**National Advisory Council on
Nurse Education and Practice (NACNEP)**

The Roles of Nurses in Primary Care

Tenth Annual Report
to the
Secretary of the United States
Department of Health and Human Services
and the
United States Congress

**Based on the 121st and 122nd Meetings of the
NACNEP**

Table of Contents

The National Advisory Council on Nurse Education and Practice (NACNEP) advises the Secretary of the U.S. Department of Health and Human Services and the U.S. Congress on policy issues related to programs authorized by Title VIII of the U.S. Public Health Service Act and administered by the Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr), Division of Nursing (DN), including nurse workforce supply, education, and practice improvement.

Executive Summary

As the projected demand for primary care increases exponentially and provider shortages intensify, necessity is driving a re-examination of the roles of nurses in primary care. The National Advisory Council on Nurse Education and Practice (NACNEP) convened two meetings in 2009-2010 to examine the roles of nurses in primary care and strategies to increase workforce capacity and effectiveness, reduce barriers to practice, and strengthen the education of nurses for primary care.

Nurses have key responsibilities for the essential components of primary care articulated by the Institute of Medicine (IOM): integrating care, increasing accessibility to care, addressing a large majority of personal health care needs, building sustained partnerships with patients, and practicing in the context of family and community (Institute of Medicine [IOM], 1996). Their close proximity to patients in every setting where primary care is delivered provides unique opportunities for nurses to influence health outcomes and cost effectiveness.

The NACNEP identified three overarching recommendations to increase access to quality primary care in the United States:

(1) Decrease barriers to primary care nursing in the United States.
The Congress and the Secretary of the U.S. Department of Health and Human Services should leverage resources to enhance primary care capacity by promoting the removal of regulatory barriers that prohibit primary care nurses from fully exercising their scope of practice. The Secretary and Congress should compel federal and state governmental bodies to revise Medicare and Medicaid funding stipulations that inhibit access to primary care directly through regulatory scope of practice challenges or indirectly through inequitable reimbursement challenges. Additionally, the Congress and the Secretary should ensure reimbursement policies are provider neutral and adequate to sustain primary care practice including nurse-led models such as nurse-managed health centers.

(2) Promote educational initiatives that support and strengthen the nursing primary care workforce.
The Secretary and Congress should leverage federal, state and local governmental financial resources to build primary health care educational program capacity and increase clinical training sites that support interprofessional team competencies and innovative technology. The Secretary and Congress should support the development, implementation, and evaluation of primary care residencies/fellowships for nurses in teaching health centers and other community-based settings to increase the nursing workforce capacity to meet increased consumer demand for primary care.

(3) Support successful nurse models of primary care.
The Secretary and Congress should leverage federal, state, local government and private resources to expand current successful models of primary care services such as nurse-managed clinics, nurse/family partnerships, and school-based nursing clinics; and evaluate outcomes using comparative effectiveness. The Secretary and Congress should support the development and testing of innovative models to meet the primary care needs of specific populations such as nursing home residents, individuals with behavioral health issues and children with special needs. Additionally, Congress should support the development and testing of innovative nurse-

led models in the medical home demonstration to expand the capacity of primary care and meet the changing public health needs for primary care. Lastly, the Secretary and Congress should increase access to and consumer engagement in primary care through convenient locations and creative use of consumer-oriented technology.

This report to the Secretary of the U.S. Department of Health and Human Services and the Congress summarizes the proceedings of the NACNEP meetings of November, 2009 and April, 2010.

Primary Care: Ideal and Reality

The Institute of Medicine defines "ideal" primary care as comprising five essential components: (1) integration within the larger medical system; (2) accessibility for the patient; (3) serviced by clinicians who are accountable for addressing a large majority of personal health care needs; (4) built on sustained partnerships with patients, and; (5) practiced in the context of family and community (IOM, 1996). It acts as the initial access point to the health care system for all care needs from newborns to the elderly, preventative care to acute illness, physical to mental issues. These fundamental components of primary care have been integrated into the patient-centered medical home model and require the skills of an interprofessional team. This team works together to assess health needs, diagnose health status, develop health plans, provide care, educate patients, monitor progress, and coordinate care (U.S. Department of Health and Human Services, Agency for Health Research and Quality, 2011; IOM, 1996). The benefits of primary care are consistently substantiated by research and include positive health outcomes, reduced costs, and the improved health of the population (U.S. Government Accountability Office, 2008).

The Institute of Medicine's Definition of Primary Care

"Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."
(IOM, 1996)

(IOM, 1996)

In practice, primary care in the United States falls short of the ideal. Integrating primary care within larger medical systems is still largely a distant goal, hampered by health system fragmentation and reimbursement mechanisms that do not support an integrated approach to primary care. The accessibility of primary care for many Americans is also limited. Some areas of the country face shortages of providers resulting in long waits for appointments, limited time with providers, and restricted office hours. Consequently, patients utilize costly emergency rooms or convenient care clinics to fill the gaps. Clinicians struggle to provide for the large majority of personal health care needs without adequate compensation. These challenges of limited accessibility and low reimbursement hinder comprehensive, continuous, community and family-oriented primary care.

These formidable challenges will confront a demand for primary care services that is expected to increase exponentially due to several factors. To start, the 2010 Patient Protection and Affordable Care Act (Public Law 111-148) will add an estimated 32 million consumers to the health coverage system. The aging of the population and the corresponding increase in health care utilization will also drive demand upwards. According to the Centers for Disease Control, chronic diseases accounted for 70 percent of the leading causes of death in the U.S. (Centers for Disease Control and Prevention [CDC], 2004). As the population ages, the need for long-term chronic disease management increases. This will intensify the demands on primary care as chronic diseases require regular and long-term medical intervention and care coordination (CDC, 2004).

Another factor driving the demand for primary care is advancements in medical technology which enable more conditions to be diagnosed and managed. Significantly, new technology often comes at a much higher cost in terms of skills, equipment and drugs (Congressional Budget Office, 2007).

The ability of health care providers to meet the rising demand for services is of increasing concern. The supply of new physicians in primary care has been outpaced by the growth in the number of medical students choosing to pursue specialty medicine. Reasons cited for this decline in selecting primary care include: poor income relative to other specialties; few primary care role models during their training; and the significant administrative time and cost required to care for complex patients (Council on Graduate Medical Education, 2009).

Access to primary care is hampered not only by the overall shortage of primary care providers but also by their uneven distribution across the country. The geographic maldistribution of primary care providers results in significant shortages in some parts of the country and oversupply in others. In 2012, 59.1 million Americans were living in areas designated as having a shortage of primary care professionals (U.S. Department of Health and Human Services, Health Resources and Services Administration [HRSA], 2011).

Growing demand coupled with workforce shortages may result in a significant increase in unmet primary care needs. The primary care workforce is under pressure to change by a convergence of forces including policy and market forces, technology, and demographic changes (Dower & O'Neil, 2011). The situation, described as a *crisis* and a *symptom of a decades-long decline in the vitality of U.S. primary care*, also presents an opportunity to reassess the delivery of primary care and realign the health care system to meet the needs of the nation (Sandy, Bodenheimer, Pawlson, & Starfield, 2009; Commis, 2007).

A system realigned for primary care would build and deploy a skilled interprofessional workforce to meet the evolving primary care needs of the growing population. Such a system would have the resources needed to deliver innovative, evidenced-based, effective primary care. Providing such a system of care will rely on:
- Developing new and/or reconfiguring current models of primary care;
- Addressing reimbursement barriers to implementing effective models primary care:
- Eliminating regulatory practices that prohibit full use of all primary care providers;
- Evaluating the health outcomes, cost-effectiveness, and accessibility of services; and
- Expanding the training opportunities required to build the interprofessional workforce.

Whatever system evolves, nurses are poised to be a critical part of the interprofessional team expanding access to quality primary care.

The Roles of Nurses in Primary Care

Nurses provide a means to increase access to high quality primary care. As the U.S. extends the reach of primary care, the size and distribution of the nursing workforce and its experience in the five essential components of primary care position the nursing workforce to respond to the nation's primary care needs.

Additionally, nurses play critical roles in nearly all health care access points—from hospitals and physicians' offices to community health centers, school health clinics, nursing homes, and public health departments. Their concerted roles in patient care across the health system provide significant opportunities to affect health outcomes. Most important is the centrality of the five essential components of primary care to nursing care: integrating care, increasing accessibility to care, addressing a large majority of personal health care needs, building sustained partnerships with patients, and practicing in the context of family and community (IOM, 1996).

Care Integration

"The most effective way to address our cost and quality challenges is to confront the root cause—the chaos in everyday health care."

The Health Care Delivery System: a Blueprint for Reform
Center for American Progress, 2009

Providing Integrated Care

The increase in the complexity of care required by patients necessitates care integration and management skills central to nursing practice. A 2006 report from the Institute of Medicine noted that Medicare beneficiaries, on average, see five physicians a year. Medicare beneficiaries with chronic heart failure, coronary artery disease, and diabetes see an average of 13 physicians a year (IOM, 2006). The primary care provider faces the challenge of coordinating care between multiple specialty practices, laboratories, hospitals and other health care providers (such as respiratory therapists and mental health specialists) in addition to managing medications, medical equipment, health education, and administrative requirements. Integrating these complex components into a coordinated health plan that improves health and well-being within the context of the patient's social and financial situation is essential to ensure that the patient's care is safe, effective, and accessible.

The nurse-managed health center (NMHC) has demonstrated success in providing integrated care in coordination with an interprofessional health team. In this model nurses collaborate with other health professionals to provide integrated patient care. The centers provide a full array of integrated services including primary care, mental and behavioral health, family planning, and prenatal services (Hansen-Turton, 2009).

Serving predominantly underserved populations with limited access to other health services, the NMHC focuses on providing integrated care within the community. The centers report high patient satisfaction, lower emergency room usage, shorter non-maternal hospital stays, lower specialty care costs, and lower prescription costs (Naylor & Kurtzman, 2010).

Integrating oral health into comprehensive primary care was pursued by an NP-managed faculty practice with very positive results. According to a study at the New York University College of Dentistry (NYUCD), 25 percent of dental patients do not have a primary care provider (Haber, 2009). That study prompted the New York University College of Nursing to open an NP-faculty practice in the College of Dentistry. This nurse-led practice offers comprehensive primary care services including health assessments, medical consultations, and treatment of acute and chronic illness and integrates oral health assessment and dental referrals as needed. In kind, the dental

providers in the NYUCD refer patients to the nurse faculty practice for primary care services and clearances for dental surgical procedures.

In her presentation to the 121st meeting of NACNEP, Dr. Haber noted that interprofessional training sessions including a chair-side program, guest lectures, and formal coursework, helped to establish and build care collaboration. NPs and dentists collaborated on several key initiatives including a smoking cessation program and an outreach program in Honduras. Additionally, dental and nursing students participated in joint clinical training which provided many opportunities for interprofessional exchange (Haber, 2009).

Although nurses show leadership and innovation in providing integrated care, it requires considerable time and resources to coordinate multiple care requirements. This coordination function, however, is not recognized for reimbursement purposes by most health care payers. "In health care, as in most markets, what is paid for is what gets addressed." (Dower & O'Neil, 2011). As patient loads increase over the next decade, the ability to integrate patient care between settings and specialties becomes more essential to quality and cost effectiveness.

Increasing Accessibility to Primary Care

The cornerstone of effective primary care is ready access to care. Accessibility incorporates multiple factors including convenience and availability of appointments, acceptability of insurance including publicly-funded insurance options, affordability of care, convenience of location in terms of the transportation options available to the patient, and ease of use for low-income, uninsured, and non-English speaking residents. U.S. primary care, however, is failing when it comes to the accessibility of care. In 2012, 59.1 million Americans live in areas designated as having a shortage of primary care professionals (HRSA, 2011).

Nurses have been pivotal to addressing the primary care shortage and increasing access to primary care. Nurse practitioners (NP) play an integral part in the delivery of primary care to underserved populations in the U.S. Their practice includes conducting comprehensive health exams, diagnosing and treating health problems, providing health education and prevention teaching, ordering laboratory tests and x-rays, prescribing medications and administering immunizations, and providing case management and care coordination. NPs provide nearly 600 million patient visits per year and surveys consistently confirm that the quality of care is equal to or better than physicians, customer satisfaction is high, and costs are effectively controlled (Naylor & Kurtzman, 2010; Lenz, Mundinger, Kane, Hopkins, & Lin, 2004; Hollinghurst, Horrocks, Anderson, & Salisbury, 2006). As the fastest growing group of primary care providers adding 8,000 per year, NPs are poised to improve access to primary care.

The NMHC focuses on increasing access to primary care services for underserved populations by operating within the community. Managed by schools of nursing and non-profit organizations for the most part, NMHCs are located where their patients are—in public housing developments, churches, schools, community centers, and homeless or domestic violence shelters. The placement of the centers within the community is essential to their effectiveness by ensuring easy access and enabling partnerships to develop with the patients and community alike. The centers have shown significant outcomes including lower emergency room usage, shorter non-maternal hospital stays, lower specialty care costs, and lower prescription costs

(Hansen-Turton, 2009).

The role of NPs in increasing access to primary care was addressed at the 121st NACNEP meeting in November, 2009. Dr. Margaret Flinter of Community Health Center, Inc. provided insights on the critical contribution made by nurses—particularly NPs. However, like other health care models, the shortage of primary care providers is a significant obstacle. Dr. Flinter stated that the competition to hire NPs at CHC, Inc. is escalating as other models, compensating for shortages in other health professions, integrate and expand the NP role (Flinter, 2009).

Some of these models utilizing NPs were designed as stopgap measures to compensate for the lack of access to primary care and to handle the overflow of primary care patients. Emergency departments, for example, opened primary care wards staffed largely by NPs to handle the significant numbers of patients utilizing primary care services in the emergency room. In Massachusetts, for instance, a recent survey of hospital emergency departments reported that 41% of outpatient emergency visits were for non-emergent conditions or emergent conditions that could be treated in a primary care setting. Another six percent of visits were for emergency care that could potentially have been prevented with timely and effective primary care (Long & Stockley, 2009).

Another model that emerged to fill gaps in access to primary care is the convenient care clinic, also known as the retail clinic. A 2009 survey of primary care physicians around the world revealed that only 29 percent of U.S. physicians--the lowest in the survey--had an arrangement where their patients could be seen after hours without going to an emergency room (Schoen, Osborn, Doty, Squires, Peugh, & Applebaum, 2009). The convenient care clinic model, predominantly staffed with NPs, was designed to fill these gaps in primary care by providing extended hours in convenient retail locations. NPs provide services for common ailments such as flu, sore throat, and high blood pressure at prices averaging $40-$70 per visit (Scott, 2006). As the model evolves, some clinics are planning to expand into more extensive primary care services such as chronic disease management. This predominantly nurse-led model is still finding its footing with total retail clinics numbering about 1,200 (Merchant Medicine, 2010).

Expanding access to primary care for children, school-based health clinics are important health access points for students who may otherwise not receive primary care. Located for the most part in schools with predominantly minority and ethnic populations, school-based clinics are staffed largely by nurses including NPs, RNs and LPNs. The model has been adapted to a variety of circumstances including on-site, full-time clinics and mobile units that serve numerous locations. According to a census conducted by the National Assembly on School-Based Health Care in 2007-2008, there are over 1,900 health clinics and health partnership programs connected with schools nationwide—1,100 of which provide primary care services (Strozer, Juszczak, & Ammerman, 2010). Of those clinics providing primary care, most provide health assessments, treatment of acute illnesses, health screenings, immunizations, and other primary care services.

The elderly, in particular frail elderly, present a full array of primary care needs including health assessment and prevention, acute care diagnosis and treatment, care coordination, and chronic disease management. There are currently 16,100 nursing homes in the United States with 1.5

million residents of whom 47 percent are over age 85 (Jones, Dwyer, Bercovitz, & Strahan, 2009; Rogers, 2010). An analysis of the 2004 survey of nursing homes revealed that 40 percent of the nursing home residents were concurrently prescribed nine or more medications (Jones et al., 2009; Dwyer, Han, Woodwell, & Rechtsteiner, 2010). Increasing accessibility to primary care for these residents would most practically happen by augmenting the role of nurses, particularly NPs. Surveys consistently confirm the quality of care provided by NPs to this population including improved management of symptoms, chronic illness, medications, and geriatric syndromes (e.g., delirium, falls); shorter lengths of hospital stays and fewer hospital re-admissions; and higher patient and family satisfaction (Naylor & Kurtzman, 2010; Lenz et al., 2004; Hollinghurst et al., 2006; Rogers, 2010).

Assuming Accountability for Addressing a Large Majority of Personal Health Care Needs

Nurses are assuming more accountability for primary care needs. Across settings and specialties, nurses at all levels are responsible for providing a diverse range of primary care services in coordination with an interprofessional team. They assess health needs, develop health plans, provide care, educate patients, coordinate transitions between providers and care settings, and manage chronic diseases. In addition, NPs are increasingly responsible for providing a full complement of primary care across the patient lifespan including diagnosing health status, providing care, ordering tests, prescribing medications, and monitoring the progress of complex patient needs (Bureau of Labor Statistics, 2010; Flinter, 2009).

Partnering with Patients

The concept of partnering with patients evolved from the rights of consumers to be informed, to be heard, to be safe, and to choose (Longtin, Sax, Leape, Sheridan, Donaldson, & Pittet, 2010). Partnering with patients involves a collaborative relationship between health care provider and patient that "…facilitates tailoring a specific intervention or specific advice to the needs and the circumstances of a particular person" (IOM, 1996). Nurses, who interact with patients at numerous points during a health care visit and over the duration of health events, frequently partner with patients to improve care. They communicate with patients to assess their current status, needs, and concerns. This feedback is used to inform the health care team and determine what care is delivered and how. Partnerships enable the patient to have a greater voice in their care and empower them in self-management (Hook, 2006). Increased participation and responsibility by the patient showed improved outcomes, greater satisfaction with care, and fewer medical errors (Sahlsten, Larsson, Sjostrom, & Plos, 2008; Williams, Freedman, & Deci, 1998, Sainio, Lauri, & Eriksson, 2001; Schwappach, 2010).

One successful model that incorporates the essential component of partnership is the Nurse-Family Partnership (NFP). NFP is a well-tested model that improves the health and social functioning of low-income first-time mothers and their babies. In the program, nurse home visitors work intensively with families to promote healthy pregnancy and maternal-child health outcomes, and effective parenting. Later on the program focuses on preventing unintended subsequent pregnancies, school drop-out, failure to find work, and welfare dependence. This long-term partnership between nurse and the mother and her family is founded on trust and mutual respect. Three randomized clinical trials and 14 follow-up studies were conducted in New York, Tennessee, and Colorado. The model achieved substantially improved maternal and

child outcomes including 56 percent fewer hospital emergency room visits for accidents and poisonings; 48 percent reduction in rates of child abuse and neglect, and; 32 percent reduction in subsequent unintended pregnancies (Nurse-Family Partnership, 2011).

Practicing within the Context of Family and Community

Family and community provide the context for delivering effective primary care. This context affects the adherence to health regimens, the availability of care and regular monitoring, and family support mechanisms. The nurse-managed health centers, along with federally qualified health centers and community health centers, have demonstrated success in providing primary care within the context of family and community. The centers provide comprehensive primary care and strive to build trust in the community and encourage sustained relationships with patients. The model has also proven adaptable to different community settings and many focus on providing care to the medically underserved. Locations include public housing developments, community centers, and homeless and domestic violence shelters. This close proximity to families and communities enable the centers to adapt care protocols around the intersecting social and economic issues that may affect their efficacy.

> Many state laws bar nurse practitioners, physician assistants, and other non-physicians primary care providers from practicing to the extent that their training warrants.
>
> (Dentzer, 2010)

The community context likewise defines the practice of the public health nurse. Public health nurses provide health screenings, referrals, assessment and early intervention for a range of health concerns, as well as case management and community-based coordination of needed health services for people with special needs and chronic illnesses. Practiced in a variety of community settings including schools, correctional facilities, and group homes, public health nursing provides health services that promote effective primary care practice.

Barriers to Primary Care Nursing Practice

As the need for primary care increases, it becomes imperative to remove barriers to nursing practice in primary care. Enabling nurses to practice to the full extent of their training and experience becomes increasingly urgent as acknowledged in the most recent IOM report, *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2010). NPs and Certified Nurse Midwives (CNMs) are integral to meeting the primary care demand though many still encounter barriers in licensure, reimbursement and credentialing.

To begin with, state licensure regulations pose considerable barriers. The regulations of some States restrict NPs and CNMs from practicing to the full extent of their training which affects their employment opportunities and choices. Restrictions in scope of practice vary from State to State which interfere with nurses practicing in potential high-need areas. Scope of practice restrictions also impact reimbursement of services from both with public and private insurance and the ability of NPs and CNMs to obtain credentialing as the primary care provider of record (Flinter, 2009). These barriers to practice inhibit access to primary care and ultimately, the health of the nation.

Current reimbursement rates for primary care services pose barriers for primary care, in general, and for nurse-led primary care, specifically. Primary care is undervalued and this is reflected in

reimbursement policies (American College of Physicians, 2006). Many services that comprise comprehensive, continuous, community-based primary care are not reimbursed or reimbursed at low rates. Moreover, practitioners are typically paid only for in-person visits when e-mail consultations and telemedicine could readily handle many patient complaints. Overall, payers do not provide adequate incentives and support for primary care (Sandy et al., 2009).

Nurse-led primary care faces even greater obstacles to reimbursement. Some federal and state agencies have historically reimbursed nurses at lower rates for providing the same care. For example, Medicare and Medicaid typically reimburse NPs at rates that are 75–85 percent of what they pay physicians for the same services. In a 2002 report to Congress, the Medicare Payment Advisory Commission (MedPAC) examined these payment practices and found "no specific analytic foundation" for the disparity in payment rates (Medicare Payment Advisory Commission, 2002).

Although disparity in reimbursement rates is beginning to change at the federal level, inequitable reimbursement policies are found in private health plans across the country. The sustainability of nurse-led practices, which are located largely in poor, underserved areas, is threatened by barriers in licensure regulations, reimbursement and credentialing. Remedying these regulatory constraints and reimbursement imbalances could have a significant impact on the accessibility of primary care and the health of the nation.

Strengthening the Primary Care Education of Nurses

Aligning nurse education with primary care takes on increased urgency as the need for primary care grows exponentially. The NACNEP identified several focus areas to strengthen the primary care education of nurses including (1) interprofessional education to prepare the health care workforce for team-driven health care; (2) enhanced clinical training capacity for nurses in primary care, and; (3) investment in the education of a diverse nursing workforce at all stages of the nurse pipeline—from entry level to faculty development.

Traditionally, academic silos and accreditation requirements have created barriers for interprofessional education. As a result, clinicians often have inadequate preparation for working in multidisciplinary teams (McNair, 2005). For teams to be effective, the team members must not only be competent in their own profession but must also display understanding of and appreciation for the roles and perspectives of the other team members. The 2003 report, *Health Professions Education: A Bridge to Quality*, called for students and providers to develop and maintain a set of core competencies including "working in interdisciplinary teams" (IOM, 2003).

Another important barrier to effective primary care training for nurses is the availability of clinical training experiences. Historically, teaching hospitals introduced students to the clinical environment including a wide range of patients and new technology. However, clinical opportunities in primary care are more limited. Few nursing students have access to the full range of community-based settings that would serve to promote primary care competencies. Exposure to primary care settings such as health centers, physician offices, and community health services would provide experience in primary care practice and increase the likelihood of students working in primary care.

Ensuring an adequate and diverse nursing workforce for primary care requires investment in nursing education from the entry level to senior faculty development. The nurse education career ladder provides multiple pathways to higher level nursing degrees. The percentage of nurses reaching higher degrees such as advanced practice masters degrees needs to be enhanced to meet the looming demand for primary care. Funding progressive steps on the career ladder enlarges the pool of candidates eligible for higher nursing education.

Recommendations

The NACNEP focused on three overarching recommendations to increase the utilization of nurses in primary care: (1) decrease barriers to primary care nursing in the United States, and; (2) promote educational initiatives that support and strengthen the nursing primary care workforce, and; (3) support successful nurse models of primary care including nurse-managed health centers and nurse/family partnerships.

(1) Decrease barriers to primary care nursing in the United States

The Congress and the Secretary of the U.S. Department of Health and Human Services should leverage resources to enhance primary care capacity by promoting the removal of regulatory barriers that prohibit primary care nurses from fully exercising their scope of practice. The Secretary and Congress should compel federal and state governmental bodies to revise Medicare and Medicaid funding stipulations that inhibit access to primary care directly through regulatory scope of practice challenges or indirectly through inequitable reimbursement challenges. Additionally, the Congress and the Secretary should ensure reimbursement policies are provider neutral and adequate to sustain primary care practice including nurse-led models such as nurse-managed health centers.

(2) Promote educational initiatives that support and strengthen the nursing primary care workforce.

The Secretary and Congress should leverage federal, state and local governmental financial resources to build primary health care educational program capacity and increase clinical training sites that support interprofessional team competencies and innovative technology. The Secretary and Congress should support the development, implementation and evaluation of primary care residencies/fellowships for nurses in teaching health centers and other community-based settings to increase the nursing workforce capacity to meet increased consumer demand for primary care.

(3) Support successful nurse models of primary care

The Secretary and Congress should leverage federal, state, local government and private resources to expand current successful models of primary care services such as nurse-managed clinics, nurse/family partnerships, and school-based nursing clinics; and evaluate outcomes using comparative effectiveness. The Secretary and Congress should support the development and testing of innovative models to meet the primary care needs of specific populations such as nursing home residents, individuals with behavioral health issues and children with special needs. Additionally, Congress should support the development and testing of innovative nurse-led models in the medical home demonstration to expand the capacity of primary care

and meet the changing public health needs for primary care. Lastly, the Secretary and Congress should increase access to and consumer engagement in primary care through convenient locations and creative use of consumer-oriented technology.

References

American Academy of Family Physicians. (2010). *Primary care.* Retrieved
from http://www.aafp.org/online/en/home/policy/policies/p/primarycare.html.

American Academy of Nurse Practioners. (2011). *Nurse practitioner facts*. Retrieved from
http://www.aanp.org/NR/rdonlyres/B899F71D-C6EE-4EE6-B3EE-
466506DFED60/5145/AANPNPFactsLogo72011.pdf.

American College of Physicians. (2006). *The impending collapse of primary care medicione
and its implications for the state of the naiton's health care: A report from the American
College of Physicians*. Retrieved
from http://www.acponline.org/advocacy/events/state_of_healthcare/statehc06_1.pdf

American College of Physicians. (2009). *Nurse practicitioners in primary care: A policy
monograph of the american college of physicians.* Retrieved
from http://www.acponline.org/advocacy/where_we_stand/policy/np_pc.pdf.

Baicker, K., Chandra, A. (2004, April). Medicare spending, the physician workforce and
beneficiearies' quality of care. *Health Affairs,* W4 184-197. Retrieved
from http://content.healthaffairs.org/webexclusives/index.dtl?year=2004.

Bureau of Labor Statistics. (2010). *Occupational outlook handbook: registered nurses; 2010-
11 edition.* Retrieved from http://www.bls.gov/oco/ocos083.htm.

Center for American Progress. (2008). *The health care delivery system: a blueprint for reform.*
Retrieved from
http://www.americanprogress.org/issues/2008/10/health_care_delivery.html.

Centers for Disease Control and Prevention [CDC]. (2004). *The burden of chronic diseases
and their risk factors: national and state perspectives*. Retrieved from:
http://www.cdc.gov/nccdphp/burdenbook2004.

Commis, J. (2007, July). Will there be enough doctors? *HealthLeaders Media*. Retrieved from
http://www.healthleadersmedia.com/content/MAG-92871/Will-There-Be-Enough-
Doctors##.

Congressional Budget Office. (2007). *The long term outlook for health care spending*.
Retrieved from the Congressional Budget Office.
http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf.

Cooper, R. (2007). New directions for nurse practitioners and physician assistants in the era of
physicians shortages. *Academic Medicine, 82*(9), 827-828.

Cooper, R., Henderson, T., & Dietrich, C. (1998). Roles of nonphysician clinicians as
autonomous providers of patient care. *JAMA*, pp. 280:795-802.

Council on Graduate Medical Education. (2009). *COGME Letter of May 5, 2009 to DHHS
Secretary and Congress concerning primary care crisis and health care reform.*
Retrieved
from http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/index.html.

Dentzer, S. (2010, May). Reinventing primary care: a task that is far too important to fail. *Health Affairs*, pp. 29:5, 757.

Dower C., & O'Neil, E. (2011). *Primary care health workforce in the United States.* The Synthesis Project: Issue 22, Robert Wood Johnson Foundation. Retrieved from http://www.rwjf.org/pr/product.jsp?id=72579.

Dunn, E. (2007). *Medical team training in the veterans health administration*. Retrieved from http://www.patientsafety.gov/mtt/WhitePaper.pdf.

Druss, B., Marcus, S., Olfson, M., Tanielian, T., & Pincus, H. (2003). Trends in care by non-physician clinicians in the United States. *NEJM*, pp. 348(2): 130-37.

Dwyer, L.L., Han, B., Woodwell, D.A., & Rechtsteiner, E.A. (2010, February). Polypharmacy in nursing home residents in the United States: Results of the 2004 National Nursing Home Survey. *American Journal of Geriatric Pharmacotherapy* (Vol. 8, Issue 1, Pages 63-72, DOI: 10.1016/j.amjopharm.2010.01.001)

Everett, C., Schumacher, J., Wright, A., & Smith, M. (2009, Fall). Physician assistants and nurse practitioners as a usual source of care. *The Journal of Rural Health*, pp. 25:4:407-414.

Fleming, D., Riley, S., Boren, S., Hoffman, K., Edison, K., & Brooks, C. (2009, April). Incorporating telehealth into primary care resident outpatient training. *Telemedicine and e-Health*, pp. (15),3:277-282.

Flinter, M. (2009). *At the heart of the patient centered health care home: from primary care nurses to care providers.* Presentation at the 121st Meeting of the National Council on Nurse Education and Practice.

Haber, J. (2009). *From mouth to heart: the oral-systemic health connection in primary care.* Rockville, MD: Presented at November 2009 NACNEP meeting.

Hansen-Turton, T. (2009). *Why nurse-led practices are critical to the success of health care reform*. Rockville, MD: Presented at the NACNEP November 2009 meeting.

Hoffman, C. (1994). Medicaid payment for non-physician practitioners: An access issue. *Health Affairs (Millwood)*, 13, 140-152.

Hollinghurst, S., Horrocks, S., Anderson, E., & Salisbury C. (2006). Comparing the cost of nurse practitioners and GPs in primary care: modeling economic data from randomized trails. *British Journal of General Practice*; 56(528):530-5.

Hook, M.L. (2006). *Partnering with patients—a concept ready for action*. Journal of Advanced Nursing Oct2006, Vol. 56 Issue 2, p133-143. Retrieved from http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?hid=14&sid=563877a5-7bf2-45d2-a041-f621ffd32b01%40sessionmgr11&vid=4.

Hooker, R. S., & McCaig, L. F. (2001). Use of physician assistants and nurse practitioners in primary care 1995-1999. *Health Affairs*, pp. 20(4): 231-38.

Hooker, R., & Berlin, L. (2002). Trends in the supply of physician assistants and nurse practitioners in the United States. *Health Affairs*, 21(5): 174-81.

Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitionersworking in primary care can provide equivalent care to doctors. *British Medical Journal*, pp. 324, 819-23.

Huang, P., Yano, E., Lee, M., Chang, B., & Rubenstien, L. (2004, August). Variations in nurse practitioner use in Veterans Affairs primary care practices. *Health Services Research*, pp. 39:4; 887-904.

Institute of Medicine [IOM]. (2001). *Crossing the quality chasm.* Washington, DC: The National Academies Press.

Institute of Medicine. (2010). *The future of nursing: leading change, advancing health.* Washington, DC: The National Academies Press.

Institute of Medicine. (2003). *Health professions education: A bridge to quality.* Washington, DC: National Academies Press.

Institute of Medicine. (2004). *Keeping patients safe: transforming the work enviroment of nurses.* Washington, DC: The National Academies Press.

Institute of Medicine. (1996). *Primary care: America's health in a new era.* Washington, DC: The National Academies Press

Institute of Medicine. (2006). *Rewarding provider performance: aligning incentives in medicare.* Washington, DC: The National Academies Press.

Jones A., Dwyer L., Bercovitz A., & Strahan G. (2009). The national nursing home survey: 2004 overview. National Center for Health Statistics. *Vital Health Stat* 13(167).

Jost, S., Bonnell, M., Chacko, S., & Parkinson, D. (2010). Integrated primary nursing, a care delivery model for the 21st-century knowledge worker. *Nurse Admin Q*, pp. (34), 3: 208-216.

Keller, L.O. (2010). *The role of public health nursing in primary care: workforce implications*. Rockville, MD: Presented at the NACNEP April 2010 meeting.

Lenz, E.R., Mundinger, M.O., Kane, R.I., Hopkins, S.C., & Lin, S.X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians; two-year follow-up. *Medical Care Research and Review*. 2004; 61(3):332-51. Retrieved from Sage Journals: http://mcr.sagepub.com/content/61/3/332.abstract.

Long, S.K., & Stockley, K. (2009). *Emergency department visits in Massachusetts: who uses emergency care and why? Massachusetts health reform survey policy brief. R*retrieved from http://www.rwjf.org/files/research/48929.pdf.

Longtin, Y., Sax, Hugo, Leape, L., Sheridan, S., Donaldson, L., & Pittet, D. (2010). *Patient participation: current knowledge and applicability to patient safety.* Mayo Clinic Proceedings, 85(1):53-62. Retrieved from www.mahoclinicproceedings.com.

Lugo, N., O'Grady, E., Hodnicki, D., & Hanson, C. (2007). Ranking state nurse practitioner regulation: practice environment and consumer health care choice. *Am J Nurse Pract*, pp. 11(4):8–24.

Mann, E., Schuetz, B., & Rubin-Johnston, E. (2010, January 20). *Publications.* Retrieved from New England Healthcare Institute:

http://www.nehi.net/publications/45/remaking_primary_care_a_framework_for_the_futur e

McNair, R. (2005). The case for educating healthcare students in professionalism as teh core content of interprofessional education. *Medical Education*, pp. 39(5), 456-464.

Medicare Payment Advisory Commission. (2002). *Report to the Congress: medicare payment to advanced practice nurses and physicians assistants.* Washington, DC: MedPAC.

Merchant Medicine. (2010). *Retail clinics in the United States.* Retrieved from http://www.merchantmedicine.com/

Mundinger, M. O., Kane, R. I., Lenz, E. R., Totten, A. M., & Tsai, W. Y. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians. *JAMA*, pp. (1): 59-68.

National Association of Clinical Nurse Specialists. (2010). *What is a clinical nurse specialists?* Retrieved from http://www.nacns.org/AboutNACNS/FAQs/tabid/109/Default.aspx.

National Council of State Boards of Nursing. (2008). *Consensus model for APRN regulation: licensure, accreditation, certification, and education.* Chicago, IL: National Council of State Boards of Nursing: http://www.ncsbn.org/consensue_APRN_Final.pdf.

Naylor, M., & Kurtzman, E. (2010). The role of nurse practitioners in reinventing primary care. *Health Affiars*, pp. (29)5: 893-899.

Nurse-Family Partnership. (2011). *Overview of the program.* Retrieved from NFP: http://www.nursefamilypartnership.org

Pohl, J., Hanson, C., Newland, J., & Cronewett, L. (2010, May). Analysis and commentary unleashing nurse practitioners' potential to deliver primary care and lead teams. *Health Affairs*, pp. 5:(2010): 900-905.

Porter, S. (2010). *AAFP board revises retail health clinic policy: academy opposes ongoing expansions in scope of service*. Retrieved from http://www.aafp.org/online/en/home/publications/news/news-now/inside-aafp/20100224retail-policy.html.

Reeves, S., Goldman, J., & Oandasan, I. (2007, Winter). Key factors and planning and implementing interprofessional education in health care settings. *Journal of Allied Health*, pp. 36(4):231-235.

Robert Wood Johnson Foundation. (2007, May). *Partnerships for training: regional education systems for nurse practitioners, and physician assistants.* Retrieved from RWJF: http://www.rwjf.org/reports/npreports/partnerships.htm

Rogers, G. (2010). *Retooling for an aging America: nurse practitioners in the 'medical director' role in nursing homes.* Presentation to the 122nd Meeting of the National Council on Nurse Education and Practice.

Sahlsten, M., Larsson, I., Sjostrom, B., & Plos, K. (2008). Nurse strategies for optimising patient participation in nursing care. *Scandinavian Journal of Caring Sciences*; 23(3): 490-7.

Sainio, C., Lauri, S., & Eriksson, E. (2001). Cancer patients' views and experiences of participation in care and decision making. *Nursing Ethics*; 8:97-113.

Sandy, L., Bodenheimer, T., Pawlson, L., & Starfield, B. (2009). The political economy of U.S. primary care. *Health Affairs*, 28(4): 1136-1144. Retrieved from http://content.healthaffairs.org/cgi/content/abstract/28/4/1136.

Schmidt, M. (2009). *Is it all about safety? National and international perspectives on teh rationale for interprofessional education: Workforce shortages, access care, and comprehensive care*. Bethesda, MD: Presented at the April 2009 ACICBL meeting.

Schoen, C., Osborn, R., Doty, M., Squires, D., Peugh, J., & Applebaum, S. (2009). A survey of primary care physicians in eleven countries, 2009: perspective on care, costs and experiences. Health Affairs, 28, no.6 (2009): w1171-w1183. Retrieved from http://content.healthaffairs.org/content/28/6/w1171.full.

Schwappach, D. (2010, April). Engaging patients as vigilant partners in safety. *Medical Care Research and Review*, 67:2, 119-148.

Scott, M. (2006). *Health Care in the Express Lane: The emergence of retail clinics.* California HealthCare Foundation Website. Retrieved at http://www.chcf.org/~/media/Files/PDF/H/PDF%20HealthCareInTheExpressLaneRetail Clinics.pdf.

Shi, L., Starfield, B., Kennedy, B., & Kawachi, I. (1999). Income inequality, primary care, and health indicators. *Journal of Family Practice*, pp. 48(4), 275-84.

Stanton, M. (2009). *Reducing costs in the health care system: Learning from what has been done.* Retrieved from AHRQ Research in Action, 9: http://www.ahrq.gov/research/costsria/

Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. *The Milbank Quarterly*, pp. 83(3), 457-502.

Strozer, J., Juszczak, L. & Ammerman, A. (2010). *2007-2008 National School-Based Health Census, Washington, D.C., :National Assembly on School-Based Health Care.* Retrieved from http://www.nasbhc.org/atf/cf/%7Bcd9949f2-2761-42fb-bc7a-cee165c701d9%7D/NASBHC%202007-08%20CENSUS%20REPORT%20FINAL.PDF.

Towers, J. (2009). *Affecting health policy: The nurse practiioner perspective*. Rockville, MD: Presented at the November 2009 NACNEP meeting.

U.S. Census Bureau Population Division. (2008). *Table 2. projections of the population by selected age groups and sex for the United States: 2010 to 2050 (NP2008-T2).* Retrieved from http://www.census.gov/population/www/projections/files/nation/summary/np2008-t2.xls.

U.S. Census Bureau. (2010). *The next four decades: the older population in the United States: 2010 to 2050, Publication Number P25-1138.* Retrieved from http://www.census.gov/prod/www/abs/p25.html.

U.S. Congress, Office of Technology. (1986). *Nurse practitioners, physician assistants, and certified nurse-midwives: a policy analysis.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2011). Patient Centered Medical Home Resource Center. Retrieved from

http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

U.S. Department of Health and Human Services, HRSA, Bureau of Health Professions. (2011). *Health professional shortage areas*. Retrieved from http://bhpr.hrsa.gov/shortage/index.html.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. (2008). *The physician workforce: projections and research into current issues affecting supply and demand.* Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. (2005). *The registered nurse population: findings from the March 2004 National Sample Survey of Registered Nurses.* Washington, DC: U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services, Bureau of Health Professions. (2010). *The national sample survey of registered nurses: findings from the 2008 survey.* Washington, DC: U.S. Department of Health and Human Services.

U.S. Government Accountability Office. (2008, February 12). *Primary care professionals: recent supply trends, projects, and valuation of services.* Retrieved from Government Accountability Office: http://www.gao.gov/new.items.do8472t.pdf

Warshaw G. (2006). Introduction: advances and challenges in care of older people with chronic illness. *Generations*. 30(3):5–10.

Williams, G., Freedman, Z., & Deci, E. (1998). Supporting autonomy to motivate patients with diabetes for glucose control. *Diabetes Care;* 21: 1644-51.

Zuzelo, P. (2010). *The role of clinical nurse specialists in primary care.* Presentation at NACNEP April 2010 Meeting.

Appendices

Glossary of Acronyms

APRN	Advanced Practice Registered Nurse
BHPr	Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services
BSN	Bachelor of Science in Nursing
CDC	Centers for Disease Control and Prevention
CNA	Certified Nurse Anesthetist
CNM	Certified Nurse Midwife
CMS	Centers for Medicare and Medicaid Services
CNS	Clinical Nurse Specialist
DN	Doctorate in Nursing
EHR	Electronic Health Record
FAAN	Fellow of the American Academy of Nursing
FQHC	Federally Qualified Health Center
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine (National Academy of Sciences)
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
MCO	Managed Care Organization
NACNEP	National Advisory Council on Nurse Education and Practice

NCQA	National Committee for Quality Assurance
NCLEX-PN	National Council Licensure Examination for Practical Nurses
NCLEX-RN	National Council Licensure Examination for Registered Nurses
NCSBN	National Council of State Boards of Nursing
NFP	Nurse-Family Partnership
NMHC	Nurse Managed Health Center
NP	Nurse Practitioner
MSN	Master's of Science in Nursing
PA	Physician Assistant
RN	Registered Nurse
SBHC	School Based Health Clinic

Charter of the National Advisory Council on Nurse Education and Practice

Purpose
The Secretary and by delegation, the Administrator of the Health Resources and Services Administration (HRSA), are charged under Title VIII of the Public Health Service Act, as amended, with responsibility for a wide range of activities in support of nursing education and practice which include: enhancement of the composition of the nursing workforce, improvement of the distribution and utilization of nurses to meet the health needs of the Nation, expansion of the knowledge, skills, and capabilities of nurses to enhance the quality of nursing practice, development and dissemination of improved models of organization, financing and delivery of nursing services, and promotion of interprofessional approaches to the delivery of health services particularly in the context of public health and primary care.

Authority
42 United States Code (USC) 297t; Section 845 of the Public Health Service Act, an amended. The Council is governed by provisions of Public Law 92-463, which sets forth standards for the formation and use of advisory committees.

Functions
The Advisory Council advises and makes recommendations to the Secretary and Congress on policy matters arising in the administration of Title VIII including the range of issues relating to the nurse workforce, nursing education, and nursing practice improvement. The Advisory Council may make specific recommendations to the Secretary and Congress regarding programs administered by the Division of Nursing particularly within the context of the enabling legislation and the Division's mission and strategic directions, as a means of enhancing the health of the public through the development of the nursing workforce.

Additionally, the Advisory Council provides advice to the Secretary and Congress in preparation of general regulations and with respect to policy matters arising in the administration of this title including the range of issues relating to nurse supply, education and practice improvement.

Structure
The Advisory Council shall consist of the Secretary or delegate who shall be an ex officio member and shall serve as the Chairperson, and not less than twenty-one (21), nor more than twenty-three (23) members selected by the Secretary. Two of the appointed members shall be selected from full-time students representing various levels of education in schools of nursing; two shall be selected from the general public; two shall be selected from practicing professional nurses; and nine shall be selected from among the leading authorities in the various fields of nursing, higher secondary education and associate degree schools of nursing, and from representatives of advanced education nursing groups (such as nurse practitioners, nurse midwives, and nurse anesthetists), hospitals and other institutions and organizations which provide nursing services. The Secretary shall ensure a fair balance between the nursing

profession, with a broad geographic representation of members, a balance between urban and rural members, and the adequate representation of minorities. The majority of members shall be nurses.

The Secretary shall appoint members to serve for overlapping 4-year terms. Members will be appointed based on their competence, interest, and knowledge of the mission of the nursing profession. Members appointed to fill vacancies occurring prior to the expiration of the term for which their predecessors were appointed shall be appointed only for the remainder of such terms. A student member may continue to serve the remainder of a 4-year term following completion of a nurse education program. Members may serve after the expiration of their term until their successors have taken office.

Subcommittees composed of members of the parent Advisory Council shall be established with the approval of the Secretary of HHS or his designee to perform to perform specific functions within the Advisory Council's jurisdiction. The Department Committee Management Officer will be notified upon establishment of each of the subcommittees and will be provided information on its name, membership, function, and established frequency of meetings.

Management and support services shall be provided by the Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration.

Meetings
Meetings shall be held at least two times a year at the call of the Designated Federal Officer or designee who shall approve the agenda and shall be present at all meetings. Meetings shall be held jointly with related entities established under this title where appropriate including the Council on Graduate Medical Education; Advisory Committee on Interdisciplinary, Community-Based Linkages; and the Advisory Committee on Training in Primary Care Medicine and Dentistry.

Not later than 14 days prior to the convening of a meeting, the Advisory Council shall prepare and make available an agenda of the matters to be considered by the Advisory Council at such meeting. At any such meeting, the Advisory Council shall distribute materials with respect to the issues to be addressed at the meeting. No later than 30 days after the adjournment of this meeting, the Advisory Council shall prepare and make available to the public a summary of the meeting and any actions taken by the Advisory Council based upon the meeting. Meetings shall be open to the public except as determined by the Secretary or other official to whom the authority has been delegated in accordance with the Government in the Sunshine Act (5 USC 552b(c)). Notice of meetings shall be given to the public. Meetings shall be conducted, and records of the proceedings kept as required by applicable laws and Departmental regulations.

Compensation
Members who are not full-time Federal employees shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for Level IV of the Executive Schedule under section 5315 of Title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Advisory Council. Members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates

authorized for employees of agencies under subchapter I of chapter 57 of Title 5, USC, while away from their homes or regular places of business in the performance of services for the Advisory Council. Any such travel shall be approved by a Federal Government official in accordance with Standard Government Travel Regulations.

Annual Cost Estimates
Estimated annual costs for operating the Advisory Council, including compensation and travel expenses for members but excluding staff support, is $336,524. Estimate of staff-years of support required is 2.2 at an estimated annual cost of $256,136.

Reports
The Advisory Council shall annually prepare and submit to the Secretary, the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a report describing the activities of the Advisory Council including its findings and recommendations.

In the event a portion of a meeting is closed to the public, as determined by the Secretary, in accordance with the government in the Sunshine Act (5 U.S.C. 552b © and FACA, a report shall be prepared which shall contain at a minimum a list of members and their business addresses, the Advisory Council's functions, dates and places of meetings and a summary of Advisory Council activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee Management Officer.

Termination Date
The duration of the National Advisory Council on Nurse Education and Practice is continuing. Unless renewed by appropriate action prior to its expiration the National Advisory Council on Nurse Education and Practice will terminate two years from the date this Charter is filed.

Approved

11/26/08   /s/ Alexandra Huttinger for
Date   Director, Office of Management

Members of the National Advisory Council on Nurse Education and Practice during the 121st and 122nd Meetings

November, 2009; April, 2010

E. Michele Richardson, MS, BSN, RN
Chair, NACNEP
Director, Division of Nursing
Bureau of Health Professions
Health Resources and Services Administration
5600 Fishers Lane, Room 9-35
Rockville, MD 20857

M. Jean Gilbert, PhD
Director, Cultures in the Clinic
Cultural Responsiveness in Health Care
5254 Calle Morelia
Santa Barbara, California 93111

Lakisha Smith, MPH
Executive Secretary, NACNEP
Chief Operations Director, Division of Nursing
Bureau of Health Professions
Health Resources and Services Administration
5600 Fishers Lane, Room 9-35
Rockville, MD 20857

Bettie J. Glenn, EdD, RN
Associate Dean Academic Affairs
University of North Carolina, Wilmington
601 S. College Road
Wilmington, NC 28403

Ellyn Elizabeth Cavanagh, PhD, MN, CPNP*
Dartmouth-Hitchcock Medical Center
Department of Pediatrics
Section of Child Development
One Medical Center Drive
Hanover, NH 03756

Diana R. Jolles, CNM, MSN
Adjunct Professor
Texas A & M University
PO Box 331652
Corpus Christi, TX 78463

Karen Cox, PhD, RN, FAAN
Executive Vice President and Co-Chief
Operating Officer
Children's Mercy Hospitals and Clinics
2401 Gillham Road
Kansas City, MO 64108

Maureen R. Keefe, RN, PHD, FAAN
Dean and Professor
Louis H. Peery Endowed Chair
University of Utah, College of Nursing
10 South 2000 East
Salt Lake City, UT 84112-5880

Shirlee Drayton-Brooks, PhD, RN, CRNP,
APRN, BC, CRRN
Director, Family Nurse Practitioner Program
Widener University
Chester, PA 19013

Cydne Marckmann, MN, ARNP
Advanced Registered Nurse Practitioner
Sound Family Medicine
3908 10th Street, SE
Puyallup, WA 98374

Karen Neil Drenkard, RN, PhD, NEA-BC*
Director, Magnet Recognition Program
American Nurses Credentialing Center
8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910

Ann Minnick, PhD, RN, FAAN
Julia Eleanor Chenault Professor of Nursing
Vanderbilt University School of Nursing
Room 424 Godchaux Hall, 21 Avenue South
Nashville, TN 37240

John J. Nagelhout, PhD, CRNA, FAAN
Director, Kaiser Permanente
School of Anesthesia
California State University, Fullerton
100 S. Los Robles, Suite 550
Pasadena, CA 91188

Joyce Elaine Beebe Thompson, DrPH, RN,
CNM, FAAN FACNM
Bernadine M. Lacey Professor of Community
Health Nursing
Western Michigan University
Bronson School of Nursing
1903 West Michigan Avenue
Kalamazoo, MI 49008

Brandon N. Respress, PhD, RN, MSN, MPH,
CPNP
Case Western Reserve University
Frances Payne Bolton School of Nursing
10900 Euclid Avenue, Room 44106
Cleveland, OH 44106

Diane J. Skiba, PhD, FAAN, FACMI
Professor and Project Director
I-Collaboratory: Partnerships in Learning
University of Colorado, Denver
School of Nursing, Campus Box C-288-03
Bldg P28, Education 2 North, Room 4215
13120 E. 19th Avenue
Aurora, CO 80045