

NATIONAL ADVISORY COUNCIL ON NURSE EDUCATION AND PRACTICE

The 133rd meeting of the National Advisory Council on Nurse Education and Practice (NACNEP) was held on Tuesday, June 7, 2016, from 9 a.m. to 5 p.m., and Wednesday, June 8, 2016, from 8:30 a.m. to 2 p.m. The meeting was conducted in person and by webinar and teleconference, based from the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 5A02, Rockville, MD 20857.

In accordance with the provisions of Public Law 92-463, the meeting was open to the public for its full duration.

Council members attending in person:

Carol Brewer	Ronda Hughes
Lenora Campbell	Linda Kim
Katherine Camacho Carr	Linda Leavell
John Cech	Teri Murray
Mary Ann Christopher	Arti Patel Varanasi
Doris Hill	David Vlahov
Mary Ann Hilliard	

Council members attending via webinar:

Sandra Nichols
Sally Reel

Council members absent:

Mary Burman, Kathleen Gallo, Rosa Gonzalez-Guarda, Margaret Wilmoth, Barbara Tobias

Others Present:

HRSA, Division of Nursing and Public Health:

Mary Beth Bigley, Chair	Kristen Hansen
Erin Fowler, DFO	Michael McCalla
Ray Bingham	Joel Nelson
Tara Cozzarelli	Denise Thompson
Kasey Farrell	Daniel Vieira
Maryam Gerdine	Janice Young

HRSA, Advisory Committee Operations:

Kandi Barnes
Yesenia Diaz
Kim Huffman
Byron Patterson

Presenters:

Christine Bachrach
Yonette Thomas
John Cech

Day 1: June 7, 2016

Introduction

Ms. Erin Fowler, Designated Federal Official for the National Advisory Council on Nurse Education and Practice (NACNEP, or the Council), convened the 133rd meeting of NACNEP at 8 a.m. on June 7, 2016, and conducted a roll call. Thirteen members were present in person, with two other members attending by webinar, confirming the legislative requirement of a quorum, so the meeting proceeded. Ms. Fowler stated that the terms of thirteen members of the Council were scheduled to end as of September 2016. The Health Resources and Services Administration (HRSA) expected fourteen new members to be confirmed by the Secretary of Health and Human Services (HHS) by that time, leaving 2 open seats on the Council. Ms. Fowler introduced Dr. Mary Beth Bigley, NACNEP Chair and the director of the Division of Nursing and Public Health (DNPH) within the Bureau of Health Professions (BHW) at HRSA.

Dr. Bigley welcomed the Council members. She thanked them for their service, and thanked the Council planning group and HRSA staff for their work in pulling the meeting together. Dr. Bigley introduced the first speaker, Diana Espinosa, the Deputy Administrator of HRSA.

Presentation: HRSA Overview

Ms. Espinosa stated that HRSA Acting Administrator Mr. James Macrae sent his regrets at being unable to attend the meeting himself. She noted that the Council's input helps to keep HRSA's policies and initiatives grounded in current education and practice. She stated that HRSA touches the lives of many people across the country: one in three people living below the poverty line relies on a HRSA-supported health center for primary care; about half of those diagnosed with HIV receive services through the Ryan White HIV/AIDS Program; more than 10 million people receive medical, dental, or mental health care through the National Health Service Corp (NHSC); the Maternal and Child Health Block Grant program provides services that reach half of the pregnant woman and more than one-third of the infants and children in the United States; HRSA supports a home visitation program under the Affordable Care Act (ACA) that reaches 145,000 rural parents and children; and HRSA supports all organ transplants in the United States, which last year reached a historic total of over 30,000 transplants completed.

Ms. Espinosa listed the five HRSA strategic goals:

- Improve access to and quality of care
- Strengthen the health workforce
- Build healthy communities
- Improve health equity
- Strengthen HRSA's operations.

Ms. Espinosa stated that HRSA is involved in preparing the workforce for the changes occurring within the health care system, and commended NACNEP for its focus on the role of the registered nurse (RN) in population health to build healthy communities.

Ms. Espinosa informed the Council that the HRSA budget request for fiscal year 2017 (FY2017) was \$10.7 billion, with the largest portion devoted to the Health Centers Program. She added that the FY2017 budget request included initiatives to support additional behavioral health clinicians in the NHSC and increased funding for providers trained in medication-assisted treatment of opioid abuse as part of a larger HRSA opioid initiative. HRSA also proposed mandatory funding for the Children's Hospital Graduate Medical Education program, and an initiative to increase access to Hepatitis C treatment for individuals co-infected with both HIV and Hepatitis C, and changes to the Drug Pricing Program that provides discounted drugs to many health care safety net organizations.

Discussion

There was a question from the Council about the HRSA Maternal and Child Health home visitation program. Ms. Espinosa replied that the program was created under the ACA, as a collaborative effort between HRSA and the Administration for Children & Families, with a budget of about \$400 million a year. The program funds states and tribal areas to implement evidence-based home visiting programs for pregnant women and families with young children, using a set of approved, evidence-based models. The states conduct a needs assessment, and typically sub-contract services to different organizations within the community. HRSA recently modified the funding formula to take into account the number of children in the state, the identified needs, and the performance of the programs.

Presentation: Bureau of Health Workforce Updates

Dr. Bigley introduced Dr. Luis Padilla, the BHW Associate Administrator. Recalling his former service on the National Advisory Council on the NHSC, Dr. Padilla thanked the Council members for their time, energy, and commitment. He acknowledged Dr. Bigley as a nationally recognized expert on nursing education and practice, and thanked her for her leadership of both DNPH and NACNEP. He said he was pleased with NACNEP's focus on population health, given the investments HRSA makes in nursing education and practice, the key role that the nursing profession plays in healthcare delivery, and the importance of population health in addressing health equity.

Dr. Padilla stated that the mission of BHW is to strengthen the healthcare workforce and to address workforce gaps to ensure that individuals across the country have access to high-quality health care. He noted that BHW was formed two years ago with a vision to have a positive impact on healthcare delivery in underserved areas, and to allow HRSA the opportunity to focus its many workforce training programs on the career continuum across education, training, and service. He emphasized the role of service, as many HRSA programs provide incentives for healthcare professionals to work in underserved areas and other communities in need.

Dr. Padilla noted that BHW had developed a strategic plan for the upcoming three years, and the input of several leaders from key health care and health consumer organizations helped to shape its goals. The first goal is to guide and inform national policy around health workforce development and distribution. Toward this goal, the National Center for Health Workforce Analysis at HRSA was created to provide data on health workforce supply, demand, and

utilization, as well as to evaluate best practices. He noted that the upcoming transition to a new administration will require HRSA to demonstrate its accomplishments. The second goal is to develop a strategic approach to guide workforce investments, and the third goal is to strengthen and facilitate academic and clinical partnerships to better prepare the graduates to work in a range of care environments. Toward these goals, HRSA has proposed a \$1.3 billion investment in the FY2017 budget. A fourth strategic goal is internal, to inspire the BHW staff to support the overall BHW mission and understand the impact of their work in the health of individuals and communities across the country.

Dr. Padilla stated that HRSA uses rapid cycle evaluation to examine its programs, mark their successes, and make adjustments to solve challenges. The emphasis is not simply on preparing more healthcare professionals, but on developing a robust, diverse, culturally confident, and skilled workforce to serve the healthcare needs of the nation.

Dr. Padilla emphasized that HRSA's nursing programs are designed to build a diverse nursing workforce, while noting challenges to improving the diversity of the workforce in all health profession. He stated that 47 percent of trainees in BHW programs are minorities or come from disadvantaged backgrounds. A growing body of evidence shows that a diverse workforce helps lead to better health outcomes for all. In FY2015, BHW spent \$268 million on nursing programs to support faculty development, enhance nursing training curricula, increase the number of qualified primary care advance nurses working in underserved areas, and expand nursing educational opportunities for individuals from disadvantaged backgrounds.

Dr. Padilla noted that there are 9,600 communities in the United States designated as health professions shortage areas. He said that the NHSC has played a major role in improving health workforce distribution across the country, while 60 percent of HRSA's advanced education nursing training program graduates have indicated their intent to work in underserved areas. HRSA is developing methods to follow these individuals, particularly those who have a National Provider Identifier number who can be tracked in HRSA's National Practitioner Data Bank.

Dr. Padilla stated that roughly one-third of BHW spending went to graduate medical education, one-third to other health professions training, and one-third to scholarships, loans, and loan repayments, with a small amount going to health workforce analysis. By discipline, medicine (49 percent) and nursing (24 percent) receive the largest amounts of support. He noted that BHW requested \$1.3 billion in FY2017 for health workforce programs, a \$45 million increase over FY2016. In terms of nursing, a \$229 million request for FY2017 represented level of funding and consistent support for the Advanced Nursing Education (ANE) program, Nursing Education, Practice, Quality, and Retention (NEPQR), the Nurse Faculty Loan Program, the Nursing Workforce Diversity (NWD) program, and the NURSE Corps Scholarship and Loan Repayment programs.

Discussion

A question from the Council concerned HRSA funding for behavioral and mental health services. Dr. Padilla replied that BHW collaborates with the Substance Abuse and Mental Health Services Administration (SAMHSA) on the Behavioral Health Workforce Education and

Training (BHWET) program, which has a strong component of integrating mental and physical health services. HRSA's FY17 budget request for BHWET was \$56 million. Dr. Padilla noted that BHWET is up for a recompetete in 2017, and HRSA has requested full authority over the program to allow more flexibility. HRSA's Primary Care and Training Enhancement program also has a component of integrating physical and mental health. In addition, HRSA has requested an additional \$70 million in FY2017 for the NHSC to add more behavioral health specialists. He added that HRSA was looking to support the most effective care models that deliver outcomes in terms of costs, quality, patient satisfaction, and staff/clinician burn out.

Dr. Cech asked about recent cuts to funding for the Area Health Education Centers (AHEC) program, which funds interdisciplinary, community-based training programs and focuses on primary care personnel in rural and other underserved communities. Dr. Padilla replied that Congress proposed to maintain the program at level funding of \$30.2 million for FY2017. He noted that AHEC is a long-standing program with proven benefits in education, clinical exposure, and directing students to primary care, but its program activities vary widely from state to state. HRSA is assessing the program and its impact on the health workforce. He reminded the Council of the three HRSA priorities of diversity, distribution, and transforming health care, and noted that AHEC is unique among HRSA programs in that it addresses all three.

Dr. Vlahov noted concerns about academic-community partnerships, and asked if there has been any attempt to link these with the Patient-Centered Outcomes Research Institute (PCORI). Dr. Padilla said that he was unaware of any direct linkages, but noted that PCORI has been supporting community-based health system organizations in developing infrastructure. He added that he previously had directed one such community-based organization, and experienced the challenges of PCORI funding. However, he agreed that HRSA could look into partnering with PCORI to help make its resources more available to HRSA stakeholders.

Overview of Agenda

After a short break, Dr. Bigley reviewed the agenda for the day. She noted that there would be two presentations on population health from the RN education perspective. These would be followed by discussion of DNP nursing and public health nursing programs, advanced nursing education, and the NEPQR program. She added that a presentation from a member of the BHW policy office would discuss drafting recommendations that are feasible, measurable, and meaningful. On the second day, there would be an extensive discussion of the draft 14th NACNEP report. She reiterated Dr. Padilla's comment on the value of the work of NACNEP in informing HRSA on the future of nursing in the evolving healthcare system.

Ms. Fowler requested the help of Council members in filling two current vacancies on the Council, adding that there is an open Federal Registry Notice for applications to NACNEP. She stated that these vacancies are in addition to the 14 nominees HRSA has submitted for final approval to the HHS Secretary to fill the roles of current members completing their terms on the Council. There was a question about qualifications or characteristics needed for the Council. Ms. Fowler replied that the Council represents all aspects of nursing from the student to the practicing RN and advanced practice levels, adding that other considerations include geographic distribution and representation from a broad range of practice settings and disciplines.

Another question was asked about the number of applications HRSA received to fill the Council vacancies. Ms. Fowler replied that there were over 260 applicants to fill the 14 to 16 seats that were open at that time. She noted that it takes significant time and effort to review the applications, select nominees, and put together a nomination packet to be vetted and cleared at the HRSA and HHS level. She added that HRSA anticipated having the full complement of new members on board in time to replace the current members scheduled to complete their terms, but if there was a delay, current members may be asked to extend their term of service. Dr. Bigley commented that vacancies on the Council could occur at any time, so that new applicants are always welcome.

Presentation: Training Nurses in Population Health Science: What, How, and Why?

Dr. Bigley introduced the speakers for the next presentation, Dr. Christine Bachrach, a research professor from the University of Maryland, and Dr. Yonette Thomas, from the New York Academy of Science. Dr. Bachrach stated that their presentation derived from a report on training in population health science for the National Academy of Medicine (NAM) that she co-authored with Dr. Thomas and Dr. Stephanie Robert, dean of the University of Wisconsin-Madison School of Social Work.

She started by defining the term *population health* as an approach that recognizes health as not just a product of biology and clinical care, but also of social, economic, cultural, environmental conditions and the behavioral and cognitive processes shaped by these conditions. Dr. Bachrach also referred to the definition of population health from Kindig and Stoddart, “the health outcomes of a group of individuals, including the distribution of outcomes within a group,” noting that *population* could be defined by geographic or political boundaries and covers key racial, ethnic, and socio-economic subgroups. She stated that focusing on larger populations permits strategies that target change at the macro level, such as by changing policies, working conditions, law enforcement practices, and built environments to make conditions more favorable to health. This approach serves as the framework for the HHS Healthy People 2020 initiative. She stated that medical care represents only the “tip of the iceberg” of population health, while multiple determinants, including education, poverty, stress, violence, and food accessibility, operate less visibly below the surface.

Within the context of health care, Dr. Bachrach noted that the basic concept of population health has evolved in ways that have caused some confusion. Healthcare providers have often equated population health with improving outcomes and reducing costs in the specific patient populations that they serve. This is more properly referred to as *population health management* because it puts the focus on improving care at the patient level. Dr. Bachrach indicated that population health management and population health are complementary, in that patient-centered approaches are key to improving quality of care and controlling per patient costs, while macro-level approaches can improve quality and reduce the overall costs of care.

In particular, Dr. Bachrach noted that the emerging field of population health science views health as the product of multiple contextual behavioral and biological causes and their interactions; focuses on the health of entire populations of people; and addresses the distribution

of health across groups. Population health science is interdisciplinary, integrating knowledge, theory, and tools from many different disciplines.

Dr. Bachrach passed the presentation to Dr. Thomas, who stated that nurses serve as the fulcrum of health care and play a vital role at the interface of healthcare and people's lives. Nurses can help identify current issues that affect the health of their patients, discern patterns across groups of patients, and help to solve problems by linking patients and families to available social and preventive services. Nurses can be part of the process that takes issues to the community and the local government, and can contribute to the development of solutions.

Dr. Thomas referred to a report from the NAM Roundtable on Population Health Improvement that addressed the need to train health professionals in basic competencies of knowledge acquisition and interdisciplinary collaboration, and to use training practices that involve integrated coursework and experience-based learning. The content should help students understand the biological, social, political, legal, and economic underpinnings of health, illness and disability, and emphasize public and global health concepts.

Dr. Thomas stated that she and Dr. Bachrach, along with the Robert Wood Johnson Health and Society Scholars Program, have been involved in the creation of a new organization called the Interdisciplinary Association for Population Health Science. One goal of this Association is to develop syllabi for undergraduate population health courses. She provided examples of several undergraduate courses on the basic concepts of population health, citing in particular a course from Boston University designed by a nursing professor that teaches conceptual and scientific frameworks of population health with an emphasis on public health nursing roles. Dr. Thomas offered some recommendations for NACNEP and the nursing community to consider:

- Design curricula around a detailed and multi-faceted vision for the nursing role in population health.
- Take advantage of existing courses in public health and social sciences to engage nursing students and provide experience with working across disciplines

For the HHS and Congress, she recommended:

- Expand investment in population health science to create the evidence base for effective interventions within clinical, community, and regional/national levels.
- Invest in training in population health science across the educational pipeline from the undergraduate to postdoctoral levels.

Discussion

Dr. Bigley thanked Drs. Bachrach and Thomas and opened the floor for questions.

Dr. Vlahov commented that the discussion of population health brought out a parallel between the typical use of vital signs by a nurse to monitor a patient in the hospital, and the use of data to monitor the health of the community. Referring to the recommendation to include public health sciences in nursing education, he asked if political science had a role to play in building the nursing role for advocacy. Dr. Bachrach replied that she considered political science to be part

of the social sciences and a very important part of understanding how to create and advocate for effective social movements to promote change.

There was discussion about population health as a buzzword. One Council member remarked that there is a cohort of nurses currently working who do not know what population health is, while newer nurses may not be able to understand the concepts well enough to articulate them as part of their role. A question was raised about the return on investment if nurses are trained in population health skills, and how organizations can bill for population health services. Another Council member asked if studies had been done on whether the nurses trained in population health are finding jobs, and if there was evidence that the health care community was looking for these nurses. Dr. Thomas stated she was unaware of any such studies.

There was a concern expressed that most nursing students are still training in acute care settings, with limited exposure to population or public health. As a result, many nursing students leave school with little understanding of and exposure to social and structural determinants of health outside of the hospital setting. Dr. Lenora Campbell stated that health care agencies are moving toward population health, and nursing schools need to catch up with the practice environments.

There was a comment about curriculum changes at Rutgers University that integrated population health in every facet of undergraduate nursing education. This change was intended to help students understand population health as inherently part of their practice, and that they needed to think about not only the individual patient but the cohort of patients. There was another comment on the need for retooling the whole nursing workforce in order to see any real gain around population health. Dr. Sally Reel stated that one troubling aspect was how to pay for the care, because payment drives so much of the change in health care.

Dr. Sandra Nichols stated that she could imagine nursing residency/training programs of the future teaching a practical, collaborative, and transformational approach to population health. She believed that nursing teams could lead population health initiatives, and receive proper reimbursement for this care. She asked the speakers if they were aware of integrated training models to help physician and nurse teams come together to promote joint management and create a shared vision of population health approaches and outcomes. Dr. Bachrach replied that efforts to address population health need to have engagement from many partners and sectors of health care, which will create new challenges for training programs in nursing and medicine. No single discipline can do everything, so professionals in different disciplines will need to learn to work with others who have specific skill sets and training.

Dr. Rosa Gonzalez-Guarda commented that as a member of the faculty of the University of Miami Miller School of Medicine, where she has taught social epidemiology, health professions schools need the institutional will to become more engaged in promoting broader education of physicians and nurses. As a result, an advisory council like NACNEP can play a significant role in providing recommendations to promote interprofessional education and training.

Dr. Ronda Hughes observed that the history of health care in the United States showed a desire to improve health, but an unwillingness to provide adequate funding. She saw a similar pattern in the discussion of population health driven by the ACA – a drive to improve the outcomes of

care through a population health focus, but a lack of adequate funding. She advocated for nurses at all levels to learn how to access and use data, a powerful but often undervalued tool.

Dr. Vlahov returned to a previous question about the job market for nurses in population health. He was reminded of the original vision of federally qualified health centers (FQHCs) to serve not just as a set of clinics, but also as an outreach to the community. He discussed the “siloining” of separate funding streams for different health disciplines which may keep people separated based on particular projects, and wondered if a population health perspective could help create greater efficiencies. Dr. Bachrach replied that HRSA funds the FQHCs, and improving them has been a big part of ongoing discussions. Providing medical and preventive care can help raise the level of a population’s health to a certain point, but further progress will depend on addressing other issues such as housing, employment, and education. She added that the value of any health care provider in doing population health is demonstrated by being able to bill for services, and nurses will need data to justify the cost of their services.

Dr. Carol Brewer noted that a student graduating from a school of nursing will go into a job that may be more or less oriented toward population health, as roles are typically defined by the institution. A nurse may take care of patients with COPD and understand that the disease is related to pollution and that many patients lack health insurance, but the individual nurse can do little to change these circumstances. Mary Anne Hilliard noted that in the current market place, health insurance companies are driving the demand for nurses in population health. These companies are starting to look at the population they serve. Dr. Arti Patel Varanasi noted the difficulty in changing educational systems and training programs to train nurses in population health. Another Council member agreed that curriculum change is a slow process.

Dr. Bachrach asked the Council members if they were aware of a white paper or similar document on the role of nurses and nursing in population health, with a clearly articulated vision. Ms. Fowler replied that HRSA was not aware of a specific white paper or similar document covering the topic. Dr. Bachrach stated that there might be a benefit in bringing representatives from nurses, other health professions, and the business community together to approach this topic, and suggested as background a 2012 article from the on-line *Journal of Issues in Nursing*.

Presentation: Montana’s Roadmap to Nursing Education: Contributing to the Health of a Rural Population

Dr. Bigley introduced Council member Dr. John Cech, Deputy Commissioner for Academic and Student Affairs in the Montana University System, as the next speaker. Dr. Cech described himself as a computer scientist by discipline, before his career as an academic administrator. He reminded the Council members that Montana is sparsely populated, with more chapels than people. He added that 54 percent of the population lives in rural or frontier areas, and 48 of the state’s 64 acute care facilities are designated as critical access hospitals. Montana is home to several tribal nations as well. He noted several population health challenges across the state, including prevalent alcohol and methamphetamine abuse, low immunization coverage among children, and the highest suicide rate in the nation.

Dr. Cech presented a “roadmap” of the nursing educational path in Montana, starting in high school where the Big Sky Pathways program aims to increase awareness in nursing careers. Using a grant from the U.S. Department of Labor, the Montana university system has been working to revise its nursing curriculum based on public health competencies published by the American Association of Colleges of Nursing (AACN). One major change was to standardize courses to ease the transition of students from practical nursing programs to 2-year community college associate degree programs and into the Montana State University 4-year baccalaureate program. The university system also worked with employers to identify the areas of greatest need, resulting in increased curricular content in rural/community nursing, gerontology, informatics, and transcultural and diversity training. He called the changes a paradigm shift, moving away from the medical model to a more patient-centered approach emphasizing health and wellness, community-based care, problem solving, and coordinating care across teams.

Dr. Cech said that the state had received a HRSA grant to place nursing students in FQHCs and community health centers (CHCs) across the state. However, the grant did not include funds to support student travel and lodging, a major concern given the size of the state and the remoteness of many communities. Dr. Cech pointed to successes that included integration of population health content across the nursing curriculum, greater coordination and diversity of programs, and increased partnerships with hospitals, health systems, and tribal governments. However, challenges remain, and he listed some recommendations, including allowing for travel expenses in student grants; developing flexibility in course content to allow students greater periods of time away from classes while doing clinicals; promoting greater collaboration among federal health agencies covering rural areas, including HRSA, the VHA, and the Indian Health Service, to reduce the burdens in clearing students for their clinical rotations; and providing extra funds to agencies that take students to allow for more staff to support students during clinical rotations.

Q & A with Discussion

A Council member asked Dr. Cech about having clinical rotations for nursing students between acute care, primary care, and community-based programs, while preparing students for the licensure exam for RNs, which focuses more on acute care. Dr. Cech replied that nursing faculty members have worked hard to balance the need to prepare students for licensure with the need to find clinical opportunities for students in rural communities that provide more public and population health opportunities.

Another question was raised on current efforts to prepare RN preceptors at the clinical sites in population health. Dr. Cech responded that there was significant involvement of both providers and faculty in the curriculum revision process. He added that funding from the Department of Labor was critical in bringing different groups from across the state together to hash out the details, which fostered much stronger relationships among providers and critical access hospitals.

A Council member asked if the new curriculum was uniform across all of Montana’s public colleges. Dr. Cech replied that it is uniform across the community college system, as well as the bachelor of science in nursing (BSN) bridge programs. Montana State University, the main school for the BSN baccalaureate entry program, educates about 80 percent of the BSN graduates for the state, and their nursing faculty have been actively involved in the discussions.

Another question was raised about faculty supervision of students while on clinical rotations at remote sites. Dr. Cech acknowledged that supervision of nursing students presented a challenge, and the schools have been working with the critical access hospitals to find supervisors with appropriate credentials.

Another Council member complimented Dr. Cech on the progress on the Montana curriculum changes, in light of the regulatory and political environments that can create barriers the seamless transitions between the different nursing levels. She noted that the standard undergraduate curriculum contains little about population health, accrediting agencies are not looking at population health in depth, boards of nursing emphasize acute care, and universities tend to focus on employment. She questioned whether there were a sufficient number of nursing jobs requiring population-based health competencies.

Another question was raised regarding the extent to which schools and health care agencies are using simulation in education and training. Dr. Cech replied that several of the Montana campuses have simulation labs, and the university system had also developed a mobile training lab with satellite capabilities to go to remote communities and provide training. He noted that such training is expensive in terms of equipment, maintenance, and staff time.

Public Comment

After a lunch break, Dr. Bigley opened the floor for public comment.

The first to comment was Leeza Constantoulakis, Government Affairs Coordinator for AACN. She stated AACN is dedicated to ensuring the graduates of its member schools are prepared to serve in all communities. AACN firmly believes, as outlined the Institute of Medicine's Future of Nursing report, in the need for higher levels of education for all nurses. The AACN board of directors recently released a report, *Advancing Healthcare Transformation: A New Era for Academic Nursing*, which examines the role of the partnerships between academic nursing and academic health centers. She stated that AACN urges NACNEP to ensure funding opportunities allow for the highest level of education, including the doctorate of nursing practice (DNP) programs. In addition, AACN retains its interest in working with HRSA to ensure funding for Title VIII programs.

The other comment was from Dr. Joan Kubb, a faculty member at the Johns Hopkins University School of Nursing and past president of the Association of Community Health Nursing Educators. From the public health nursing perspective, she said, the definition of public health nursing has always stressed the importance population health. She added that addressing population health requires money, but that funding for public health nursing education, particularly at the master's level, is not adequate to meet the needs.

Presentation: Division of Nursing and Public Health Updates

Dr. Bigley introduced LCDR Joel Nelson, Deputy Director of DNPH, and Ms. Kasey Farrell, Chief of the DNPH Nursing Education and Practice (NEP) branch. LCDR Nelson briefly reviewed the mission, vision, and strategic goals HRSA and BHW, tying these into the DNPH

mission to advance the nurse workforce in education, training, and service. He asked the Council members to help DNPH identify the gaps in the current programs, and anticipate changes and trends.

LCDR Nelson reiterated the priorities of BHW to increase the diversity of the healthcare workforce, improve the distribution of healthcare providers, and transform health care in line with the ACA. He noted that vulnerable and underserved populations have unique health care needs, and DNPH wants to make sure that nursing students are prepared to practice in a wide range of settings to help meet those needs. The themes interwoven throughout the Division's funding opportunity announcements (FOAs) include academic and community partnerships, interprofessional education and team-based models of care, and revising the nursing curricula to increase time spent in the community. Grantee institutions and or organizations are expected to regularly assess their progress toward the objectives of the grant.

He noted that Title VIII of the Public Health Service Act provides the legislative mandate for DNPH programs. As HRSA focuses on rural, underserved, and vulnerable populations, DNPH programs have incorporated population health management approaches that emphasize preventive and primary care and reduce the need and demand for acute care. He turned the presentation over to Ms. Farrell.

Ms. Farrell stated that President Lyndon Johnson signed the Nursing Training Act in 1964, laying the foundation for federal aid in nursing workforce development programs. She informed the Council that her branch oversees the NEPQR program, which has four primary areas: Interprofessional Education and Collaborative Practice, Interprofessional Education and Collaborative Practice—Behavioral Health Integration, Veterans' Bachelor of Science Degree in Nursing, and BSN Practicums in Community Settings.

Ms. Farrell added that the NEP branch administers the Nursing Workforce Diversity (NWD) program. NWD was designed to increase nursing educational opportunities for individuals from disadvantaged backgrounds and from racial and ethnic minorities, toward the goal of having the nursing workforce reflect the diversity of the communities it serves. The program utilizes four evidence-based strategies to help these students: academic and peer support, mentoring, institutional and community partnerships, and student financial support. In 2015, HRSA collaborated with the National Institutes of Health (NIH) to test and disseminate nursing workforce diversity strategies around holistic review and admissions, which have been identified as a successful strategies to increase the diversity of students admitted to schools of nursing.

In overviewing other DNPH programs, Ms. Farrell said the DNPH NEPQR program has three priority areas: education, practice, and retention. Starting in 2012, the program shifted to target interprofessional education and collaborative practice. The BSN Practicum in Community Settings, a new program in NEPQR, will focus on increasing training opportunities for BSN students in primary care community-based settings, particularly in rural and underserved communities. Also new in NEPQR is the Behavioral Health Integration program. This program expands nurse-led primary care teams to include a behavioral health provider, toward the goal to decrease behavioral health disparities and increase access to care.

Ms. Farrell turned the presentation back over to LCDR Nelson for a discussion of the Advanced Nursing Education (ANE) branch. LCDR Nelson stated that CDR Tara Cozzarelli was the new Branch Chief for ANE, which has four programs in its portfolio: ANE, Advanced Education Nursing Traineeship (AENT), Nurse Anesthetists Traineeship (NAT), and the Nurse Faculty Loan Program (NFLP). The NFLP was established to increase the number of qualified nurse faculty in schools of nursing. It provides awards to the schools to fund loans to nursing students who are committed to becoming new faculty members. As the program currently operates, schools are allowed to develop different mechanisms to identify promising students. NFLP is currently funded at \$24 million per year. Awards are dispersed annually, and all eligible grant applicants, currently around 180 schools, receive some portion of the allocated funds.

LDCR Nelson stated that there are two other programs for nurses that fall outside of DNP under the purview of the HRSA Division of Health Careers and Financial Support, but are funded under Title VIII: the Nurse Corps Loan Repayment Program, which provides assistance with loan repayment to RNs or advanced practice nurses who agree to work in critical shortage or health professional shortage areas, or to serve as nurse faculty in an accredited school of nursing; and the Nurse Corps Scholarship Program, which provides financial support to qualified students in nursing school in exchange for a commitment to work in one of these shortage areas.

He added that the NAT, with an annual appropriation of approximately \$2 million, funds traineeships for students in nurse anesthetist programs. NAT is intended to increase the number of nurse anesthetists who choose to practice in rural and underserved areas, where a nurse anesthetist may be the sole anesthesia provider. He stated that NAT could serve as a model in promoting long-term training in rural or underserved areas.

LCDR Nelson moved on to discuss ANE and AENT. He described ANE as a three-year, competitive program that supports partnerships between academic institutions and clinical practice sites. It works to improve the didactic and experiential training of advanced practice nursing students, as well as to train preceptors. Complimentary to ANE, AENT funds experiential training for advanced practice nursing students, focusing specifically on primary care nurse practitioners and nurse midwives. Students in this program undergo three- to six-month field training experiences. As with NAT, AENT is looking to create a longitudinal, meaningful training experience with rural or underserved populations in a primary care setting.

Discussion

A question was raised on the effectiveness of these programs in achieving their goals. Dr. Bigley replied that for programs that have been around for several years, DNP asked grantees to submit performance measures on a regular basis. For DNP primary care nurse practitioners and nurse midwives programs, about 60 percent of graduates stay and practice in underserved areas. For the NFLP, about 500 students graduate each year, but they can be hard to track over the long-term. From incomplete data, the success rate to have students stay and practice in underserved areas is about 60-70 percent. One new program that DNP initiated in 2016 was a virtual job fair. About 50 schools signed up and the event attracted around 260 students.

Another question was raised about the type of behavioral health professional embedded with nurse-led teams in the BHI program. Ms. Farrell replied that the program requires the teams to be led by an advanced practice nurse and to contain a behavioral health specialist, either a psychiatric nurse practitioner, a mental health professional, or a social worker; and a consulting psychiatric provider. The only restriction was that the team had to be interprofessional.

A council member asked about the length of funding for the NWD grants. Dr. Bigley replied that the decision had not been made for FY 2017, and the council member advocated for a 4-year cycle to coincide with the length of most nursing programs. Dr. Bigley noted that the NWD program uses evidence-based approaches to help students from disadvantaged backgrounds complete school, with most resources targeted to assist students during the first year. Efforts to promote holistic review in admissions have increased the diversity of medical, pharmacy, and dentistry students. She added that schools of medicine also report that more students are entering primary care, a change that would benefit nursing as well.

LCDR Nelson stated that DNPH has considered combining the ANE and AENT programs, allowing grantees to receive funding for both structural enhancements and trainee support under one program. A council member spoke in favor of the combined approach and suggested it would help to remove some barriers to supporting students pursuing graduate programs or working with certain clinical partners.

Dr. Bigley posed a question to the Council about the size of the grants, noting that in FY2015 the ANE grants increased to a maximum of \$700,000, while grants for interprofessional programs increased to a maximum of \$500,000, which represent significant investments for HRSA. A small community health center may not need the maximum, and can request a lower amount. However, DNPH is trying to evaluate the optimal amount for grants. A Council member who had been involved in applying for HRSA grants responded that the infrastructure needs of an organization are often roughly the same regardless of the size of the grant. Smaller organizations may need more grant support because of the added cost of administrative oversight.

Another Council member asked how successful schools with the most diverse student populations are in competing for HRSA grants. Dr. Bigley replied that a review of the upcoming awards for the NWD grants showed a better distribution than in past years. She added that HRSA provides grant-writing support on its web site, and grant officers are available to assist applicants. Schools may also consider working with a partner organization that has had success in receiving grants. She acknowledged that grant applications prepared by a professional grant writer are more likely to succeed in the competitive process than those written by faculty members, who may have little training or experience in grant writing. LCDR Nelson added that DNPH offers technical assistance calls when an FOA is published, providing the opportunity for prospective applicants to connect with the associated project officers.

Dr. Bigley pointed out that organizations other than nursing schools are eligible for the DNPH grants through NEPQR. Nurse-led clinics have been successful, and many are connected to academic institutions. A major challenge in applying for a HRSA grant is having the staff and infrastructure to collect the data required for performance measure recording.

Dr. Cech asked if community colleges are eligible to apply for DNP grants. LCDR Nelson replied that they are, adding that there are mechanisms such as funding priorities and special considerations designated by legislation, or other possible programmatic steps, to try to give preferences to organizations whose programs can demonstrate a benefit for rural or other underserved populations, and public health nursing through state and local departments.

Dr. Vlahov raised the question of the role of HRSA in shaping nursing education and practice. Dr. Bigley replied that these areas are in the DNP bailiwick, but HRSA has less influence in working with state boards of nursing or changing the exam for nursing licensure. The goal is to prepare a more flexible nursing workforce prepared to work in settings outside of acute care, and nursing leaders across the country seem to be sharing this message. She referred to Dr. Cech's presentation, observing that the curriculum changes in Montana came about largely because the different constituent groups came together. As one result, clinical sites are preparing their employees to be better educators and preceptors for students.

A Council member commented that the ACA has pushed health care in the direction of population health, and asked about the potential impact of the upcoming change in administration. Dr. Bigley replied that the ACA has made fundamental changes in the delivery and quality of care, regardless of the political environment. LCDR Nelson emphasized that DNP programs are evidence-based and that data collection on the programs helps determine future program priorities. A concern was expressed that nursing schools are not preparing students to address the challenges they meet in the workplace, leading to discontent that may drive nurses out of the profession.

Dr. Bigley discussed BHW's RN to Community Health Center program involving partnerships among academia, practice, and communities. Applicants had to identify a partner, and many of the successful ones had partnerships with CHCs in underserved communities. She emphasized that the partners must work together. For example, nursing school faculty could provide education to nurses at the clinical site, and invite nursing staff members to talk with faculty and inform them of changes in practice models. A Council member suggested that helping community-based organizations reduce the burden of grant applications was one way to help the funds flow to where they are needed most.

Presentation: From Council Recommendation to Policy: The Process

Dr. Bigley introduced the next speaker, Ms. Sara Williams, Acting Director of BHW's Division of Policy and Shortage Designation, to discuss the process of how Council recommendations are implemented into policy. Ms. Williams said that HRSA looks to its advisory councils for recommendations on matters of budget, legislation, and policy, and that advisory councils are strongest when they are aware of the areas in which HHS has the authority to make changes in policy or regulations, programs, or resource allocations. The main considerations for Council members to consider when proposing changes include:

- Is this a legislative or policy recommendation?
- Does HHS have the authority to make the change?
- Who is the appropriate audience?
- What is the best way to share the recommendation?

She stressed the importance of stating clearly who had the authority to make the change typically either Congress or the HHS Secretary. She noted that methods for providing recommendations include letters to Congress, annual reports, and the *A-19* process. When an advisory council recommendation falls outside of the influence of Congress or the Secretary, the best method may be a white paper or policy brief that could be shared more generally.

Ms. Williams noted that strong recommendations present a precise action that can be tied to a specific change that the Secretary or Congress can make. She provided some examples of strong recommendations from several advisory council reports, and suggested some areas where NACNEP might make policy recommendations. However, she noted that the federal Office of Management and Budget will not be preparing a budget for FY 2018, due to the coming change in administration, thus specific budget recommendations would be difficult to carry forward at the current time.

Discussion

Dr. Bigley reminded the Council members that the Title VIII legislation was originally drafted in 1964. It has been revised along the way, and the ACA made some major changes. Title VIII is currently in the reauthorization process.

A question was raised on how many NACNEP recommendations have been implemented. Dr. Bigley replied that the Council's recommendations on interprofessional education and practice have been at least partially implemented through the NEPQR FOAs, which now require an interprofessional component to all programs. Ms. Williams added that Congressional staff members often refer to particular reports and may request more information, so the reports are read and acted upon.

Small Group Discussions

The Council divided into three small groups for 30 minutes of discussion on recommendations to propose for the 14th NACNEP report, and then re-convened in the main meeting room.

Group 1

Group 1 identified two recommendations:

1. The Secretary and Congress shall authorize NEPQR funds for student and faculty lodging and travel to achieve knowledge, skills and attitudes in population health, clinical rotations in rural underserved, and frontier areas. These rotations are critical for increasing the number of training sites that provide services.
2. The Secretary and Congress shall authorize NEPQR funds to provide financial incentive to be awarded to rural facilities that partner with academic institutions for serving as clinical site for nursing students. This incentive would encourage individuals to work and serve in rural and frontier areas to improve population health.

Dr. Bigley suggested that these recommendations could be implemented through revising and strengthening the language in the DNPH FOAs. Related to the second recommendation, there was discussion about the need to include more than just rural and frontier areas, because inner city areas also have great needs and can face similar difficulties accessing quality health care.

Group 2

Group 2 suggested two recommendations:

1. Remove barriers to cross-state practice and expand scope of practice to allow for academic flexibility.
2. Fund demonstration projects to prove the viability of interdisciplinary population health models.

There was some discussion that private sector companies are often reluctant to explore new ventures unless there is a proven model to follow. Examples were raised about the implementation of meaningful use of electronic health records and the Accountable Care Organization model from the ACA, both of which gained wider implementation after successful demonstrations.

Group 3

Group 3 proposed 5 recommendations:

1. Greatly expand investment in population health science, including infrastructure and training, to create the evidence base for effective nursing interventions within clinical, community, and regional/national levels.
2. Refocus dollars for innovative nursing practice models in nursing education in population health that include academic, clinical and community partners.
3. Invest in infrastructure and training across the nursing education pipeline from undergraduate to postdoctoral studies to incorporate a population health perspective as utilized across the spectrum of clinical and community settings.
4. Increase investments to sponsor student and faculty travel and housing (i.e., accommodations) as well as allow for investments to distant/remote clinical sites.
5. Provide HRSA funds to convene a meeting of partners and stakeholders to define competencies and roles of nursing in population health (i.e., product: white paper, nursing competencies).

There was discussion about the use of the term “population health science” versus “population health research.” A Council member mentioned that the presentation from Drs. Bachrach and Thomas used population health science. There was further discussion about the translational science institute at the NIH, working to bring the basic sciences closer to the clinical sciences.

Dr. Bigley adjourned the meeting for the day.

Day 2: June 8, 2016

The second day of the meeting was called to order at 8:30 a.m. Ms. Fowler conducted a roll call. A quorum was confirmed. Dr. Bigley provided a brief overview of Day 1 of the meeting. She then introduced two Council members, Dr. Arti Patel Varansi and Dr. Carol Brewer, to lead the discussion on the draft 14th NACNEP report.

Discussion: 14th NACNEP Report

Dr. Varanasi introduced the members of the writing team. She said she was encouraged that some of the recommendations that came out of the Day 1 small group sessions echoed those included in the draft, while new ideas emerged as well. She reminded the Council that NACNEP has a legislative mandate to produce an annual report with recommendations, to submit to the HHS Secretary, as well as the Senate Committee on Health, Education, Labor, and Pensions, and the House Committee on Energy and Commerce. All NACNEP reports are publicly available. Dr. Varanasi provided an overview of the report, stating that the U.S. healthcare system is placing an increasing emphasis on addressing population health in the community, while nursing practice and education remain focused on providing acute care in the hospital. The report outlines different definitions of population health, and discusses both Federal and private sector population health initiatives.

Dr. Brewer continued by stating that the report addresses the issue of educational competencies and nursing roles in population health management. She cited some examples of population-based approaches, including the use of patient registries to broaden preventative screening, and efforts to reduce community-wide environmental factors such as asthma triggers. Some educational competencies in population health include:

- Community health
- Data collection and analysis
- Rural health
- Telehealth
- Interprofessional practice

She reviewed the recommendations in the current draft report, and noted that the final report is due no later than September 30, 2016.

In opening the floor to general discussion, Dr. Bigley suggested reviewing the recommendations in the report from the perspectives raised by the Day 1 presentation by Ms. Williams:

- Who is the audience?
- What is the appropriate method?

Dr. Brewer brought up some examples related to changing nursing roles, including the work of the Center for Medicare & Medicaid Innovation and its Bundled Payments for Care Improvement (BPCI) initiative, and the “Culture of Health” program sponsored by the Institute for Healthcare Improvement and the Robert Wood Johnson Foundation. She mentioned other educational competencies to consider, including consumer engagement, interprofessional

practice, multisector collaboration, and predictive analytics. Referring back to a previous comment on nurses in acute care, she mentioned that even the patients on an acute care ward constitute a population, and nurses play a significant role in assessing trends in that population and developing initiatives to improve care. She stated that nurses need to look at the patients they care for as a population, in order to shift the paradigm of health care to population health.

A comment was raised that identifying current problems is one step, but the role of an advisory council is to recommend solutions. Dr. Cech referenced the recommendation that Congress promote a more comprehensive public health infrastructure in rural, inner city, and other underserved areas. He also asked if it would help to add wording related to funding for adequate broadband capacity. For an example, he pointed to Little Bighorn College in Montana, where many people from the local community gather with their laptops and cell phones on the weekends, because it is the only nearby location where they can find internet access.

Dr. Hughes stated that the recommendations might need to contain a distinction between educational competencies for undergraduate and graduate students. For instance, undergraduates may need to learn about data collection and basic analysis, while graduate student may need to learn about predictive analytics. A member commented on the need to connect educational recommendations with the return on investment. Another comment expressed the value of the nursing perspective in health services research.

Ms. Hilliard suggested that each recommendation be attached to a measurable outcome. Another council member suggested that funding demonstration projects showing cost-effectiveness might attract business interest. There was discussion of possible resistance from nurses to changing roles and delegating traditional functions to less-trained healthcare team members. A suggestion was made to convene a group of stakeholders that have funded practice innovations in population health to define the relevant educational competencies and discuss revising nursing curricula.

Dr. Nichols identified four central themes in the report: population health management, innovation, the nurse-patient relationship, and affordability. She stated that nurses have the opportunity to drive initiatives promoting a healthier lifestyle and preventing disease.

Dr. Reel said that population health concepts needed to become embedded in nursing education, from the undergraduate to the doctoral level. She added that nursing cannot drive population health alone, so nurses will need to learn to collaborate and work within teams. She also noted the importance of working with state boards of nursing state boards so that nurses can practice their roles in any setting, whether in acute care or in the community.

Regarding the flow of the report, one Council member suggested focusing on emerging models of care from current research. She identified the main areas of the report as: defining the nursing function and roles, defining educational competencies; developing the appropriate educational scaffolding; and supporting demonstration projects both in education and practice.

Dr. Nickels asked if the Council members believed there should be a fundamental shift in nursing curricula to emphasize population health, in preparing nurses to meet the challenges of health system transformation. Dr. Cech agreed, adding that this perspective coincided with one

of the recommendations to expand investment in population health science to create the evidence base for effective nursing interventions. He suggested the creation of a population health certificate as a concrete method to encourage nurses in practice to learn more about population health management.

Dr. Bigley asked the Council to break into four smaller groups, with each group focused on a specific target area of policy, practice, education, research, and policy. After roughly 20 minutes of discussion, the full Council reconvened.

The policy group suggested that there is a need for more interagency collaboration to break down barriers between policy and regulation. The group also discussed the role of CMS to drive reimbursement policies to incentivize population health initiatives and to allow nurses to practice to the full extent of their training and licensure.

The research group proposed two recommendations:

1. NACNEP recommends that HRSA Title VIII funding opportunity announcements include educational and practice demonstration projects that evaluate the effectiveness and outcomes of population health nursing roles and competences.
2. NACNEP recommends that the Secretary work with NINR, PCORI, CTSA, and other relevant research groups to conduct population health-focused research to create a robust evidence base for effective nursing and interprofessional programs.

The education group also proposed two recommendations:

1. The Secretary and Congress shall authorize NEPQR funds for curricular innovations that integrate population concepts across the nursing educational pipeline from undergraduate to post-doctoral studies.
2. The Secretary and Congress shall authorize funding to convene an interprofessional and community stakeholders working group that will define population health competencies for nurses.

The practice group proposed leveraging HHS and HRSA investments to define the function and roles of pre-licensure nursing students and post-licensure RNs working in a multi-sector environments to enhance the continuum of care. There was concern expressed that nursing is coming late into the population health model, and the recommendations should be written to provide flexibility in how DNPH FOAs and programs approach innovations in population health training and education.

Dr. Cech noted that changing the nursing licensing exam to cover population health topics is one way to drive a curriculum change. Dr. Bigley replied that change would be needed on all levels of education to meet the demands of an evolving health care system, and that NACNEP can advise HRSA on how to leverage the federal investment in nursing education.

Presentation: Ethics Orientation and Overview

Dr. Bigley introduced Carmen Marimon, JD, an ethics advisor in the HRSA Ethics Office. Ms. Marimon provided the council members with an overview of the ethics rules for members of

federal advisory committees, who serve as special government employees (SGEs) for the time of the committee service. She stated that the definition of an SGE is “someone who serves 130 days or less in the Federal Government as an employee.” The presentation covered government rules on conflict of interest, standards of ethical conduct, and restrictions on outside activities. Ms. Marimon provided her contact information, encouraging any members to contact her or her colleagues in the HRSA ethics office with any questions or concerns.

Travel Guidelines

Ms. Fowler introduced Kandi Barnes of the HRSA Advisory Committee Operations office. Ms. Barnes reviewed the requirements for advisory council members to make travel arrangements to attend a meeting, and the documentation required. There were several questions related to specific requirements. Ms. Wilson provided contact information Ms. Regina Wilson, the HRSA travel advisor, for any further questions.

Dr. Bigley stated that the terms of several of the Council members were scheduled to expire at the end of September. A package with the nominations for new members had been completed and forwarded to the HHS Secretary for approval. However, it was possible that the package would not be approved and returned in time, meaning that several members of the Council could be asked to extend their current term.

Presentation: Nurse Education, Practice, Quality and Retention (NEPQR) Updates and Discussion

Dr. Bigley introduced Ms. Tara Spencer, MS, RN, Project Officer in the DNPH Nursing Education and Practice Branch. Ms. Spencer provided a programmatic overview of NEPQR and solicited the Council for recommendations on future programmatic direction. She noted the creation of the National Center for Interprofessional Practice and Education (NCIPE), which focuses on advancing interprofessional practice in education by providing technical assistance, collecting data, and demonstrating best practices in interprofessional practice and education. Looking forward to FY2018, Ms. Spencer said that DNPH wants to create a program that uses the key elements from successful grantees in these programs that HRSA funds, and incorporates the key aspects of the BHW vision, which is to provide better opportunities for education and training for service in the community in underserved communities and primary health care in rural settings, improving health care delivery, and improving the outcomes in the underserved communities. She turned the floor over to Dr. Bigley for questions and discussion.

Discussion

A Council member asked about the connection between the Interprofessional Collaborative Practice program, which ended in 2015, and the NCIPE. Dr. Bigley replied that NCIPE was originally a stand-alone project, awarded in 2013 to the University of Minnesota. It launched a web site and put together resources for practice and education. A Council member commented that interprofessional education is a significant method for integrating population health concepts in the clinical setting. Dr. Bigley said that a discussion at a recent NAM meeting revealed that none of the health professions have devised effective ways to promote population health,

interprofessional practice, cultural competency, or global health. Dr. Vlahov suggested the creation of a “national center for population health” as a public/private partnership. Dr. Bigley responded that the NCIPE was developed as a public/private partnership, and its FOA was structured to make sure all funders agreed to the same objectives. Dr. Campbell also spoke in support of exploring a national center for population health, because of the difficulty in addressing the full range of social determinants of health. It was suggested that DNP could look into providing funding for capstone projects in population health among doctor of nursing practice (DNP) students.

Dr. Reel observed that the discussions of interprofessional collaborative practice and population health involve a very complex transformation of health care and education, which are challenging and often take several iterations to work. She noted the importance of bringing together the entities in education, practice, and regulation.

Another Council member asked about the size of the Veteran’s to BSN program. Dr. Bigley replied that there were 40 grantee organizations, covering about 1,500 veterans. Like the NWD programs, the veterans’ program provided a range of services such as financial assistance.

Dr. Bigley brought up a suggestion to set up a grant mechanism through NEPQR for junior faculty members, similar to the K (early career) mechanism for researchers through NIH, to encourage DNP or other doctoral students to design and test different models of care. As a nursing school dean, Dr. Vlahov supported the idea to help get more faculty members supported as they begin their careers. There was further discussion related to the use and value of the K award mechanism. Dr. Vlahov mentioned that the K award concept is in line with retooling for a new generation of faculty.

A council member proposed a funding mechanism to create a cohort of fellows in nursing leadership positions to promote population health. Dr. Leavell mentioned that the U.S. Army nurse corps is able to bring in trained leaders to assist with sharing knowledge and creating opportunities to develop new nursing roles. Dr. Bigley replied that there is a need to start with training faculty and nursing preceptors to teach new population health competencies and roles.

Dr. Reel asked about the possibility of structuring a NEPQR program to develop nursing leaders. She mentioned the possibility of working through FQHCs as ideal locations for a post-doctoral fellowship to address primary care and nursing leadership in population health. Dr. Bigley reminded the council that DNP must remain within its legislative authority in attempting to create new programs.

A Council member asked if NEPQR funds could go to a state association of FQHCs to facilitate the training of nurses in communities of need, as one way to address population health. Dr. Bigley replied that DNP could look into that approach. Another Council member suggested holding a summit meeting to bring together health care payers, providers, and academia, to start a conversation to allow the payers and providers to say what they need and expect from nursing.

Dr. Bigley asked if this is the type of investment the Council wanted to see to advance nursing, primarily at the practicing RN level. She added that Congress would want to see how much

money was saved and how many lives were improved in five years, through supporting a population health approach in nursing education and practice. A Council member commented that the focus would have to be toward promoting wellness and advancing primary care. She added that nursing would have to be proactive to protect its roles and duties, as some health care organizations are already shifting some nursing duties to unlicensed personnel.

Conclusion

Ms. Fowler mentioned that the Council members would be contacted when the dates of the next meetings were finalized, and asked for their continued input into drafting 14th annual NACNEP report. Volunteers would be needed to help plan the next meeting. In closing, Dr. Bigley thanked the Council members for a very productive meeting. Dr. Bigley adjourned the meeting at 2 p.m.