

Achieving Health Equity through Nursing Workforce Diversity

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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 (BHP), Division of Nursing (DN), including nurse workforce supply, education, and practice improvement.

Executive Summary

A diverse nursing workforce is essential for progress towards health equity in the United States. Advances in nursing workforce diversity over the past decade are the result of efforts by national, federal, and nursing stakeholder groups to develop and implement effective policies and programs to promote diversity in the profession. The registered nurse (RN) workforce today is more diverse than it was a decade ago by 5% bringing the proportion of White RNs down to approximately 75% (HRSA, 2013). More than half of today's RNs hold a bachelor's or higher degree (HRSA, 2013). The advanced practice registered nurse (APRN) workforce, those with a master's or doctoral degree, has expanded in both number and diversity. APRNs are independent care providers who often locate in underserved and minority communities. The growth of online education has expanded access to nursing education in rural and resource-challenged communities. K-12 Science, Technology, Engineering and Math (STEM) "pipeline" programs have brought more underrepresented minority students into the health professions. A decade's effort to strengthen underrepresented minority representation in leadership roles in the health professions has begun to change the culture of healthcare.

But despite these successes, the United States is far from achieving the goal of a health workforce that mirrors the nation's diverse population. Barriers to success include weak representation of minorities among nursing faculty and within healthcare organizations, especially in leadership roles; and admissions policies and practices that fail to encourage and support underrepresented minority students and applicants to health professional education institutions. There is no national dataset on nursing workforce diversity in the United States, and no source of data on diversity program outcomes that can be used to plan and evaluate efforts.

In this report, the National Advisory Committee on Nurse Education and Practice (NACNEP) summarizes progress in nursing workforce diversity over the past 10 years within the broader national mission of eliminating health disparities, and provides recommendations for continued efforts to promote diversity in nursing. In discussions that took place during scheduled council meetings, the NACNEP identified two overarching recommendations:

1. **To promote nursing workforce diversity to achieve health equity**, the Secretary and the Congress should support the development of strategic partnerships in communities with significant racial, ethnic and linguistic minority populations, and disadvantaged populations to offer recruitment and employment opportunities. Specifically:
 - a. To promote more equitable distribution of the nursing workforce, Congress should initiate incentive programs to reward provider organizations and health systems that recruit and retain a diverse pool of nursing professionals in rural and underserved areas.
 - b. Congress should promote collaboration among the U.S. Department of Education; U.S. Department of Labor; Science, Technology, Engineering, and Mathematics Education (STEM) collaboratives; the National Science Foundation; Area Health Education Centers (AHECs); HRSA's Division of Nursing; and other nursing stakeholders to develop strategies for recruiting, graduating, and employing underrepresented minorities in nursing, starting with pipeline programs in middle schools.
 - c. To leverage resources and maximize the impact of its workforce diversity programs,

HRSA should promote collaboration among programs within the Bureau of Clinician Recruitment and Service (BCRS) and the Bureau of Health Professions (BHP).

2. **To support effective decision-making and evaluation of diversity program outcomes**, the Secretary and Congress should fund 1) the development and dissemination of data to track diversity in nursing education, and 2) the establishment of a national clearinghouse of best practices in advancing diversity in nursing education and employment. Specifically:
 - a. HRSA should support the development and maintenance of a clearinghouse of best practices from successful nursing diversity programs, and implement strategies to disseminate these model programs to guide future programs.
 - b. The Secretary and Congress should encourage nursing stakeholder groups to create an ID to track nursing graduates from the point of licensure, similar to the AAMC ID used throughout the individual's journey through medical school and residency.
 - c. The Secretary and Congress should support the creation of publicly available data resources on diversity in nursing schools' applications, admissions, graduates, and qualified students who were not admitted.
 - d. Congress should fund the development of a program to monitor, evaluate, and disseminate data on the impact of nursing education and workforce diversity programs on training outcomes, post-training employment, and clinical practice and outcomes.

Achieving Health Equity through Nursing Workforce Diversity: Advances and Challenges

Introduction

National consensus documents released over the past decade provided recommendations to promote diversity in the health professions. These consensus documents included the 2004 Sullivan Commission report; the Institute of Medicine's (IOM) Quality Chasm series, and HRSA's National Advisory Council on Nurse Education and Practice (NACNEP) 2000 report to Congress on diversity in nursing. The recommendations in these reports focused on the need for institutional cultural change in the health professions and in health professions educational institutions, and on the importance of initiatives that reduce barriers to health professional training for underrepresented minorities. To prepare this report, NACNEP reviewed the recommendations from these earlier reports, and evaluated evidence for the impact of policies and programs related to these recommendations on nursing workforce diversity.

The Sullivan Commission described three principles that shaped their vision: 1) the need for more focus on cultural change in health professional educational institutions, 2) exploration of non-traditional paths for underrepresented minority students to enter into the healthcare professions, and 3) commitment to diversity at the highest levels within health professional educational institutions (Sullivan, 2004). Similarly, in its 2004 report, *In the nation's compelling interest: Ensuring diversity in the health professions*, the IOM directed recommendations for increasing diversity towards health professional educational institutions; federal, state and local government; health professional accreditation institutions; and the U.S Congress.

The NACNEP 2000 report stated that nursing workforce diversity goals should be directed towards recruitment, retention, and graduation of underrepresented minority students and faculty in both educational and practice environments. The report recommended formal evaluation of the outcomes of programs designed to promote diversity; and underscored the need for cultural change in education and practice environments to increase diversity and improve standards of practice, patient outcomes, and access to care (NACNEP, 2000).

Based on its review of the aforementioned national recommendations and the progress towards diversity in nursing over the past 10 years as evidenced by data from the Health Resources and Services Administration (HRSA), the American Association of Colleges of Nursing (AACN), and the National League of Nursing (HRSA, 2013; AACN, 2013a; Budden et al., 2013), the NACNEP identified two persistent challenges:

1) To eliminated disparities in access to care; and 2) to develop a national clearinghouse for data and best practices for promoting diversity in nursing. NACNEP's recommendations for addressing these challenges are provided in this report.

In framing the recommendations, NACNEP discussed several inter-related concepts or principles that are germane to workforce diversity initiatives. These principles include the value of diversity within the health professions, the national goal of health equity, and the urgent need to eliminate health disparities by addressing the broader social determinants of health. A discussion of these key principles follows.

Key Concepts and Terms

HRSA's Nursing Workforce Diversity grants are funded under **Sec. 821 of the Public Health Service Act, 42 U.S.C. § 296m**, which awards grants to increase nursing education opportunities for individuals who are from disadvantaged backgrounds, including racial and ethnic minorities underrepresented in the nursing workforce.

HRSA defines diversity as “the multiplicity of human differences among groups of people or individuals. Increasing diversity means enhancing one’s ability to recognize, understand and respect the differences that may exist between groups and individuals. Increasing diversity in the health care workforce requires recognition of many other dimensions, including, but not limited to gender, sexual orientation, race, ethnicity, nationality, religion, age, cultural background, socio-economic status, disabilities, and language.”

HRSA's Bureau of Health Professions (BHP) is committed to increasing diversity in health professions education and training programs, and in the health workforce. This commitment extends to ensuring that the United States has the right clinicians, with the right skills, working where they are needed. The following Diversity Guiding Principles have been adopted by BHP to facilitate diversity in the health professions workforce:

- Health professions training programs recruit, train, and support a workforce that is reflective of the diversity of the nation.
- Health professions training programs address all levels of the health workforce from pre-professional to professional.
- Health professions training programs recognize that learning is life-long and should be supported by a continuum of educational opportunities.
- Training programs help health care providers develop the competencies and skills needed for intercultural understanding, and expand cultural fluency especially in the areas of health literacy and linguistic competency.
- Health professions training programs recognize that bringing people of diverse backgrounds and experiences together facilitates innovative strategic practices that enhance the health of all people.

Healthy People 2020 defined health equity as "attainment of the highest level of health for all people." According to Healthy People 2020, the term “disparities” has often been interpreted to mean racial or ethnic disparities, yet many dimensions of disparities exist in the United States, particularly in health and health outcomes (OMH, 2010). In the U.S. Department of Health and Human Services (DHHS) Action Plan to reduce Racial and Ethnic Health Disparities, health disparities are defined as “differences in health outcomes that are closely linked with social,

economic and environmental disadvantage” (DHHS, 2013). Exposure to health risks and access to quality care are influenced by race and ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location. Models of health disparity also recognize the complex relationships among these variables that produce the observed disparities in health and health outcomes (IOM, 2009).

The World Health Organization (WHO) has taken a holistic view of the social determinants of health that includes access to goods and services, such as healthcare and education; conditions of work and leisure, and conditions of homes, schools and communities. Inequity is a major driver of the disparities observed in health and health outcomes across the United States (CSDH, 2008). Unequal distribution of access to resources results in health-damaging experiences for some and health-promoting experiences for others.

Workforce Diversity and Health Equity

Diversity in the healthcare workforce can improve access to and quality of care available to minorities and underserved populations (HRSA, 2006). Racial and ethnic minority providers show greater willingness to practice in underserved areas. This results in increased access to culturally and linguistically appropriate services; and to safe and timely care, including preventive and specialist services (Mead et al., 2008; Betancourt et al., 2003). Healthcare professionals from underrepresented minority and disadvantaged groups are significantly more likely than their White colleagues to remain in or return to practice in underserved communities (NRC, 2004; Gilliss, 2010), and to offer care to patients with Medicaid as the primary insurer (Betancourt, 2003).

The bulk of the evidence that supports the relationship between health workforce diversity and improved outcomes of care for minority populations is based on studies of independent practitioners (physicians, physician’s assistants (PAs), nurse practitioners (NPs), and certified nurse-midwives (CNMs) in primary care (Gillis, 2010). It is difficult to generalize these findings to the nursing profession as a whole; however, a rich body of evidence shows that health outcomes are improved by a match between patient and the care provider relative to race and language. This match is referred to as concordance.

Race and language concordance is associated with greater patient satisfaction and improved patient-provider communication, which can improve the quality and outcomes of care (NRC, 2004). Research has also shown that minority patients prefer a healthcare professional of their own race or ethnic background (NRC, 2004). These findings indicate that race and language concordance may improve patient engagement and access to care.

As healthcare reform emphasizes the role of primary care in disease prevention, efforts must also include outreach to minority and vulnerable communities to engage individuals and organizations in health promotion and disease prevention. Outreach, too, can be facilitated by culturally and linguistically competent healthcare professionals within a truly representative healthcare workforce (ACMH, 2009).

Organization of the Report

NACNEP reviewed the evidence base for documented success in increasing diversity in the nursing workforce, and national consensus guidelines for addressing persistent challenges. The next section summarizes advances in nursing workforce diversity over the past decade. Advances include greater diversity in the registered nurse workforce and multiplication of efforts to increase the number of underrepresented minorities in advanced practice roles and in healthcare organizations' workforces. The report acknowledges the success of pipeline programs for science, technology, engineering and math (STEM); and other mentoring initiatives in K-12 education that help prepare underrepresented minority students for careers in the health professions.

The following section focuses on challenges in promoting workforce diversity in nursing, including weak minority representation within nursing faculty, lack of public awareness about career options available within the profession, and admissions policies and practices that fail to recruit and retain qualified underrepresented minority students. This section also outlines NACNEP's recommendations for the development of tools for decision-making and evaluation of nursing diversity programs, including the need for standards for data on race, language, and ethnicity; methods for tracking nursing students and graduates of nursing programs; methods for increasing diversity within nursing faculty and other leadership roles; and implementation of admissions practices and policies that promote diversity in health professional educational institutions.

Discussion of the evidence and available guidelines is included in each section of the report. In several important areas, for example, within healthcare organizations and within nursing faculty, best practices for promoting diversity have been identified and made available, but weak minority representation persists, especially in leadership roles and in programs leading to master's and doctoral degrees.

Advances in Nursing Workforce Diversity

Advances in nursing workforce diversity over the past 10 years reflect the priority that national and nursing stakeholder groups have placed on diversity efforts in health professional educational institutions and healthcare organizations. The American Association of Colleges of Nursing (AACN) and the National League for Nursing (NLN) with other nursing stakeholder groups established, as a priority, the enhancement of racial, cultural, and linguistic diversity in the workplace (AACN, 2013a; NLN, 2010). The American Hospital Association linked the recruitment of underrepresented minority nurses to the elimination of health disparities (AHA, 2013). In connecting these two national goals, the AHA has charted a course for diversity initiatives that ties the needs of communities to hospital staffing priorities.

As early as 1983, the National Research Council recognized that to promote a diverse workforce in nursing, programs to finance the education and training of nurses from underrepresented minority groups must be accompanied by the development of partnerships between educators and future employers (NRC, 1983). A flourishing example is the Department of Veterans Affairs' Enhancing Academic Partnerships Program, known as the VA Nursing Academy (<http://www.va.gov/oa/vana>). The VA Nursing Academy is a partnership between Veterans

Administration facilities and accredited schools of nursing that focuses on faculty professional development; increasing enrollment in baccalaureate nursing programs; supporting educational and practice innovations; and recruitment and retention of nurses in the Veterans Administration system.

Advances in nursing workforce diversity include an increasingly diverse registered nurse (RN) workforce; a greater number of advanced practice registered nurses; implementation of successful K-12 “pipeline” programs that improve access to health professions education and career advancement; and a decade’s history of guidelines for healthcare organizations’ workforce diversity initiatives. These advances and HRSA Division of Nursing’s workforce diversity initiatives are described in the next section.

The Registered Nurse (RN) Workforce

Recent data points to an increasingly diverse registered nurse workforce (HRSA, 2012; AACN, 2011; IOM, 2010a) but we are still far from the goal of having a healthcare workforce in the United States that mirrors our diverse population. Men are a small but increasing proportion of nurses (AACN, 2011). Current estimates show that men are approximately 9-11% of the nursing workforce (Budden et al., 2013; HRSA, 2013). Racial and ethnic minorities compose 33% of the U.S. workforce, but only 25% of the nursing workforce, a modest increase over the 2000 racial and ethnic minority nurse population of 20% (HRSA, 2013).

RNs in a recent national workforce survey by the National Council of State Boards of Nursing (NCSBN) were 83% White/Caucasian; 6% Black/African American; 6% Asian; 3% Hispanic/Latino; 1% Native Hawaiian or other Pacific Islander; and 1% Other. The proportion of White RNs in this study differs from the 75% proportion reported by HRSA in recent report (HRSA, 2013) because of different sampling methods. NCSBN drew its sample from RN licensing data and represents all RNs licensed in the United States, whereas HRSA sample included currently employed RNs and those seeking employment as RNs.

In the NCSBN survey, an examination of RNs by job title showed that “nurse executive” and “nurse faculty” roles had the least diversity, while “staff nurse” had the most diversity (Budden et al., 2013). These data illustrate the need diversity programs that focus on educational and career advancement for underrepresented minority RNs.

Advanced Practice Workforce

Advanced practiced registered nurses (APRNs) are registered nurses with graduate-level education (a master’s or doctoral degree). APRNs are trained in preventive and diagnostic care, and treatment, including prescribing medicine and other therapies, and referring patients to specialist care. The number of APRN graduates in nursing increased by 67% between 2007 and 2011 (HRSA, 2013).

Increasing the number of APRNs is considered a promising strategy for increasing the primary care workforce. APRNs are more likely than other primary care practitioners to locate in underserved areas and provide services to vulnerable communities (Gillis, 2006). More than half of the APRNs in the United States currently practice in primary care (AHRQ, 2011). APRNs from minority backgrounds can help address health disparities and the meet the need for

culturally and linguistically appropriate services (CLAS) as recommended by the U.S. Office of Minority Health.

In addition to being important, independent providers of care, master's and doctorally-prepared nurses educate the future nursing workforce (HRSA, 2013). The shortage of nurse faculty, especially those from racial and ethnic backgrounds, is among the persistent challenges discussed in this report.

Data shows that nurses from minority backgrounds recognize a need to pursue higher levels of nursing education beyond the entry level. Minority nurses are more likely than White nurses to pursue baccalaureate and graduate degrees in nursing (AACN, 2013a), but the paucity of underrepresented minority RNs reduces the pool of potential minority master's and doctoral students in nursing. Low diversity in the RN workforce is a factor in the shortage of minority nursing faculty, and the weak representation of minority nurses in leadership positions. These findings underscore the value of "pipeline" interventions to draw more underrepresented minority students to nursing.

Pipeline Programs

K-12 Pipeline Programs

Pipeline programs in the health professions have a documented record of success across a spectrum of academic entry points, including secondary school (DHHS, 2009). Increasing diversity in nursing can start with pre-professional K-12 programs that promote Science, Technology, Engineering and Mathematics education which are known collectively as STEM programs. The STEM Education Coalition (<http://www.stemedcoalition.org/>) is comprised of multiple stakeholders who work to raise awareness and increase funding for programs that inspire young people to pursue careers in STEM fields. Among the core principles of the coalition are to expand the diversity of the STEM workforce by supporting underrepresented minorities, veterans, women and rural populations in STEM fields; and to attract and retain underrepresented minority students and educators.

The Area Health Education Centers (AHEC) are a combined HRSA and state-funded national program that engages pre-college, college and graduate students; and maintains support of these students through retention programs in the health care workplace. Although AHEC's have historically focused on the medical pipeline, they now address a broader spectrum of health professions, including nursing, to stimulate interest among students in health and science careers. As an illustration, in 2011 and 2012 the NYS Erie-Niagara AHEC provided five health career programs to over 500 students in two counties. This program partners with a local college of nursing with support from a HRSA Nursing Workforce Diversity grant to encourage disadvantaged high school students from Buffalo to enroll in nursing school. The NYS AHEC also places students in clinical settings, particularly rural settings, and engages area clinicians and educators in ongoing professional development to help retain a qualified workforce in underserved areas.

Lessons learned from the Health Professions Partnership Initiative, which is jointly funded by the Robert Wood Johnson and the Kellogg Foundation, indicate that the most effective designs for

pipeline programs include structured activities targeted at a well-defined cohort of young student participants. Structured activities facilitate the measurement of outcomes. The set of program activities should be simple. Successful interventions can be sequenced to expand the program or to include multiple program sites. Staging of growth allows time for local cultural change that, in turn, increases acceptance and participation in the program (RWJF, 2009). Program success is associated with attention to implementation fidelity, technical capacity for measuring and recording outcomes, and inter-organizational collaboration (DHHS, 2009).

Unfortunately, diversity pipeline programs have tended to focus more on implementation than on evaluation of program outcomes (Oscós-Sanchez et al., 2008). Both process and outcome evaluations are necessary to evaluate program quality and impact. Process evaluations, which are the most common approach to pipeline program evaluation, provide information about who was served and what interventions were introduced, as well as barriers and facilitators to implementation. Outcome evaluations which are less frequently performed can provide data on program and intervention effectiveness (DHHS, 2009). In the relative absence of outcome data, new diversity pipeline programs lack evidence to guide them towards success.

Retention and Career Advancement

Hospitals are preferentially hiring nurses with bachelor's degrees in response to national-scale initiatives, including the IOM's influential report on the future of nursing. Hospitals are also influenced by Medicare penalties for poor quality outcomes and quality measures such as 30-day readmission rates, as well as other large-scale market forces. To promote diversity in the nursing workforce, RNs from associated degree programs and diploma-educated RNs need access to BSN and higher education for career advancement. Access to career promotional opportunities, including education, on-the-job training, and professional development is also a key determinant of job satisfaction and nurse retention (Jones, 2005).

Distance education is changing the way content is accessed, delivered and evaluated. The recent growth of online programs for completing the BSN and graduate programs in nursing has improved access for rural and place-bound RNs, and those who face time-related barriers and competing life demands. In rural and underserved areas where nurses are fewer, electronic interaction between students and nurse mentors, or e-mentoring, has been shown to bridge distances between students and mentors. E-mentoring also minimized status differences and allowed for more frequent interactions between students and nurse mentors. Students reported greater social ease, and mentors observed that interactions were more thoughtful in both directions (Kalisch et al., 2005).

Diversity within Healthcare Organizations

As noted earlier, national consensus reports of the past 10 years focused primarily on institutional change in health professional education institutions and healthcare organizations. This focus stimulated healthcare organizations across the country to establish committees and task forces to plan and evaluate diversity initiatives. Today, guidance is available to healthcare institutions as a result of several national initiatives to promote diversity, including the findings of the U.S. Department of Health and Human Services' Advisory Committee on Minority Health and the Office of Minority Health. These guidelines can be used to plan and evaluate nursing workforce diversity programs within healthcare organizations. For example, the Office of

Minority Health has established national standards on Culturally and Linguistically Appropriate Services (CLAS). These standards were designed for use in health care organizations. The 14 national standards are organized around three themes: Culturally Competent Care; Language Access Services; and Organizational Supports for Cultural Competence. Standards for organizational support include:

- a written strategic plan that outlines the diversity goals, policies and operational plans;
- organizational self-assessment of CLAS-related activities;
- collection and integration into electronic health records of data on patient race, ethnicity, and primary language;
- maintenance of relevant community socio-demographic profiles;
- development of collaborative relationships with communities and community organizations; and
- the establishment of a conflict and grievance process. (OMH, 2013).

According to the Advisory Committee on Minority Health, all healthcare reform commissions both public and private should also include sub-committees that address health disparities and workforce diversity.

Recent national survey research suggests that the healthcare community in the United States sees diverse leadership as a valuable business resource, and links diversity with achievement of strategic goals including patient satisfaction and improved staff and patient outcomes. Underrepresented minority healthcare professionals in a national survey observed more diversity initiatives within their organizations yet they observed weak outcomes in terms of minority representation in the organizations. In this study, minority respondents identified lack of commitment from top management as the greatest barrier to success (Witt/Kieffer, 2011). Promotion of a diverse healthcare workforce requires development of diverse executive leadership and governing bodies.

Other effective models that engage healthcare organizations include loan repayment programs sponsored by hospitals; state nurses' association "honor rolls" for hospitals' diversity-focused recruitment efforts; and reimbursement benefits for hospitals demonstrating gains in nursing workforce diversity. Such programs can increase the number of nurses from minority communities who are then hired by hospital systems to provide care for an increasingly diverse patient population.

Diversity Initiatives in HRSA's Division of Nursing

In August 2012, the Division of Nursing (DN) hosted an all-grantee summit titled, "Nursing in 3D: Workforce Diversity, Health Disparities, and Social Determinants of Health." The 3D Summit convened nursing workforce experts, nursing and public health stakeholders, and nursing workforce diversity grantees in face-to-face meetings, webinars, and on social media to engage in a dialog about the "Transition from Health Disparities to Health Equity" framework. Summit events focused on current efforts that use workforce diversity as a strategic tool to

address the social determinants of health. To disseminate information from the 3D summit, the DN commissioned a journal supplement in *Public Health Reports*. To further diversity goals, a webcast on successful grant writing was offered in October 2012 for schools of nursing and healthcare organizations that had not previously received funding from the DN.

In 2013, HRSA's funding opportunity announcements within the Nursing Workforce Diversity grant program were revised to reflect the social determinants of health and health disparities. Sixteen schools of nursing received grants to extend their efforts beyond individual-level interventions, such as scholarships, stipends, and pre-entry/mentoring activities, and to address the larger social and structural forces that influence health and well-being. Failure to recognize and address these social and structural forces has impeded efforts to diversify the nursing workforce, increase access to quality care, reduce health disparities, and improve health equity.

Expansion of military and veterans' programs has been identified as a promising way to increase diversity within the nursing workforce, faculty, and leadership (NACNEP, 2010). In 2013, the Nurse Education, Practice, and Retention: Veterans' Bachelor of Science Degree in Nursing (VBSN) program awarded nine institutions funding to recruit veterans into baccalaureate of nursing programs and to prepare them for practice and employment. These nine schools will also develop career ladders that include academic and social supports, career counseling, mentors and linkages with veteran service organizations and community health systems.

The next section describes persistent challenges to diversification of the healthcare workforce. Challenges persist within health professional educational institutions' admissions policies and practices and within efforts to diversify nursing faculty. Evidence-based programs are needed to promote nursing as a career for underrepresented minority youth. This next section also discusses the need for a nationally-comparative dataset on diversity in nursing, and an information clearinghouse for best practices in the field.

Persistent Challenges in Workforce Diversity

In the context of healthcare reform and national efforts to improve healthcare safety and quality, a consensus exists that while quality is improving, broad and equitable access to quality care is not (AHRQ, 2012). For quality measures tracked by the National Health Care Quality Report, less than 60 percent of patients received the recommended care across all communities (IOM, 2010b). Minorities receive lower quality care as compared to the general population, and continue to face more barriers in access to healthcare (AHRQ, 2012).

The health professions must evolve to equitably meet the needs of a rapidly changing U.S. population characterized by racial, ethnic and language diversity, and a range of culturally-influenced health and healthcare beliefs and preferences (NRC, 2004). Despite more than a decade of concentrated effort, marked disparities persist across a wide range of healthcare outcomes. Disparities exist in surgical outcomes and cancer care; maternal and infant mortality and morbidity; access to screening, preventive care and ambulatory services; and treatment for heart disease and HIV/AIDS (ACMH, 2009).

Variations in patterns of disparities and unevenness in quality of care also exist across geographic areas, type of care, and health plans (IOM, 2010b). The current health care workforce is poorly distributed geographically to serve the most vulnerable populations of the United States. A majority of nurses live and work in urban areas. Although 24% of licensed practical/vocation nurses (LPNs) reside in rural areas, only 16% of RNs do so (HRSA, 2013). Rural residents experience geographic barriers to both primary and specialty care.

As the educational preparation of today's nursing workforce is predominantly at the associate degree level, most nurses need to work within existing healthcare organizations. Locating these services in underserved areas (Gillis, 2006) and engaging healthcare organizations in the planning and implementation of diversity initiatives to draw minorities into nursing remains important. This also indicates the need for better national data on the geographic distribution of the workforce and of vulnerable populations to inform policy planning and decision-making. Quality improvements in health care tend to be locally-based (IOM, 2009).

An IOM (2009) report suggests that the measurement of care processes and outcomes are necessary to address the quality of care provided by individual clinicians and institutions. Yet in today's team-based care delivery system, it can be difficult to link an individual clinician to a patient's outcomes. The absence of national, comparative data on healthcare processes and outcomes hinders efforts to improve the quality of care. In this report, the NACNEP recognizes the importance of national data resources to promote best practices in workforce diversity, but emphasizes that an absence of data resources is not an excuse for inaction. The imperative is to act now to address the lack of diversity in nursing.

Diversity within Nursing Faculty

The ability to attract students from underrepresented minority groups is strongly connected to a diverse faculty, but a dearth of racial and ethnic minority faculty in schools of nursing persists (AACN, 2013a; NLN, 2010). Factors that contribute to overall faculty shortages in nursing schools across the United States include the large proportion of retirement-eligible faculty; higher compensation in clinical and private sector settings compared to academic settings; and inadequate workforce production of potential nurse educators (master's and doctoral graduates) as a direct result of nursing schools' constraints on admissions (AACN, 2012). In 2011 alone, U.S. nursing schools turned away more than 75,000 qualified applicants, with 2 out of 3 schools reporting faculty shortages as a reason (AACN, 2012).

The shortage of faculty from racial and ethnic minority populations is particularly acute. Diversity within nursing faculty has not kept pace with advances in the diversity of student bodies or nurse workforce diversity. Racial and ethnic diversity among nursing faculty also lags behind overall minority representation among U.S. faculty across disciplines (NACNEP, 2010). In addition to encouraging underrepresented minority student recruitment, minority faculty members provide underrepresented minority students with mentors, and help create a community of support that encourages retention and graduation.

The under-representation of racial and ethnic minority students in nursing education programs is greatest in programs that lead to graduate-level education, a master's or doctoral degree, which is

required for faculty positions (IOM, 2010a; HRSA, 2006). Few racial or ethnic minority nurses with advanced academic degrees choose faculty careers over clinical careers as APRNs (IOM, 2010a; AACN, 2013a). Although the reasons for this choice are complex, the dearth of minority nursing faculty may indicate to underrepresented minority students that the school of nursing does not value diversity, or that faculty opportunities do not exist for them within the profession (AACN, 2013a).

The AACN and the NLN have identified strategies for increasing the diversity in nursing education. Included among these recommended strategies are: a) identifying best practices for recruiting underrepresented minority faculty, b) encouraging underrepresented minority leadership development, c) advocating for programs that remove barriers to faculty careers such as faculty loan programs, d) developing underrepresented minority faculty scholarships programs, and e) advocating for more federal funding for nursing workforce development programs.

An online tool called the Nurse Faculty Query (NuFAQs) was released in 2012 to help current and potential faculty explore career issues, including tenure; work-life balance; and integration of teaching, clinical, and research roles (AACN, 2012). Nursing stakeholder groups have also collaborated to design career ladders and career support for underrepresented minority nursing scholars to pursue faculty and leadership roles (AACN, 2013a).

In 2010, NACNEP released a report on the faculty shortage in nursing that addressed the lack of diversity within nursing education. To increase diversity, the report recommended the launch of public awareness campaigns by nursing and healthcare organizations; national advertising; collaboration among colleges of nursing and historically black colleges and universities; and expansion of military and veteran programs.

Promoting Nursing as a Career

In the specific context of nursing workforce diversity, a challenge to pipeline programs is to interest young people from racial and ethnic minority groups in nursing as a profession. A review of the literature found that the biggest influence promoting exploration of nursing as a career is personal experience with a nurse, either as a patient or by having a nurse in the family (Donelan et al., 2008). Although research shows that African Americans and Latinos hold nurses in high regard, there is uncertainty among the general public about nursing as a profession.

The public is poorly-informed about the potential for career advancement in nursing, and the existence of advanced clinical and leadership roles within the profession (Campbell-Heider et al., 2008; Donelan et al., 2008). Most people are unaware of career options such as nursing faculty in higher education. Public education campaigns to highlight career advancement opportunities in the profession could contribute to nursing workforce and workforce diversity goals.

Despite a decade or more of pipeline programs and broad recognition of the nursing shortage and its impact on the health of the U.S. population, there is little national data on attitudes towards nursing as a profession and how this varies by age, race, gender and ethnicity (Donelan et al., 2008). In a notable exception, Donelan and colleagues combined several surveys of public attitudes about nursing conducted in 2006 and 2007, including one that oversampled African

American and Hispanic/Latino respondents in order to draw inferences about attitudes of underrepresented minority groups towards careers in nursing. The authors found that one in four Americans has personally considered a career in nursing, and that racial/ethnic minorities were more likely than Whites to have seriously considered a nursing career. In these studies, African-American/Black respondents were more likely than Whites (94% versus 89%) to have recommended a career in nursing to other people (Donelan et al., 2008).

According to the authors of this study, "...prolonged and persistent effort is needed to educate people about nursing careers, to stimulate the expanded production of nursing faculty, and to bring creative approaches to financing nursing education and workforce improvements to convert the large numbers of interested candidates into the nursing profession." (Donelan et al., 2008, p. Sidebar: Executive Summary).

Admissions Policies and Practices

Once a student becomes interested in a nursing career, s/he must apply for acceptance into an accredited program. According to a recent report from the American Association of Colleges of Nursing (AACN), in 2011, 75,587 qualified applicants were turned away from baccalaureate and graduate nursing programs due to a shortage of faculty, clinical instructors, and clinical sites; lack of classroom space; and budget constraints (AACN, 2013b).

Some universities admit freshman into pre-nursing without guaranteed admission into the actual nursing program. Thus, competition for nursing educational "slots" is fierce. Community colleges that have open admissions policies may accept students into nursing programs, but fail to ensure adequate academic progression. Underrepresented minority students often lack the support needed to complete the prerequisites at a rate that ensures entry into clinical training. Racial and ethnic minority students who enter college benefit from programs designed to improve academic self-efficacy and the sense of belonging, and to combat negative stereotypes that adversely impact academic performance (Oscós-Sanchez et al., 2008).

Prospective students must become educated consumers who search for and apply only to accredited schools of nursing with a proven track-record of successful graduates. It is essential that university officials, nursing faculty, and program administrators maintain current knowledge of the requirements for nursing education and practice, including licensure and certification, and use this knowledge to provide sound advice to their students.

Health professions educational institutions could follow the guidelines for admissions procedures set out in the recommendations of the National Research Council (NRC) report, "*In the Nation's Compelling Interest: Ensuring diversity in the health care workforce*". In this report, the NRC recommended that Congress should fund programs under Public Health Service Act Titles VII and VIII to collect and disseminate information on best practices to enhance the diversity of the healthcare workforce. Information about best practices could then serve to guide future and expanded diversity programs.

The National Research Council report recommended that procedures for health professional educational institutions should include comprehensive review of applicants encompassing

background and past learning experiences; training of admissions committee members to increase cultural humility; de-emphasis of standardized test data; and inclusion of members from underrepresented racial and ethnic minority groups and racial and ethnic minority faculty on admissions committees (NRC, 2004).

Tools for decision-making and evaluation of diversity programs

Standards for race, language, and ethnicity data

In its report on the future of health workforce disparity efforts in the United States, the IOM reaffirmed the priorities set forth by the National Priority Partnership in 2008. The original recommended priorities were the following: patient and family engagement, population health, safety, care coordination, palliative care and overuse. The IOM recommended two additional national priorities: 1) access to care and 2) improved health systems infrastructure capabilities (IOM, 2010b). At the request of the Agency for Healthcare Research and Quality (AHRQ), the IOM established a sub-committee on standardization of race and ethnicity data whose recommendations can serve as a model for a data clearinghouse of best practices.

In the context of health systems infrastructure, the sub-committee joined others (IOM, 2009; DHHS, 2009) in recognizing a fundamental need in the United States for a standardized collection of data on race, ethnicity, language and socio-economic variables (IOM, 2009) to support the development of health disparity data resources for the nation. In this context, the term “variable” refers to dimensions of race, ethnicity, and language, and “category” to the possible discrete groupings of individuals that can occur within any variable.

According to the sub-committee, the five standard Office of Management and Budget (OMB) race categories (Black or African American, White, Asian, American Indian or Alaskan Native, and Hawaiian or other Pacific islander) combined with a single “yes or no” choice to Hispanic/Latino ethnicity is not sufficiently granular to capture important disparities. Whereas locally-relevant categories selected from a national standard set of granular ethnicities will ensure compatibility and comparability with other data collection efforts.

The IOM recommended the use of an “OMB Plus” set of 10 to 15 additional ethnicity categories from which a locally-relevant selection could be made. This would likely include national origin or place of birth, which would permit identification of culturally distinct groups such as the Hmong or those of French descent in the State of Maine, and facilitate targeted efforts to reduce disparities in health, health outcomes, and access to health-related resources.

Consumers and potential consumers of disparities data include a diverse range of stakeholders who vary in specific area of interest, data needs, and technical capacity to use data to plan for change (IOM, 2009). Flexible yet standardized nomenclature and routine inclusion of more fine-grained categories of ethnicity and language can support the development and dissemination of evidence-based decision support tools for planning nursing workforce diversity initiatives across a range of educational, employment and institutional arenas.

Data for tracking students and graduates

Tracking students along the educational pathway into employment requires sophisticated data systems and processes. These data would include diversity-relevant socio-demographic information, and educational data on applications, admissions, graduations, and qualified

students not admitted. A nationally-comparative dataset on admissions policies and practices that tracked diversity program outcomes could inform future policy and decision making.

Admittedly, the problem of collecting data on graduates in nursing programs is complex. Data are maintained in multiple locations within educational institutions, for example, in admissions offices and in financial aid offices. Data may be in different formats making it difficult to meld data systems into one repository. Once students graduate, they may be lost to data-tracking processes. Unlike medical students, nursing students do not have a national identification number assigned when passing their board exams that can be used later to track practice and employment characteristics. For medical students, the Association of American Medical Colleges (AAMC) ID is used throughout the individual's journey through medical school and residency as an identifier in their services programs for students including into residencies and Board Certification exams.

To promote effective program design, standardized evaluation of nursing education and workforce diversity programs will require data on training outcomes, post-training employment, and clinical practice. This will provide the evidence base for a national clearinghouse on best practices. Variability across diversity pipeline programs creates a challenge for the use of standard formats but Uniform Data Sets are a valuable and multi-purpose tool for evaluation (DHHS, 2009). For example, web-based Uniform Data Sets could be used to create a database for analysis by external agents and aide in the identification and dissemination of best-practices in diversity pipeline planning. At present, limited data sources are available about diversity program outcomes or the factors that are associated with program success.

Recommendations

1. **To promote nursing workforce diversity to achieve health equity**, the Secretary and the Congress should support the development of strategic partnerships in communities with significant racial, ethnic and linguistic minority populations, and disadvantaged populations to offer recruitment and employment opportunities. Specifically:
 - a. To promote more equitable distribution of the nursing workforce, Congress should initiate incentive programs to reward provider organizations and health systems that recruit and retain a diverse pool of nursing professionals in rural and underserved areas.
 - b. Congress should promote collaboration among the U.S. Department of Education; U.S. Department of Labor; Science, Technology, Engineering, and Mathematics Education (STEM) collaboratives; the National Science Foundation; Area Health Education Centers (AHECs); HRSA's Division of Nursing; and other nursing stakeholders to develop strategies for recruiting, graduating, and employing underrepresented minorities in nursing, starting with pipeline programs in middle schools.
 - c. To leverage resources and maximize the impact of its workforce diversity programs, HRSA should promote collaboration among programs within the Bureau of Clinician Recruitment and Service (BCRS) and the Bureau of Health Professions (BHPPr).
2. **To support effective decision-making and evaluation of diversity program outcomes**, the Secretary and Congress should fund 1) the development and dissemination of data to track diversity in nursing education, and 2) the establishment of a national clearinghouse of best

- practices in advancing diversity in nursing education and employment. Specifically:
- a. HRSA should support the development and maintenance of a clearinghouse of best practices from successful nursing diversity programs, and implement strategies to disseminate these model programs to guide future programs.
 - b. The Secretary and Congress should encourage nursing stakeholder groups to create an ID to track nursing graduates from the point of licensure, similar to the AAMC ID used throughout the individual's journey through medical school and residency.
 - c. The Secretary and Congress should support the creation of publicly available data resources on diversity in nursing schools', including applications, admissions, graduates, and qualified students who were not admitted.
 - d. Congress should fund the development of a program to monitor, evaluate, and disseminate data on the impact of nursing education and workforce diversity programs on training outcomes, post-training employment, and clinical practice and outcomes.

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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, as 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.

Subcommittees composed of members of the parent Advisory Council shall be established 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 otherwise 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, and 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 for excluding staff support, is \$232,436. Estimate of staff-year of support required is 2.5 at an estimated annual cost of \$323,368.

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, 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 on November 30, 2011.

Members the National Advisory Council on Nurse Education and Practice during the 123rd and 124th Meetings

(November 18-19, 2010 and April 11-12, 2011)

Michael Bird, MSW, MPH

Public Health Consultant

Start Date: 10/26/12

End Date: 9/1/16

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End Date: 9/1/16

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End Date: 9/1/16

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