NACNEP ⋮ National Advisory Council on Nurse Education and Practice

Meeting on May 12, 2020

The 142nd meeting of the National Advisory Council on Nurse Education and Practice (NACNEP, or the Council) was held on Tuesday, May 12, 2020. The meeting was conducted via webinar and teleconference, based from the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Rockville, MD 20857. 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. Maryann Alexander
Dr. Cynthia Bienemy
Dr. Mary Ellen Biggerstaff
Dr. Mary Brucker
Dr. Steven Brockman-Weber
Dr. Ann Cary
Dr. Tammi Damas
Ms. Christine DeWitt
Dr. Christopher Hulin
Dr. Rose Kearny-Nunnery
Dr. Maryjoan Ladden
Rev. Dr. Lorina Marshall-Blake
Ms. Donna Meyer
Dr. Luzviminda Miguel
Dr. Janice Phillips
Col. Bruce Schoneboom
Dr. Patricia Selig
Ms. LaDonna Selvidge

Others Present:

Dr. Camillus Ezeike, Designated Federal Official, NACNEP
Ms. Leslie Poudrier, Division of Nursing and Public Health, HRSA
Mr. Raymond J. Bingham, Division of Nursing and Public Health, HRSA
Ms. Kimberly Huffman, Advisory Council Operations, HRSA
Ms. Robin Alexander, Advisory Council Operations, HRSA
Ms. Zuleika Bouzeid, Division of Extramural Affairs, HRSA

Tuesday, May 12, 2020

Welcome and Introduction

Dr. Camillus Ezeike, Designated Federal Official (DFO) for NACNEP, convened the 142nd meeting of NACNEP at 9:00 a.m. on May 12, 2020. He conducted a roll call and 19 members were present to confirm the presence of a quorum, so the meeting proceeded. Dr. Ezeike described the purpose of the meeting as hear from two panels of experts about the effects of the COVID-19 pandemic on the nurse workforce. The Council will also continue discussions to develop recommendations for its 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 provided a brief review of the agenda and the plan for the meeting. She asked if any Council members had any feedback or comments on the minutes of the previous meeting. No comments were offered, so the minutes were approved.

Bureau of Health Workforce Update

Luis Padilla, MD

CAPT Russell introduced the first speaker, Luis Padilla, MD, Associate Administrator, BHW. Dr. Padilla greeted the Council members and wished them a happy National Nurses Week. He noted that the NACNEP meeting provided HRSA with the opportunity to listen to experts from the field on how to support the current workforce, as well as to prepare the future workforce for new public health emergencies. At over 3.5 million strong, nursing is the largest component of the healthcare workforce, and many nurses are bearing the brunt of the COVID-19 pandemic on the front lines of the healthcare system. He said that all are saddened by the loss of nurses and other healthcare workers who have died from COVID-19 while caring for patients and supporting their community.

Dr. Padilla said that HRSA is helping to lead the nation's pandemic response through its critical role in improving healthcare access and quality to people who are geographically isolated, or economically and medically vulnerable. He informed the Council of recent HRSA awards:

- Nearly $583 million to over 1,300 HRSA-funded health centers across the country to expand COVID testing, a vital consideration for reopening the economy.
- Over $1.4 billion to help local communities with virus detection, prevention, and treatment, and to maintain capacity for staffing
- Over $90 million to support 581 Ryan White HIV/AIDS program centers to minimize the impact of the pandemic on people living with HIV/AIDS.

Dr. Padilla said that HRSA had compiled a list of COVID-related frequently asked questions (FAQs) to address concerns from grantees and provide guidance on the agency's programs and services. HRSA developed a telehealth site, telehealth.hhs.gov, to provide information about federal efforts to support telehealth services, which have rapidly expanded in the pandemic response. He noted that the use of telehealth technology will change both the delivery of care and the training of new clinicians. He reviewed other steps HRSA had taken to support rural hospitals and practices that are struggling through the pandemic, and provided a brief overview of the flexibilities HRSA had adopted to allow grantees to fulfill program requirements in light of the disruptions in health care delivery and clinical training forced by the pandemic.

Q and A

CAPT Russell opened the floor to questions from the Council members. Dr. Ann Cary asked about the kinds of support HRSA could offer to schools and communities to improve internet connectivity in rural areas and other locations with poor access, which is a necessary component of telehealth services. Dr. Padilla agreed that a significant portion of rural communities lack broadband access. He stated that the HRSA Federal Office of Rural Health Policy had provided additional funding to support infrastructure, and has been working with the Federal Communications Commission to improve connectivity and broadband access.

Panel Discussions: The Nursing Workforce during the COVID-19 Pandemic

CAPT Russell moved to the next item on the agenda, involving two panel discussions on the nursing workforce during the COVID-19 pandemic. She introduced the two moderators: Dr. Tammi Damas, the director of education and academic affairs, office of the provost at Georgetown University in Washington, D.C.; and Dr. Janice Phillips associate professor at Rush University and director of nursing research and healthy equity at the Rush University Medical Center in Chicago, Illinois.

Panel Discussion #1: Preparing and Educating Nursing Students during the COVID-19 Pandemic

Dr. Damas said that the first panel discussion would focus on preparing and educating nursing students through the COVID-19 pandemic. She introduced the three panelists:

- Cynthia Bienemy, PhD, RN (Director, Louisiana Center for Nursing, Louisiana State Board of Nursing)
- Maryann Alexander, PhD, RN, FAAN (Chief Officer, Nursing Regulation, National Council of State Boards of Nursing)
- Ann Cary, PhD, MPH, RN, FNAP, FAAN (Chair, Board of Directors, American Association of Colleges of Nursing)

Cynthia Bienemy, PhD, RN

Dr. Bienemy stated that her work with the Louisiana State Board of Nursing (LSBN) allowed her take part in many discussions related to nursing education capacity in response to the pandemic. She shared a brief timeline showing the rapid changes that occurred as hospitals began to deny students for schools of nursing the opportunity for clinical experiences, often for a lack of personal protective equipment (PPE) such as facemasks and gloves. By March, many schools began requesting guidance from the LSBN regarding feasible options for clinical experiences for their students, as many were forced to close their physical buildings and transition to on-line educational formats. This transition involved a steep learning curve for both faculty and students. Schools also began to explore increased use of simulation to provide students with clinical experiences and develop critical thinking skills.

Dr. Bienemy reviewed some of the regulatory waivers and flexibilities that have helped nursing students meet their training requirements. She said that Louisiana was able to accelerate the graduation of nursing students who had met all of the requirements and attained the required clinical competencies. Temporary licenses were instituted to allow these students to enter the nursing workforce before they were able to take the nursing licensure exam, the NCLEX-RN. In addition, there was a pre-graduation disaster permit that would allow senior nursing students to work as an RN applicant, while also acquiring their clinical hours needed for graduation. While many of these students were excited to enter the workforce at the critical juncture of the pandemic, many also expressed concern about entering the rapidly changing healthcare arena without the proper training in infection control and with inadequate access to PPE.

Maryann Alexander, PhD, RN, FAAN

Dr. Alexander noted that the National Council of State Boards of Nursing (NCSBN) is working with state governments in responding to the COVID-19 pandemic. She said the pandemic is placing significant demands on the nursing workforce, while hampering the education and training of prelicenure nursing students. Clinical experiences with patients are an essential part of every nursing program curriculum and are mandated by all state boards of nursing for licensure, but many hospitals and health care facilities have determined that pre-licensure RN students should not be in contact with patients and have discontinued student clinical experiences within their facilities. She provided an overview of changes undertaken by different state boards of nursing to allow flexibility in letting senior nursing students obtain clinical and didactic hours to meet their graduation requirements. Several boards increased the allowable amount of simulation experiences, as well as permitting didactic classes to be completed on-line.

Dr. Alexander pointed to an issue brief published by NCSBN, *U.S. Nursing Leadership Supports Practice/Academic Partnerships to Assist the Nursing Workforce during the COVID-19 Crisis*. One proposal in this brief was to recommend allowing nursing students to be employed by a healthcare facility in the role of student nurse in conjunction with the educational institution, while receiving academic credit for their clinical hours. She described the potential benefits of such a program as having students meet program requirements while being a part of the national response to the pandemic crisis; helping students learn the principles of population health and emergency management; and demonstrating innovation in the midst of a serious disruption in the traditional learning environment. However, she recommended that nursing programs consult with the state board of nursing to ensure that such a program aligns with state requirements.

Dr. Alexander said that NCSBN is encouraging nursing programs, leaders, faculty, to set up these types of partnerships with hospitals, nursing care facilities, while finding ways to offer appropriate supervision of these students. Students in these positions may be able provide most routine patient care, freeing up more experienced nurses to care for COVID patients. Dr. Alexander recommended that programs inform the students of the risk and responsibilities associated with working in a health care facility at this time, and inform students about their rights to be protected from infection and options for completing clinical practice requirements in other ways.

Dr. Alexander added that NCSBN had recently published some free courses for students as well as experienced nurses covering a range of topics, including care of patients with COVID-19, epidemiologic modes of transmission, proper donning and removal of PPE, legal and ethical issues, and maintaining hopefulness in the midst of the pandemic.

Ann Cary, PhD, MPH, RN, FNAP, FAAN

The next panelist was Dr. Ann Cary, Past Chair, Board of Directors, American Association of Colleges of Nursing (AACN), and current Dean and professor at Marieb College of Health & Human Services, Florida Gulf Coast University (FGCU). Dr. Cary said that she would speak about how the pandemic had impacted nursing education at school across the country. In the initial stages of the pandemic, many schools closed their campuses and shifted from face-to-face

classes to online educational formats. Dr. Cary noted that many schools do not have the resources to employ instructional designers, who can be key to transitioning courses to online or remote formats. This rapid change to remote learning created many challenges for schools, faculty, and students, including:

- Variable application of instructional design for online courses
- Issues of access for both faculty and students to appropriate hardware and internet connectivity
- Rushed selection and implementation of software for online education formats
- Professional development gaps for faculty engaged in new educational delivery methods
- Inconsistent guidance from state regulators and accrediting bodies.

Dr. Cary said that sites for clinical experiences vanished almost overnight. Hospitals and other clinical venues needed to prioritize employee training and PPE supplies, as well as patient care and safety. She reminded the Council that early in the pandemic response, much was unknown about the spread of the disease and the risks of infection. As a result, many schools turned to simulation to provide some clinical experiences and help develop critical thinking skills. However, there was some conflicts with regulators in regard to substituting simulation for clinical time, and little was known about how the use of simulation might affect performance on the nursing licensure exam, NCLEX-RN, or on board certification exams for advanced practice registered nurses (APRNs), which includes nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), certified nurse midwives (CNMs), and clinical nurse specialists. Dr. Cary added that there remains great uncertainty about when schools may re-open, and when clinical sites may be ready to accept students again. Schools are having to assess many different potential scenarios as the develop plans to re-open in the fall of 2020. However, many are reporting robust applications and an intent to enroll new students, while making contingency plans for remote learning.

In terms of faculty, many schools are facing fiscal uncertainty and must be tentative in their ability to commit to faculty hires. These conditions could exacerbate faculty shortages by disrupting the pipeline of doctoral students and accelerating retirements among current faculty.

Dr. Cary referred to the pandemic conditions as creating a form of a natural laboratory experiment, posing the question: is the concept student "seat time" in face-to-face classes and hours in clinical settings still relevant, or should nursing education focus more on the development and assessment of professional competencies?

Dr. Cary argued that universities and schools of nursing need to develop the infrastructure for a variety of instructional formats, including online education and clinical simulation. The use of software technology can help identify where students may have learning gaps, or help promote access to education in rural and other remote locations. She said schools must also develop the pedagogical evidence to determine what methods work best for clinical training. Faculty will need professional development in the creation and use of simulation and the validation of different learning and teaching strategies. She added that nursing also could take advantage of this time to work with other healthcare disciplines to create more unified and team-based approaches to clinical education.

Dr. Cary recommended that grant funding be broadened to allow funding for more professional development in remote education, cover the use of instructional designers, and fund the entrepreneurial development of software applications using simulations and employing multiple learning strategies. He also recommended more investments in software technology that employs artificial intelligence and machine learning, to further develop the concept of precision education for undergraduate and advanced practice nursing students.

Q and A

Dr. Damas opened the floor to questions from the Council, and posed a question to Dr. Cary about how to determine when students might be able to return to clinical sites for training. Dr. Cary said that the site must guarantee access to PPE, and students may decline to take care of certain patients if they do not feel confident or do not feel adequately protected from potential infection. In addition, the students must sign a waiver acknowledging that they will adhere to the requirements of the site in terms of infection control training and practices.

Dr. Damas followed up by asking about the response of AACN to the transitioning of nursing schools to remote learning, in terms of meeting accreditation standards. Dr. Cary noted that AACN is not an accrediting organization, but they do work closely with accreditors to maintain educational standards. She said that accreditors are looking into the efficacy of remote learning and the different pedagogies being used to deliver online education and clinical simulation. Since some distance education has been occurring for a number of years, accreditors have looked into the course content and the student outcomes. However, the rapid transition to distance education brought on by the pandemic will create challenges in measurement and assessment, as accreditors look to see the student outcomes in terms of scores and passing rates on licensure and certification exams.

CAPT Russell asked Dr. Cary to elaborate on the rapid transformation at FGCU from in-person to online education. Dr. Cary replied that her university had a number of individuals in place as instructional designers, and they were able to work with the nursing faculty to take course materials and reformat for online education while maintaining the engagement of the students. She added that FGCU already had an online format in place, easing the transition.

Dr. Bienemy said that even before the pandemic, many newly licensed nurses expressed concerns that they did not have adequate resources and support in their transition into practice. These concerns are one reason for a high turnover rate of new RNs. In areas and hospitals dealing with the pandemic, many new nurses are worried that about being put into high-risk situations without proper training or PPE. One new nurse was quoted in a recent article saying that a year residency program should be available for all new RN graduates, as a three-month orientation on one unit is inadequate preparation. In some cases, new graduates are being hurried through orientation because units are short of staff, and then expected to pick up 60-plus hours a week to help their unit. Nurses may need to learn to say no, because their empathetic personalities may lead them to neglect their own needs.

Col. Bruce Schoneboom expressed concern that nursing schools with greater financial resources and capacity could afford to hire instructional designers to help in the transition to more distance learning content, while other schools without adequate resources might fall behind. Dr. Cary

replied that more schools are supporting instructional designers, and they can be a shared resource within an institution. There was a recommendation to allow HRSA grants to fund instructional designers to help transform and strength nursing programs. Dr. Maryjoan Ladden asked about including more content on disaster preparedness and public health issues within nursing, as well as interprofessional collaboration. One member mentioned the need to continue to strengthen the academic-practice partnership, particularly around the preceptorship and nurse residency programs.

Panel Discussion #2: Supporting the Current Workforce during the COVID-19 Pandemic: Views from the Field

Dr. Ezeike moved to the second panel discussion on supporting the current workforce through the COVID-19 pandemic. Panel moderator Dr. Phillips introduced the three panelists:

- Aisha K. Mix, DNP, MPH, RN, NHDP-BC (Rear Admiral, Assistant Surgeon General, Chief Nurse Officer, U.S. Public Health Service)
- Steven Brockman-Weber, DNP, RN, MS (Chief Nursing Officer, Ascension Health, Texas)
- Christopher Hulin, DNP, MBA, CRNA (President, Middle Tennessee School of Anesthesia)

Aisha K. Mix, DNP, MPH, RN, NHDP-BC

Rear Admiral Mix said that in her role as Chief Nurse of the Public Health Service (PHS), she oversees almost 1,400 active duty nurse and over 3,000 civilian nurses working throughout HHS. She also advised the HHS Secretary through the office of the Surgeon General on strategies for nurses to protect, promote, and advance the health and safety of the nation. She described nursing as the backbone of the nation's disaster response.

Rear Admiral Mix described the phases of disaster response:

- Before the event
  - Prevention and mitigation
  - Preparation
- After the event
  - Response
  - Recovery

While the aftermath of an emergency event naturally focuses on the response, nurses have the responsibility to lead throughout all of the stages. However, there is no consistent approach for preparing nurses for these challenges. She said that the World Health Organization and the International Council of Nurses have developed competencies to include within nursing curricula, including preparation planning, communication, incident management, safety and security, and assessment in relation to individuals, families, and communities.

Rear Admiral Mix said that the public health nursing response to the pandemic is complex and requires a whole community approach, which includes:

- Contact training and investigation of known infections
- Community education
- Population-specific interventions
- Direct care for both COVID and non-COVID patients.

Rear Admiral Mix said that more people are having to navigate illness with COVID at home than in the hospital, so community education is critical. She also acknowledged that populations who were marginalized prior to the pandemic tend to be at higher risk, while continuing to deal with poor access to care. She said that the PHS has deployed more than 400 nurses from the beginning of the crisis to work in areas including case management of returning American citizens from the impacted areas of the world, care coordination and case planning, and airport screenings to monitor the health of travelers entering the U.S., as well as work within HHS to coordinate the overall mission. PHS officers re in the field ae coordinating and administering COVID-19 diagnostic testing and in coordination with HHS agencies, state and local public health authorities and private and public clinical laboratories. In addition, PHS nurses are engaged in missions that provide direct clinical care for patients that are in alternative care sites who have tested positive for the COVID-19 disease.

Rear Admiral Mix indicated that the work has taken a significant toll on the PHS nursing staff. Personal safety is a concern that is shared with supervisors and every nurse engaged in this response. Nurses have significant concern not only for themselves but also for their family members and others that are close to them. Many nurses are having to self-isolate to protect their families and loved one, which have a psychological impact that compounds those that they were already experiencing in the work setting. Nurses are accustomed to self-sacrifice, but in the rapidly changing environment of the pandemic they risk severe impacts on their emotional, physical, and mental health.

However, she added, communities, healthcare organizations and at all levels of government, people are taking notice and understand the need to rally around nurses and other health care providers engaged in the front lines of the fight against COVID. She emphasized the need to link the needs of the education and academic environment with the needs of the practice environment. The pandemic has provided the opportunity to educate and refresh the knowledge of nurses on infection control practices to reduce risk of transmission. Nurses also have to educate others on infection control.

Rear Admiral Mix also noted the importance of employee assistance programs and mental health services, to address the health and well-being of nurses as they face the ongoing challenges of the pandemic. Maintaining mental health and wellness needs to be a priority, to give nurses permission to practice self-care. ADM Mix added that workforce recovery needs to be part of the disaster planning from the beginning. Investment in recovery will strengthen the public health workforce and help maintain improvements in population health across the country.

In her recommendations to the Council, Rear Admiral Mix said the concepts of public health emergencies and disaster response need to be included across the range of nursing education,

beginning in the undergraduate level. Public health nursing needs to be recognized as a specialty that would benefit from nurse residencies and experiences that introduce nurses to population health and the social determinants of health. She shared an experience from a recent leadership training exercise, when the question was posed about the importance of the mission versus the officers. Leaders have to first take care of their officers, and the officers will take care of the mission. She encouraged NACNEP to engage with and understand how to take care of nurses so that they can continue to serve the health of the nation's people.

Steven Brockman-Weber, DNP, RN, MS

Dr. Brockman-Weber, Chief Nurse of Ascension Texas, described Ascension Health Care as a leading not-for-profit faith-based healthcare organization with hospitals in 20 states and the District of Columbia. Ascension Texas consists of over 120 locations in the state, including academic centers, a free-standing children's hospital, and some critical access hospitals.

He noted that Ascension Texas had a staff of almost 30 nurses specially trained for infectious disease response (IDR) units, who were deployed back in February 2020 to receive some of the first COVID patients off of cruise ships returning with infected passengers. A group of IDR nurses also traveled to San Antonio in early March to help with the initial response, which helped set the stage for planning the disease response from a system perspective. He shared some of the initial data indicating a raid rise in new COVID cases.

Dr. Brockman-Weber said that one of the initial steps involved creating the capacity to accept a potentially large volume of patient requiring admittance to an intensive care unit (ICU) for ventilator management. There was discussions on stopping or delaying elective procedures, setting up triage areas, re-purposing beds, and training staff. There were also efforts to quickly ramp up telehealth capacity. He noted that Ascension Texas quick went from conducting around 100 telehealth visits per week to around 1,800 per day. The system also looked to create capacity by partnering with other facilities with as nursing homes and children's hospitals, as well as community health centers. Dr. Brockman-Weber noted that the final phase of planning was for recovery, to resolve issues that arose in the pandemic response, reimagine care, and look at how the system could function most effectively in the future.

Dr. Brockman-Weber noted a range of responses from the medical and nursing staff, particularly in relation to potential redeployments. He noted a wave of resignations and early retirements. However, he also noted staff members willing to go to the hardest hit areas to help. In some hospitals, acute care staff were re-assigned to help in emergency rooms and ICUs. He said that APRNs in Texas did not have full practice authority, but in response to the pandemic, the Texas board of nursing lightened some of the requirements to allow for greater practice authority. In addition, some schools of nursing allowed early graduation, and Ascension Texas worked with the state board of nursing to allow these graduates to work under the supervision of an RN.

Dr. Brockman-Weber described some of the steps needed to support the hospital staff. He noted the importance of PPE for staff caring for potentially infectious patients. However, due to shortages, the hospitals worked with their infection control experts on ways to conserve and re-use PPE, particularly masks and isolation gowns, to make sure the equipment remained safe and

functional. He noted that many staff members were reluctant to go home for fear of carrying the infection to their children and loved ones, or who were sending their families away, something he said he had never dealt with before. He noted the importance of testing for COVID, but insufficient testing supplies caused a range of problems.

Dr. Brockman-Weber noted that hospitals modified nursing documentation to help track the amount of time that nurses spend in rooms with COVID patients. Hospitals also revised procedures for intravenous fluids and medications, to minimize the number of times a nurse would need to enter COVID rooms. With the help of the IDR staff, nurses were retrained on the proper donning and removal of PPE.

Dr. Brockman-Weber reviewed some other steps taken by Ascension Texas to support their staff, including continuation of pay for staff member in units forced to temporarily close, childcare assistance for frontline staff, and employee assistance programs to help maintain staff wellness. Staff were offered free hotel rooms for those who needed to stay close to the hospital or who were fearful of spreading infection to their families, and a travel nurse program for nurses who volunteered to help provide additional staffing in hard-hit areas. He added that nurse researchers in the Ascension Health system are developing a research project on the pandemic response, called *Behind the Mask, the Pandemic Perspective from the Front Line*.

Christopher Hulin, DNP, MBA, CRNA

Dr. Hulin said that his talk would concentrate on the work of CRNAs and focus on three areas: practice, education, and policy. He noted that much of the discussion would apply to other APRNs. He noted that before the pandemic, he considered health care a solid and stable field for employment. However, once the pandemic struck, almost all elective operative procedures were cancelled and revenues quickly dried up. For his discussions with other CRNAs, many had to take up to a 50 percent pay cut and almost a complete drop in patient volumes.

In light of the pandemic, Dr. Hulin said that CRNAs needed to determine where else can they add value outside of the operating room, and how can they best utilize their skills. Given the rapid changes in patient care and the need to adapt, the pandemic response provided an opportunity for CRNAs and other APRNs to shine. He shared a tiered staffing model for the pandemic, developed by the Society of Critical Care Medicine. In this model, RNs, APRNs, physicians, and other professionals not trained in intensive care can take over patient care in non-acute units and provide support to more highly trained and experienced staff handling sicker patients and COVID cases. He said that CRNAs are adept at airway and ventilation management and sedation protocols. In the areas hit hardest by the pandemic, many were able to fill that role in the ICUs. He noted that the Veterans Administration had invested in training for CRNAs, allowing many to take over ventilator management in the ICU setting.

In discussing the educational needs for CRNAs and other APRNs, Dr. Hulin said that there is currently little money in developing formal continuing education courses, because a lot of material is available for free and easily accessible over the internet. However, there is a need for a unified educational resource to improve standardization of care. He pointed to educational

needs in long-term ventilator management, point-of-care testing and ultrasound, sedation and pain management, and medication management.

Dr. Hulin noted that he had witnessed partnerships developing between APRNs and CRNAs in a team approach to patientcare. He raised the possibility of a dual degree to bridge the gap between CRNAs and other APRNs, which would require funding to develop.

On the policy side, Dr. Hulin said that the pandemic response has demonstrated the flexibility of APRNs, and provided a good opportunity to demonstrate expanded roles. He recommended making a request to Congress that the temporary easing of restrictions on scope of practice for APRNs be made and to reduce some unnecessary supervisory burdens. He said that solidifying full practice authority for APRNs offered the chance to reduce healthcare costs and improve healthcare access. He also suggested creating a permanent solution to simplify the issue of cross-state licensing, to improve the mobility of healthcare providers.

Q and A

Dr. Phillips opened the floor to questions from the Council members. She started with a question for Rear Admiral Mix about organizational changes within PHS in response to the pandemic. Rear Admiral Mix replied that PHS maintains a posture of readiness, and that the pandemic has brought the concepts of population health to the forefront. One challenges has been to maintain a sufficient supply of health professionals for deployment, while also to having enough to continue caring for the vulnerable and underserved populations.

Dr. Phillips then asked Dr. Brockman-Weber about adjustments being made to accreditation standards in order to fast track new RNs into the work force. Dr. Brockman-Weber said that Ascension Texas worked with the state board of nursing to ensure that graduate nurses had completed their requirements and could be placed in residency programs to help provide staffing support. The other regulatory piece was to remove restrictions to full practice for APRNs.

Dr. Phillips turned to Dr. Hulin, and asked for his ideas on the best ways for HRSA to support health care professionals. Dr. Hulin stated there is a need for grant money to develop an organized and accredited post-graduate continuing education program to develop advanced skills, which could focus on areas such as critical care medicine, as well as the opioid crisis and pain management using opioid-sparing techniques.

Col Schoneboom offered some comments on the experience at Johns Hopkins with the pandemic. First, the hospital had to re-engineer some of its units to create negative pressure areas for COVID-19 patient wards. Second, with much of the surgical staff idled, the anesthesia department developed its own curriculum to help CRNAs learn some of the skills of respiratory therapists, which allowed them to be deployed throughout the health care system and into the ICUs. As a result, no staff members were furloughed or laid off.

Captain Russell asked Rear Admiral Mix to expand on her comments about work force recovery for public health nursing. Rear Admiral Mix replied that there is a need to introduce population health and social determinants of health concepts in public health nursing at the undergraduate and pre-licensure level. She suggested a targeted focus to engage pre-licensure nursing students

in rotations that expose them to community-based settings. Dr. Cary commented that new nursing competencies under development with the AACN address those two areas.

There as a question raised about developing competencies in contact tracing and related public health measures for nurses, to address a huge gap in the workforce in dealing with a pandemic. Rear Admiral Mix referred to her discussion on disaster management as a part of the work that public health nurses do, which requires an extensive skill that includes contact tracing and contact observation. There was further discussion of retraining nurses and other healthcare staff members to provide support in an emergency response, although not all staff may feel comfortable training in new areas or facing the risks inherent in responding to a pandemic.

National Health Service Corps Priorities For FY20

Israil Ali, MPA

Dr. Ezeike introduced the next speaker, Israil Ali, Director, Division of National Health Service Corps, BHW, HRSA. Mr. Ali thanked the Council for their contributions in support of the National Health Service Corps (NHSC) and the primary care workforce. He noted that the Council's recommendations submitted in 2019 are weaved through the NHSC priorities for the future. He said the BHW administers the NHSC and other health workforce investments to strengthen the workforce, with a focus on building healthy communities by supporting qualified health providers in medicine, nursing, dentistry, and behavioral health to provide services in the areas of the United States with limited access to care. BHW accomplishes its mission by leveraging scholarships, grants, and loan repayment awards to help professional students and clinicians advance their education and training and provide services in underserved communities.

Mr. Ali said that NHSC currently has over 13,000 clinicians, serving as the safety net providers within their communities and providing care to over 13 million people across the country. He highlighted two new programs intended to address the nation's opioid epidemic: the Substance Use Disorder Workforce Loan Repayment Plan, intended to expand and improve access to quality substance use disorder treatment in underserved areas; and the Rural Community Loan Repayment Plan, launched in conjunction with the Federal Office of Rural Health Policy, to improve access to treatment in rural areas. He outlined other programs intended to support the pipeline for future healthcare providers. He added that many NHSC graduates continue to serve in areas of greatest need after completing their service obligations.

Mr. Ali said that most of the 1,700 sites approved for NHSC service are outpatient facilities, providing primary care, medical, dental, or behavioral health services, including substance use disorder treatment. Each site must be located in a Health Professional Shortage Area (HPSA) and be committed to providing services to the community without regard to ability to pay. He reviewed some of the successes of the program from 2019.

Mr. Ali listed the priorities of the NHSC for FY 2020 as:

1. Operationalizing Characteristics of Providers Likely to Remain in a HPSA
2. Dedicate Support to the NHSC Pipeline
3. Optimize data collection and utilization

Mr. Ali described two HRSA resources intended to help connect providers with available positions in clinics and community health centers: the Health Workforce Connector, which lists job vacancies as NHSC-approved sites across the country, and the HRSA-sponsored Virtual Job Fairs, which helps interested candidates locate employment opportunities in high-need areas.

Q and A

CAPT Russell thanked Mr. Ali for his presentation. She reminded the Council members of the DNPH investment in the Advanced Nursing Education – Nurse Practitioner Residency program. Its purpose is to prepare new nurse practitioners for primary care practice in community-based settings that benefit rural or underserved populations, such as NHSC-approved sited, through a 12-month residency program with a clinical and academic focus. She informed the members that they had been charged to provide some comments and feedback for the residency program.

A question was raised about the opportunity for a nurse faculty residency program, to provide a transition period for those entering faculty roles. There was a comment that such a residency period could be of benefit, as the onboarding new faculty members is happenstance at best, and a residency period could help build teaching competency. A second question was raised to address the possibility of HRSA funding for a nurse practitioner residency program in acute care. There was a reply that the current program is targeted for primary care or behavioral health practice integrated in a community-based setting.

Another topic was raised concerning the previous suggestion from Dr. Hulin about a dual program as a bridge between nurse practitioners and CRNAs. Dr. Hulin said that such a program could broaden the skillsets of the practitioners to create a well-prepared critical care specialist. There was a comment that some CRNAs have returned to school to obtain a second certification as a nurse practitioner and serve as a full-scope provider for patients who suffer from a chronic pain condition. He suggested the NHSA might be interested in exploring this course of action for its opioid response programs. Mr. Ali noted that CRNAs have provide important services in primary care, specifically in the rural community, and they are included in the rural community loan repayment program.

Council Discussion: 17th Report Outline

Dr. Ezieke moved to the next agenda item, a discussion of the draft of the Council's 17th report. Dr. Ladden said the discussion would primarily cover: the number of new nursing faculty needed to address the long-term faculty shortage; different models of faculty and preceptor preparation, and competency-based faculty assessment. She invited Council members to recommend policies and initiatives to alleviate the faculty shortage, and outlined some of the main issues identified by the writing subcommittee.

Dr. Ladden said that results from recent studies anticipate an increase in faculty retirements in the near future, with 30 percent of the faculty working in 2015 set to retire by 2025. The number of research-based doctor of philosophy (PhD) graduates has remained flat or even slightly declined in recent years, while the number of practice-based doctor of nursing practice (DNP) graduates has grown substantially. While both groups represent doctorally prepared nurses, they are not interchangeable in terms of training, skills, research preparation, and facility or

preference for teaching. Many nurses with PhDs choose to enter higher-paying clinical roles for their initial employment, and may only consider teaching later in their careers. She said that the faculty role in general is poorly understood.

Dr. Ladden referred to a previous NACNEP report from 2010, which also addressed the faculty shortage. She said that the situation had not changed significantly in the interceding years. Of particular concern, a shortage of faculty will contribute to or exacerbate the shortage of nurses, as there is an insufficient number of faculty to prepare new nurses.

Dr. Ladden discussed the first section of the draft report, on federal, state, and philanthropic foundation approaches to address the nurse faculty shortage. She mentioned HRSA nursing workforce initiatives, including the Nurse Faculty Loan Program (NFLP), which provides repayment of student loans for graduate nurses who enter faculty roles. She noted the National Institute of Nursing Research, a part of the National Institutes of Health, which funds predoctoral research awards that help prepare new faculty. She also referred to presentations from the previous NACNEP meeting on programs from the Robert Wood Jonson Foundation, the Jonas Foundation, the Gordon and Betty Moore Foundation, and other, which have provided financial support to several programs intended to grow the numbers of nurse faculty.

There was some discussion of actions taken by several states to attract more nurses into teaching, including scholarships, grants, and student loan repayment. One member said that while health systems and rural hospitals need RNs, they are often unwilling to make investments in the faculty and preceptors needed to educate and train them. There was further discussion about the need for academia and practice to collaborate to encourage and develop more PhD-prepared nurses. One potential initiative was raised about having healthcare systems grant release time to clinical nurses who want to teach, and help pay part of their teaching salaries. One member discussed a program in Maryland, administered by its higher education commission, to attract more nurses into education programs and to teach at institutions within the state.

Dr. Ladden raised the question about non-traditional partners that may support programs to develop nurse faculty, such as pharmaceutical companies, health insurers, or major drugstore chains. One member mentioned AARP, which has supported several campaigns to attract more students into nursing and into advanced practice and faculty roles. Dr. Patricia Selig mentioned the role Apple had played in helping some nursing schools transition to more technology-based learning platforms and online learning content.

Dr. Cary said that one problem is a devaluation of the faculty role. In some schools, nurses in many PhD programs are trained solely to become nurse scientists. They receive little or no training in education, and have no obligation serve as teachers or to create the next generation of nurses, scientists, and faculty. There was some discussion about promoting joint PhD-DNP programs, or to include more educational competencies within DNP programs, as ways to prepare more nurses with the facility to teach. There were several comments on improving the messaging and promoting the image of nursing faculty to attract more students into the role.

Dr. Cary moved the discussion to the second question about the different types of models for nurse preceptors, and preparing preceptors to guide students in the clinical learning experience.

Dr. Brucker discussed the preparation of nurse midwives. She said midwife preceptors minimum requirements for faculty in terms of practice years, qualifications, and educational degree, and are required to have at least one year of experience. She noted a recent study, though, that explored why all qualified midwives do not precept students. One of the major barriers was work productivity. With midwives, as with other APRNs, having a student often decreases the number of patients seen as a measure of productivity, which in turn can cause issues with Medicare compliance. She suggested that some regulations on productivity need to be reviewed and loosened in order to attract more preceptors. There was some follow-up discussion related to new guidelines from CMS that changed some requirements for clinicians in teaching roles, removing some of the documentation burden.

Dr. Brockman-Weber suggested developing some specific educational competencies for preceptors to prepare them for their role in educating students. Improving the preparation of preceptors may also ease some of the teaching responsibilities of didactic faculty.

There was a question raised in terms of interprofessional education and allowing some of the education of nurses to be done across disciplines. Dr. Ladden noted that the role of the preceptor is different in different health professions. She referred to the National Center for Interprofessional Education and Practice, at the University of Minnesota. This Center was initially funded by HRSA, and now has several funding sources from philanthropic organizations. She said that the Center may be able to speak preceptor requirements and the roles of preceptors in the different health professions.

Dr. Ezeike mentioned that HRSA had expanded its definition of faculty to include the role of the preceptor, allowing more preceptors to be eligible for grant funding and loan repayment programs like the NFLP.

Dr. Ladden expressed concern that HRSA had removed the requirement for specific educational coursework for students under NFLP. Dr. Ezeike said that the requirement for certain mandatory classes was not removed, but was made less prescriptive, due to feedback received from the schools and other stakeholders. Schools may still offer the educational courses, but may also develop other avenues to deliver similar content. There was concern expressed about the importance of maintaining the science of education behind nursing education and faculty preparation. Schools that do not offer the coursework can partner with other programs to make the content available to their students. If certain content is left to the discretion of the schools, the faculty preparation may be inadequate. There was a recommendation for HRSA to restore the mandatory educational coursework.

Dr. Ladden reminded the Council members that HRSA addressed the nurse faculty shortage ten years ago with similar types of recommendations that NACNEP is considering in its current report. However, not much changed in the ten year period after the release of the 2010 Report. She urged the members to consider how HRSA might create partnerships with other agencies and outside organizations, and to work on some recommendations that are not specifically within HRSA's realm, so that their recommendations can have greater impact, rather than having more reports ten or twenty years down the line exploring the same issues.

The discussion moved to the third section of the report, on regulations for faculty credentials and faculty or preceptor to student ratios. Dr. Mary Ellen Biggerstaff said that regulations on faculty requirements vary from state to state, and the federal government has little oversight in this area. She cited the example of regulations on nurse staffing, in which in fourteen states address nurse staffing in hospitals, with one state (California) specifically setting required minimum staffing ratios. Similarly, there is little state regulation on faculty-student ratios. However, educational accrediting bodies can have significant influence in setting standards.

Dr. Biggerstaff laid out some of the questions that had arisen:

- Is the regulatory variability a major barrier for faculty and preceptors?
- Should there be standard reimbursement for all preceptors across the country?
- What regulations are needed to improve preparedness of faculty and preceptors?
- Should educational standards be set by the federal government, the states, or the credentialing bodies?
- What barriers to faculty and preceptor preparation can NACNEP address through its recommendations?

Dr. Phillips noted that she and Dr. Biggerstaff had created a table outlining some of the accrediting bodies and faculty credential requirements, including some information on faculty-student ratios.

Dr. Schoneboom commented that the Council on Accreditation of Nurse Anesthesia Educational Program sets requirements on the faculty-student ratio in the clinical setting, and specifies what type of faculty can supervise student, so that a nurse anesthetist student they can only be supervised by an anesthesiologist or certified registered nurse anesthetist.

On the need for improved preparation of faculty and preceptors, there was a question raised related to the need for faculty preparedness, or published competencies for faculty or preceptors. Dr. Alexander replied that her group had completed a study to be published soon providing data that many faculty who enter the role are extremely unprepared. For example, many have never been taught how to write for publication. Outcomes would be improved if faculty had more preparation for their roles in education and research.

Another question was raised from an administrative standpoint on the challenges of supporting or encouraging more staff to serve as preceptors. Dr. Alexander replied that a major constraint is the lack of support within the healthcare or hospital system for preceptors, because overseeing students reduces their clinical productivity. She cited the need for health systems to make real investment in allowing time for experienced staff members to precept, and to support their training for the role. One possible recommendation that HRSA may be able to address would be to develop an online course to help nurses interested in precepting to develop a better understanding of the role, how to teach and evaluate students, what type of oversight they need, and how to match your experience with their learning objectives.

Dr. Cary noted that HRSA had funded preceptor projects in the past, and wondered if there were any lessons learned from those projects that could help inform NACNEP in making its recommendations. The specific questions she raised included:

- Were the project successful in increasing the number of preceptors?
- If so, what strategies did they use?
- What strategies did not work?
- What interventions were used to attract, educate, and retain preceptors?

Dr. Ezeike replied that there could be issues with the data elements collected, but there was an opportunity to capture lessons learned for previous projects.

Discussion Summary

In summary, while seeking creative solutions to the nurse faculty shortage, the Council discussion covered:

- Funding for faculty residency programs to improve success in academic roles.
- A stronger emphasis on educational competencies and the science of education in doctoral programs.
- Steps to elevate the status and visibility of faculty roles.
- Building and strengthening academic-practice partnerships to promote the role of clinical preceptors, with grant funding to develop preceptor training.
- Promoting interprofessional education, to include training across health care disciplines.
- Improved use of remote access technology for rural areas.
- Investment by hospitals and health systems in preceptor preparation and training, and standard reimbursement for clinical preceptors.
- Research on recruitment strategies for clinical preceptors, including a HRSA review of program outcomes on preceptor recruitment.

Council Discussion: Recommendations for the 17th Report

The Council members concluded the discussion by proposing some draft recommendations for inclusion in the 17th Report, to be further refined by the writing committee. These included:

- Promoting and broadening the use of simulation as a pedagogical strategy.
- Permitting the use of instructional designers to support faculty in preparing on-line classes and other remote learning opportunities.
- Providing HRSA funding to develop telehealth and distance education infrastructure, and open-source apps and products for virtual simulation.
- Piloting nurse faculty residency programs as a faculty retention strategy.
- Infusing disaster competencies into pre-licensure training and education, and funding faculty and curricula development for disaster preparedness.
- Encouraging HRSA to explore federal-private partnerships to leverage HRSA funding, cast a wider net for partners in co-funding initiatives.
- Promoting faculty diversity by increasing recruitment of faculty from diverse backgrounds.

Public Comment

Dr. Ezeike opened the floor for public comment. Over 20 members of the public attended the meeting. However, there were no public comments offered during the comment session.

Conclusion

CAPT Sophia Russell provided an overview of meeting and recapped the next steps in developing the Council's report ahead of the next Council meeting on Aug. 11, 2020. She summarized the common themes from the report discussion:

- The need to develop faculty residency programs.
- Post graduate support programs for new nurses.
- Ongoing professional training as it relates to COVID19/Disaster Management.
- The significance of the instructional designer role in creating a virtual nursing curriculum to meet the student didactic and clinical learning requirements.

Meeting Adjourn

Dr. Ezeike adjourned the meeting at 4:30 p.m.

Acronym and Abbreviation List

AACN	American Association of Colleges of Nursing
APRN	Advanced Practice Registered Nurse
BHW	Bureau of Health Workforce
CNM	Certified Nurse Midwife
CRNA	Certified Registered Nurse Anesthetist
DFO	Designated Federal Official
DNP	Doctor of Nursing Practice
DNPH	Division of Nursing and Public Health
FAQs	Frequently Asked Questions
FGCU	Florida Gulf Coast University
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
ICU	Intensive Care Unit
IDR	Infectious Disease Response
LSBN	Louisiana State Board of Nursing
NACNEP	National Advisory Council on Nurse Education and Practice
NCSBN	National Council of State Boards of Nursing
NFLP	Nurse Faculty Loan Program
NHSC	National Health Service Corps
NP	Nurse Practitioner
PhD	Doctor of Philosophy
PHS	Public Health Service
PPE	Personal Protective Equipment
RN	Registered Nurse