National Advisory Council on Nurse Education and Practice

The 135th meeting of the National Advisory Council on Nurse Education and Practice (NACNEP) was held on September 26-27, 2018. The meeting was conducted in person, at the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Rockville, MD 20857. The meeting was also available for public access by webinar and teleconference.

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

Council Members Attending:

CAPT Sophia Russell, Chair
Dr. Marsha Howell Adams
Dr. Maryann Alexander
Dr. Cynthia Bienemy
Dr. Mary Brucker
Dr. Ann Cary
Dr. John Cech
Dr. Tammi Damas
Ms. Mary Ann Hilliard

Dr. Ronda Hughes
Dr. Christopher Hulin
Dr. Linda Kim
Dr. Maryjoan Ladden
Rev. Dr. Lorina Marshall-Blake
Ms. Donna Meyer
Dr. Teri Murray
Dr. Roy Simpson

Council Members Absent:

Ms. Mary Ann Christopher, Col. Bruce Schoneboom

Others Present:

Ms. Tracy Gray, Designated Federal Official, NACNEP
Mr. Raymond Bingham, Technical Writer, Division of Nursing and Public Health, HRSA
Ms. Kimberly Huffman, Advisory Council Operations, HRSA
Ms. Kandi Barnes, Advisory Council Operations, HRSA
Ms. Nicole Hollis-Walker, Division of External Affairs, HRSA

Day 1: Wednesday, September 26, 2018

Introduction

Ms. Tracy Gray, Designated Federal Official (DFO) for the National Advisory Council on Nurse Education and Practice (NACNEP, or the Council), convened the 135th meeting of NACNEP at 8:30 a.m. on Wednesday, September 26, 2018, and conducted a roll call. Seventeen members were present in person, confirming the legislative requirement of a quorum, so the meeting proceeded.

Ms. Gray introduced CAPT Sophia Russell, the director of the Division of Nursing and Public Health (DNPH) within the Bureau of Health Professions (BHW) at the Health Resources and Services Administration (HRSA). By the Council's charter, the DNPH Director serves as the NACNEP chair. CAPT Russell welcomed the Council members and provided a brief overview of the meeting agenda and expectation. She noted that Day 2 of the meeting would be starting

earlier than on the posted agenda, at 8:15 a.m., to accommodate the schedule of Dr. Patricia Brennan, Director of the National Library of Medicine (NLM). Dr. Brennan will be speaking on the role of the NLM in fostering high reliability healthcare systems.

CAPT Russell provided a brief overview of the mission and priorities of HRSA and BHW. She stated that HRSA supports over 90 programs that provide healthcare to those who are geographically isolated or otherwise economically or medically vulnerable. Awardees include colleges and universities, hospitals, community clinics, local governments, and private entities.

Within HRSA, CAPT Russell explained, BHW works to develop and strengthen the health workforce and connect trained professionals with communities in need. BHW programs provide grants, scholarships, and loan repayment that support the training of students and providers, emphasizing the connections between education, training, and service. In particular, nursing workforce development programs, authorized primarily under Title VIII of the Public Health Service act, are a part of the BHW portfolio of investments. In fiscal year (FY) 2018, these nursing workforce programs received in increased appropriation of $20.6 million over FY 2017, to a total of almost $250 million. She added that each BHW notice of funding opportunity (NOFO) in FYs 2018 and 2019 must link to one of the four Department of Health and Human Services (HHS) priorities:
- The opioid epidemic,
- Value-based care,
- Health insurance reform,
- Drug pricing.

CAPT Russell stated that in FY 2018, DNPH invested $124 million to educate providers on pain management techniques, as well as opioid abuse prevention and treatment. This investment demonstrates the commitment of HRSA and BHW to addressing the opioid crisis.

CAPT Russell added that BHW collects a wide range of data to assess the impact of its workforce programs, and the Bureau is committed ensuring that this data is accurate, accessible, and secure. HRSA is implementing a clinician tracking project to better identify where clinicians are practicing and what services they are providing. BHW recently launched a pilot program to assess overall retention of its National Health Service Corps participants in rural and under-served areas.

In conclusion, CAPT Russell reminded the Council members of their charge, to provide recommendations to the HHS Secretary and Congress on nurse workforce, nursing education, and nursing practice and improvement.

Presentation: From Council Recommendation to Policy: The Process

CAPT Russell introduced the first speaker, Ms. Lauren Spears, Branch Chief of the Health Workforce Policy Branch in the Division of Policy and Shortage Designation in BHW, to discuss the process of developing recommendations and implementing them into policy. Ms. Spears said the purpose of an advisory council's recommendations is to inform the HHS Secretary and Congress of changes needed or strengths to build on in the programs under the council's charge. Recommendations are strongest when they address areas where the Secretary, Congress, or HHS has the authority to make a change in a program, or in how resources are allocated. NACNEP is

required be statute to submit an annual report, which is the most common way for the Council to provide its recommendations. Another way to provide a specific recommendation or set of recommendations would be through a letter to the Secretary. A third avenue for providing recommendations is a white paper or policy brief, which can address a specific topic.

Ms. Spears said that a recommendation may focus on either a legislative or a policy change. Legislative recommendations are addressed to Congress. For example, the Council could use a recommendation to convey its support for a particular piece of congressional legislation under consideration. A legislative recommendation can be submitted through the A-19 process, which can assist an agency in planning for legislative proposals or objectives within its annual budget request. However, the A-19 process is generally reserved only for very high-level proposals.

Most recommendations address policy. These can be further broken down to:
- regulatory, changing or revising a particular regulation,
- programmatic, changing or strengthening a particular program, or
- funding, changing a funding priority in a future NOFO.

Ms. Spears shared some examples of strong recommendations which identify a clear audience, suggest a specific action, and address a matter that HRSA has the authority to change.

Q and A

One member asked for a specific example of a recommendation from an advisory committee that was implemented in policy. Dr. Ann Cary noted that she has seen the requirements of HRSA NOFOs change in response to a recommendation, such as by adding language to address interprofessional education or rural health. Dr. Murray noted that the HRSA nursing workforce diversity program changed from a three-year to a four-year program as a result of past discussions and recommendations from NACNEP.

There was some discussion about making recommendations specific, such as addressing funding for one program, or general, to address a broader need. Ms. Spears replied that a specific recommendation is useful if the Council recognized a pressing issue, but general recommendations place fewer limits on the actions of HRSA and have a better chance of being implemented. In response to another question about NACNEP's scope, Ms. Spears stated that NACNEP is limited to oversight of programs under Title VIII by legislation and by its charter.

DNPH Updates

CAPT Russell introduced Ms. Kasey Farrell, Chief of the Nursing Education and Practice branch within DNPH. Ms. Farrell stated that she would be discussing the two programs within her branch: Nurse Education, Practice, Quality, and Retention (NEPQR), and Nursing Workforce Diversity (NWD).

Ms. Farrell said that NEPQR was authorized under the Title VIII, Section 831 and 831-A, with broad statutory authority allowing a lot of flexibility in addressing the development and advancement of the nursing workforce. There are three sub-programs within NEPQR:
- Interprofessional Collabortive Practice: Behavioral Health Integration (IPCP: BHI), which looks to incorporate behavioral health care within nurse-led primary care teams.

- Veterans Bachelor of Science in Nursing (VBSN), established in FY 2013, which focuses on helping to transition military veterans with medic or nursing experience into civilian nursing careers.
- Registered Nurses in Primary Care (RNPC), the newest program started in FY 2018, which is working to recruit and train nursing students and practicing nurses to work at the top of their scope of practice in community-based primary care settings.

Ms. Farrell added that NWD was authorized under the Title VIII, section 821, and focuses on increasing educational opportunities for students from disadvantaged backgrounds, racial and ethnic minorities that are typically under-represented in the field of nursing. NWD is implementing evidence-based strategies to address the social determinants that impede the success of students in pursuing nursing, which include academic and financial support, access to diverse mentors and role models, and holistic review for admissions.

Ms. Farrell then introduced Ms. Tracy Gray, Chief of the Advanced Nursing Education (ANE) branch in DNPH. Ms. Gray listed the programs under ANE:
- The Advanced Nursing Education program, which supports infrastructure and curriculum-building and is geared towards training and preparing advanced practice registered nurse students to work in rural and underserved communities;
- The Advanced Nursing Education Workforce (ANEW) program, which also covers infrastructure, curriculum-building, along with traineeships;
- The Nurse Anesthetist Training (NAT) program, which supports the training of nurse anesthetists through payment for tuition and stipends;
- The Nurse Faculty Loan Repayment (NFLP) program, which helps support the development of nursing faculty;
- The Sexual Assault Nurse Examiner (SANE) Workforce program, a new program to promote training and certification of forensic nurses as sexual assault nurse examiners.

Ms. Gray said that ANE received over $7 million in additional funding in FY 2018 for ANEW and NAT to provide administrative supplements for additional training focused on pain management and addressing the nation's opioid crisis.

Q and A

There was a question about the origins of the SANE program. Ms. Spears replied that there was an appropriation of $8 million for FY 2018 to create the program, and the DNPH ANE branch responded quickly to develop the NOFO. CAPT Russell added that many other groups collaborated in developing the program, including the HRSA intimate partner violence workgroup and Office of Women's Health, the Indian Health Service, and the Department of Justice. Ms. Gray noted that the call for the SANE program arose from a 2016 Government Accountability Office report that identified the need for more nurses trained as SANEs. She noted that this program differed from other HRSA training programs in the there is a specific SANE certification process. The program was designed to help retain more nurses with this certification in rural and underserved communities, and to provide them with support so that they can function effectively and avoid burning out in the role.

There was some discussion on supporting telehealth efforts through training, which is included in the language of many HRSA training NOFOs.

Dr. Christopher Hulin asked about some restrictions on the use of funds in the NAT program which have created some difficulties in developing new training modalities, such as workshops on opioid use. Ms. Gray thanked Dr. Hulin for the feedback, and replied that there are specific rules on how schools can use the grant funds.

Dr. John Cech asked about how the NFLP program can help in very rural and frontier states, where finding qualified faculty members is always a challenge. Ms. Spears replied that the NFLP can help with loan repayment or forgiveness for nursing students in graduate programs who agree to serve as faculty after graduation. There was further discussion about the need for preceptors in clinical settings, and a reply that HRSA research has indicated that that students feel more equipped to practice, particularly in rural and underserved areas, if they had a good preceptor and good experience while in school. There was further discussion about the limitation of the NFLP program among nurse midwives, who are required to practice for one year before going into teaching.

Dr. Ronda Hughes raised the issue of paying preceptors for their teaching services, which is adding to the expenses for the school or for the student. Ms. Farrell replied that the RNPC program was designed to allow for more preceptor support, as well as for student expenses such as travel to rural sites for clinical experiences.

A Council member asked about the collaboration between different divisions of the HRSA BHW, and how the different advisory committees (ACs) can work together to support professional education. Ms. Spears replied that there are over 45 programs under BHW, and the HRSA leadership interacts with all of the programs to look for ways the programs can intersect. Ms. Kimberly Huffman, Director of the Advisory Committee Operations (ACO) office at HRSA, added that the DFOs of the five different ACs meet regularly and discuss areas where they might collaborate or address issues that cut across the different professions. HRSA also collects recommendations from all of the ACs in a central database.

Presentation: Nurses' Roles in Advancing Value-Based Healthcare

CAPT Russell introduced the next speaker, Dr. Linda Burnes Bolton, the Vice President of Nursing at Cedars-Sinai in Los Angeles, California. Dr. Bolton said that her talk would focus on value-based health care across the system, with a focus on measuring outcomes and costs for every patient, integrating multi-site care delivery systems, building a technology platform to assist with providing care and collecting data, and addressing value as it matters to the patient, rather than just reducing expenses. She stated the goal as working to balance clinical excellence with improved population health. She described population health management as "working in a coordinated manner to improve the overall health and well-being of patients across all settings under a risk-bearing financial arrangement." Population health places an emphasis on wellness and health promotion, uses a team-based care approach, and includes outreach to the patient between clinical encounters to provide education and support for self-care.

Dr. Bolton stated that the Centers for Medicare and Medicaid Services (CMS) has set a target that 30% of Medicare payments will be tied to quality or value through alternative payment models other that the traditional fee-for-service.

Dr. Bolton provided one example of improved efficiency at Cedars-Sinai with the introduction of Progression of Care Rounds, a nurse-led, multidisciplinary approach to support the patient and avoid re-admissions through the use of nurse practitioner (NP) house calls, home care, check-ins, case management, and disease management. Through this process, the hospital noted a reduction in avoidable admissions, readmissions, and lengths of stay. Dr. Bolton provided some examples of other programs across the country.

Dr. Bolton described some central tenets for nursing roles in promoting population health: working to improve overall health and health maintenance; deploying nurses where people live, work, and go to school; engaging customers and their families as equal partners in their care; and working within teams to address the social determinants of health. Using this approach, she stated that it would be possible to imagine a future where good health is valued and flourishes in all areas and social sectors, individuals have the means and opportunity to lead healthy lifestyles, and business, government, and individuals work together to promote health.

Q and A

Dr. Roy Simpson asked about financing for the opportunities and grants needed to develop innovative programs that can save hospitals money. Dr. Bolton responded that the first step is to make the business case for return on investment. Ms. Lorina Marshall-Blake commented that some health insurers and other funders may work with local clinics to achieve successful outcomes in supporting high-quality care and improving the health of more people, even in an area that may be marginalized.

Dr. Maryjoan Ladden noted that a key role of nurses is identifying what the patient and family value in the health care they receive, and asked about operationalizing this function across the healthcare team. Dr. Bolton replied that identifying value begins by engaging the patient and family at the healthcare facility and asking about their goals, such as the need to maintain mobility or independence. Engagement provides the motivation for the patient and family to work with the healthcare team and learn how to manage the disease or condition to accomplish what matters to them, as opposed to working toward what to the provider or the health system regard as important outcomes.

Dr. Terry Murray asked about making the business case for nursing care in terms of prevention, because of the difficulty in documenting the cost of adverse events that do not happen and translating that into terms of return on investment. Dr. Bolton replied that the Cedars-Sinai staff holds weekly meetings to examine events that saved patients from unnecessary hospitalization. For example, it is important to determine the cost of a hospitalization against the cost of deploying an advanced practice nurse to help a patient and family manage at home.

Dr. Hulin raised the issue of pre-surgical optimization to reduce post-operative complications. Dr. Bolton cited an example of patients receiving joint replacement. Cedar-Sinai staff engage the patient and family before surgery to conduct a home visit to assess safety, as well as to

provide education about what will occur after surgery, how to stay safe and avoid readmission, and how to manage pain. These steps have helped reduce length of stay and improve outcomes.

Presentation: Centers for Medicare & Medicaid Services: Value Based Care

CAPT Russell introduced the next speaker, Ms. Jean D. Moody-Williams, RN, MPP, the deputy director of the CMS Center for Clinical Standards and Quality. Ms. Moody-Williams stated that she would discuss how CMS is approaching the transition from fee-for-service, paying for the number of services provided, to value-based care. She stated that CMS defines value-based care as "paying for health care services in a manner that directly links performance on cost, quality, and the patient's experience of care."

Ms. Moody-Williams described a framework for moving to a value-based care system, consisting of four Categories:
- Category 1 is the current fee-for-service model, in which payment is not linked to quality and value.
- Category 2, covering many current CMS programs, involves fee-for-service payments that contain a link to quality and value through reporting of outcomes and providing incentives for quality improvement.
- Category 3 is built on the fee-for-service platform but contains alternative payment models that reward quality and involve shared saving.
- Category 4 involves total cost-of-care, population-based payment.

She said CMS has found that many providers would prefer population-based payment, which allows them greater control over how the money is spent and the opportunity to develop innovative programs to achieve specific outcomes.

Ms. Moody-Williams described another CMS value-based program launched in 2017, the Meaningful Measures Initiative. The different areas of focus under Meaningful Measure are: promote effective communication and coordination of care, promote prevention and treatment, work with communities, to promote healthy living, make care affordable, improve safety and reduce harm, and strengthen person and family engagement. In 2015, CMS began to implement an incentive program using one of two tracks: the Merit-based Incentive Payment System (MIPS), or Advanced Alternate Payment Models. The primary goal was to improve Medicare beneficiary outcomes.

Ms. Moody-Williams outlined another CMS program, the Patient and Family Engagement strategy, with the vision to engage patients and caregivers in the design and delivery of their health care, under the values of
- Patient-centered care,
- Health literacy,
- Accountability,
- Respect.

In describing some of the impacts of these value-based programs, Ms. Moody-Williams noted that CMS has found improvements in many of its quality measures and a decrease in harmful incidents and hospital readmissions, leading to a net savings of over $300 million.

Q and A

Dr. Simpson asked how staff registered nurses (RNs), very few of whom have a doctoral degree, are going to impact value-based care, given the complexities of the multiple CMS programs. Ms. Moody-Williams replied that she has worked with groups that help formulate nursing curricula around integrating value-based care concepts. She added that CMS is working to support clinicians in providing integrated patient-centered care. For the future, it is expected that as nurses and other clinicians enter documentation into the electronic health record (EHR), they will receive feedback on their patient populations to help improve outcomes, such as noting if diabetic patients are not coming in for their routine checkups.

Dr. Hulin noted a potential unintended consequence relating to hiring for groups of clinicians, arising from MIPS data collection tied to the national provider identifier (NPI) number. He gave the example of a good provider working within a low-performing clinical group wanting to change jobs. That provider's low MIPS score from the previous group will contribute to lowering the score for the new group, which could create difficulties in hiring decisions.

Ms. Mary Anne Hilliard commented that the Council is trying to figure out what advice to give to Congress on how to train nurses to promote value-based care. She about recommendations in terms of preparing nurses for the future. Ms. Moody-Williams replied her nursing education contained no mention of the cost of care, or about basing care on value. She said that nursing curricula will need to begin with the basics of introducing the concepts of the different types of care arrangements. One advantage for current nursing students is their familiarity with the EHR, which will help them to learn how to use that to coordinate care.

Presentation: Advancing a Model of Value-Based Care:

Person-Centered, Population Focused, Team Led.

CAPT Russell introduced Margaret Flinter, APRN, PhD, c-FNP, FAAN, the Senior Vice President and Clinical Director of the Community Health Center Inc. (CHCI), a Federally Qualified Health Center (FQHC) located in Connecticut that serves over 150,000 patients each year while leading practice transformation initiatives across the country. As a family nurse practitioner, Dr. Flinter has held progressive roles in the organization as CHCI has transformed from a free clinic to one of the country's largest and most innovative FQHCs.

Dr. Flinter stated that she would discuss how to achieve a model of value-based care. She described the three characteristics central to value-based care as person-centered, population-based, and team-led. Value-based care models must ensure that health care is accessible to all, improves health outcomes, and engages patients and communities, while also controlling costs and helping providers find joy in their practice. She stated her belief the if we can improve health, close care gaps, achieve better outcomes, reduce health disparities and achieve overall cost savings for individuals enrolled in value-based health insurance plans, we can do it for everybody regardless of income, insurance, or social determinants of health.

Dr. Flintner stated that her experience is derived from the community health center (CHC) movement, which now encompasses roughly 26 million people cared for by 1,400 CHCs around the country. CHCs were developed around some core principles, such as the integration of behavioral health services, that the rest of the health care system is starting to embrace.

Dr. Flintner said that CHCI was established 46 years ago, and has grown into a state-wide organization that cares for around 100,000 people each year. Its three foundational pillars are: clinical excellence, research and development, and training the next generation. It is home to the Weitzmann Institute, which conducts research into the clinic's quality improvement efforts to make the practice of care more effective for the patient and more satisfying for the provider.

Dr. Flintner added that CHCI has worked to bring primary care to those with health or social conditions that are often considered difficult to manage, as well as populations that can be difficult to reach. CHCI works to develop a sense of belonging by the patient, and accountability by the providers. CHCI has developed a "panel management" design, which she described as an organized, population based, multidisciplinary approach to gather information, identify a client's unmet needs, and communicate with the client. Under a new CMS model, they gained greater access to data on their patients, enabling them to better understand the patient's health history and anticipate needs. While all staff members are involved in changing practice, Dr. Flinter noted in particular the information technology team, which has been able to take data derived from multiple streams and present it in ways that are actionable by the healthcare team.

Dr. Flinter referenced an initiative known as the Leap Project, which started with a group of 300 clinical practices that has been narrowed down to 30 that are being studied intensively. Some common characteristics to these practices are that the providers are supported by a core team, RNs an important component of these teams. In many cases, the RNs have moved beyond the traditional role of triage, and are working more independently to educate and counsel patients on complex care management.

In looking to the future, Dr. Flinter expressed her belief that the nation is at a critical moment, noting that several influential leaders and organizations have developed definitions of primary care as accessible, available, equitable, affordable to both the patient and society, satisfying to the provider, and delivered in the local community and in the context of a continuous health relationship. While primary care forms the bedrock of the healthcare system, several trends are influencing the direction it takes, including the spread of "retail" health clinics and the use of technology to advance telehealth and "virtual" patient-provider relationships. Nursing must provide leadership not just at the level of practice and education, but also in policy, business, and technology, to assure that the system is measuring things that make a difference in people's lives and remains accessible to the most vulnerable.

Q and A

Dr. Ladden asked what sorts of skills RNs and advanced practice RNs (APRNs) need to succeed in the evolving primary care roles. Dr. Flinter replied that CHCI looks for nurses who are committed to mastering primary care, and who are intelligent and curious. She would like to see more nurses to have the opportunity for a clinical rotation in a community-based primary care rotation. Topics that could be added to the current nursing curricula include quality improvement and data analysis. She also believed that the nurse residency model becoming more common in acute care settings could be adapted for primary care as well.

There was a question about the value of a continuous healthcare relationships, especially in the geriatric population. Dr. Flinter replied that she strongly believed in that type of relationship, but

some research shows that many individuals, especially those who are young, relatively healthy, and have only sporadic interactions with health providers, may not feel that a continuous relationship is important.

Another question dealt with the use of data in the "ideal" patient environment. Dr. Flinter stated that there are many sources of data available, for example from Medicare or Medicaid databases, but they can be difficult to find and use. Technological innovations can help improve both the use of data and the communication between providers.

Lastly, there was a question of drug pricing. Dr. Flinter agreed that drug prices can be unpredictable, which presents challenges in primary care and other settings. At times, the cost and availability of a drug might influence prescribing, and some organizations are looking into developing ways to make generic drugs more available.

Presentation: Nursing Scope of Practice

CAPT Russell introduced Winifred Quinn, PhD, FAAN, the co-director of the Center to Champion Nursing in America at AARP, to speak on nursing scope of practice. Dr. Quinn said that the Center to Champion Nursing in America and the Future of Nursing Campaign for Action are joint initiatives of the AARP Foundation and the Robert Wood Johnson Foundation (RWJF). These initiatives were started in response to recommendations from the Institute of Medicine (now the National Academy of Medicine) on the future of nursing. These recommendations centered around advancing nurse education, positioning nurses as leaders, improving workforce data, increasing diversity, and promoting interprofessional collaboration and scope of practice.

Dr. Quinn said that RWJF has worked toward creating a culture of health, with an emphasis on health equity. A culture of health means encouraging wellness and paying more attention to the social determinants of health, which include access to affordable and safe housing, healthy foods, exercise, and transportation. Nurses are vital to this culture change, as they are the largest segment of the health care workforce, spend the most time with patients, support family caregivers, and implement new models of care that can improve prevention, wellness and population health outcomes.

One emphasis of the Campaign for Action, Dr. Quinn noted, is on family caregivers of individuals with long-term illness or disability. An AARP report found that family caregivers are often required to provide complex care with minimal preparation or training. As a result, the care recipient may require a hospitalization that could have been prevented. AARP is working on state-level legislation that would require hospitals to identify a caregiver for a patient upon admission, and provide training on caregiving skills and tasks. In addition, AARP has created several videos to help provide caregivers with training.

In terms of scope of practice, Dr. Quinn said that nurses need to work to the top of their training and scope of practice to promote efficiency. She referenced a recent bill passed at the federal level that allows nurse practitioners and other APRNs, as well as physician assistants (PAs), to prescribe medication-assisted therapy to individuals with opioid use disorders. Dr. Quinn said there is a need for more APRNs, especially in a patient-centered care system. AARP, along with several nursing organizations, has worked to support undergraduate and graduate nursing education funding through both Title VIII and Medicare.

To promote value, the healthcare system is moving toward team-based care, with APRNs as team leaders and the patient and family caregivers as key members. The American Nurses Association has said team-based care offers expanded access to care, as well as more effective and efficient delivery of services that are essential to high quality care such as patient education, behavioral health care, self-management support, and care coordination. Team-based care also supports job satisfaction.

However, Dr. Quinn noted that scope of practice, particularly for APRNs, remains restricted in many states. For example, 28 states still require APRNs to contract with physicians to provide the care. In response to a question, she said that many of the states where these restrictions apply have very strong and well-organized opposition. AARP is very committed to this issue because having full access to all clinicians promises to promote better health outcomes and shorter wait times. She added that nursing needs to make that case that having nurses work to their scope of practice improves access to care for those most in need, and provides services that people value.

Dr. Quinn referred to an AARP paper on innovation, technology, and telehealth. The paper explored the promises of telehealth, along with barriers to access and consumer concerns about quality, cost, and privacy. She said that telehealth offers the possibility of helping older adults live at home rather than being forced into a nursing home. AARP is working on a new Medicare fact sheet to explain what telehealth services Medicare covers, as well as a policy spotlight on telehealth and access to broadband internet services, particularly in rural areas. She mentioned several innovative proposals from nursing programs in telehealth, including using a combination of virtual reality, augmented reality, and voice operated information as well as video to help a distant-based nurse or interdisciplinary team monitor patients at home, and the use of virtual reality to help students with training in cardiopulmonary resuscitation.

Q and A

There was a question about providing advice to Congress on funding for nurse education and practice. Dr. Quinn noted that Medicare provides over $8 billion each year in funding for graduate medical education, but has only provided some finding for graduate nursing education since the passage of the Affordable Care Act in 2010. She referenced a blog post from nurse researcher Linda Aiken on a study that found that APRN recipients of this funding were working in 31 states, providing a significant benefit. She added the importance of attracting more nurses from minority and disadvantaged backgrounds so that nursing better represents the communities and populations it serves.

Dr. Hulin followed up with a question on how to recruit more minority nurses into faculty positions. Dr. Quinn replied that AARP has developed a mentoring training program, and has been engaging educational institutions that serve a range of students, with the hope of attracting more minority students and faculty. There was discussion that the nursing profession as a whole needs to become more diverse. There was a comment that if Medicare funding for graduate nursing education can be sustained, then a portion of that funding should go toward the preparation of ethnic and racial minority students, as well as men, in nursing. Another Council member brought up the issue of holistic review of applications to nursing programs, which can facilitate greater inclusion of minority students

Dr. Ladden commented that the nursing profession has been discussing the issues around the faculty shortage for at least the last ten years. One point has been the lower salary for faculty positions versus clinical positions. She noted that joint faculty-clinical appointments present an option for addressing the pay disparity. Dr. John Cech said that his home state of Montana has had success with joint appointments of nursing faculty with local hospitals.

Council Discussion: Letter to the HHS Secretary on CMS rule change

Dr. Cary led a discussion on a proposal to send a letter from the Council to the HHS Secretary expressing support for a recent CMS rule change to allow documentation by a medical student to be used by a teaching physician for billing under Medicare Evaluation and Management (E/M) codes. One Council member prepared a draft letter to the HHS Secretary on the CMS rule change. The members reviewed the draft and decided to pursue the letter, asking the Secretary to encourage CMS to expand the definition of "student" to cover NP and PA students, as well as to allow other teaching clinicians, such as NPs, to use student documentation for billing in the same manner as teaching physicians. The letter will be further revised to address the concerns of nurses related to this rule change, and to clearly identify the four major categories of advanced practice nursing: NP, certified nurse midwife (CNM), certified registered nurse anesthetist (CRNA), and clinical nurse specialist (CNS).

Public Comment

CAPT Russell opened the meeting to comments from the public. There were no comments.

Conclusion

CAPT Russell adjourned Day 1 of the meeting at 4 p.m.

Day 2: Thursday, September 27, 2018

Call to Order

CAPT Russell called the second day of the meeting to order at 8:15 a.m., and Ms. Gray conducted a roll call. A quorum was confirmed, so the meeting proceeded.

Presentation: The National Library of Medicine:
Fostering High Reliability Health Care Systems

CAPT Russell introduced Patricia Brennan, RN, PhD, Director of the NLM. Dr. Brennan stated that she is a nurse and an industrial engineer, with the focus of her doctoral studies in decision-making and decision support. In her position with the NLM, she saw an opportunity to change the way people think about health and healthcare, and how people respond in their environments. From her background in industrial engineering, she has an interest in how health systems operate, and how to provide the information necessary to improve performance.

Dr. Brennan said that all healthcare providers are on a journey together to improve the health of individuals, communities, and society. NLM plays a role by providing information and resources to clinicians and health scientists, to improve the quality, efficiency, and reliability of healthcare services.

Dr. Brennan noted that the information substrate for healthcare delivery and decision-making is increasingly data focused, but there is a wide range of data sources. NLM conducts research into methodologies and data analytics to help make data more understandable and interpretable, both to clinicians and the general public. NLM works to advance high-reliability health care by enhancing information delivery, promoting access to research data, and fostering common data elements and value sets. The library is best known for its information resources, including PubMed for journal citations, and Clinicaltrials.gov as a repository of clinical trial opportunities and results. Dr. Brennan said that one of the key resources that the NLM offers hospitals is MedlinePlus Connect, which provides authoritative information for use in patient education materials and discharge summaries.

Dr. Brennan presented the ten-year NLM strategic plan, released in 2017. She described the plan as based on three goals:
- **Accelerate discovery and advance health through data-driven research.** NLM has a role in advancing methodologies in biomedical informatics and data science to foster data sharing and create a more sustainable infrastructure.
- **Reach more people in more ways through enhanced dissemination and engagement.** While NLM is highly trusted, many who could make use of its services are not aware that it exists or how to access it. NLM is seeking to make its programs more accessible and to enhance the delivery of information.
- **Build a workforce for date-driven research and health.** NLM is expanding its doctoral and postdoctoral training in biomedical informatics and data science, and strongly committed to increasing diversity.

Dr. Brennan concluded by saying that NLM is committed to remaining a trustable, trusted, and valued source of information for the country and the world.

Q and A

Dr. Damas asked if the NLM offered any type of analysis of research in a specific area that could generate new hypotheses. Dr. Brennan replied that NLM does not offer such services, known as natural language processing or machine learning algorithms, but can facilitate others in doing so through its literature databases such as PubMed Central.

Dr. Simpson asked about how to educate the clinician workforce in data science, given the multiple different educational levels. Dr. Brennan replied that entry into practice needs to be stronger, and current clinicians need to be offered ongoing opportunities to learn and advance their knowledge. One point to make was to teach nurses and other clinicians that asking questions is more important than answering them, in order to maintain the drive to keep learning. Dr. Brennan added that HRSA and the federal government need to invest in keeping the faculty up to date and promoting professional development.

CAPT Russell asked about the inclusion of nursing informatics and data science within nursing curricula. Dr. Brennan expressed her concern that nursing has tended to treat informatics as a technical component, rather than foundational to nursing education and practice. She said that the profession needs nurses who have the advanced expertise in informatics to design and deploy health information systems as vital tools for practice. Nurses need to be able to access information for patient care, while understanding the individual patient in context.

Dr. Brennan added that more undergraduate courses need to provide experience with electronic tools that analyze data. Learning these basic tools will help more nurses understand and engage with data science. Nurse with doctoral training in data science will be able to use their expertise to develop methods that illuminate nursing phenomenon and illustrate the value of nursing care. In addition, clinical nurse researchers are the largest group of nursing scholars, and need to work with data scientists to answer nursing and science questions. Data science approaches can offer new insights to interpretive empirical methods and provide information that is more categorical, classification-oriented, and exploratory than a clinical trial. She said that research should be a team engagement, and recommended that every doctoral student work with a data science team to explore new research models and methods.

Dr. Brucker asked about so-called "predatory publications" that are diverting the work of many clinical faculty. Dr. Brennan replied that the NLM has many partners in the publishing industry, and it encourages researchers to publish in high-quality journals. However, as a federally funded entity, NLM often must index journals that might be considered predatory, and noted there are many perverse incentives for faculty members to publish, even in journals that might be considered less-desirable, in order to maintain their faculty appointments. However, she also stated there was a need to connect journal publication to other forms of dissemination through social media outlets, in order to develop new ways for scientific communication.

One council member asked if ongoing, lifelong learning should be a requirement to maintain a nursing license. Dr. Brennan agreed that lifelong learning was vital and should be required. She added, though, that nursing needs to find other incentives, such as making lifelong learning an opportunity for those who want to differentiate their practice. Nursing needs to help the public understand that there are nurses with different levels of specialization and expertise, and that

specialization can build sophistication in understanding the human response to health conditions and improving health management.

Discussion: Council Business

CAPT Russell moved to the next item on the agenda, a discussion of Council business. She said that the Council needs to set dates for its upcoming meetings, and Council membership and nominations. She asked Ms. Gray to provide an overview of federal requirements for NACNEP meeting dates, as well as the council membership and the nomination process.

Ms. Gray stated that, per its legislation and charter, NACNEP is required to meet a minimum of two times per year. In recent years, the Council has typically held a two-day meeting in-person at the HRSA headquarters, and another meeting by teleconference and webinar. The Council already has one in-person meeting scheduled for FY 2019, January 28-29, 2019. A second meeting was scheduled to be conducted by webinar on May 21, 2019.

Ms. Gray also noted that six current members are due to roll off of the Council in March 2019. HRSA is looking for nominations for new members. She reminded the members that NACNEP should be comprised of leading authorities in the various fields of nursing; nursing education at the associate, baccalaureate, and graduate levels; full-time students enrolled in schools of nursing; practicing professional and advanced practice registered nurses; hospitals and other institutions and organizations that provide nursing services, the general public. Members are appointed by the HHS Secretary, and the membership should have broad geographic representation, adequate representation of minority populations, and a balance between urban and rural areas. Nominations are accepted on an on-going basis, and all of the requirements and the nomination procedure can be found on the NACNEP web site. However, the nomination and vetting process can take up to a year or more, so HRSA may look to extend the terms of the current members for six months, to allow sufficient time for new members to join. She asked the members to encourage colleagues who might be suitable for the Council to apply.

There was a question about the timing of the NACNEP reports. Ms. Gray replied that the Council's 15th report, currently in progress, would have been due by September 30, 2018. However, NACNEP did not meet until late in the FY. As a result, the deadline for this report was pushed back. The 16th report will be due by September 30, 2019, which means the draft must be completed by the end of August 2019. During the January 2019 meeting, the Council will conduct a final review of the 15th report, to prepare it for submission. The Council will then begin preparations and discussions for its 16th report. Ms. Gray noted that HRSA can provide some support from a technical writer in the preparation, review, editing and formatting of the reports, but the writer has several commitments outside of NACNEP so review of the report can take two weeks or more.

Given the compressed timeline for the Council to prepare its 15th report, there was a suggestion to hold another meeting soon by teleconference, which was agreed to by consensus. After some discussion, the meeting was scheduled for November 19, 2018.

Ms. Kim Huffman, the chief of Advisory Committee Operations for HRSA, provided a quick overview for the members on the requirements for travel and lodging reimbursement for their

attendance. She reminded the members who traveled to the meeting that they would receive an honorarium for the two days of the meeting and one travel day.

Council Discussion the NACNEP 15th Report to Congress

CAPT Russell turned the floor over to Dr. Cary of the NACNEP writing committee, to lead the discussion on reviewing the draft of the Council's 15th Report. Dr. Cary thanked the writing team members for their extensive work the report. She noted that the report was divided into three sections -- team-based care, nursing scope of practice (SOP), and health information technology (health IT). She added that each section was developed independently. As a result, there was no attempt in the current draft to build any transitions or reduce redundancies, which will be an editorial function in the preparation of the final draft. She asked the members to focus their comments and feedback on the content of each section. There was a question on how the members might add their comments directly in the draft, such as by sharing the file on a shared platform. Ms. Huffman replied that HRSA cannot create a shared file, due to security concerns. However, the members can share the document in a manner that best serves their needs.

The first section to discuss was on team-based care to support the approach to value-based healthcare delivery and nurse's role in that delivery. This section was written by Dr. Cary and Dr. Lorena Marshall-Blake. The section opened by defining team-based care, then discussing how to educate nurses to function in a team environment, and the impact that team-based care has on the quality and safety of care. In writing this section, the authors relied on an evidence-based approach using both Cochrane databases and individual research reports.

Dr. Simpson said that within team-based care, care coordination is largely the domain of nursing. Based on their clinical knowledge, nurses can help guide the team and manage the contributions of each member. In responding to a comment that social workers also perform care coordination, he noted that social workers can provide some transitional care, but they lack the clinical background to coordinate care from the clinical aspect. He offered to share articles to help flesh out this topic in the draft.

Dr. Linda Kim noted that one missing aspect as a description or explanation of specific rules of what it means to be in a team-based care delivery model, and the role that nurses play. She said that functioning within a team required a specific set of skills such as providing mutual support and cooperation, and team communication. In addition, nurses may need to develop a specific competency within the team, such as chronic disease management.

Dr. Bienemy commented on the need to establish the connection between value-based care the team-based care models. She reminded the Council that members of Congress are not healthcare professionals, so the connection needs to be explicit. She wanted to see a stronger focus on the ways that nursing can lead the charge toward value-based care, along with a discussion of the potential barriers.

There was a comment that many schools claim to provide team-based education. However, research has shown that is team-based care is not cemented at the educational level and not practiced or reinforced within the organization, then the concepts will be dismantled. The organizational culture must embrace the team-based care approach, which allows people to

practice to the top of their license to be effective, which contributes to value-based healthcare. One subsection under team-based care provides several exemplars of team-based care.

There was discussion on the audience of the report. The main audience is Congress, for use in developing policy on nursing education and the nursing workforce. Other stakeholders include organizations in the health professions, education and practice, as well has healthcare delivery systems that employ nurses. The Council discussion and the writing of the report support the development of the Council's recommendations, while in turn the recommendations serve to sharpen the focus on the report. The report and the recommendations serve as a platform to invoke change.

In developing the health IT section, Dr. Rhonda Hughes commented that her guiding framework was optimizing the use of nursing leverage in healthcare to enable value-based care, which also related to nursing scope of practice. She related her experiences in talking with legislators in South Carolina to inform them that NPs often serve as the primary care providers in medically underserved communities. Opening up the scope of practice for NPs in the state led to more affordable care, which the legislators could appreciate.

There was a discussion on the need to include nursing under Science, Technology, Engineering, and Mathematics (STEM) professions, which was related to the report section on health IT. Nurses are not generally recognized for their knowledge and science base, and education funding has shifted to attract more students into STEM professions. There was a comment that the nursing profession consists of over 3 million educated people which is larger than the armed forces in American. In addition, one in 44 registered voters is a registered nurse. Listing nursing under the STEM professions would help in funding nursing education and the nursing pipeline.

Moving to SOP, the authors provided background about where APRNs are at now in relation to working to the full versus limited SOP, and discussed the positive health outcomes and cost-effective services when nurses are allowed to practice to the top of their licensure. In this way, RNs and APRNs can take the lead in value-based healthcare but gave.

There was discussion about nursing licensure in relation to SOP and care management. It was brought up that licensure is a state matter, while HRSA is a federal agency. Some states are adopting transitions of practice laws requiring that APRNs have collaborative agreements that a physician signs that have no bearing on mentorship or education, and holds minimal benefit for the nurse in terms of education or mentorship. It was proposed that residency programs for nurses would provide a greater benefit, while contributing to value-based care. It was suggested that promoting residency programs to facilitate nurses practicing in rural and other underserved areas would help improve access to care, addressing the mission of HRSA. Another comment was that APRNs wishing to enter independent practice in rural or underserved areas also need to develop data management and business skills. There was also some discussion that some organizations are trying to address scope of practice restrictions through anti-trust laws.

There was a comment that HRSA has received feedback that newly-graduated RNs often have not had the experience of working the complex patient populations of many CHCs. As a result, DNPH has developed its new NOFOS to try to forge those experiences by giving preference to

those universities that recruit students from rural and underserved areas and are able to partner with CHCs to offer a wider range of clinical experiences for students.

Moving the discussion to health IT, Dr. Hughes stated she approached this section from the perspective how IT can facilitate care and achieve greater value by leveraging the strengths and expertise of nursing, as well as by looking at some of the challenges in using the EHR to improve patient care. The federal government made a huge investment in the deployment of EHRs throughout the country. However, nursing documentation was often left only as a free-text section, and thus cannot be incorporated in a meaningful way in the patient record. As a result, nursing documentation cannot be extracted, and most EHRs neglect a very rich source of information that could enhance patient care. In addition, nurses at the bedside lack anything that sets their care in the EHR as separate and distinct. Thus, the outcomes of nursing care are difficult to track for hospitals and health organizations, as well as for health insurers.

Another important issue in health IT is telehealth. The role of nursing be expanded into particularly rural and underserved communities through the use of telehealth, and research has shown that telehealth can have particular value in helping with care in the home, especially after hospital discharge.

A third issue to address is the need for more resources to training nurses in data science, as well as the need to prepare more faculty. In particular, HRSA might need to devote more funds into faculty training so that they could receive skills in data science.

Dr. Simpson noted that an addition to the section that he would like to see is the relationship of nursing with the federal Office of the National Coordinator of Health IT (ONC), the federal office that has promote use of the EHR. He expressed concern that ONC does not currently have a nurse at its executive table.

Dr. Simpson further noted that the NPI system was set up by CMS to cover all health professions, but most nurses have not obtained an NPI number. Use of the NPI system can help in tracking nursing services. He cautioned against becoming confused between costing, pricing, charging and variable billing. NACNEP is not looking to address the dollar costs as much as the value and contributions that nurses provide to healthcare.

In concluding the discussion, Dr. Cary thanked the Council members for their feedback on the report draft, and for beginning to develop the recommendations. It was rsuggested that the writers of the sections prepare a revised draft with 1-2 recommendations each, for review and consideration ahead of the meeting scheduled for November 19, 2018.

On a question about the logistics for the 15th Report, it was noted that once the Council has completed the draft and it has been reviewed and edited by the HRSA technical writing support, the Council members will review the final report and conduct a final vote to approve.

Public Comment

CAPT Russell opened the floor for public comment. There were no comments.

Conclusion

CAPT Russell provided a brief recap of the meeting presentations and discussions.

Ms. Gray quickly reviewed the proposed timeline:
- November 19, 2018: The Council will hold a one-day virtual meeting to
  - Review the revised 15th report and provide additional feedback.
  - Discuss potential topics for 16th Report
  - Form a writing committee for the 16th report and a planning committees for upcoming meetings.
- January 28-29, 2019: The Council will hold an in-person meeting at HRSA headquarters in Rockville, MD, to:
  - Provide a final review of the 15th Report.
  - Receive presentations from experts for the 16th Report topic.
  - Discuss the priorities for the 16th report and recommendations
  - Develop and outline and timeline.
- May 21, 2019: The Council will hold a one-day virtual meeting on to
  - Finalize the 16th report.
  - Begin discussions on topic for 17th Report.
- August 30, 2019: Final draft of 16th Report submitted to HRSA technical writer.
- September 30, 2019: The 16th Report is due for submission.

Ms. Gray adjourned the meeting at 2 p.m.

List of Abbreviations

AC	Advisory committee
ACO	Advisory Committee Operations
ANE	Advanced Nursing Education
ANEW	Advanced Nursing Education Workforce
APRN	Advanced practice registered nurse
BHW	Bureau of Health Professions
CHC	Community Health Center
CHCI	Community Health Center Inc.
CNM	Certified Nurse Midwife
CRNA	Certified Registered Nurse Anesthetist
CNS	Clinical Nurse Specialist
CMS	Centers for Medicare and Medicaid Services
DFO	Designated federal official
DNPH	Division of Nursing and Public Health
EHR	Electronic health record
E/M	Evaluation/Management
FQHC	Federally Qualified Health Center
FY	Fiscal year
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IPCP: BHI	Interprofessional Collabortive Practice: Behavioral Health Integration
IT	Information technology
MIPS	Merit-Based Incentive Payment System
NACNEP	National Advisory Council on Nurse Education and Practice
NAT	Nurse Anesthetist Training
NEPQR	Nurse Education, Practice, Quality, and Retention
NFLP	Nurse Faculty Loan Repayment
NLM	National Library of Medicine
NOFO	Notice of funding opportunity
NP	Nurse practitioner
NPI	National Provider Identifier
NWD	Nursing Workforce Diversity
PA	Physician assistant
RN	Registered Nurse
RNPC	Registered Nurses in Primary Care
RWJF	Robert Wood Johnson Foundation (
SANE	Sexual Assault Nurse Examiner
SOP	Scope of practice
STEM	Science, Technology, Engineering, and Mathematics
VBSN	Veterans Bachelor of Science in Nursing