Flinter and Blankson, they were presented with questions from the council and had the opportunity to clarify points made during the presentation.

Public Comment

All lines were open and made available for public comment post a lunch break. The following public attendees present in the room had the floor first:

Anastasia Trent, BSN, RN representing the National Association of School Nurses:

I'm a graduate student at the University of Maryland, School of Nursing, studying community and public health nursing. And I am here today representing the National Association of School Nurses. I have a statement I'd like to read:

“As an RN and a parent of two healthy children I feel confident knowing my children have school nurses available to address their health needs whether they are playground injuries, acute illness or vaccine verification and administration programs. As the sole healthcare provider in a setting where the primary focus is not health, school nurses have been required to practice interprofessionally for over a century by collaborating with teachers, parents, counselors, primary care providers and health departments.

Children do not leave their health problems outside of the school building. With increasing rates of chronic disease and illness, such as asthma, allergies, and diabetes, community and school based healthcare has become more important. Take ‘John’ for example, who has newly diagnosed Type I Diabetes. In order for ‘John’ to maintain health and reach his academic potential a healthcare team based in his community is essential. He needs care all day, every day, at home and at school. Primary care providers and specialists must work with school nurses, parents and teachers to achieve this. Imagine now that ‘John’ is a vulnerable student who faces barriers in access to care. School nurses coordinate care to ensure that new students get the services they need.

School nurses are an often overlooked source of valuable health care to millions of students every day, kind of like the invisible nurse. As a health leader in the school setting, school nurses focus on health of student populations by recognizing and promoting the relationship between health and academic success. Evidence shows that healthy children learn better.

Health care reform’s current shift in focus from acute care to community-based disease prevention and health promotion provides an amazing opportunity to affect health on population levels. However schools of nursing primarily focus on studies in acute care, which leave the public and community-based nursing professions significantly understaffed. By increasing the presence of public and community-based health in undergraduate nursing education, students can experience in interprofessional based practice focusing on care coordination, and population health.

Nemours Health and Prevention Services in Delaware provides an exemplary model of interprofessional practice. The Student Health Collaborative between primary-care providers and school nurses allows the school nurse to view pertinent health information on student medical records electronically. Potential improvement of this system involves creating a

seamless network with reciprocal communication among school nurses, primary care providers, medical homes, and parents.

By improving collaboration and communication systems within school health care teams, the school-nursing practice can be advanced to improve overall student health. Thank you.”

Another comment from the public came from Lauren Inouye who is the Associate Director of Government Affairs for the American Association of Colleges of Nursing:

“I want to first and foremost say that AACN appreciates and commends the advisory committee’s work to examine the future of nursing care and its deepening intersection of building a strong interprofessional practice. AACN also understands the importance of integrating public and community health into nursing education at all levels; and this is one focus that our Futures Task Force will be discussing further in the coming months.

The association is committed to preparing our students, faculty, and institutions for enhanced interprofessional practice and appreciates the opportunity to share with the committee some of the initiatives we are engaged in to develop more streamlined approaches to educating our workforce to meet the impending challenges. AACN and the American Organization of Nurse Executives have created an Academic-Practice Partnership Steering Committee with the goal of strengthening the collaboration between academic and practice settings so that nursing is positioned to lead change and advance health, including supporting the recommendations of the IOM Future of Nursing report.

In 2012, a set of eight guiding principles were created to support intentional and formalized relationships based on mutual goals, respect, and shared knowledge for these partnerships. Principle number seven states that a commitment is shared by partners to support opportunities for nurses to lead and develop collaborative models that redesign practice environments to improve health outcomes, including joint interprofessional leadership development programs. The steering committee has posted examples, toolkits, and an online collaboration community to move these principles forward, many with a focus on interprofessional teams.

AACN echoes Dr. Hassmiller’s call for role modeling within interprofessional practice. As you know, AACN is a partner in the Interprofessional Education Collaborative, or IPEC, which engages six health profession disciplines aimed at developing core competencies for students that increase seamless team-based care, communication, and foster interprofessional environments in the academic setting that translate into practice.

To ensure that IPEC’s work is translated to health professions educators, regional conferences, including IPEC’s Interprofessional Faculty Development Institute, shares with faculty how to enhance health professions teams. We believe education is the basis for establishing strong interprofessional practices. Thank you.”

The next public comment came from Miss April Stidham, a graduate student from East Tennessee State University:

“East Tennessee State University, College of Nursing has a long history of implementation of grants from the Department of Health and Human Services, HRSA, Bureau of Health Workforce

in the Division of Nursing and Public Health. We have these grants to expand and strengthen nursing workforce and improve our access to care and integrate education into nurse-managed clinics.

At ETSU, we have 10 nurse-managed clinics, and through these grants, we're able to set up interprofessional clinics with disciplines that are part of our university, which are the AHSC disciplines. We're looking at pharmacy, nutrition; we have social work students, psychology students are coming onboard in the College of Medicine next year, so it's a large, expanded interprofessional IP clinic team.

So these grants offer an immense impact on the primary care to our area. Our area is rural. It's underserved. We also have a lot of uninsured and underinsured patient populations, so vulnerable populations. These grants focus on multiple chronic conditions, a complex of care, chronic care. So, basically, with our grants, we do offer large number of patients with culturally sensitive needs and cultural issues. We have a Hispanic population there, too, as well in northeast Tennessee, and a lot of our patients are Hispanic, because they're uninsured. So, basically, in this rural area of Appalachia and low income, these clinics are valuable.

Over the years, hundreds of nursing and other health profession students have had life-changing clinical experiences with these practice grant funded sites. ETSU demonstrates a longstanding commitment to interprofessional education with a history of common courses in community and work among nursing, medicine, public health, and other disciplines for over 20 years.

We have had good outcomes from our grants -- with these grants. We have had the NEPQR, which is the Nurse Education, Practice, Quality, and Retention grant, and the ANE grant, the Adult Nursing Education program grant. With these grants, we have seen sustainability in patients with chronic disease, with hypertension. We've had 24 patients in the in-home program through the NEPQR grant, who have diagnosed with hypertension; pre- and post-data have shown that their blood pressures are now well-controlled with a mean systolic blood pressure of 125 and a diastolic pressure of 78. So, basically, through these services, these patients have had maintenance of their blood pressure. We also have a lot of diabetics in the area. So their mean average A1Cs for these types of populations that we serve the patients have been 6.5, which is good.

So the final objective for these grants, we also have a lot of interprofessional student learning experiences. We have a lot of disciplines involved. We talk about medication safety, heart disease, health literacy. We do medication reconciliation and all of these that are now factors with interprofessional clinics that are important. We have had interprofessional graduate students participate in practicum experiences in the clinic and the homes of older adults; and these have allowed opportunity for students and faculty to broaden their understanding of health disparities in the population that we live in.

The AMEC ANEP grant is allowing ETSU to incorporate interprofessional education into the Advanced Nursing Education Program grant to focus on IPE, Interprofessional Practice in Education, and it's centered around multiple chronic conditions.

So, we would like to say at ETSU that we would like to have the sustainability of these grants. And that we feel like these grants are committed to high-quality interprofessional education with nursing education and other disciplines to relate to the health care reform. And that we feel like these are accessible, affordable, and quality, and it also increases our skills as far as collaboration between disciplines. Thank you.”

There were no public comments offered from remote participants.

Gallery Walk – NACNEP Council

The council broke up into three small groups to talk about the strengths, opportunities, and challenges of interprofessional practice. They were instructed to draw from both their personal and professional experiences in respect to nursing practice with interprofessional teams. Comments, thoughts, and themes were captured by the council members as each group rotated among the three broad topic areas. The council members were also instructed to start to thinking about how their comments could then be framed as a recommendation. Post deliberation all of the groups returned to the main meeting room to report back to the group as a whole. With the public present the council continued to discuss the end product of the gallery walk, and had an opportunity to clarify thoughts recorded as well as identify areas of overlap or redundancy.

Group Discussion – NACNEP Council

The council deliberated further on what was discussed during the breakout gallery session. Below is a small piece of some of the topics/themes that came out of the gallery walk session:

Strengths

- Public Trust. Credibility, closeness with the nurse as a provider as oppose to other providers. Team care will not exist without trust among the players.
- Leadership in Population Health
- Navigating and coordinating resources across systems
- Perspective of full continuum of care
- Integrity
- Nursing workforce represents a diverse population

Opportunities

- While some nurses may be able to negotiate with hierarchies of power (academy, federal, systems), this may not apply to all. Potential to translate this into leadership and leadership positions. Both a leadership and presence vacuum.
- Patient navigators have potential but are a concern; nurses have opportunity to clarify the role of nurses on the team.
- What is the cost benefit and “value add” for having a nurse on the team? Example (Geitner putting RNs on chronic care teams).
- Money for **post graduate residencies** for post bachelors and DNPs (post licensure residency for DNPs); mentoring environment. Essential.
- The community health clinic- the triage, expanded hours, protocols, and types of care provided; NPs focused on mental health. The BSN can take a role like community engagement and population based care to form a collaborative team with police, social service, housing. Nurse led community based collaborative.

- Billing modifiers into claims data (recommendation for CMS) to be more visible with research and data.

Challenges

- Academia, slow moving and cannot keep pace with movement in the field (“teamlets” and ACOs).
- We are not setting the institutional policies and decisions that affect nursing.
- We don’t have the faculty to teach the skills to navigate the larger health systems.
- Academia and practice are siloed and evolving separately.
- We need evidence that is based on research that is proven effective.
- Licensing. If essentials address it, accreditation of nursing schools and credentialing.

Summary of Day #1 and Adjournment

Dr. Mary Beth Bigley encouraged the council to review the articles that were sent to council and made available to the public attendees. The following four articles provided were:

- Creating Clinical and Economic “Wins” Through Integrated Case Management: Lessons for Physicians and Health System Administrators
- Health Affairs: At the Intersection of Health, Health Care and Policy
<http://content.healthaffairs.org/content/33/6/980.full.html>
- Patient-Centered Medical Home Initiative Produced Modest Economic Results for Veterans Health Administration, 2010-12
- Role of the Registered Nurse in Primary Health Care: Meeting Health Care Needs in the 21st Century (Available online at www.sciencedirect.com)

Dr. Bigley also provided a synopsis of the deliberations that occurred after the gallery walk breakout session. The council was informed that tomorrow, the second day of this two day meeting, included taking the summary of deliberations from the breakout session today, and formulating it into recommendations. Dr. Bigley reminded the council that the recommendations need to be concrete, actionable items that can be moved forward. Dr. Bigley posed an option to the council which was to not wait until the mandated annual report to present recommendations. She stated that if there are recommendations that the council really want to move forward with, for example two recommendations to the Centers of Medicare and Medicaid Services, then the council could write it up.

Dr. Bigley then updated the council on the status of the 12th NACNEP Report to Congress. She stated that it was in its final stage and again thanked the writing team for their hard work.

Opening Remarks Day #2

Rebecca Spitzgo, the Associate Administrator for the Bureau of Health Workforce, provided welcome remarks as well as her professional background. She went on to describe the reorganization that took place, combining the former Bureau of Health Professions (BHP) and Bureau of Clinician and Recruitment Service (BCRS) into the Bureau of Health Workforce (BHW). This became effective May of 2014. She provided the rationale for this change stating that one of the reasons why this reorganization occurred was to bring the agency’s workforce

programs back together within HRSA. Ms. Spitzgo provided a further synopsis stating that the new bureau has a budget of over a billion dollars, over 40 programs, and over 450 staff making it the largest bureau within this agency. Ms. Spitzgo then went on to describe the activities and roles that some of the divisions within the bureau undertake, such as the six research centers that aid the bureau look across what is going on out in the field for workforce. The former Division of Nursing is now the Division of Nursing and Public Health. With the addition of a public health division and inclusion of mental and behavioral health to nursing programs the activity within the Division of Nursing and Public Health has grown substantially. Ms. Spitzgo discussed the impact other divisions within the bureau are making as well.

Ms. Spitzgo explained an ongoing focus includes efforts to address oral health needs and geriatric care programs. She also described cross-cutting priorities for BHW, which include increasing workforce diversity, implementing interprofessional practice and education models, and ensuring better health workforce placement in underserved areas. Funding Opportunity Announcement formats will be revised to make them more user-friendly, allow more time for applications to be submitted, and scrutinized to ensure that proposals align with HRSA and BHW priorities.

Regarding Affordable Care Act updates, Ms. Spitzgo reiterated the importance of outreach to help consumers enroll or change insurance plans. She shared the enrollment period dates (12/15/14 to 2/15/15) and resources for healthcare providers and consumers available through grants.gov, marketplace.cms.gov, Coverage to Care (C2C). A new section called SHOP is being developed to help small business owners to select insurance.

NACNEP council members offered several constructive comments and clarifying questions post Ms. Spitzgo's presentation.

Agenda Review for Day #2 (November 6, 2014)

Dr. Mary Beth Bigley provided a quick overview of the agenda for the second and last day of this two-day meeting. Please see the agenda on the NACNEP website:

<http://www.hrsa.gov/advisorycommittees/bhpradvisory/nacnep/index.html>

Sustainability in Today's Evolving Interprofessional Practice Healthcare Environment – Presented by Tine Hansen-Turton, MGA, JD, FCPP, FAAN

Cost Effectiveness of Advanced Practice Nurses as Primary Care Providers

Ms. Tine Hansen-Turton cited a 2007 Massachusetts study that found using NPs for primary care potentially saved the state approximately \$8 billion dollars. In general, the primary care provided by APRNs has proven to be of high quality while reimbursement rates remain cost effective. A Medicaid insured patient treated at a FQHC will pay an average \$150 per patient encounter, whereas the same patient seen at a NMHC would be paid \$5-\$30 per patient encounter. The pay discrepancy makes NMHCs more vulnerable to closure unless they can continue to be federally grant subsidized, or increase greatly the volume of patients seen to approximately 10/hour which could negatively impact care quality.

UDS data collection provides important evidence-base for NMHC cost effectiveness compared with Community Health Clinics. Since the ACA was passed, more insurance companies are beginning to contract with NPs and NMHCs because the patient outcomes data is very positive (ex. improved diabetic glucose levels) and saves insurance companies money.

Barriers to NMHCs becoming FQHCs and Sustainable Businesses.

The following activities are expected to be done while operating as a clinic seeing patients:

- Rules governing academic-affiliated practices (*education model*) becoming FQHCs (*business model*)
- To obtain a state license—some states require an agreement with a collaborative physician that takes time and costs money
- Selected collaborator must apply to the State Board of Nursing for approval (maybe a month)
- Medicaid credentialing alone can take up to a year
- Years of time it takes NMHCs to become independently run non-profits
- Nurses not included in Medicaid Insurance contracts even though they see an estimated 30% of Medicaid patients
- Need to identify target population early, and expand stakeholder support beyond national groups and gain local community stakeholder support.
- Time for ancillary staff—ex. CMAs to get trained and get an MA number from the state Medicaid office (potentially 4-6 months)
- Negotiating insurance contracts (additional 3 months or more)—and 30% of insurance companies are not contracted with NPs or NMHCs.
- Nurses must gain knowledge to better understand ins and outs of business planning, start-up, and management which takes time to master and often need hands-on guidance from mentors.
- Many NMHCs serve large numbers of Spanish-speaking populations which also requires additional preparation.
- A large component of population health care is preventive health education and home environmental assessment which are currently not reimbursable services under the current health system.
- HRSA grant funding ends after 3 years which is insufficient time for the NMHCs to get fully sustainable. Furthermore it is difficult to strategic plan because the badly needed start-up grant funds are not guaranteed, renewable or extendable despite promising early outcomes.
- Gaining community support and establishing trust with a vulnerable patient base is hard to maintain if the NMHC has to close due to lack of funding and it becomes very difficult to re-open and re-establish those relationships should funds become available again.

Suggested strategies for NMHC sustainability

- Get NMHCs defined legally
- Get NMHCs recognized by CMS and added to insurance company contracts.
- Increase reimbursement rates for nurses for performing same services as physicians. (*Medicare currently reduces pay for NPs services by 15% of what MDs receive*).

- Create Fellowships and increase APRN curriculums to better prepare nurses for the business of establishing, running and sustaining NMHCs, retail and SBHCs.
- Extend the time frame for HRSA grants beyond 3 years to allow NMHCs to get firmly established
- Provide NMHCs with support to adopt EMRs, and data collection systems that will help collect UDS data that will allow stakeholders to see the investment return from the services nurses provide.
- Offer more conferences that will provide continuing education for nurses to learn business skills.

Advanced Care/Case Management Strategies with Positive Clinical and Financial Outcomes in an Interprofessional Practice Environment - Presented by Cheri A. Lattimer, BSN, RN

Case/Care Management (CM)

Case Management and Care management are often used interchangeably—but may mean different things to different people. Case management is based on an interdisciplinary care model in that teams often include patients, family caregivers, RN and APRN nurses, counselors, physicians, social workers, pharmacists, and other health resource professionals. The division of labor and reimbursement issues will become more commonplace as interdisciplinary teams form. To that end, case management definitions and standards of practice were developed. In addition, reimbursement codes are expanding to include transitional care and chronic disease management.

As more health care is being delivered in community and home settings, nurses that were trained to work primarily in acute care settings will need additional education and training to work effectively in community health settings. Once these new skills are acquired, nurses and other team members will need preparation to work to the full extent of their practice scopes. Unlike utilization review or discharge planning nurses, Professional Case Managers (CM) have advanced training and certification in case management. A challenge is that currently there are few structured programs that teach Professional CMs.

NCQA and URAC are accreditation bodies that use CM standards of practice for meaning, qualifications, and to evaluate aspects of service delivery. Consultants often use these standards when they are asked to come in and develop various programs, and may refer to the Case Management Model Act—created by Ms. Lattimer’s organization, when addressing legal aspects of care.

Before these CM standards were developed, healthcare employers struggled with defining the CM job, writing position descriptions, and knowing what qualifications to look for in a potential CM job applicant. It was not uncommon to assign a nurse doing utilization review and simply change his/her title and suddenly designate him/her a “case manager” without a clear job definition and no additional training!

Like many healthcare occupations, a shortage of professional CMs is anticipated because the average experienced CM is 55 years old, and the average amount of time and experience it has taken to become a quality CM is 10 years. To aid in preparing a new generation of CMs, an

online, 60 Hour, 16-module, interactive toolkit that includes gaming simulation and narrative features was developed. The tool enables learners to earn continuing education credit and test competencies virtually before interacting with and assessing live patients. Pre-and post-tests are included that further measure knowledge and skills development. The tool has been well-received by a number of institutions that use the modules both as an onboarding tool for new employees and as a means to help Human Resource Managers better understand what qualities to look for in a CM applicant.

Another tool Ms. Lattimer's organization produced is an Integrated Case Management Training online program. The software allows nurses and social workers to evaluate patients in four domains: biological-medical, behavioral-substance abuse, psycho-social side, and the healthcare system. The program builds in a color-coded patient acuity score to aid in measuring the investment return in dollars and to track a patient's functional status along a health continuum and toward accomplishing individual goals. The tool measures core learning by way of a final examination, has been used successfully by Blue-Care Tennessee to train 146 nurses, and will continue to be used as an onboarding tool.

Ms. Lattimer's organization conducted a CM study in New York over a 2-year course that looked at Case-Managed patient outcomes. Study findings revealed reduced inpatient admissions, reduced emergency room utilization, and reduced patient acuity scores that were directly linked with Case Management activities provided by the team of nurses, physicians, pharmacists, and community entities. These outcomes also resulted in reduced costs and patient functionality improvement.

Legislative Issues and CM

CM codes now allow billing physicians and advanced practice nurses to use clinical staff in clinics and be able to bill for care coordination management. This code can be used every month for a 20-minute visit to do thorough assessment, education, and coordination with the patient and the family caregiver.

The Wyden Bill, the Better Care Program and Blumenauer bill that proposes more mental health wraparound are anticipated to be introduced in 2015. CMSA believes that for the medically complex, chronically ill patient 45-60 minutes may be more realistic and will advocate for the expanded time limit in 2016.

Other CM challenges are interfacing HIT systems; defining reimbursement guidelines for teams including modes of delivering CM care which can be face-to-face, telephonic, instant messaging, in a home or in an office setting; and multistate professional licensing; and insurance plan variances across states.

These issues of standards must be addressed to ensure that studies evaluating CM effectiveness are based on true professional case management tasks—and not what someone mistakenly “perceives” as Professional Case Management”

NACNEP council members offered several constructive comments and clarifying questions post Ms. Lattimer's presentation.

Reimagining the Future of Primary Health Care and the Role of the Nurse on the Interprofessional Practice Team – Presented by Ellen-Marie Whelan, PhD, NP, FAAN

Health Care Costs

Dr. Whelan discussed with the council where the future of health care is going and how her organization is creating some pretty exciting opportunities for nursing. When it comes to reimbursement, previously it didn't really matter whether the outcome was successful (e.g. right leg being amputated instead of the left). Dr. Whelan stated that this is one thing that is being reexamined. What are we reimbursing? Does it make sense to be reimbursing those things? If we're paying for patients to get better, how do we pay for that? Dr. Whelan stated that there are huge opportunities for nurses.

Value Based Purchasing

Dr. Whelan explained that value-based purchasing is when we talk about how we're not just paying for the service. We aren't just paying for an improved outcome. We are really looking to see where value, which is that combination of better practice at less expensive cost, comes together. The general principles for value-based purchasing are: (1) define that end goal, not just the process for getting there. So, for example, is the patient's hypertension in check or has the patient gotten better from his appendicitis; (2) all providers' incentives must be aligned; (3) the right measure has to be developed and implemented quickly. Dr. Whelan stated that she thinks that nurses need to be thinking a lot about what is it that we are measuring. She said there is a lot of discussion about what people are measuring to look at success. It's challenging for nursing, and even more so challenging for interprofessional education. Dr. Whelan said that we need to ask the question: What is the outcome that we are looking at that says we've got there because interprofessional education was better? Dr. Whelan stated that CMS is actively supporting quality improvement, and then engaging the community and patients because it is a very important issue.

Innovation Center – An Overview

Our mission is "to test innovative payment and service delivery models that will reduce program expenditures while preserving or enhancing care." CMMI is allowed to fund models that will decrease costs or even just keep costs neutral if the goal is to improve outcomes. Dr. Whelan stated that when they find success which is, in part defined by the actuaries, when they can actually say that they've either decreased costs or it hasn't gone up and outcomes have improved.

Dr. Whelan said in reviewing the individual model's success, when CMMI has found something, they can then make a bigger policy change in Medicaid or in Medicare because of what they've learned. CMMI is conducting a lot of different models to see what works with a wide variety of patient populations and providers, and innovative approaches to care and payments. Dr. Whelan stated that they recognize that they all won't all work because they know there's no easy answer or single bullet. As a result, they are exploring different formulas to see what is working. Dr. Whelan said that CMMI has been mapping out where they have funded and found that they are pretty much funding programs where people live. Dr. Whelan offered to the council to review the Innovation Center's webpage which has more detailed information on all of the

models as she presented about four to the council. The website for the Center for Medicare and Medicaid Innovation is: www.innovation.cms.gov. Dr. Whelan said that the common thread for all of the models presented is how all of them demonstrate a change in the way payments are done. The four models presented were:

- Accountable Care Organizations (ACO's)
- Bundled Payments for Care Improvement
- The Comprehensive Primary Care Initiative
- Strong Start

NACNEP council members offered several constructive comments and clarifying questions post Dr. Whelan's presentation.

Voices from the Council: Members Share Professional Experiences and Expertise in Practice Environments – What's Working and Why – Presented by Kathleen Gallo, PhD, MBA, RN, FAAN

Dr. Gallo presented what is working in the aspect of interprofessional teams in an acute care setting. She provided a pictorial slide that identified all of the healthcare providers on the team. There were four nurses present in the picture that represented an interprofessional team on a cardiothoracic unit. Dr. Gallo reiterated that without those nurses providing primary care, the team would not be a fully functioning team able to provide safe quality care.

Dr. Gallo then provided another scenario and mentioned the term “deference to expertise” - meaning that when there are teams of interprofessional health care providers, there is no hierarchy, but rather deference to expertise or affirming the expert. Dr. Gallo brought up the point that the nurse is usually the one constant around the clock during the patient experience. This is especially true in the acute care setting. Dr. Gallo stated that there is no team-based care without the RN in acute care. (End on page 122)

Group Work – NACNEP Council

The council then separated again into small groups to deliberate on the information provided both yesterday and today and to start developing some recommendations for the upcoming report.

Some of the preliminary recommendations that were presented to the group were:

- Remove the legislative scope of practice barriers. (Note: ask Congress to convene a group to address organizational/institutional barriers).
- Grant nurse managed healthcare organizations FQHC status and provide training and technical assistance (add reimbursement - Medicaid/Medicare)
- Provide training programs and removing the barriers for RNs and APRN in primary care for them to participate in PCMH and other primary care models and serve as team leaders in a primary care setting.
- Implement nurse residency/nurse fellowship programs (BSN/APRN).
- Nurses, nursing education programs, and nursing associations should prepare the nursing workforce to assume leadership positions across all levels, while public, private, and

governmental healthcare decision makers to ensure that leadership positions are available to and filled by nurses. (IOM)

- The federal government should take action to support nurses completion of a transition to practice program after they have completed a pre-licensure or advanced practice degree program or when they are transitioning into new clinical practice area. (IOM)
- Include the retraining (re-tooling) of nurses for new emerging roles. For example, care management, transitional care programs, primary care coordination and psychiatric nursing training programs as well as public health nursing.
- Build an infrastructure for the collection and analysis of primary healthcare workforce data. Ensure that nursing data is delineated.
- CMMI/DOL/HRSA/VA and AHRQ should support HRSA/NINR partnerships to develop research and evidence of the role of nurses on teams and link the role to patient outcomes.
- HRSA should support demonstration projects that support nurse education programs that collaborate with health systems to develop a nursing workforce that meets the health care needs in a transforming health system (such as team-based care , community-based care, faculty development, career transition programs, business principle\payers).
- HRSA should convene joint National Advisory Councils (NACs) to develop joint recommendations regarding Interprofessional Education and Collaborative Practice.
- Congress and HRSA should invest in initiatives that will enhance the nation's ability to collect, analyze and report on Interprofessional Collaborative Practice (IPCP).
- Congress, HRSA and CMS should revamp reimbursement models to better reflect the types and levels of services provided by nurses at all levels and other direct providers.
- Obtaining National Provider Identification (NPI) numbers should be a requirement for all nurses at all levels.
- Congress, HRSA and CMS should investigate the feasibility of NPI numbers for other direct care providers.
- Where appropriate, HRSA should require the use of IPCP or IPECP in its FOAs.
- HRSA should reinstate and/or support initiatives that promote IPECP and remove profession-specific siloes (e.g., Models that Work).
- Congress and HRSA should support initiatives for the development and implementation of new models for nursing education.
- Congress, HRSA and CMS should revamp current approaches to funding post-licensure training such as nurse residency programs.

Next Steps

The next NACNEP council meeting is being planned for the Spring of 2015. A set of dates will be sent out to the council seeking a majority vote on a date and once finalized, will be announced in an upcoming federal register notice.

CDR Hunter-Thomas adjourned the meeting at 4:30 pm EST.

These minutes will be formally considered by the Council, and any corrections or notations will thus be incorporated.

Approval of the Minutes by the Bureau of Health Workforce/Division of Nursing and Public Health Staff:

Mary Beth Bigley, DrPH, MSN, APRN, Chair/NACNEP

CDR Serina Hunter-Thomas, DFO/NACNEP
