

NACNEP : National Advisory Council on Nurse Education and Practice

Meeting Minutes: 144th NACNEP Meeting, December 2-3, 2020

The 144th meeting of the National Advisory Council on Nurse Education and Practice (NACNEP, or the Council) was held on December 2-3, 2020. The meeting was conducted via webinar and teleconference, and hosted by the Health Resources and Services Administration (HRSA). In accordance with the provisions of the Federal Advisory Committee Act (Public Law 92-463), the meeting was open to the public for its duration.

Council Members in Attendance

Chair: CAPT Sophia Russell
Dr. Mary Ellen Biggerstaff
Dr. Ann Cary
Ms. Christine DeWitt
Dr. Rose Kearney-Nunnery
Dr. Maryjoan Ladden

Rev. Dr. Lorina Marshall-Blake
Dr. Luzviminda Miguel
Dr. Janice Phillips
Dr. Patricia Selig
Ms. LaDonna Selvidge

Others Present:

Dr. Camillus Ezeike, Designated Federal Official, NACNEP
Mr. Raymond J. Bingham, Division of Nursing and Public Health, HRSA
Ms. Kimberly Huffman, Advisory Council Operations, HRSA
Ms. Janet Robinson, Advisory Council Operations, HRSA
Ms. LaShawn Marks, Advisory Council Operations, HRSA

Wednesday, December 2, 2020

Welcome and Introduction

Dr. Camillus Ezeike, Designated Federal Official (DFO) for NACNEP, convened the 144th meeting of NACNEP at 9:00 a.m. ET on Wednesday, December 2, 2020. He conducted a roll call and eleven of the twelve current members were present to confirm the presence of a quorum, so the meeting proceeded. Dr. Ezeike described the purpose of the meeting as review, finalize, and approve Council's 17th Report to Congress, *Preparing Nurse Faculty and Addressing the Shortage of Nurse Faculty and Clinical Preceptors*. Dr. Ezeike turned the meeting over to CAPT Sophia Russell, NACNEP chair and the Director of the Division of Nursing and Public Health (DNPH), in the Bureau of Health Workforce (BHW), HRSA.

CAPT Russell welcomed the Council members, and asked them to introduce themselves. She briefly reviewed the meeting agenda. One member asked if any new Council members were on the call. Dr. Ezeike replied that the Council currently had eleven members, and no new members had been appointed. A new slate of members had been prepared and was awaiting approval.

CAPT Russell asked if any Council members had feedback or comments on the minutes of the August 2020 NACNEP meeting. The members offered some minor edits. With those changes, the minutes were approved.

Presentation: Bureau of Health Workforce/DNPH Nursing Program Updates

Ms. Tara D. Spencer, MS, RN
Chief, Nursing Education and Practice Branch

Ms. Adanna I. Agbo, MPH, MSN, RN, PHNA-BC
Chief, Advanced Nursing Education Branch

CAPT Russell introduced the first two speakers: Ms. Tara Spencer, Chief of the Nursing Education Practice (NEP) branch, Division of Nursing and Public Health (DNPH), and Ms. Adanna Agbo, Chief of the Advanced Nursing Education (ANE) branch, DNPH.

Ms. Spencer stated that DNPH is a division with the HRSA Bureau of Health Workforce (BHW), and operates under Title 7 and Title 8 of the Public Health Service Act. She described Title 8 has having has statutory funding preferences to support projects that benefit rural populations and other underserved populations, or that help to meet public health nursing needs in state or local health departments. She said that DNPH has three branches: NEP, ANE, and Behavioral and Public Health, and provides oversight of HRSA's nursing, behavioral, and public health workforce programs. In fiscal year (FY) 2020, DNPH operated on a budget of approximately \$319 million, supporting academic institutions, clinical facilities, and academic-clinical-community partnerships through a variety of funding mechanisms that include grants, cooperative agreements and contracts. She added that DNPH also serves as the lead in the BHW opioid workforce investments.

Ms. Spencer said that Title 8 funding is used to implement programs that support development in nursing training programs, faculty development, and technical assistance and dissemination. Under Title 8:

- Section 811 supports ANE programs that promote the enhancement of nursing education and practice and provides traineeships for individuals in advanced nursing education programs.
- 821 supports nursing workforce diversity programs.
- Section 831 supports programs under Nurse Education, Practice, Quality, and Retention.
- Section 846A established the Nursing Faculty Loan Program (NFLP).

Ms. Spencer described one role of NACNEP as providing recommendations to help guide DNPH decisions on implementing legislation and congressional appropriations and in helping to revise current programs or create new ones, in alignment with HHS, HRSA, and BHW priorities.

Ms. Spencer turned the presentation over to Ms. Agbo, to review the role of NACNEP recommendations in program implementation. Ms. Agbo stated that DNPH strives to incorporate the recommendations made by NACNEP it is reports and other publications into the implementation of current programs and plans for future program revision and creation.

Ms. Agbo reviewed the NACNEP reports over the previous 10 years, and provided several examples of how NACNEP recommendations were implemented to address:

- Nurse faculty development;
- Strengthening the nursing primary care and public health workforce;
- Promoting health equity through nursing workforce diversity and the integration of social determinants of health into nursing preparation;
- Incorporating interprofessional teams in nursing education, training, and practice; and
- Preparing nurses for new roles in population health management and the transition to value-based care.

Ms. Spencer concluded the presentation by summarizing the key themes from the NACNEP reports and recommendations:

- Advancing the role of nursing in primary care,
- Diversifying the nursing workforce to address the social determinants of health and improve population health,
- Infusing team-based care in nursing education and practice, and
- Promoting innovative models of training and practice that include simulation, virtual learning, tele-education, telehealth, and academic-practice partnerships.

Q and A

CAPT Russell thanked Ms. Spencer and Ms. Agbo for their presentation and opened the floor for questions and comments. She started the discussion by asking how DNP worked across HRSA and other federal agencies to promote the nursing workforce within the context of entire interprofessional health workforce, citing the examples of the Nurse Practitioner Residency (NPR) program. Ms. Agbo replied that DNP examined trends in health care and the health workforce in seeking to offer nursing students similar support programs available within other disciplines. She noted that the BHW Division of Medicine and Dentistry funds residency programs for physicians, and the Veterans Health Administration also has a graduate level residency program for advanced practice registered nurses (APRNs) who have completed graduate degree. DNP recognized the need to support nurses not only as students, but beyond as they enter their careers. Nurse practitioners (NPs) can serve as primary care providers in underserved areas, helping to address the maldistribution of healthcare providers. Thus, DNP viewed the NPR program as a worthwhile investment to provide new graduate NPs seeking to become primary care providers in underserved areas with a period of transition.

Dr. Maryjoan Ladden asked about any lessons learned from the review of NACNEP reports that could help the Council be more effective in formulating and phrasing its recommendations in its future work. Ms. Spencer said that NACNEP plays a major role in keeping DNP current with what is going on within nursing education and practice as the health care system changes and evolves. The input from the Council can help DNP be more forward thinking and proactive as it revises its existing programs or develops new ones, rather than just reacting to past trends. Ms. Agbo added that DNP has to take into account several factors and constraints, including its authorizing legislation, and the mission and priorities of HRSA and HHS.

Dr. Ann Cary asked about the possibility of developing connections with other health workforce advisory committees (ACs) supported by HRSA, as a means to promote interprofessional development. Dr. Ezeike replied that composition of the NACNEP membership allows for members from outside of the nursing profession, and that the other ACs often include representatives from nursing. CAPT Russell added that the chairs of all five ACs within BHW were brought together recently in response to the strategic workforce plan under development by HRSA, as mandated by Section 3402 of the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act. She noted that the current NACNEP meeting would include a roundtable panel including the AC chairs. It was further noted that all AC meetings are open to the public, and there was further discussion about ways for the ACs to develop regular interaction, such as the creation of a liaison position.

Dr. Janice Phillips raised the issue of developing interprofessional programs, such as nurse-led interprofessional teams to address the social determinants of health. Ms. Agbo replied that interprofessionalism had been infused in many programs. Ms. Spencer cited the example of the Behavioral Health Workforce Education and Training Program that includes nurses within that interprofessional where they train alongside physicians, psychologists, social workers, and others. She added that some programs have been co-funded with the HRSA Bureau of Primary Healthcare. In addition, DNP has developed a collaboration with the Department of Labor for its Opioid-Impacted Family Support Program.

There was discussion about the dissemination of the NACNEP reports. Dr. Ezeike stated that all AC reports are submitted to the HHS Secretary and to two congressional committees, and they are available to the public through the various AC web sites. The AC members and other stakeholders can play a significant role in promoting wider distribution. He added that BHW is engaged in a project to capture the recommendations from all AC reports to be visible to all BHW divisions. This project is intended to help the BHW program staff to better integrate and incorporate the recommendations from the different ACs.

Discussion: CARES Act, Section 3402 Report:

Moderator: CAPT Sophia Russell
Chair, NACNEP

CAPT Sophia Russell provided a brief overview of the main provisions of the 2020 CARES Act, Section 3402, which required the Department of Health and Human Services (HHS) to develop a health workforce strategic plan. She stated that HRSA was the lead HHS agency in the development of this plan, and HRSA had created a workgroup to draft the strategic plan. The workgroup decided to solicit input from all five HRSA's health workforce advisory committees. In November 2020, HRSA convened a meeting of the five committee chairs, and provided a draft framework to be distributed to all committee members with a request for feedback. CAPT Russell thanked the NACNEP members for their prompt response to this request, and stated that a draft letter to the HHS Secretary had been prepared combining the NACNEP comments.

The Council members reviewed the draft letter and several offered suggestions to strengthen the language. The letter was approved to go forward, pending minor editorial revisions.

Final Review of the NACNEP 17th Report and Recommendations

Moderator: Dr. Ann Cary
NACNEP member

CAPT Russell turned the meeting over to Dr. Ann Cary, the lead of the NACNEP writing workgroup. Dr. Cary conducted a section-by-section review of the draft 17th Report. After discussion, there was a consensus of all the members that the report and its recommendations expressed the views and the will of the Council, and the Report was approved, pending final minor edits and formatting requests. There were three recommendations approved for the report:

1. The U.S. Congress, through HHS and the Department of Education, should allocate specific funding to programs that promote an increase in the number of nurse faculty and clinical preceptors, and that support nurse faculty development by incorporating academic coursework in nursing education theory and pedagogy within graduate nursing curricula to prepare nurses to assume teaching positions as either faculty or preceptors upon completion.
2. The U.S. Congress should provide funding for the Health Resources and Services Administration (HRSA) to develop a nurse faculty residency program that emphasizes strategies to improve faculty recruitment, preparation, development, and retention.
3. The U.S. Congress should allocate specific funding for the creation of a national center devoted to nursing education and the development of nurse faculty and clinical preceptors. NACNEP further recommends that HRSA lead the implementation of this center as a federal-private partnership, in coordination with professional nursing and non-federal philanthropic organizations.

Review and Next Steps

CAPT Russell thanked the Council members and HRSA staff for their participation in the meeting, and in particular for their robust review and discussion of the draft 17th report. She noted that, based on the feedback from the members, the technical writer supporting NACNEP will make additional edits to the report text, and the final draft will be provided to the members for their review.

Meeting Adjourn

Dr. Ezeike adjourned the first day of the meeting at 3:00 p.m.

Thursday, December 3, 2020

Welcome and Roll Call

Dr. Ezeike opened the second day of the meeting at 9 a.m. ET, and conducted a roll call. The presence of a quorum was confirmed, and the meeting proceeded. CAPT Russell briefly reviewed the presentations and discussions of Day 1.

HRSA's Innovative Women's health Programs: Updates

Mr. Lee A. Wilson

Director, Division of Healthy Start and Perinatal Services
Maternal and Child Health Bureau, HRSA

CAPT Russell introduced the first speaker, Mr. Lee A. Wilson, director of the Division of Health Start and Perinatal Services in the Maternal and Child Health Bureau (MCHB), HRSA. She added that Mr. Wilson has worked to advance policies and programs that support maternal and women's health, infant health, and the health and safety of the children with special healthcare needs.

Mr. Wilson shared that HHS had been undertaking a process over the last nearly a year around maternal health, and the U.S. Surgeon General just released the Maternal Health Action Plan and the Call to Action were announced by the office of the surgeon general. Reading from the press release, he said that the plan "provides a roadmap for addressing risk factors before and during pregnancy, improving the quality of and access to maternal and postpartum care and supporting a research agenda to fill gaps in current evidence." He said that the goal of the plan was to make the United States one of the safest countries in the world to have a baby, regardless of age, race, income, or region of the country, and noted three targets:

- Reduce maternal mortality by 50 percent.
- Reduce low-risk cesarean deliveries by 25 percent.
- Achieve blood pressure control in 80 percent of women of reproductive age with hypertension.

Mr. Wilson said that the missions and work of NACNEP and MCHB have a lot of overlap. He further noted that nursing has been consistently ranked as the most trusted profession. He added that he had invited one of the nurses on the MCHB staff, Ms. Sandy Lloyd, to attend the presentation and help address any questions from the Council. He said that the mission of MCHB is to improve the health and well-being of America's mothers, children and families, and its vision is to strive for an America where all mothers, children and families are able to thrive and to reach their full potential.

Mr. Wilson said that the first director of what was once known as the Children's Bureau, Julia Lathrop, had said in a 1916 report to Congress that maternal deaths were on the rise, the United States fares worse than most other developed countries in maternal health, and the majority of maternal deaths are preventable. She could have been talking about America today in 2020. Maternal deaths continue to rise, the rates in the United States are worse than in most other parts

of the world, and at least 60 percent of maternal deaths are preventable. So, the national problems related to maternal health have been around for more than a century. He also described significant disparities which have proven difficult to resolve: the risk of maternal mortality for Black women blacks is two to three times than for White women, while Hispanics, Native Americans and other groups, including women in rural areas, are also at higher risk.

Mr. Wilson said that MCHB had a budget of about \$1.35 billion in 2020. Its three largest investments include the Title V Maternal and Child Health block grants; the Maternal Infant and Early Childhood Home Visiting Program; and Healthy Start. The remaining MCHB programs cover a variety of topics crucial to maternal and child health.

Mr. Wilson noted that MCHB developed three key priority areas for its programs:

- Access to high-quality, accessible, affordable care, care in accordance with the needs of the person receiving the care.
- Innovation to address structural hurdles and challenges such as workforce shortages and maldistribution.
- Data collection, analysis, and application.

Mr. Wilson briefly reviewed the two largest MCHB programs. The Title V Block Grant program, with an annual appropriation of around \$690 million, supports the public health infrastructure for women and children in the United States through block grants to states. In FY 2019, its programs reached over 60 million people, including 92 percent of all pregnant women in the country, 98 percent of infants and 60 percent of children. He added that over two-thirds of the states reported using their block grant funds to pay for some or all of the cost associated with maternal mortality review committees to address maternal health.

Mr. Wilson noted that the Maternal Infant and Early Childhood Home Visiting program, with an appropriation of around \$400 million a year, funds states, territories and tribal entities to develop and implement evidence-based voluntary home visiting programs for pregnant women and parents with young children up to kindergarten age, who live in at-risk communities. He said that one key element of home visitation is to promote health and wellbeing of the pregnant women. He noted that the program is evidence-based and built on decades of scientific research demonstrating that home visiting by a nurse, social worker, or early educator during pregnancy in the first year of life improves a broad range of health and developmental outcomes.

Mr. Wilson went on to discuss the Healthy Start initiative, with an annual budget of \$125 million. He described the purpose of Healthy Start as to improve health outcomes before, during and after pregnancy and to reduce racial and ethnic differences in rates of infant death and adverse perinatal outcomes. The program provides grants to communities at high risk for a range of adverse outcome such as infant mortality, low birth weight, pre-term birth, and maternal morbidity and mortality.

He said that Healthy Start served over 81,000 women and children in 2018. Most women enrolled in the program were low-income, from minority populations, and had lower educational

attainment than their peers. However, because of Health Start, they were more likely to be insured, to have a usual source of health care, and to have been screened for depression.

Mr. Wilson stated that one of the most innovative approaches to women's health is the MCHB Alliance for Innovation on Maternal Health (AIM), a national data-driven maternal safety and quality improvement initiative. Its purpose is to identify and use proven safety and quality implementation strategies to reduce preventable maternal mortality and severe morbidity across the United States. Mr. Wilson reported that AIM is currently working in 38 states and has implemented maternity "safety bundles" in around 1,500 birthing hospitals throughout the country that offer standardized, evidence-based approaches to improve patient outcomes in such areas as obstetric hemorrhage, severe hypertension, and obstetric care for women with opioid disorders. The safety bundle approach is grounded in the "four R's:"

- Readiness,
- Recognition and prevention,
- Response, and
- Reporting and learning.

Mr. Wilson provided a brief overview of Maternal Health Initiative (MHI), a grant program designed to assist states in bringing together maternal health experts, programs, and resources to implement state-specific solutions to improve maternal health and reduce health disparities. Compared to AIM, which is focused on clinical settings, MHI is aimed at infrastructure development on a broader scale, with the goal to improve maternal health outcomes by spurring multidisciplinary collaboration, collecting and analyzing maternal health data, and promoting innovation. The MHI award recipients are required to establish a state-focused maternal health taskforce and to develop a strategic plan. The initial round of MHI awards was funding a several innovative projects, including:

- Mobile clinics to provide prenatal care in rural and underserved areas.
- Telehealth approaches to reaching mothers and families that are having difficulty accessing obstetric services and other care.
- Training of healthcare providers in implicit bias to address health equity.
- Rural training tracks for obstetric residents and certified nurse-midwife who will stay in rural practice.
- Behavioral health outreach to improve maternal outcomes.

Lastly, Mr. Wilson described the Supporting Maternal Health Innovation Program, a technical assistance center that provides support for capacity building, resource development, collaborations with local and national stakeholders, and leadership in the maternal health space. The program created a maternal health policy repository and resource toolbox that includes models and innovative strategies and resources for funding models, reimbursement strategies, telehealth and remote services, and behavioral health and substance abuse.

Q and A

Sophia Russell thanked Mr. Wilson for highlighting the release of the HHS action plan to as well as the Surgeon General's call to action to improve maternal health. She said that the HRSA Maternal Health Workgroup is actively engaged in supporting these activities. She asked Mr.

Wilson about the challenges and any lessons learned from use of mobile clinics for maternal health service delivery in rural and underserved areas.

Ms. Lloyd responded that some of the activities had been paused due to the COVID-19 pandemic, so there is little information to share on outcomes. She noted that efforts are underway to get the programs up and running again. She said that some states are using the grants to operate vans to provide the mobile care, while others are setting up simulation vans that travel to rural communities to provide education and simulation training for providers.

There was a question about the extent of the MCHB programs. Mr. Wilson replied that there are programs in all 50 states as well as the District of Columbia, Puerto Rico, the Virgin Islands, and several U.S. territories.

Dr. Cary asked about any experience that MCHB might have with public-private partnerships in support of its initiatives. Mr. Wilson replied that the rollout of the Maternal Health Action Plan including an announcement of a series of public-private activities. However, given the recent release of the plan, he was not able to go into detail.

Public Comment

While several members of the public attended the webinar, there were no public comments offered during the comment session.

Panel Discussion: Bureau of Health Workforce Advisory Committees

Dr. Ezeike opened the next session by introducing the chairs of the five BHW advisory committees for a panel discussion:

- Nicole Brandt, PharmD, MBA, BCGP, BCPP, FASCP, chair, Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL)
- Anita Glicken, MSW, chair, Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD)
- Erin Fraher, PhD, MPP, chair, Council on Graduate Medical Education (COGME)
- CAPT Sophia Russell, DM, MBA, RN, NE-BC, SHRM-SCP, chair, NACNEP
- Keisha R. Callins, MD, MPH, chair, National Advisory Council on the National Health Service Corps (NACNHSC)

Dr. Ezeike noted that the chairs had met recently on November 3, 2020, to review the draft framework of the CARES Act health workforce plan and to identify a timeline for ACs to provide their feedback. He stated that NACNEP decided to host this panel discussion provide the forum for the chairs of BHW committees to meet and continue collaborations on the healthcare workforce education and practice issues that cut across disciplines.

Dr. Brandt introduced herself as a professor at the University of Maryland, a clinician, and an advocate for interprofessional practice. She said that ACICBL provides advice and recommendations to the HHS secretary and Congress concerning policy and program

development on federal programs under its charter. The focus on ACICBL is interprofessional education and practice, and community-based health care delivery. Its recent reports have covered improving population health and health equity, revamping clinical training sites, and developing an age-friendly health system. She said that all AC reports are in the public domain. She noted that the COVID-19 pandemic has stressed the healthcare system and greater attention is needed for emergency preparedness, as well as training on utilizing social media to combat myths and misperceptions. She thanked NACNEP for including the panel session, providing an opportunity for all of the AC chairs to share the important work of their committees.

CAPT Russell said that NACNEP addresses a range of issues related to the nursing workforce, nursing education and nursing practice improvement, and specifically policy matters arising in the administration of Title VIII of the Public Health Service Act. She reviewed some of the nursing workforce programs under the purview of NACNEP. She said that recent the NACNEP reports have covered:

- Interprofessional education and practice.
- Population health management.
- Nursing leadership and the transition to value-based care.
- Integration of social determinants of health in nursing education practice and research.

CAPT Russell added that the current report nearing publication concerned the nurse faculty shortage and the need to develop more nurse faculty and preceptors. She agreed with the previous speaker that the COVID-19 pandemic impacted the entire health workforce, while also forcing changes to nursing education and clinical training.

Dr. Glicken stated that ACTPCMD recognizes that voices of the ACs are vitally important in the time of the pandemic due to the rapid and dynamic shifts in education, science and practice, such as the use of technology for telehealth and education, and the shifts in payment policies and provider roles. She said that other impacts of COVID-19 will likely be a post-pandemic backlog of delayed primary care, as well as finding ways to address evolving needs of those who have been chronically impacted by this disease. She welcomed the opportunity to learn about the other ACs and seeing how they might align their efforts to advance growth and optimization of the health workforce.

Dr. Glicken said that ACTPCMD provides advice on policy, program development, and other matters that concern medicine and dentistry activities as authorized under Section 747 and 748 of the Public Health Service Act. The committee is also charged with making recommendations for appropriation levels for programs under Part C of Title 7 of the PHS Act, the Primary Care Training and Enhancement grant. These programs cover primary care training and enhancement, academic units for training, career development orgs, behavioral health and primary care, residency training, and physician assistant programs. ACTPCMD also covers programs in predoctoral training and general pediatric and public health dentistry and dental hygiene, post-doctoral training and general pediatric and public health dentistry, dental faculty loan repayment and career development. Many of these programs promote primary care practice in rural and underserved areas, and address the need for future leaders who can support innovative projects for healthcare delivery transformation. The most recent committee report dealt with community

partnerships to improve population health. Other report topics have included improving wellbeing of primary care trainees, faculty and clinicians, primary care and oral health education in rural and underserved populations, chronic disease and prevention and management, interprofessional education, and integration population health and social determinants of health, implicit bias, structural racism and health equity, and increasing resilience and mitigating burnout in our workforce along with more recent developments in telehealth. The committee is in the process of completing its 18th report, which will focus on the needs of underserved rural communities in maternal and child health.

Dr. Fraher said that COGME has a very broad charge to advise on health workforce trends, training issues, and financing policies and provide that input to the HHS secretary and to the Committee on Health Education Labor and Pensions at the U.S. Senate and on the House side to the Committee on Energy and Commerce. COGME has 18 members, with 14 outside experts appointed by the HHS Secretary, as well as four ex officio members, including representatives from the office of the assistant secretary for health, the Center for Medicare and Medicaid Services, the Department of Veteran Affairs, and HRSA. The COGME members represent practicing primary care physicians, physician organizations, foreign medical graduates, health insurers, business and labor, and medical students.

Dr. Fraher noted that COGME has been working to advance team-based patient-centered health workforce training and investments, and is committed to expanding training for interprofessional teams that provide integrated whole person care. She added that COGME has promoted the use of workforce data to evaluate the return on the investments being made by the federal government in health workforce education and training. COGME also recognizes that the sites of care are shifting from acute to ambulatory community and home-based settings. COGME submitted a letter to Congress recommending an increase in funding for the Health Careers Opportunities Program to increase recruitment and retention of students from minority and disadvantaged populations to increase the diversity of the health workforce. In June 2020, COGME sent a letter to the HHS Secretary Azar concerning the pandemic response and recommending immediate action to bolster telehealth accessibility, provide financial relief for vulnerable practices and critical access hospitals, address workforce stress and burnout, support federal program flexibilities, and strengthen and modernize the public health workforce.

She added that COGME is currently at work on publishing three issue briefs focused on developing and sustaining the rural health workforce. The first issue brief, recently published, highlighted the struggles in rural America around health disparities and health care access. The other two in development will discuss rural healthcare workforce training and developing sustainable models of financing, and promoting generalism in practice in rural communities.

Dr. Callins said that the NACNHSC is composed of healthcare providers and administrators, similar to the other committees, and has the responsibility to advise the HHS Secretary and Congress on the priorities of the National Health Service Corps (NHSC). Given its diverse group of member that can include physicians, nurse practitioners, mental health providers, and other health professionals, the NACNHSC can serve as a sounding board for policy changes. The NACNHSC publishes white papers and briefs on a variety of issues, mostly concerning

providing health care for underserved and vulnerable populations. She commented that had been involved with the NHSC for many years, starting early in her career as an NHSC Scholar.

Some of the major issues that NACNHSC has addressed include mental health care, maternal mortality and morbidity, workforce training and interdisciplinary teams, cultural competence in health care, and preventing healthcare provider burnout and supporting resilience. She commented that the COVID-19 pandemic has exacerbated several ongoing health workforce issues, and placed an increased emphasis on telehealth services. She said that the NACNHSC looked forward to creating linkages with the other ACs to address cross-cutting issues, such as encouraging more providers to work and remain in rural communities and other communities of need, and strengthening the interdisciplinary team-based approach health care at the community level. Dr. Callins said that one major issue is modernizing healthcare delivery and training to integrate new and emerging technologies, including telehealth, to provide services and to meet the needs of different populations. These processes need to start at the training level. She closed by sharing a quote, “Those closest to the problem are also closest to the solution.”

Q and A

Dr. Ezeike posed two questions to the panelists:

- How do you develop and sustain interprofessional education and practice for better community health?
- How can HRSA link its trained health providers to the community needs of rural and underserved populations?

Dr. Callins addressed her comments to the second question. She said that the NACNHSC has been engaged in discussion on the role of mentorship and teamwork. From her own experience as an obstetrician in a rural community, she has built a network of other providers that she can call when she has a question or needs support. When she has students who rotate with her, she introduces them to the needs of the community. Investing in that mentorship can help expose medical residents and other healthcare workforce professionals in training to strengths, resources, and challenges of different communities, in hopes of sparking their interest to continue serving in an underserved area.

Dr. Fraher replied that COGME is preparing a set of issue briefs on rural health care that address both questions. The first issue brief covers rural health disparities and the need to assess rural healthcare needs. The second issue brief covers investments in training and infrastructure. The third brief focuses on the types of training needed for rural practice. The nature of rural care focuses on teamwork and thus COGME supports an interprofessional approach.

Dr. Brandt stated that the recent ACICBL reports had covered enhancing community-based clinical training sites, and addressing challenges and opportunities in underserved areas. In particular the Area Health Education Centers (AHEC) program helps to get trainees out to communities in need. She said that new payment models that transition away from fee-for-service are needed to promote interprofessional teams. She added that the pandemic response has accelerated a trend toward telehealth as a way to reach geographically or socially isolated populations and reduce barriers such as transportation. She noted that an area that one area needing attention for interprofessional education and training is accreditation standards.

CAPT Russell said that NACNEP has highlighted the need to improve provider quality by strengthening workforce competencies and interprofessional collaboration, addressing health disparities and the social determinants of health, and building community connections. Dr. Glicken added that current training of health professionals is siloed. Interprofessional collaboration needs to be woven in throughout the curriculum, not just seen as an add-on requirement. She agreed with Dr. Fraher that training-in-place programs help students understand community resources and needs.

Dr. Maryjoan Ladden asked the chairs if they had an interactions or work with the National Center for Interprofessional Practice and Education (the National Center) at the University of Minnesota, a public-private partnership begun several years ago with funding from HRSA and several philanthropies. Dr. Fraher replied that she was familiar with the work of Dr. Barbara Brandt, the Director of the National Center. She noted two principles that she learned from Dr. B. Brandt: 1) interprofessional education had to proceed hand-in-hand with interprofessional practice for the lessons to be absorbed; and 2) the patient had to be at the center of the care team and part of the team. Dr. N. Brandt stated that she had also worked with the National Center. In inner-city neighborhoods of West Baltimore, they used to the term “neighbors” in referring patients, as a result of feedback from the local community organizations. She also emphasized the presence of the “digital divide” with the lack of access to technology and internet connectivity in many low-income or rural communities. Her program worked with the university and other stakeholders to place iPads and related devices into the hands of community members to improve access to telehealth and other resources.

Dr. Glicken stated that she had paid close attention to the issue of the transition in interprofessional care from education to practice. She emphasized the importance of policy changes at both the local and national level to promote interprofessional care, as well as having relevant metrics in place to assess the outcomes of that care. She noted that in her role as the Executive Director of the National Interprofessional Initiative on Oral Health, she had helped implement the Smiles for Life curriculum, which teaches providers across all health professions about oral health integration in primary care, and has been viewed by over 2.5 million providers.

Dr. Callins echoed the previous comments about interweaving training and practice within the NHSC. She also emphasized the need to integrate the social determinants of health into training, because often half or more of the care provided by the healthcare team does not directly involve medical care but addressed other elements such as housing or food insecurity. Another vital point centered around promoting provider resilience and wellbeing, and preventing burnout.

In further discussions, the AC chairs and the NACNEP members noted several areas of commonality between the issues confronting each committee, and indicated a strong interest in improving communication avenues between the respective committees and pursuing opportunities for interprofessional collaboration.

Council Discussion: Planning for 2021-2 and the 18th Report –Challenges and Opportunities Facing Nursing Education and Practice for the Next 3-5 Years

CAPT Russell moderated a discussion on the future activities of NACNEP, pointing toward the preparation of its next (18th) report. In looking to the future, the Council members discussed how the education of health care professionals will need to adapt to changes in care, and how HRSA can take the lead in preparing and strengthening the nursing workforce. Specific topics to consider included:

The impact of the COVID-19 pandemic

- The long-term residuals of the disease and impact on health care
- Preparing the workforce for future public health crises – What are the lessons learned?
- The impact on:
 - The current workforce -- practice, education, retention
 - Post-COVID nursing school enrollment, and faculty retention/retirements

Issues of technology: What are the competencies needed for the nurse of the future?

- Use and adoption of telehealth, distance learning, remote patient monitoring
- Infrastructure needs and investment
- Simulation for clinical training
- Use of smart technology – how to prepare the workforce
- Microcredentialing

Interprofessional education and practice

- How to leverage and evaluate the use of doctor of nursing practice-prepared nurses
- Collaboration
- Barriers to scope of practice
- Accreditation and reimbursement
- Need for data-driven information

Health literacy

- Example – COVID-19 and vaccine uptake
- Evolution of science
- Community preparedness in nursing curricula
- Adoption of best practices for community and population health

Shift from acute care to ambulatory care, community care settings

- Nurse-led community health centers, Federally Qualified Health Centers
- Integration of mental and behavioral health into primary care
- MCHB innovative models, e.g., mobile health clinics
- How to collaborate with the local community to find shared solutions
- Training in place in community settings, promote interest in public health

Emerging environmental health issues

- Climate change
- Environmental toxins
- Social determinants of health

Review and Next Steps

CAPT Russell offered a brief review of the presentations and discussions over the two days of the meeting. She noted that the NACNEP 17th Report would be finalized, pending final comments from the members and final edits by the technical writer. The Report would then be submitted to the HHS Secretary and Congress, and published within the next two months. She asked the members to work with their respective organizations and institutions to publicize the recommendations.

CAPT Russell noted that the terms of three departing members of the Council would be expiring: Dr. Ann Cary, Dr. Maryjoan Ladden and Dr. Lorena Marshall Blake. She thanked them for their time, efforts, and service to the Council, and for their contributions to the NACNEP reports in advancing nursing education, training, and policy.

Adjourn

Dr. Ezeike reminded the members that the next NACNEP meeting was scheduled for March 9-10, 2010. He adjourned the meeting at 2 p.m.

Acronym and Abbreviation List

AC	Advisory Committee
AHEC	Area Health Education Center
AIM	Alliance for Innovation on Maternal Health
ANE	Advanced Nursing Education
APRN	Advanced Practice Registered Nurse
BHW	Bureau of Health Workforce
CARES	Coronavirus Aid, Relief, and Economic Security
DFO	Designated Federal Official
DNPH	Division of Nursing and Public Health
FY	Fiscal Year
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
MCHB	Maternal and Child Health Bureau
MHI	Maternal Health Initiative
NACNEP	National Advisory Council on Nurse Education and Practice
NEP	Nursing Education Practice
NFLP	Nurse Faculty Loan Program
NP	Nurse Practitioner
NPR	Nurse Practitioner Residency