125th Meeting of the National Advisory Council on Nurse Education and Practice

November 7-8, 2011

Participants

Council Members

Julie Sochalski, PhD, FAAN, RN, Chair, NACNEP
CDR Serina Hunter-Thomas, MSA, RN, Designated Federal Officer, NACNEP
Mary Lou Brunell, RN, MSN
Shirlee Drayton-Brooks, PhD, RN, CRNP, APRN, BC, CRRN
Karen Neil Drenkard, PhD, RN, NEA-BC, FAAN
Bettie J. Glenn, EdD, RN
Susan Hassmiller, PhD, RN, FAAN
Jeanette Ives Erickson, MS, RN, FAAN
Gerardo Melendez-Torres, Nursing Student
Brandon N. Respress, PhD, RN, MSN, MPH, CPNP
Monica Rochman, BSN, RN
Rhonda A. Scott, PhD, RN
Diane J. Skiba, PhD, FAAN, FACMI
Linda Speranza, PhD, MS, MEd, ARNP-C
Joyce Elaine Beebe Thompson, DrPH, RN, CNM, FAAN, FACNM

Presenters

Janet Heinrich, DrPH, FAAN, RN, Associate Administrator, Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (USDHHS)
Julie Sochalski, PhD, FAAN, RN, Chair NACNEP; Director, Division of Nursing, BHPr, HRSA
Mary Beth Bigley, DrPH, RN, Acting Director, Office of Science and Communications, Office of the Surgeon General, USDHHS
Carolyn M. Clancy, MD, Director, Agency for Healthcare Research & Quality, USDHHS
Michele J. Orza, ScD, Principal Policy Analyst, National Health Policy Forum, George Washington University
Marla E. Salmon, ScD, RN, FAAN, Professor, School of Nursing, University of Washington
Kenneth E. Thorpe, PhD, Executive Director, Partnership to Fight Chronic Disease; Professor, Department of Health Policy and Management, Rollins School of Public Health, Emory University
Irene M. Wielawski, Health Care Writer and Editor

Monday, November 7, 2011

The 125th Meeting of the National Advisory Council on Nurse Education and Practice (NACNEP) was convened at 8:30 a.m. on November 7, 2011 at the Georgetown University Hotel and Conference Center in Washington, D.C. by CDR Hunter-Thomas, DFO for NACNEP.

Opening Remarks

Dr. Julie Sochalski welcomed the NACNEP Council members and introduced the first speaker, Dr. Janet Heinrich, the Associate Administrator, BHPr, HRSA.

Dr. Heinrich gave an overview of HRSA's programs and initiatives to expand the diversity, recruitment and retention of the health care workforce. HRSA is moving forward on many fronts including increasing the supply of primary care providers, supporting the development of new models of care including interprofessional education and collaborative practice, and introducing new performance measures to assure program accountability.

Dr. Julie Sochalski welcomed Council members, reviewed the agenda, and gave an update on HHS, HRSA and DN activities and their impact on DN programs:

- All-Advisory Committee meeting and expanded Council authorities;
- Changes to DN FY 2012 funding opportunity announcements to meet the HHS/HRSA strategic goals;
- DN participation in Nursing Forums convened by the Bureau of Clinician Recruitment and Service to reach out to broadest constituency of nursing programs;
- Opportunities for programs to collaborate and promote synergies across HRSA and other federal programs;
- Update on CMS Medicare Graduate Nursing Education Demonstration Program;
- Update on rule-making for Shortage Designation Areas;
- Introduction of new DN staff;
- DN response to the White House veterans' initiative awarding grant supplement to explore opportunities for enlisted military personnel and returning veterans to receive academic credit for military training and health care delivery experiences (which was reported on White House blog).

Nursing Workforce Development Priorities

Council members submitted themes that they considered to be priority areas for nursing workforce development. These themes framed the discussions for the break-out sessions on Day Two. The themes included: increasing primary care education, including in pre-licensure programs; increasing access to nursing education overall and baccalaureate education; interprofessional education and team-based care; use of technology; diversity of faculty, leadership, and students; improved data collection and management; evidence based practice and dissemination; team-based care and management of and care coordination for preventable chronic illness; and need for better analysis of impact of care.

Presentations to the Council

Ms. Irene Wielawski addressed the Council on nursing from the public's perspective. She spoke to the council about her experiences in the health care system as the daughter of an Alzheimer's patient. Ms. Wielawski told the Council that even informed patients misread their own symptoms and rely on health professionals in their time of most need. She also commented on her struggles with the health care system over her mother's care and the failure of health professionals to provide informed and humanistic care. She told the story of her mother being interviewed at the emergency room despite suffering from Alzheimer's disease and giving misinformation.

Regarding nurses, Ms. Wielawski commented that nurses fill the vacuum of coordinating care and act as advocates for the patient, and that only nurses are taught to bring a "360 degrees perspective" when meeting the patient's needs—the definition of "patient-centered.". She noted

that the public and the media are on the side of nurses. She cautioned that the aggressive side of nursing, that side that wants "a seat at the table," is disconnected from what the public perceives of nurses. The use of power language, for example, leaves out the language of the public. She also commented that nurses could take a lead on eliminating jargon and promoting better communication across the health professions.

Dr. Michele Orza offered insights on nursing from the public health and policy perspectives. Dr. Orza discussed the non-medical determinants of health which include everything that goes on before entering the medical system that keeps people out of the medical system. She encouraged the Council to think about the public health perspective and move the emphasis away from health care and towards health. Health care has a relatively small impact on health when compared with the non-determinants of health. Nurses can play a key role in preventing patients from becoming unhealthy in the first place.

Additionally, Dr. Orza stated that the structure of the health care system should draw from the patient's perspective not the profession's perspective, i.e., from the view points of the patient, family, and the community. She noted that it is difficult to see how the current system can give the public what it needs. She also told the Council that nurses have a lot of power although they do not necessarily have a "place at the table." Dr. Orza cited their moral authority and leadership, and that they are held in higher regard by the public than physicians. She noted that the big health problems that confront us have community causes and need community solutions.

Finally Dr. Orza encouraged re-thinking on how health care professionals are trained and evaluated. She noted that most people would be surprised to learn that health professionals are not educated together. She recommended rethinking core courses and to focus on training in teams: focus on competencies rather than on disciplines.

Dr. Kenneth Thorpe remarks focused on the high cost of a fragmented health care system and the pressing need to reduce spending. The sharp increase in the prevalence of chronic disease and comorbidities and associated and avoidable hospital readmissions are evidence of a health care system that is not adequately managing these costly patients. Yet while the magnitude of spending is enormous so are the opportunities to save.

Dr. Thorpe discussed provisions of the ACA including team care, transitional care, medication management, and health coaching. However, like many parts of the ACA, many of these provisions were authorized but not appropriated. With no new funding, savings must be found in the current system to begin new initiatives.

Dr. Thorpe stated that CMS needed to undertake a concerted national strategy for evidence-based care coordination. Such a strategy would include having the new Innovations Center support demonstration projects using team-based models of care and to evaluate and ultimately scale-up successful models. CMS has the authority to scale these initiatives nationally if they improve quality and are less costly. Investment in a national strategy is key, though the appetite for new spending is lacking. Currently Medicare does not pay for care coordination although the program is largely responsible for the chronic ill population.

Dr. Thorpe noted the importance of demonstrating quality and cost outcomes of team-based care, e.g., lower costs for salary-based team practice. He also noted the importance of team-based training, and acknowledged the challenges in interdisciplinary education. He underscored the need for greater community-based training for providers.

Public Comment

The public comment session was opened.

Adjournment

CDR Hunter-Thomas adjourned the meeting at 5:00 pm.

Tuesday, November 8, 2011

CDR Hunter-Thomas convened the meeting at 8:30 a.m. and Dr. Sochalski introduced the first speaker, Dr. Marla Salmon.

Dr. Salmon shared her perspectives on NACNEP and the future of DN. She emphasized the importance of NACNEP's role in advising the Congress and noted the importance of the altitude of the advice. She encouraged NACNEP to lead from the perspective of the public's good, to focus on capacity-building to meet the goals of health reform, and to advise on where and how nursing workforce development achieves those goals and meets the public's need. She advocated for purposeful partnerships that add value to everyone's role in meeting the public's needs.

Dr. Salmon described four critical functions of the DN for NACNEP to reflect upon in their stewardship role: 1) planning and analytics towards building nursing capacity; 2) strategic leveraging of funding; 3) innovative and novel solutions to build education and practice; and 4) providing technical assistance and policy advice on the best ways to use our resources.

Dr. Carolyn Clancy addressed the Council on the patient-centered initiatives at AHRQ and the opportunities for nursing engagement in them. She presented background information on ARHQ and on focused on patient-centeredness as a critical yet still relatively under-explored domain of quality care. She highlighted the gaps in knowledge of how our interactions with patients influence quality of care and outcomes and the central role of nurses as patient coaches and advocates, the hallmarks of patient-centeredness. She described gains in quality over time and arenas in which AHRQ-supported nursing research has been key. She highlighted two new programs—the Patient-Centered Outcomes Research Institute and the Partnership for Patients Program—and the role they are playing in putting patients first, at the center of care delivery. These initiatives join others that are focused on improving quality and safety of care and reducing unnecessary and occasionally harmful care.

Dr. Clancy commented on the difficulty of recruiting and retaining providers in primary care. She noted the importance of incentivizing interprofessional training and determining how to develop teams that work effectively. She noted the growing interest in Patient-Centered Medical Homes and related provisions in the Affordable Care Act and AHRQ's work in these areas. She underscored the importance of building the evidence base to support quality care and the role that nurses must play to build the base of nursing practice. One area where nurses have led and could build upon that work is in chronic disease management. She noted opportunities to conduct

comparative effectiveness studies that will help to determine what works. She commented on new procedures to be adopted in the accrediting of medical education that entail assessing the structure and quality of the clinical training sites and clinical experiences.

Dr. Mary Beth Bigley addressed the Council on prevention and policy perspectives. The Affordable Care Act authorized the creation of the National Prevention Council, whose mission is to provide ongoing leadership across 17 federal departments and led to the development of the National Prevention Strategy. The Council has an advisory group that will advise on policies and recommendations regarding life style, chronic conditions, integrated health and health promotion. Dr. Bigley summarized the National Prevention Strategy report which was released in June 2011. This is a national evidence-based strategy will guide prevention activities across the federal government and is aligned with Health People 2020.

The National Prevention Strategy Goal is to increase the number of Americans who are healthy at every stage of life. This overarching goal was broken down into four focus areas. The first is creating, sustaining, and recognizing healthy and safe communities that promote health and wellness through prevention. The second focuses on clinical and community preventive services, particularly ensuring that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing. Empowering people by supporting them in making healthy choices is third. Lastly, the National Prevention Strategy goal includes eliminating health disparities, and improving the quality of life for all Americans.

Dr. Bigley stated that an implementation document is being developed currently and that nurses have a critical role to play in the implementation. Council members discussed the lack of funding for public health, the need for nurses to embrace a broader perspective on public health, and the need for partners in the community to be involved.

Breakout Groups

NACNEP Council members formed two groups to discuss the strategic priorities for NACNEP and Nursing Workforce Development. Each group presented their findings to the full Council.

Break-out Group #1 Strategic Priorities List:

1. Assure a diverse nursing workforce that has the competencies to meet the needs of the public. The essential skill set includes, but not limited to:
   a. Community/population focus
   b. Interprofessional team approach
   c. Evidence-based practice (all inclusive, self-supporting, patient-centered)
2. Increase education capacity and degree advancement opportunities for diverse geographic, socioeconomic and academically hard-to-reach groups.

Goals and Outcomes

1. Decrease disparities
2. Increase racial/ethnic representation
3. Increase access
4. Improve health outcomes

Strategies

1. Seamless articulation (CNA, LPN/LVN, RN to BSN, etc.)
2. Interstate access to programs
3. Simulation and online education
4. Academic service partnerships
5. Scholarships
6. Funding for Capacity building in schools of nursing (demonstration projects)
7. Explore ability for nursing inclusion in Centers of Excellence
8. Revisit USPHS Primary Care Policy Fellowship
9. Work with DM & BHPr and other external organization on strategies to apply interprofessional collaboration.
10. Convene organizations that are responsible for collecting data on nursing workforce to identify sources and potential for aggregation to national level while minimizing duplication and being cost efficient.
11. Develop 'buy-in' from other professions to build interprofessional care

Break-out Group #2 Strategic Priorities List:

1. Increasing education for primary care at all levels.
2. Training/practice opportunities in team-based care (across all settings)

Strategic Priorities for #1: Primary care education:

1. Introduce primary care at all levels (High school through college)
2. Priorities for funding are in primary care (community-based)
3. Look at primary care areas for clinical practice for nursing students (all in acute care now)
4. FQHC – partner with larger organizations
5. Broaden the primary care designation to community based care.
6. In long term care there is a lot of routine care issues, but we need to expand this practice.
7. Team based care – crucial to have interprofessional Groups.
8. Get nurses into settings where physicians are not available. Nurses will take the lead.
9. More training sites for primary care, increasing education on evidenced based care for both students and faculty.
10. Competency - Knowledge skills and professional behaviors to provide primary care. Skills need to be from a variety of settings.
11. Programs are required to define the competencies they are teaching and how they measure how they are met.
12. Do we demonstrate competencies through actual hands-on experience or through simulation? A certain percent in each method.
13. Interprofessional teamwork – biggest concern across all levels of education. Also increase experiences with the public (professional organizations).
14. Students have a difficult time delegating, teamwork, being knowledgeable about systems (healthcare environment has changed there are health systems not just a hospital combining long term care, assisted living, rehab, etc), escalation of care (moving to resident or attending). Residency programs very important in primary care.
15. Educating faculty is key.
16. Faculty Practice Models need to be implemented.
17. Main outcome: where do they end up working? Employer and alumni surveys.

Strategic Priorities for #2: Team-based training:

1. Interprofessional education – bring in other disciplines to teach in nursing and have nursing go out to other areas.
2. Depending on what the patient's needs are will determine who will lead the team. In our current model, different disciplines are represented, but the MD is still the team leader.
3. What does nursing uniquely contribute to the public's good?
4. Team-based care is not in a lot of educational programs.
5. Need for evidence to get to the front-line quicker. Teaching critical appraisal skills to enhance the transfer of evidence.
6. Partnership with NINR or other Research agency to look at funding translational research.
7. Dissemination through publication and presentation (T4 science – evidenced based practice).
8. Outcome: Content in the programs and clinical experiences and faculty teaching.

NACNEP 11th Report

The Writing team for the 11th NACNEP Report to Congress opened discussion on the Draft Recommendations. The Council discussed the importance of linkage with STEM, outreach to middle schools for the nurse pipeline, and other basic skill requirements needed for admission to nursing school including reading and writing. Data needs and availability were also discussed particularly in relation to diversifying the student nursing population. The draft recommendations with revisions will be distributed to the Council members for further refinement.

Public Comment

Jan Tower of the American Academy of Nurse Practitioners (AANP) offered access to data collected by the AANP and recommended future collaboration with the Council. Jan Ahearn of the American Association of the Colleges of Nurses (AACN) offered the Council access to their nurse enrollment data and provided a website which includes testimony as well as critical data elements: http://www.aacn.nche.edu/.

The Council wants to develop data sharing strategies and determine which organizations are collecting which data elements so that duplicate data collection could be avoided.

Adjournment

CDR Hunter-Thomas adjourned the 125th meeting of NACNEP at 5:00 pm.

Julie Sochalski, Chair, NACNEP — 1/14/13 Date

CDR Serina Hunter-Thomas, Designated Federal Officer, approved the meeting minutes.

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CDR Serina Hunter-Thomas, DFO, NACNEP — Date