

NATIONAL ADVISORY COUNCIL ON NURSE EDUCATION AND PRACTICE

The 139th meeting of the National Advisory Council on Nurse Education and Practice (NACNEP) was held on Tuesday, May 21, 2019, from 8:30 a.m. to 4:00 p.m. The meeting was conducted virtually by webinar and teleconference.

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

Council members attending virtually:

CAPT Sophia Russell, Chair
Dr. Maryann Alexander
Dr. Cynthia Bienemy
Dr. Mary Brucker
Dr. Ann Cary
Dr. Tammi Damas

Ms. Mary Anne Hilliard
Dr. Ronda Hughes
Dr. Christopher Hulin
Dr. Linda Kim
Dr. Maryjoan Ladden
Rev. Dr. Lorina Marshall-Blake
Ms. Dona Meyer
Dr. Teri Murray
COL Bruce Schoneboom
Dr. Roy Simpson

Council members absent:

Dr. Marsha Howell Adams
Dr. John Cech
Ms. Mary Ann Christopher

Others present:

Ms. Tracy Gray, Designated Federal Official, NACNEP
Ms. Robin Alexander, Management Analyst, HRSA
Ms. Kimberly Huffman, Advisory Council Operations, HRS
Dr. Tiandong Li, Statistician, HRSA
Ms. Deitra Scott, Nurse Consultant and Project Officer, HRSA

Tuesday, May 21, 2019

Welcome, Meeting Purpose, and Approval of Minutes

Tracy Gray, MBA, MS, RN, Designated Federal Officer (DFO) and Chief, Advanced Nursing Education Branch, HRSA

Ms. Tracy Gray, Designated Federal Officer (DFO) for the National Advisory Council on Nurse Education and Practice (NACNEP, or the Council), convened the 139th NACNEP meeting at 8:30 a.m. on Tuesday, May 21, 2019, and conducted roll call. The legislative requirement of a quorum was confirmed. She thanked participants for their work in preparing for today's meeting, especially the Writing and Planning Committees.

Ms. Gray informed the group that the purpose of today's meeting is to review, discuss, and edit the first draft of the 16th Report. The presentations by experts and review of articles distributed for discussion will also help to further develop the 16th Report.

Ms. Gray informed members that the tenure of the following members will expire on September 30, 2019: John Cech, Mary Ann Christopher, Mary Anne Hilliard, Ronda Hughes, Linda Kim, and Terri Murray. HRSA has received nominations to replace those leaving the Council and are currently under review.

She informed the Council that members who are leaving will receive certificates of appreciation signed by the Assistant Secretary of Health as well as a letter of appreciation signed by Dr. Sigounas, HRSA's Administrator.

The Council approved the April 1, 2019 minutes unanimously.

Ms. Gray introduced CAPT Sophia Russell, director of the Division of Nursing and Public Health (DNPH) within the Bureau of Health Workforce (BHW) at the Health Resources and Services Administration (HRSA). By the Council's charter, the DNPH Director serves as the NACNEP Chair. CAPT Russell welcomed Council members and provided brief opening remarks.

Opening Remarks

CAPT Sophia Russell, DM, MBA, RN, NE-BC, NACNEP Chair, and Director, Division of Nursing and Public Health, HRSA

CAPT Russell thanked Ms. Gray and the staff for their work in supporting the Council. She also wished everyone happy belated National Nurses Week, which began on May 6, 2019. CAPT Russell said she hoped that members were recognized for their nursing contributions through their respective organizations.

CAPT Russell congratulated the Council on the completion and official submission of NACNEP's 15th report to Congress: *Nursing Leadership in the Transition to Value-Based Care*. The goal of today's meeting is build on that momentum by further developing NACNEP's 16th

Report. The report focuses on ensuring that graduating nurses are well equipped to care for underserved populations through community engagement and by incorporating concepts of the social determinants of health, and that faculty are prepared to teach them.

NACNEP is not alone in incorporating social determinants of health (SDOH) into nursing education and practice. The [Future of Nursing 2020-2030](#) report, developed under the auspices of the National Academies of Sciences, Engineering, and Medicine, will also address SDOH.

CAPT Russell reviewed the mission, vision, and priorities of the Bureau of Health Workforce. The priorities reflect the overarching goals that define the Bureau's programming. She asked Council members to please keep these in mind as they consider recommendations for the 16th report. She reviewed the agenda and introduced the next speaker, Mr. Daniel Viera, form HRSA's National Center of Health Workforce Analysis, also known as NCHWA.

NCHWA conducts research to inform program planning, development, and policy making by examining a broad range of issues that impact the nation's health workforce. NCHWA helps track national trends and examines issues that impact supply and demand, distribution, and preparation of the nation's health workforce. Its research allows HRSA to develop responsive programs, health workforce policies, and apply resources where gaps and needs exist.

National Sample Survey of Registered Nurses

Daniel Vieira, MSN, RN, National Center of Health Workforce Analysis (NCHWA), BHW, HRSA

Mr. Viera's presentation focused on the National Sample Survey of Registered Nurses (NSSRN). The survey has been conducted approximately every four years since 1977 and is meant to be a periodic assessment of the U.S. nursing workforce. It provides quality data for the nursing profession to support research and planning of future workforce needs.

The survey covers a variety of topics including the state of current licenses, education/training, workforce participation, income, demographic characteristics, nurse practitioner question, and information on professional nursing certifications. It is mandated through the Public Health Service Act.

In 2012, a National Sample Survey of Nurse Practitioners was conducted to capture data on Advanced Practice Registered Nurses around the country. In 2018, the 10th cycle of the survey was implemented. The 2018 survey was redesigned and improved in collaboration with the U.S. Census Bureau and various stakeholders. Improvements were made based on changes to health care policy and best practices in survey methodology.

The redesign incorporated questions from both the NSSRN and HRSA's National Sample Survey of Nurse Practitioners. This approach enlarged the overall sample size, allowing researchers to fine-tune findings. The revised survey collects data on new delivery systems and health reforms and improves the sampling frame by matching to Census administrative data. It also selects a representative sample at the state and national levels for nurse practitioners (APRNs), along with registered nurses (RNs).

New questions added to the survey were suggested by stakeholders and other groups, such as leading nursing organizations and nursing researchers. Questions were added in the area of telehealth, the electronic health record, team-based care, military and deployment status, preceptor programs, and questions related to the National Practitioner Data Bank.

Census survey experts provided input on reducing the survey's response burden, optimizing its appearance, suggesting wording for questions, and providing drop down lists and skip patterns. The revised survey underwent cognitive/usability testing and review by external experts as well as stakeholders. Testing helped to ensure that responses were capturing the essence of the questions being asked. Key changes were also made to the methodology.

Results for the 2018 survey are expected by the second half of 2019. Survey deliverables will include a findings report, a methodology report, a code book, and a public use file that will include state and county information. A restricted use file will also be available to those with special sworn status within the Census Bureau to allow researchers to obtain a more granular level of information about the survey.

Discussion

- Dr. Simpson asked if the survey also accounted for the state boards. Mr. Viera replied that the National Sample Survey of Registered Nurses collects information from a variety of stakeholders, including the National Council for State Boards of Nursing and individual state boards.
- Dr. Simpson asked if the survey was manual or automated. Dr. Li replied that individuals are first reached by mail and can respond via a paper questionnaire or online.
- Dr. Simpson asked if there was taxonomy or dictionary for the terms used in the questionnaire. Dr. Li said there was no taxonomy. The questions are in plain language. If a term needs to be explained, it is explained in the questionnaire itself.
- Dr. Bienemy asked what was the response rate. Dr. Li said it was around 26 percent.

Transitions of Care

Mary D. Naylor, PhD, RN, FAAN, Professor, University of Pennsylvania School of Nursing

Dr. Naylor discussed the transitional care model (TCM). TCM is a cost-effective, advanced practice, nurse-led model. It improves transitions of older adults navigating a series of complex – and often fragmented – systems of care.

A growing segment of the aging population copes with complex health and social needs. These challenges are especially burdensome for those that live in rural communities. The care for these individuals may be complicated by functional deficits, cognitive deficits, and mental and behavioral health problems. Additional challenges include language and cultural differences, poverty, and social isolation.

While some older adults are cared for by their spouses, children, grandchildren, neighbors, church members, or paid care workers, others have no caregivers and are socially isolated. It is

exceedingly challenging for these individuals to navigate health care settings such as hospitals, post-acute care, and home-base care.

Advance Practice Registered Nurses (APRNs) have been involved in helping individuals transition from hospital to post-acute settings and back to their homes. Initially, the focus was for APRNs to assume the responsibility for the care of a population as they moved through multiple transitions in health and healthcare. However, some approaches now focus on identifying and engaging individuals in the community to reduce their need for use of emergency department or hospital services, when appropriate.

The transitional care model works by screening those in the community, hospital, and long-term care settings who are at the highest risk for poor outcomes. APRNs assume the primary responsibility of care management throughout episodes of acute illness and oversee/support longitudinal follow-up. They establish and maintain a trusting relationship with older adults and family caregivers and also engage them in the design and implementation of plans of care that are aligned with their preferences, values, and goals.

TCM prepares and educates older adults and family caregivers to prevent/identify and quickly respond to worsening health and social needs. By having the same APRN help the older adult and family caregivers to navigate multiple clinicians and various health/community sectors, the TCM promotes continuity by preventing a breakdown in care.

The transitional care model has been the subject of significant investments by the National Institutes of Health and has been studied in multiple, randomized clinical trials. Work funded by the National Institute of Aging applied the TCM to assisted living facilities and long-term care environments. Results showed improved access, reduced errors, enhanced care experiences, and improving symptoms, function, and quality of life all while reducing caregiver burden. Studies on health resource use and cost outcomes have also demonstrated mean savings ranging from \$3000 to \$5000 per patient, showing that the transitional care model can generate Medicare savings.

The TCM has also been implemented in partnership with various health systems/communities including Trinitas Regional Medical Center, Cedars-Sinai, Yale New Haven Health, and Bluegrass Care Navigators.

Dr. Naylor offered the following overarching recommendations:

- Accelerate widespread use of the TCM to maximize contributions of nurses in addressing the challenges of a rapidly growing population of older adults with complex health and social needs.
- Expand testing of the TCM to older adults living in rural/underserved communities (e.g., non-English speaking) who have not been a focus of prior efforts.
- Test technological innovations designed to broaden access of the TCM to a much wider population of older adults with complex care needs.

- Position the existing and emerging nursing workforce with the competencies, tools, and resources essential for high-quality implementation of evidence-based transitional care and population health.
- Test the older adult, family caregiver, and cost outcomes achieved by implementing the TCM using BSN prepared nurses compared with MSN/DNP prepared nurses.

Discussion

- Dr. Cary asked if the TCM used a standardized SDOH assessment. Dr. Naylor said they used a standardized assessment that incorporates data queries related to both health and social needs.
- Dr. Simpson asked if they had encountered barriers with respect to APRNs in the various states it was implemented. Dr. Naylor said they have capitalized on the full scope of practice in those states where nurses can prescribe, while in other states the model was adapted.
- Ms. Gray asked who pays for the APRN in the model. Also, when the case is assigned is the point of entry at the hospital or primary care level? Dr. Naylor said it varies. In some cases patients need help navigating from the hospital to post-acute care to home, while in others they go from post-acute to home. Payment can vary depending on the reimbursement source.
- CAPT Russell asked if they were looking to have professionals to complement the team. Dr. Naylor said the APRN-coordinated, team-based model relies on various individuals to support the patient.

Demonstration Projects

Barbara Todd, DNP, CRNP, ACNP-BC, FAANP, Adjunct Assistant Professor, University of Pennsylvania School of Nursing; Director, CMS Graduate Nurse Education (GNE) Demonstration Project, Hospital of the University of Pennsylvania

Dr. Todd discussed the genesis of the Graduate Nurse Education (GNE) project at the Hospital of the University of Pennsylvania. She also discussed lessons learned and challenges related to the project's implementation.

In 2012, the Centers for Medicare & Medicaid Services (CMS) issued a call for applications for a new initiative designed to increase the nation's primary care workforce by supporting facilities that train APRNs.

The CMS initiative, through which the GNE project was funded, was mandated by the Affordable Care Act. The initiative's primary goal was to increase the provision of qualified clinical training to APRN students. More specifically, it provided APRNs with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for Medicare beneficiaries.

The demonstration project also served as a test of the feasibility, effectiveness, and cost of increasing the production of APRNs. Evidence from prior studies has shown that APRNs can provide safe, effective care. Unfortunately, there are not enough APRNs. Nursing schools have stated that a barrier to producing more APRNs includes a lack of clinical training opportunities. Also, although there are plenty of student applicants, the capacity of nursing schools to expand is limited due to a shortage of preceptors and faculty. The CMS initiative was designed to address some of these challenges.

The CMS initiative was implemented through two models: 1) single hospitals and its primary affiliated nursing school along with community partners, and 2) regional consortia with multiple nursing schools and hospitals, and various community partners covering a geographic area. The GNE project at the Hospital of the University of Pennsylvania belonged to the second group.

The goals of the GNE were to:

- Provide Medicare beneficiaries with improved access to health care provider services by significantly increasing the number of APRNs educated in the Greater Philadelphia Region.
- Create an efficient, collaborative, and replicable networking model among hospitals, regional nursing schools, and clinical partners.
- Allow for monitoring, data collection, and information exchange through coordinated communication among regional health care systems, nursing programs, and clinical partners.

Results of the GNE project showed an increase in APRN enrollment in greater Philadelphia from 1,164 to 2,287 students in 6 years. Graduates increased from 394 to 752 over the same period. A GNE alumni survey showed that 50 percent of the students responding held their first position in the state of Pennsylvania, 25 percent were employed at sites where they carried out their clinical training, and 25 percent were from underrepresented groups. A substantial portion of graduates were working in primary care.

Other results showed that the cost of training of an APRN to graduation (in addition to tuition) was estimated to be less than \$30,000 compared with the cost of community-based residency training of primary care physicians in the Teaching Health Center demonstration project, which was \$150,000 per year. Also, the cost per incremental APRN trained was lower as the number of nursing schools in each demonstration hub increased. Affiliation of a school of nursing with a hospital was found to decrease the average clinical training costs of APRN education by the school of nursing.

Challenges included the sustainability of the GNE project once funding ended. Some schools were also concerned that their enrollment would decrease as they would no longer have access to funding to incentivize preceptors. One of the lessons learned was that the demonstration was complex and perhaps could be simplified in future demonstrations, particularly as it relates to operations. Also, clinical preceptor engagement was found to be crucial as was the need to centralize clinical training rotations in a region.

Discussion

- A participant asked if GNE trainees were delivering care that involved social determinants of health. Dr. Todd replied that the GNE did not, although they have done so through another HRSA-funded project, the Academic Practice Partnership.
- CAPT Russell asked what the Council should keep in mind to ensure that their recommendations are realistic. Dr. Todd said it would be important to determine if funding would be temporary or more sustainable. Also it may help to have an approach that is regional vs. a single university site.
- Dr. Simpson asked how the training costs absorbed by the community-based setting or the acute care setting was offset. Dr. Todd said that 50 percent of the education was not funded through the education project. In some cases this led to preceptors not being allowed to precept by the organization as it was considered a productivity drag.
- Dr. Murray asked Dr. Todd's advice on how to further engage with the community in a demonstration project. Dr. Todd replied that working with a nurse-led consortium is key.
- Ms. Gray asked if payments to sites also included preceptor costs. Dr. Todd said the payment did not go directly to the preceptor, but the site. Some sites may have paid preceptors directly while others may have used it to offset other costs.

Literature Review on SDOH Curricular Integration

Rhonda Hughes, PhD, Lead, NACNEP 16th Report Writing Committee and Council Member

Dr. Hughes presented a literature review on the SDOH and curricular integration. Healthy People 2020 defines SDOH as “conditions in the environments in which people are born, live, work, play, worship, and age, that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”

SDOH are important because some studies estimate that medical care only accounts of 10 to 20 percent of the modifiable contributors to health outcomes. The other 80 to 90 percent are dependent on health behaviors, social/economic factors, and the individual's physical environment.

In a 2018 article by Dr. Murray, *Overview and Summary: Addressing Social Determinants of Health: Progress and Opportunities*, she stated that “Health problems begin long before patients seek a health care provider...” and that “interventions outside of the health care system that affect everyday life are more likely to impact health status than care rendered within the institutions.”

Teaching SDOH helps students to understand the origins of disease using a multilevel approach that incorporates a variety of factors including psychological/physiological stress, poverty, social isolation, neighborhood characteristics, and other factors. SDOH shifts the locus of learning from disease to patients. It also introduces a “life course” approach, with factors that may contribute to wellness and disease.

The report, *A Framework for Educating Health Professionals to Address the Social Determinants of Health*, published by the National Academy of Sciences, Engineering, and Medicine, offers input on faculty development and community partnerships that allow students to learn about SDOH.

A review of programs across the country showed variations in length and intensity of SDOH training, differences in the communities involved, and the presence of both experiential and nonexperiential components to teaching SDOH. Service learning was found to be one of the most common educational approaches to learning SDOH. The report also stated a need to evaluate effectiveness and outcomes of incorporating SDOH into programs and curricula and stressed that SDOH should be an obligatory course, instead of an elective or extracurricular activity.

In their article, *Preparing Today's Nurses: Social Determinants of Health and Nursing Education*, Thornton and Persaud (2018) state that SDOH should be integrated throughout the curriculum, instead of being presented solely through a course. Integrating SDOH throughout the curriculum encourages students to “understand, reflect, analyze, and apply content to potential experiences and encounters.”

Thornton and Persaud also state that clinical opportunities can serve as vehicles to integrate SDOH into the population being served at the clinical site. It provides an opportunity for students to use clinical training to understand the connection between SDOH and the challenges that patients face on a daily basis and throughout their lives, particularly after being diagnosed with a chronic condition.

Additional approaches discussed by Thornton and Persaud to teach SDOH include using simulations, motivational interviewing and empathetic enquiry, a social justice and advocacy approach, and service learning.

Discussion

- Dr. Ladden asked if there was anything in the literature to address education about equity and inequities. Dr. Hughes said that case studies have been used at both the graduate and undergraduate level to address this.
- Dr. Murray said that she found equity to be related to laws, policies, zoning, and power structures, as opposed to SDOH.
- Dr. Bienemy said it would be important to show the relationship between SDOH and health care disparities as well as health equity.
- Dr. Cary said the report did not address epigenetics. It may be helpful to integrate an epigenetics piece into the report.
- Dr. Alexander suggested including in the report schools that have been exemplary at incorporating SDOH into their curriculum and clinical partnerships. Dr. Ladden said the

University of Minnesota has developed a report on accelerating interprofessional practice in community based settings.

- A participant added that there are some schools that have nurse-led clinics that could be listed as exemplars for SDOH. Texas Tech University is one of them.
- Dr. Schoneboom asked what was found in the literature with respect to incorporating SDOH into specialty practices, like anesthesia. Dr. Hughes said some of the literature proposes the case study approach – the idea of looking at a patient in context and not just as a disease or a surgical case, but looking at all the factors involved.

Overview and Editing of the 16th Report Draft

Rhonda Hughes, PhD, Lead, NACNEP 16th Report Writing Committee and Council Member

Dr. Hughes walked the Council through the report. The Council reviewed the report in detail and offered edits, suggestions, and substantive changes. The Council also asked questions and made suggestions regarding the order, breadth, and organization of some of the report's sections.

A detailed file with all of the suggested edits proposed by the Council was developed and submitted to Council members following the meeting. The most salient suggestions resulting from the discussion are presented below and are organized by each of the report's main sections.

Working Title

- National Nursing Advisory Report on Nursing and Social Determinants of Health: Education, Practice and Research.
- Integration of Social Determinants of Health in Nursing Education, Practice, and Research.

Introduction

- Incorporate statistics from Kaiser and the Commonwealth Fund on SDOH, particularly on economic and other costs.
- Develop a list of SDOHs.
- Present a historical perspective of how nurses have impacted SDOH over time.
- Incorporate information from the [May 2019 Health Affairs](#) blog on SDOH and children.
- Add information on social isolation and its impact on older adults and new mothers.
- Add a “Call to Action” paragraph about how addressing SDOH can positively impact outcomes (e.g., Boston Children’s Hospital [Asthma Initiative](#)).

Education

- Add information on clinical learning in addition to service learning.
- Discuss adding SDOH to courses other than nursing.
- Make a connection between SDOH and the development of health disparities.

- Emphasize the importance of creating academic-community partnerships.
- Add a section on faculty development.
- Reduce the length of the section on telehealth, but discuss how telehealth can impact access, reduce costs, and engage people, as this is part of HRSA's objectives.

Practice

- Include the collection of data through EHR.
- Show gaps and make recommendations regarding the need to educate practitioners on SDOH.
- Stress lifelong learning and the need to educate those in practice.

Research

- Discuss current research and research that still needs to be done (i.e., state of the science).
- Add a section on research gaps.
- Discuss the lack of longitudinal SDOH studies in nursing.
- Strengthen the “ask” for research demonstration projects.
- Discuss the need for research that evaluates the integration of SDOH into curricula.

The 16th Report will be revised by the Writing Committee following today's meeting to incorporate the Council's input. The Writing Committee will also meet on June 4, 2019 to discuss further development of the report.

Public Comment

Tracy Gray, MBA, MS, RN, DFO, and Chief, Advanced Nursing Education Branch, HRSA

Ms. Gray opened the floor for public comment. No comments were offered.

Next Steps

CAPT Sophia Russell, DM, MBA, RN, NE-BC, NACNEP Chair, and Director, Division of Nursing and Public Health, HRSA

Tracy Gray, MBA, MS, RN, DFO, and Chief, Advanced Nursing Education Branch, HRSA

CAPT Russell thanked everyone for their participation and their dedication to nursing education and practice. She also thanked members of the Writing and Planning Committees for work done in advance of the meeting. CAPT Russell then provided a brief recap of the meeting.

CAPT Sophia Russell, NACNEP's Chair, informed the Council that the 15th Report had been reviewed by HRSA's Administrator and is now on its way to the Secretary of Health. Ms. Gray encouraged all Council members to let other stakeholders know that this resource is available.

Ms. Gray reviewed the process surrounding the development and submittal of the 16th Report. HRSA will be receiving the final report from the Council on August 27, 2019. The report needs to be completed and finalized by the end of the fiscal year, on September 30, 2019.

The Council reviewed and agreed to the timeline below.

Timeline	
June 4	Writing Committee meets to discuss the development of the 16 th Report
June 24	Writing Committee submits 16 th Report revisions to the Technical Writer (TW)
July 25	Writing Committee receives the second draft from the TW
Aug 6	Writing Committee submits revisions to the TW
Aug 23	Writing Committee receives the final report from the TW
Aug 27	HRSA posts the final report for the Council's review
Sept 30	Deadline for the 16 th Report

DRAFT

List of Abbreviations

APRN	Advanced Practice Registered Nurse
BHW	Bureau of Health Workforce
BSN	Bachelor of Science in Nursing
CMS	Centers for Medicare and Medicaid Services
DFO	Designated Federal Official
DNPH	Division of Nursing and Public Health
DNP	Doctorate of Nursing Practice
GNE	Graduate Nurse Education
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
NACNEP	National Advisory Council on Nurse Education and Practice
MSN	Master of Science in Nursing
NCHWA	National Center of Health Workforce Analysis
NSSRN	National Sample Survey of Registered Nurses
RN	Registered Nurse
SDOH	Social Determinants of Health
TCM	Transitional Care Model