NACNEP ⋮ National Advisory Council on Nurse Education and Practice

Meeting Minutes: 158th NACNEP Meeting, August 7-8, 2024

The 158th meeting of the National Advisory Council on Nurse Education and Practice (NACNEP, or the Council) was held August 7-8, 2024. The meeting was hosted by the Division of Nursing and Public Health (DNPH), in the Bureau of Health Workforce (BHW), Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS), and conducted by a remote videoconference platform. In accordance with the provisions of the Federal Advisory Committee Act (Public Law 92-463), the meeting was open to the public for its duration.

Council Members in Attendance

Chair: Dr. Leah FitzGerald
Ms. Susan Cannon
Ms. Patricia Dieter
Ms. Kristie Hartig
Dr. Meredith Kazer
Dr. Kae Livsey
Dr. Nina McLain
Dr. Courtney Pitts
Dr. Carolyn Porta
Ms. Constance Powers
Dr. Teresa Shellenbarger
Ms. Christine Smothers

HRSA Support Staff Present:

Dr. Justin Bala-Hampton, Designated Federal Officer, DNPH, HRSA
Mr. Raymond J. Bingham, DNPH, HRSA
Ms. Janet Robinson, Advisory Council Operations, HRSA

Wednesday, August 7, 2024

Welcome and Introductions

Dr. Justin Bala-Hampton, the NACNEP Designated Federal Official (DFO), convened the 158th meeting of NACNEP on Wednesday, August 7, 2024, at 10:00 a.m. ET. He stated that the purpose of NACNEP was to provide advice and recommends to the HHS Secretary and to Congress on policy and program development activities pertaining to the federal programs authorized under Title VIII of the Public Health Service (PHS) Act, covering a range of issues related to the nursing workforce, nursing education, and nursing practice improvement. He noted that the Council was currently comprised of 11 of a possible 23 total members. As described under the Council's authorizing legislation, Section 851 of the PHS Act, the NACNEP members represent: nursing students and professionals at all levels, schools of nursing, healthcare organizations, and the public.

Dr. Bala-Hampton conducted a roll call, indicating the attendance via the virtual platform of all eleven of the Council's current appointed members. He confirmed the presence of a quorum, allowing the meeting to proceed.

Dr. Bala-Hampton provided a brief overview of recent staffing updates within BHW. He noted that Dr. Luis Padilla had left his position as the BHW Associate Administrator to serve as the chief health officer for the National Association of Community Health Centers. In his place, Dr. Candice Chen, former director of the BHW Division of Medicine and Dentistry, had returned to HRSA to serve as the acting BHW Associate Administrator. In addition, Shelia Pradia-Williams had retired from her position as the BHW Deputy Associate Administrator. In her place are two acting Deputy Associate Administrators, Israil Ali and Eliza Hepner. Lastly, Dr. Bala-Hampton informed the Council that he had recently accepted a promotion to the position of senior advisor in the Office of the Associate Administrator at BHW. He stated that he would be staying on as the NACNEP DFO until a permanent replacement could be found.

Dr. Bala-Hampton turned the meeting over to Dr. Leah FitzGerald, the DNPH director and NACNEP chair. Dr. FitzGerald noted that the members had been provided with the minutes from the last NACNEP meeting in May 2024, and asked for any comments. No comments were offered, and a motion was made and seconded to approve the minutes. The minutes were approved by unanimous consent.

Discussion and Vote: NACNEP 20th Report Draft (Day 1 and 2)

Moderator: Leah FitzGerald, PhD, FNP-BC, FAAN
Chair, NACNEP

NACNEP members reviewed the early draft of its 20th Report developed by the Council's writing group, providing the support and rationale for the five recommendations approved during the May 2024 NACNEP meeting.

Section 1

NACNEP member Dr. Meredith Kazer led the discussion on the draft report text developed in support of Recommendation 1, which calls for federal funding of direct reimbursement demonstration projects that quantify the impact of nursing care on the quality of care and on patient outcomes. She noted that compensation for services is one way to define the value. However, the nursing profession has struggled to connect its contributions to patient care with appropriate reimbursement and compensation models. Acute care settings like hospitals, which are major employers of registered nurses (RNs), tend to view nursing only as a labor charge to be minimized, not as a revenue source for services provided. However, a growing body of literature has explored the value of nursing care and demonstrated the negative impact on patient outcomes of a high patient load for nurses, while surveys have indicated that unsafe and stressful working conditions are driving many nurses from the profession. Federal funding to create demonstration projects would serve to increase awareness within Congress of the challenges faced by the nursing profession in terms of the impact on health care throughout the nation.

Sections 2 and 3

Council member Dr. Kae Livsey led a discussion covering the sections of the draft report on creating sustainable academic-practice partnerships and a revision to one of the previously approved recommendations to call for modifying Medicare reimbursement rules to better reflect the health care services provided by RNs and advanced practice registered nurses (APRNs).

After some discussion, the Council reached a consensus that the proposed recommendation related to Medicare reimbursement was too vague and impractical. The Council voted unanimously to remove that recommendation. There was a suggestion to redistribute some of the supporting text in that section to the other report sections.

Regarding the academic-practice partnerships, one member commented that current partnerships using innovative models of transition to practice for graduate nursing students or workforce retention for practicing RNs often lack the broad institutional support needed to remain sustainable. The goal of the recommendation was to encourage the building of teams across all sides of the partnership to allow the models to build support and thrive in the face of staffing or leadership changes.

There was a comment that the draft text related to transition-to-practice had a major focus on nurse residency programs, but that the Council had wanted to be less prescriptive about the types of programs the recommendation could support. The health care environment might lack the capacity to support residency programs in all areas, so overemphasizing residencies could cause the recommendation to be ignored or dismissed.

There was another comment that the draft section contained many terms, such as *internship*, *residency*, *fellowship*, *clinical placement*, and *immersion experience*, that might be unfamiliar to an outside reader. There was a suggestion to refer to the guiding principles from the American Association of Colleges of Nursing (AACN) on the purpose and use of academic-practice partnerships. The intent of the Council was to provide space for healthcare organizations to think in broader terms that could envision new ways to support the nursing workforce and help advance the profession.

There was a comment referring to previous Council deliberations on the need for consistent funding of nursing education along the lines of the graduate medical education model. There was further discussion on the limits of nursing programs authorized under Title VIII of the PHS Act, which generally involve a grant mechanism without a long-term, sustainable funding stream. In addition, the primary intent of Title VIII is to address nursing education, which provides the Council with limited authority to address broader issues of nursing practice.

Section 4

Council member Dr. Nina McLain led the discussion on the fourth section, focused on a recommendation to remove regulatory barriers that limit the practice of APRNs. She stated that the number of physicians located in rural and other underserved areas is insufficient to meet the demand, limiting access to care. APRNs could help fill this gap, and studies have shown that APRNs offer a comparable quality of care to physicians. However, many health insurers and payors require physician supervision of APRNs, limiting APRN autonomy. Medicare and Medicaid rules allow states to opt out of this requirement, and an increasing number of states have already accepted or are currently exploring that option.

Dr. McLain emphasized that the Council must avoid taking an "us vs. them" approach, but rather emphasize that APRNs are educated and trained to provide quality care, and can work as independent practitioners within an interprofessional team to broaden health care access.

Dr. McLain further noted that scope of practice and licensing issues are regulated at the state level. However, NACNEP can recommend steps for Congress to explore that would incentivize states to adopt models that allow APRNs to work to their full scope of practice. In addition, NACNEP can recommend mechanisms to allow APRNs to be compensated at a level comparable to physicians for the care they provide.

There was a suggestion to include more information in this section on the different barriers to practice faced by different types of APRNs. There was a comment on the need for text to clarify that Congress cannot directly impact state health workforce licensing and regulations. There was a further comment that having some states opt to remove the physician oversight requirement for APRNs may influence where practitioners choose to practice and thus impact health outcomes on a state-by-state level, creating areas of haves and have-nots. Another Council member noted that differences between states already exist, citing the example of states that opted out of Medicaid expansion and the resultant impact on health care outcomes.

Section 5

NACNEP members Christine Smothers and Dr. Caroline Porta led the discussion on the fifth recommendation, concerning the need for funding to integrate emerging technologies such as artificial intelligence (AI) into nursing education and practice. Ms. Smothers said that the recommendation was responding to the need to develop nursing school programs that improve the literacy of nursing students in the use of emerging health care technologies, including AI.

On the practice side, she noted the need to involve nurses in the early stages of technical innovations to ensure that the design and usage of new technologies align with the needs of clinical practice and support the coordination of interprofessional health care teams. She noted the need for a comprehensive infrastructure spanning all levels of nursing education and practice to improve the incorporation of new technologies into healthcare, and to bolster the voice of nursing in aligning these new technologies with the realities of clinical practice.

Dr. Porta added that the Council had discussed the need for greater nursing involvement in the development of the tools and technologies used in both education and practice. Thus, the focus of the recommendation was on programs to enhance the technological literacy and skills of nurses as members of the health care team, and to center nursing in the drive to use technology to make health care more effective and efficient. She added that this recommendation could serve as an initial step to a more comprehensive future Council report on the incorporation of AI and related technology into nursing education and practice.

The Report Title

Dr. Kazer led a brief discussion on the title of the report. The writing committee offered two options:

1. At the Inception Point: Creating Care Systems for the Future of Nursing
2. Creating Systems of Care that Value Contributions of the Nursing Profession

Dr. Kazer noted that in crafting the first title, she reviewed the draft report and recommendations, along with references that discussed how the nursing profession had responded to societal changes in the past and faced "inception points" to maintain its relevance. She expressed her belief that nursing was facing another such point, and the NACNEP report and recommendations

were necessary to keep the profession moving in a positive direction. She added that Dr. Livsey had suggested the second title, to emphasize the push by the Council and other nursing organizations to emphasize and enhance the value of nursing in the health care system.

There was a general consensus to accept #1, and one Council member suggested a wording change from "inception" to "inflection," to emphasize the need for a change in direction. In further discussion, there was a suggestion to reword the title as "The Inflection Point: Creating Care Systems for the Future of Nursing." The draft title was approved by unanimous voice vote.

Conclusion

Based on the discussion, the Council voted unanimously to remove one of the previously approved recommendations and decided to reorganize some of the draft text to strengthen the rationale of the remaining four recommendations:

- Fund direct reimbursement demonstration projects that quantify the impact of nursing care on quality patient outcomes.
- Create sustainable academic-practice partnerships across environments of care that result in data-based demonstration projects supporting transition to practice and retention of a diverse nursing workforce.
- Remove practice barriers to APRNs.
- Provide funding to support the infusion of nurse-centered technology and integration of artificial intelligence into nursing care delivery, in both education and practice.

At the conclusion of the discussion, Dr. Bala-Hampton that the writing group will revise the draft text based on the Council members' feedback to prepare a final draft ahead of the December 2024 NACNEP meeting.

Discussion: Planning for the NACNEP 21st Report

Moderator: Leah FitzGerald, PhD, FNP-BC, FAAN
Chair, NACNEP

Dr. Leah FitzGerald led a discussion to review some potential topics for the NACNEP 21st Report, which would be due in January 2026. She listed some of the priorities of upcoming notices of funding opportunities from DNPH, which included integrating behavioral health care into primary care; improving readiness to practice; promoting workforce retention and reducing burnout; and enhancing workforce diversity.

Potential topics raised during the discussion included developing programs to reduce stress and burnout in the nursing workforce, incorporating new technologies into nursing education and practice, and addressing challenges in the education of the post-Covid generation of nurses. There was a suggestion to focus the report on APRN scope of practice, with emphasis on the role of family nurse practitioners and certified nurse midwives in addressing the ongoing crisis in maternal and newborn care, as well as the deployment of nurses and the development and use of new technologies outside of the hospital to improve health equity.

Thursday, August 8, 2024

Presentation: Resilient and Ready Together: CMS Priorities and Updates

Jean Moody-Williams, RN, MPP
Deputy Director, Center of Clinical Standards and Quality
Centers for Medicare & Medicaid Services

Jean Moody-Williams, Deputy Director of the Center of Clinical Standards and Quality (CCSQ), Centers for Medicare & Medicaid Services (CMS), opened her talk by stating that CMS, like HRSA, is part of the Executive Branch of the federal government. The CMS priorities under the current administration were focused on advancing health equity, expanding access, engaging partnerships, driving innovation, protecting the Medicare trust fund, and fostering operational excellence. CCSQ encompasses many programs that serve as levers of change, including developing clinical standards, establishing safety and quality guidelines, improving data analysis, and building effective and secure information systems. However, it is not part of the Center for Medicare, which determines payment policies.

Ms. Moody-Williams noted that over 200 nurses work within CMS to provide a strong clinical voice. CMS has created a Nursing Steering Committee to allow for professional nursing to have more input into the health care policy process and for the work of CMS to be informed by their education, experiences, and perspectives. The members of this committee have expertise in a range of subject matter areas, including clinical regulation, quality improvement, data collection and analysis, program management, value-based purchasing, and payment.

Ms. Moody-Williams gave a brief overview of the CMS Merit-based Incentive Payment System (MIPS), which serves to support innovative clinical models for a range of health care practices. Over 86,000 nurses and nurse practitioners, including over 26,000 certified registered nurse anesthetists (CRNAs), report into the MIPS database on healthcare quality measures for patients such as reducing hospital readmission rates, improving blood pressure control and diabetes management, and providing preventive screening for a variety of health conditions.

Ms. Moody-Williams noted that CMS has long identified the need for adequate nurse staffing as a vital component of nursing home quality of care. The agency posts staffing information on the CMS Nursing Home Compare website as an aid to consumers in evaluating nursing homes, and is finalizing rules to set minimum staffing standards for RNs and nursing assistants and to require an RN onsite at all times. Noting current workforce shortages, CMS has been working with HRSA to launch a national nursing home staffing campaign.

She noted a major concern among nurses related to workplace safety. CMS has issued memoranda to the directors of its hospital surveys to assess whether the correct protocols are in place to enforce safety standards, prioritize safety, and minimize exposure to workplace violence to ensure the effective delivery of health care. Also, understanding that scope of practice continues to be a major concern, CMS issued another memo offering guidance to reduce or remove some regulatory barriers impacting nurse midwives.

In 2024, CMS updated some language in the Medicare Physician Fee Schedule (PFS) to emphasize the importance of APRNs in providing care in rural health clinics and federally qualified health centers. CMS is preparing further refinements to the PFS in 2025 to update payment policies and rates with a focus on services in behavioral health, dental and oral health care, telehealth, and opioid treatment.

Q and A

One Council member commented in support of incentives for RNs to work in nursing homes in rural areas, which often struggle with staffing, and asked if CMS could incentivize states to allow APRNs to practice more independently to increase access to care. Ms. Moody-Williams replied that CMS must defer to state practices in most cases. She added that some CMS funds go toward training nurses, with the goal of improving staffing. However, nursing scope of practice issues are outside its purview and had not been discussed.

One council member commented on the difficulty in capturing efforts or interventions that are provided by RNs and APRNs for reimbursement under Medicare. As an example, RNs often work in primary care teams to provide services such as annual wellness checks, care coordination, and management of chronic conditions. However, under current rules, RNs are not able to bill directly for such services and billing is done incident to the medical provider, with the result that the professional services provided by the nurse are not captured or acknowledged but are absorbed under general administrative charges. Ms. Moody-Williams replied that the Medicare Innovation Center is working on different models of reimbursement, especially related to primary care settings, that might have the opportunity to capture the work of the RN. She also stated the PFS rules for 2025 are open for public input, adding that Council members have the opportunity to submit comments and suggestions.

There was a question about how to apply for membership to the CMS Nurse Steering Committee. Ms. Moody-Williams offered to put Council members in touch with the CMS staff member who leads the committee.

Presentation: Advocating for Removal of APRN Barriers to Care

Janet Setnor, MSN, CRNA, Col. (Ret.), USAFR, NC
President, American Association of Nurse Anesthesiology

Janet Setnor introduced herself as the current president of the American Association of Nurse Anesthesiology (AANA), as well as a 26-year veteran of the United States Air Force Reserve, and a civilian medical provider as a CRNA. She stated that CRNAs are often the sole providers surgical anesthesia in rural hospitals across the country.

Ms. Setnor said that the AANA is working to remove current barriers that limit the ability of CRNAs to practice to the full scope of their education, training, and experience, with the principal barrier being the requirement in many states that CRNAs practice under the "supervision" of an physician, who need not be an anesthesiologist. She pointed to several studies that have shown the removal of the supervision requirement could increase health care access, quality, and safety, while reducing health care costs. Allowing CRNA independent practice also promises to reduce the current anesthesia workforce shortage.

During the height of the pandemic, CMS waived supervision requirements for reimbursement of CRNAs under Medicaid Part A. During this time, there was no evidence that patient care outcomes deteriorated. In addition, several states took steps to opt out of the CMS supervision requirements for CRNAs, while malpractice insurance rates for CRNAs have declined in recent years as a further indication of the safety of CRNA practice. However, this waiver expired at the end of the pandemic public health emergency.

Ms. Setnor highlighted the importance of independent CRNA practice in rural and other underserved areas. One study found that CRNAs were more likely that anesthesiologists to work with lower income populations and in areas with lower median incomes and larger populations of citizens who are under or unemployed, uninsured, or on Medicaid, providing a public benefit by reducing disparities in health care access in the United States.

Ms. Setnor emphasized that nurse practice acts for CRNAs differ from state to state. However, all CRNAs undergo extensive training and are required to pass a national certification examination, participate in continuing education, and undergo recertification every four years. Physician supervision of CRNA practice has no proven benefits to patient care but studies have demonstrated increased costs.

Ms. Setnor stated that the AANA is working with other APRN professional associations as a coalition to introduce and support the Improving Care and Access to Nurses Act, a bill that would allow APRNs and other health care providers besides physicians to provide certain health care services, and to be reimbursed under CMS rules. This bipartisan legislation includes removal of regulatory barriers in both Medicare and Medicaid. It is supported by over 200 organizations, including many nursing and advanced practice nursing groups, the National Rural Health Association, AARP, the American Healthcare Association, and the American Public Health Association's Public Health Nursing Section. AANA has participated in numerous meetings and engaged in written correspondence with federal agencies and administration staff calling for the removal of practice barriers for APRNs.

Q and A

One Council member noted the contradiction that CRNAs who serve in the military can be on the front lines with a Special Forces unit, deliver lifesaving care under dangerous battleground conditions, and follow soldiers through the entire course of their care. However, when they return from deployment and step onto U.S. soil, they are no longer allowed to provide autonomous care for their patients.

Another Council member asked about the Medicare opt-out provision. Ms. Setnor replied that the opt out is primarily a billing provision under Medicare. However, regulations for physician supervision of CRNAs vary by state, and certain states no longer require supervision. She clarified that the Medicare opt-out provision applies only to CRNAs, and not to other APRNs. She added that the coalition of APRN nurse organizations has gotten stronger and done a better job of working together to push for regulatory changes. Nurses need to become more assertive in letting the public know about the level of education and training that APRNs undergo in the United States, which is looked upon as the gold standard across the globe. In addition, APRNs need to have representation on all state boards of nursing.

There was a question about the education and training that CRNAs undergo compared to anesthesiologists. Ms. Setnor replied that physicians take a different initial path than CRNAs in that they learn the medical model, while CRNAs start their education and practice under the nursing model. Nurses on the CRNA path must obtain a bachelor of science in nursing. Then, they typically work in a critical care unit, where they receive over 2,000 hours of bedside critical care experience for each year of work. By the time most students apply to a CRNA program, they have between 4,000 to 8,000 clinical hours of bedside care. However, once students enter the three-year CRNA training program, their preparation is almost identical to their physician anesthesiologist colleagues, using the same textbooks, seeing the same patients, and having the same graduation requirements. As a result, CRNAs have comparable educational background and training requirements as nesthesiologists.

Public Comments (Day 1 and 2)

The Council received multiple oral comments from the public attendees:

- Toni Odejimi, an editorial intern for the on-line news and information service *Politico*, inquired about the major concerns related to the current shortage of nurses. Dr. Bala-Hampton advised the Council members that they could answer in their personal capacity as experts in nursing. Two Council members, Dr. Nina McLain and Dr. Meredith Kazer, provided brief responses related to barriers that some APRNs face in providing care in rural and other underserved areas, concern over the drop in nursing school enrollments documented for the previous year, and the impact of stress and burnout on the quality of life for nurses in the workforce.
- Pamela Watson-Konrath, MSN, APRN, past president of the Wisconsin Association of Clinical Nurse Specialists and current member of the Legislative/Regulatory Committee of the National Association of Clinical Nurse Specialists, outlined efforts to push the state legislature of Wisconsin to modernize APRN legislation. Watson-Konrath noted that the Wisconsin Association of Clinical Nurse Specialists and National Association of Clinical Nurse Specialists have collected articles on APRN practice and offered to share these resources with NACNEP.
- Ijah Egwuonwu, BSN, RN, PHN, expressed concern over the current nursing shortage and the decline in nursing school enrollment. Egwuonwu stated that attracting more students to the profession and helping nurses thrive will require efforts to improve the work environment, provide career resources, enhance interprofessional communication, and support clinical excellence.
- Simmy King, DNP, MBA, FAAN, Chief Nursing and Informatics Office for the Children's National Hospital, spoke in support of efforts to improve retention in the nursing workforce. King noted that burnout is among the top reasons that nurses leave the profession, so providing more funding to help address the mental health needs of nurses will improve retention. King also asked if NACNEP held interprofessional meetings or discussions as the Council developed its position statements or recommendations.
- Pam Pfeiffer, EdD, MSN, RN, CNE, Dean, College of Nursing at George Fox University, addressed the need for more funding and programs directed to improving nurse retention through decreasing stress and supporting resilience and well-being. Pfeiffer also spoke in

support of enhancing academic-practice partnerships, especially in rural and other underserved communities where such partnerships can make a real difference in promoting access to health care.

- Leondra Weiss, MN, RN, Nurse Manager, Harborview Medical Center, University of Washington Medical Center, and chair of the ambulatory advocacy committee with the American Association of Ambulatory Care Nurses, thanked the Council for their work in promoting the role of nursing in ambulatory care.

Next Steps

Dr. Bala-Hampton noted that he would be following up with the members of the writing group to begin revise the report draft following the feedback provided in the discussions.

Closing

There was a motion made and seconded to adjourn the meeting, and the motion passed by unanimous voice vote. Dr. Bala-Hampton adjourned the meeting at 2:30 p.m. ET.

Acronym and Abbreviation List

AANA	American Association of Nurse Anesthesiology
AI	Artificial Intelligence
AACN	American Association of Colleges of Nursing
APRN	Advance Practice Registered Nurse
BHW	Bureau of Health Workforce
CCSQ	Center for Clinical Standards and Quality
CMS	Centers for Medicare & Medicaid Services
CRNA	Certified Registered Nurse Anesthetist
DFO	Designated Federal Official
DNPH	Division of Nursing and Public Health
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
MIPS	Merit-based Incentive Payment System
NACNEP	National Advisory Council on Nurse Education and Practice
PFS	Physician Fee Schedule
PHS	Public Health Service
RN	Registered Nurse