GEORGE MASON UNIVERSITY

Testing a Funding Allocation Methodology For Title VIII Programs: Phase II

Second Expert Panel Meeting

January 30, 2002
Arlington, Virginia

FINAL
Meeting Summary

Wednesday, January 30, 2002

INTRODUCTIONS

PJ Maddox, EdD, RN, _Principle Investigator and Mary Wakefield, PhD, RN , Co-Principle Investigator, GMU Center for Health Policy, Research & Ethics

Dr. Wakefield opened the meeting by having participants introduce themselves. Division of Nursing (DoN) staff present at the meeting included: **Denise Geolot**, PhD, RN, director, Division of Nursing; and **Carole Gassert**, PhD, RN, DoN project officer. The George Mason University Research Team included the co-principle investigators **Mary Wakefield**, PhD, RN, and **PJ Maddox**, EdD, RN; project manager **Eileen O'Grady**, PhD, NP; technical consultants **Graham Atkinson**, PhD, health economist, and **Marc Chinoy**, meeting facilitator; demographer **Marty Atherton,** PhD,**;** and research analyst **Victoria Doyon.**

Expert Panel members attending the meeting were: **Eula Aiken**, PhD, RN, executive director, Southern Regional Education Board Council on Collegiate Education for Nursing**; Carole Anderson**, PhD, RN, vice provost for academic administration, Ohio State University; **Linda Burnes Bolton**, Dr.PH, RN, vice president and chief nursing officer, Cedars Sinai Medical Center, Los Angeles; **Shirley Chater**, PhD, RN, adjunct professor, Institute for Health and Aging, School of Nursing, University of California, San Francisco; **Mary Foley**, MS, RN, president, American Nurses Association; **Charlene Hanson**, EdD, RN, family nurse practitioner and professor emerita, Georgia Southern University; **Arthur Levin**, MPH, director, Center for Medical Consumers; **Virgilio Licona**, MD, associate medical director, Plan de Salud del Valle, Ft. Lupton, Colorado; and **John Supplitt**, MPH, MBA, director, Section for Small and Rural Hospitals, American Hospital Association. A list of all Expert Panel members and their affiliations is available on the Center's Web site at *http://chpre.gmu.edu*[click on Funding Allocation Project]

Dr. Aiken distributed to the panelists two documents from the Southern Educational Research Board, a report entitled "Expected Competencies of Nurse Educators" and a study showing a serious shortage of nursing faculty in the region. They will be available on the Board's Web site at *www.sreb.org*/. Dr. Wakefield then reviewed procedures for public comment, comments from the audience may be made at the close of the meeting and written comments may be submitted from February 4 to March 4. Instructions and mechanisms to submit public comments are available through the project website at: *http://chpre.gmu.edu*[click on Funding Allocation Project].

OVERVIEW OF PROJECT CHARGE & MEETING OBJECTIVES

Dr. Wakefield

Dr. Wakefield gave a brief overview of the project charge. Congress directed the Division of Nursing to support a process for developing a funding allocation methodology for the three major programs in Title VIII: Part B, advanced education nursing; Part C, nursing diversity; and Part D, basic nursing education and practice. In Phase I of the project, Dr. Len Nichols developed a proposed methodology for allocating funds across the three programs, and in the current Phase II, the Expert Panel will test that methodology using a six-step process. The objectives for the panel's second meeting were: to review the data and data gaps around the 10 factors identified as the most important at the first meeting; to discuss and revise assumptions that define the context of allocation decisions; and to specify goals and priorities for each of Title VIII's three parts.

Dr. Geolot requested a correction in the minutes of the first meeting to clarify that DoN has conducted several studies to evaluate the effectiveness and impact of its nursing programs. The corrected minutes were approved by the panel.

OVERVIEW OF FEDERAL GOALS AND PRIORITIES FOR TITLE VIII

Dr. O'Grady

To prepare the Expert Panel for work in setting goals and priorities for Title VIII funding priorities, Dr. O'Grady gave a summary of the Health Resources and Services Administration's (HRSA's) and Division of Nursing's missions and strategies, preference language in the law (P.L. 105-392), priorities DoN currently uses to review grants, and historical funding levels for DoN programs. (Dr. O'Grady's PowerPoint presentation is available on the project Web site).

She emphasized that Part B advanced education nursing projects support an array of graduate level programs, including RN to master's degree programs, post master's certificate programs, and programs for nurse midwives, nurse practitioners, clinical nurse specialists, nurse anesthetists, nurse educators, nurse administrators, public health nurses, nurse informatics, and others as determined by the Secretary. Under Part B, priority is given to nurses who will provide primary care and who will practice in health professional shortage areas (HPSAs).

Dr. O'Grady pointed out that Part C on nursing workforce diversity is the only part of Title VIII that funds projects for pre-entry preparation for K-12 students to attract young people from disadvantaged backgrounds into nursing. It also funds retention activities and provides student scholarships and stipends.

Part D, basic nursing education and practice, has a larger service component to it than the others, Dr. O'Grady said. The seven priority areas in this part relate to: improving access to primary care in underserved areas; providing care for underserved and high-risk populations; providing managed care and quality improvement; developing cultural competencies; expanding enrollment in baccalaureate programs; promoting career mobility; and providing education in informatics, including distance learning methodologies.

Dr. O'Grady also listed the factors that the Expert Panel must consider in developing the funding allocation methodology, as required in the law's Part F. First, the panel should match the funding level to population needs, taking into account the need for and distribution of health and mental health services among medically underserved populations and in HPSAs. Other factors to be taken into account: provider-population ratios; use of whole rather than fractional counts in determining the number of providers; the counting of only employed providers; the number of families below 200 percent of the poverty line; infant mortality and low-birth weight rates; the percentage of the general population that are members of racial or ethnic minority groups and that are specifically of Hispanic ethnicity; the number of individuals who live in HPSAs and in medically underserved areas; the percentage of the population that is elderly; the extent of provider choice; the impact of care on hospitalizations and emergency room use; and the number of people lacking English-speaking proficiency. The law also asks the panel to consider the need for and distribution of health services for difficult-to-count populations, such as homeless individuals, migrant and seasonal workers and their families, HIV-infected individuals, and drug abusers. In addition, the panel must specify the language and cultural skills needed to provide services to members of racial or ethnic minorities. Finally, the law requires the panel to consider using morbidity and mortality data from the Centers for

Disease Control and Prevention and data from the Health Plan Employer Data and Information Set (HEDIS).

Dr. O'Grady described the point system that grant reviewers use in evaluating proposed projects under Parts B, C, and D (see her PowerPoint presentation for slides listing the criteria for each part). Out of a possible total of 100 points, projects receive points for certain factors, such as project need, clarity of project plan, or linkages with the community and practice sites. While the criteria differ somewhat for the three programs, Dr. O'Grady emphasized that all have a diversity and cultural competency component. All three parts also give priority to projects that focus on rural or underserved populations or address public health needs in state and local health departments, as provided in the statute.

The final point in Dr. O'Grady's presentation related to the level of DoN education funding from 1994 to 2001. Over the last eight years, the overall level of funding for all programs has increased significantly, by as much as 12 percent in 1997 and 17 percent in 2001. Yet between the programs, she said, there has been very little change up or down during that period, less than 1 percent. The Expert Panel is being asked to look at how funds have been allocated in the past and to consider the need to change allocations, according to the priorities the panel establishes, Dr. O'Grady concluded.

Discussion

- **Nursing educators** -- Dr. Geolot noted that the list of individuals supported under the advanced education nursing program includes nursing faculty, as well as other clinical specialists identified by the Secretary.
- **Diversity issue** -- Much of the discussion following Dr. O'Grady's presentation focused on the issue of increasing nursing workforce diversity. In response to questions from Mr. Supplitt, Dr. Geolot said DoN has for many, many years given priority to projects that emphasize the recruitment of individuals from disadvantaged backgrounds and members of racial and ethnic minority populations. Because diversity counts in scoring all projects, not just those under Part C, DoN's review process "stimulates potential grantees to focus on that area," she said. Dr. Hanson agreed that applicants work very hard to strengthen their projects so as to address the issue. Dr. Licona, however, expressed concern about the low representation of minorities in all nurse categories despite DoN's point system. He stated for the record that he does not favor an approach that weaves diversity into each program in lieu of Part C's "stand alone" strategy. Asked whether the broader approach limits the number of grants funded under Part C, Dr. Geolot said DoN receives more proposals "under workforce diversity than we're able to fund." Dr. Wakefield added that "it's not a question of either/or"; the school and faculty need the flexibility to determine which approach is best for them.

  Dr.. Aiken stressed that there is a "disconnect between what we say and what we do because the disparity still exists today." The intentions and objectives are there, but something happens to many of the disadvantaged people recruited into the programs; somehow they "get lost along the way," she said. In looking at the diversity component of grants, Dr. Anderson said, "we have to go beyond trying to recruit people" to evaluating what "the program does to support these people once they're admitted." Higher education institutions are admitting more minority students every year, she said, but "they're not graduating any more." Dr. Chater added that the problem would never be solved until the "white middle-class curricula" we impose on all health professions students is replaced with curricula with "multi-cultural aspects."

- **K-12 education** – Dr. Anderson and Dr. Aiken raised the related issue of preparing younger students for college. Until we devote more resources to K-12 programs to help students get ready for college or life-long learning, "we're just spinning our wheels," Dr. Aiken said. The pipeline issue in nursing, as well as other health professions, has long been a concern, said DoN's Dr. Geolot, and virtually all nursing grants under Title VIII programs and many grants in medicine, dentistry and allied health under Title VII programs within the Bureau of Health Professions must have a K-12 component.

UPDATE ON PHASE II PROJECT TECHNICAL APPROACH

Dr. Maddox

Phase I Recommended Allocation Process

Dr. Maddox briefly reviewed the funding allocation process recommended by Len Nichols, PhD, in Phase I of the project. (Dr. Nichols' July 2000 report to DoN and an executive summary are available as background materials on the Center's Web site, as well as his January 2002 paper "How Many Nurses Will We Need? An Essay on Why the Current Literature Cannot Substitute for Expert Judgment." Also available on the site is Dr. Maddox' PowerPoint presentation.)

The report concluded that because current data cannot link the nursing workforce with population-specific requirements, adjusted for average age and sex, the allocation process cannot follow a "heavily quantitative approach," Dr. Maddox said. Dr. Nichols recommended instead "a qualitative allocation" drawing both on available data and on expert judgments.

As he stated in his paper, "Quantitative work is not a substitute for expert judgment.... Good quantitative work can supplement and support good judgment, and [data] will be useful in shaping perceptions and guiding judgment." In conclusion, Dr. Nichols wrote:

> "Nursing care will always be central to any health care delivery system. However, the very diversity of sites within the complex U.S. system, its recent and expected future pace of change, and the heterogeneous array of health professionals that can work effectively with nurses in alternative care delivery settings make it very difficult to derive nurse staffing requirements.... Therefore, expert judgment about appropriate resource allocations in nursing education and supply will continue to be necessary, for the variables involved are just too complex to quantify completely in any formulaic way.".

Discussion

- **Lack of data** -- Mr. Supplitt asked how the panelists can reconcile the qualitative approach recommended in the report with Congress' data-specific directive in Part F, as described by Dr. O'Grady. Dr. Maddox said that the legislation allows the Expert Panel the option of weighing in on how good the data is and determining in the end how useful it is, both conceptually and in practical application; that judgment will be reflected in the panel's final report to Congress. As Dr. Wakefield pointed out, in that report the panel will speak to each of the specific items in Part F and will have to explain "what [conclusion] we came to and how we got there and the limitations and the strengths of our approach."

A more fundamental problem, said Mr. Levin, is the lack of data on the effect of different interventions on outcomes, especially on population health and in underserved communities. He also expressed frustration at the lack of consensus on the supply and distribution of other health care professionals, including physician specialists and primary care providers, and how that affects the nursing workforce. Dr. Foley said she was not concerned about the inability to come up with concrete nurse staffing requirements. The law "asks us to look at what needs to be done to meet national nursing service goals, and I think that's within our realm," she said. Dr. Bolton said the panel would be able to meet its mandate "by looking at exactly what nursing's contribution is to the health of the public without necessarily having to quantify how many nurses we need to do that." Dr. Licona commented that the nursing workforce could be influenced by unforeseen developments, such as future federal policy changes.

Available Data and Data Gaps

Dr. Maddox continued her presentation on the Phase II technical process with an update on available data and remaining data gaps. She reminded panelists that the GMU team identified over 123 data sources, including 90 unique sources, that can contribute quantitatively to the panel's deliberations (the table of data sources is posted on the project Web site). Although not "all the dots have been connected," she said, the team has found valid and reliable sources of data in the following areas: RN

demographics, health care workforce supply and participation, health care delivery system production and efficiency, population demographics, public health needs and characteristics, and economic conditions and trends.

Following the Expert Panel's first meeting in October, the GMU team modified the proposed analytic framework that the panel will use in testing the funding allocation methodology (the revised chart is part of Dr. Maddox's PowerPoint presentation on the project Web site). At that meeting the panelists considered the seven contextual factors proposed originally by the technical team and ended up with a list of 10 factors that they believed are important in determining nursing workforce requirements (see the minutes and meeting summary for the first meeting).

Dr. Maddox told the panel that the team has also updated the framework to link existing and known data sources to the 10 factors and important population-specific variables. She drew attention to the following areas where credible data exists:

- Nurse resources
  - Nurse population (licenses, distribution, employment, level, education, demographics, employment setting, salary)
  - Nurse pipeline (U.S. educated, basic and post-basic, enrollment/graduations, student demographics, institutional characteristics, foreign educated)
- Demand for nursing personnel
  - Across health care delivery settings (hospital, long-term care, public health/community)
- Health system users/public health data
  - Sociodemographics, health status, distribution

But data gaps, she said, exist in some areas, especially:

- Data linking RN contributions to population health outcomes
  - Population (total and density, number of families under 200 percent of the federal poverty level, number of uninsured, percent from racial/ethnic groups, percent residing in HPSAs, MUPs, percent who are elderly, number without English proficiency)
  - Health status (infant mortality, low-birth weight, ADL, IADL
    Health services (MUPs, HPSAs, homeless, migrants, number of HIV-infected, mental health need by MUP and HPSA)

Another major area where data sources are lacking, she said, relates to Factor 1– all other sources (federal, nonfederal, private) that fund nursing education and nursing workforce development – which had been added to the list of factors at the first meeting. This factor points to understanding the unique funding contribution Title VIII contributes to US nursing workforce development in total. There are no known data sources that can identify the total investment from all sources or even just from the federal government alone because so many different agencies are involved and often their contributions "are embedded in some atypical areas," Dr. Maddox said. And although the team certainly knows how much DoN spends under Title VIII, it can't determine its percentage share of total national expenditures compared to the other funding sources.

The problem of data gaps "reinforces the importance of expert opinion and the use of a qualitative approach in allocation Title VIII funds," she concluded.

PLANNING ASSUMPTIONS FOR TESTING ALLOCATION METHODOLOGY
Dr. Maddox

Dr. Maddox presented a partial list of draft assumptions, developed by the GMU team using available data, to identify key population and health system needs and moderating factors that the panel should use in developing the allocation formulas and scenarios for testing (see her PowerPoint presentation). The assumptions were developed by scanning available data, published health sector reports and research from a variety of sources including: American Hospital Association Futurescan 2001; Bureau of Labor Statistics; Census Bureau; Institute of Medicine's Committee on Quality of Health Care in America; and the Health

Resources and Services Administration's Bureau of Primary Care and Bureau of Health Professions' Division of Nursing.

The intent of the presentation was to "create some significant exchange" among panel members on their views about population and health system needs to inform their later judgments about Title VIII goals. The list of assumptions is expected to expand and undergo modification based on panelist input among and upon further data consideration. Following are the draft planning assumptions presented to the panel and highlights of Dr. Maddox's comments:

- Growth of the elderly population, 1960-2050, will increase need for providers – "One of the most important trends...is the aging of the U.S. population and in particular, the growth of the elderly and the frail elderly, and the ratio changes between young and old-age cohorts."
- Health professions jobs will grow at twice the rate of all occupations through 2008 – Total health professions increased 28 percent since 1998, compared to 14 percent for all U.S. employment – "a trend that is across the vast majority of the health professions," including registered nurses (22 percent increase).
- Physician supply versus distribution – The U.S. has an average of 260 physicians per 100,000 population.
- For the U.S. as a whole, the physician supply appears adequate, 2000-2015 – While the population is expected to grow 13 percent and the need for physicians will increase 18 percent, due to medical advances and aging of the population, the physician supply will increase 23 percent.
- Workforce maldistribution remains a problem – Maldistribution is particularly a problem in rural areas and in urban areas with underserved populations and for certain specialties. An estimated 13,000 primary care physicians will be needed to alleviate the problem.
- Projections of supply and requirements for full-time RNs, 2000-2020 – A shortage of nurses nationally is projected to start in 2007, at least, although "geographic concerns" about maldistribution already exist.
- Age distribution of the RN population, 1980-2000 – The average age of nurses grew older, as did the average age at entrance to the field. One of the most significant contributors to the projected nursing shortage will be losses due to the retirement of older nurses.
- Distribution of RNs by racial/ethnic background, 2000 – Although the U.S. population as a whole is becoming increasingly diverse every year, a comparable growth rate is not seen in nursing-related fields and in most health professions.
- Employment settings of RNs, 2000 – Hospitals continue to be the largest employment sector (59.1 percent), but increases are seen in areas of ambulatory care and nursing homes/extended care facilities and are expected in public health.
- Basic nurse education of RN populations, 1980-2000 – While the output from diploma programs declined, associate degree and baccalaureate programs increased and are the two most important suppliers of new nurses.
- Distribution of RNs in each racial/ethnic group by highest preparation, March 2000 – Lack of diversity is a major concern, especially for advanced practice nurses.
- RNs prepared for advanced practice, March 2000 – Among all advanced practice nurses (7.3 percent of RN population), almost half are nurse practitioners, followed by clinical nurse specialists, nurse anesthetists, and nurse midwives.
- Actual and "real" average annual salaries of full-time RNs, 1980-2000 – Adjusted for inflation, wages have been relatively flat. But because of the shortage, "fairly significant adjustments" in wages are expected, as have already been seen in the hospital industry and other sectors.

The initial planning assumptions should also include assumptions about economic conditions, health care consumer trends, the impact of technology, cost and clinical performance, managed care trends, and workforce trends, listed below:

- **Economic conditions**
    - Health care expenditures are rising again, despite managed care or government policy.

- Medical cost inflation in the next 5 years will be driven by aging of the population, rising cost of health plans and pharmaceuticals, and higher health care wages due to the tight labor market.
- Inpatient days will continue to rise, due to older and sicker patients.
- Hospital finances will tighten, largely because of reimbursement policies.
- Hospitals will continue to cut costs.
- Continuing focus on centers of excellence and further specialization is expected, driven by patient safety movement and productivity and technology enhancements.
- Maldistribution of the health workforce will continue to be a problem, particularly in nursing.
- Nursing staff shortages in all sectors will worsen as the overall nursing shortage increases.

- **Health care consumer trends**
  - Informed consumers will demand the latest drugs and treatments.
  - The aging of the population will drive up hospital and ambulatory care utilization.
  - Racial and ethnic diversity of the population will continue to increase.
- **Impact of technology**
  - Advances in gene therapy and new diagnostic tools and pharmaceuticals will emerge.
  - Other technological advances will include enhanced imaging, implanted medical devices, and "information therapy" on the Internet.
  - Clinical centers of excellence will focus provider competition on quality and technology.
  - Although technology certainly is an important factor in health care, it's unlikely to "reduce the demand or change the productivity among providers."
  - The capabilities of technology are increasing yet the adoption of new technology for efficiency purposes is under-realized, mainly because of cost and user factors.
  - Technology advances do have an impact on professional roles and the needs for ongoing education.
- **Cost and effectiveness of care**
  - Hospitals' financial outlook will remain mixed, with possibly very slow improvements in profits, but worse conditions in rural areas.
  - Hospital closings will increase, possibly to 50 per year, due to these cost-related factors.
  - Declining revenues and increasing pharmaceutical costs and wages will pressure hospitals and health systems to cut costs.
  - Quality will continue to be a business strategy to improve patient safety but also to lower clinical costs and improve efficiency.
  - New roles in hospitals will emerge, including the "hospitalist" to improve efficiency and lower inpatient costs.
- **Managed care trends**
  - HMO enrollment is flat or declining as employers react to higher premiums, but PPO enrollment is growing, now covering over 90 million.
  - Despite recent rate increases for Medicare HMOs, many HMOs are leaving the Medicare risk market.
  - Market-dominant hospitals and medical groups are challenging HMOs for better payments and in many cases are successful.
- **Health workforce**
  - A tight labor market and the aging of the workforce will increase the scarcity and the value of "human capital" in the 21st century. In a time of scarcity, nurses and physicians are seeking more economic opportunity and support for quality care. In addition, union activity among health care workers is rising, with demands focusing on quality and wages.
  - Lack of diversity across health professions, especially in basic and advanced nursing, is a continuing problem.
  - Staff shortages will worsen as the nursing workforce ages and retires.
  - The projected physician surplus could instead become a shortage if 40 percent of current physicians decided to cut back hours or retire early.

Discussion

Discussion about these and other assumptions ensued. The following are some of the questions and points raised by panel members about the initial list of proposed assumptions:

- **Nursing faculty shortage** – Dr. Hanson recommended that the assumptions take into account the loss of nursing educators due to age-related retirement. Dr. Anderson pointed out that enrollment in all nursing programs is declining. With the faculty shortage problem, "even if you get more people interested [in enrolling], schools cannot absorb them."
- **Non-hospital settings** – Although 60 percent of nurses work in hospital settings, Dr. Hanson said, nursing programs "don't really deal with the added competencies" needed for the other 40 percent who work in non-hospital settings; that percentage will increase, she added, given the recession.
- **Other factors in nursing shortage** – Another problem not addressed in the assumptions, said Dr. Bolton, is that the shortage of pharmacists, physical therapists, and others is "driving nurses away because it changes the way they work." On a related point, she said, nurses are leaving their jobs because of a shortage of specialty nurses, especially those needed to provide higher levels of care for the aging population.
- **Nursing environment** – Both Dr. Bolton and Dr. Hanson expressed concern that the proposed assumptions do not include environmental issues – such as long hours or physical demand – that cause many nurses to reduce their hours significantly or leave nursing for other professions. Mr. Levin asked how nursing's work environment compares to other professions.
- **Early retirement** – Questioning the data's use of 65 as the age of retirement, Dr. Anderson and Dr. Bolton pointed to data showing that the trend is for hospital nurses to retire in their 50s. Nurses are either retiring or moving from inpatient care to ambulatory care or other settings as they get older "because of the hard labor in hospitals," said Dr. Bolton. Mr. Levin suggested it would be helpful to see data comparing age distribution in nursing with other health professions.
- **Impact of technology on nursing** -- Dr. Bolton suggested that technology advances will increase the demand for certain types of nurses trained to use new devices and techniques; nurses who lack these skills will leave the workforce. Technology also has important implications for nurse education: Dr. Hanson said faculty could be trained to use distance-learning programs to bring nursing education to rural areas, thus alleviating some maldistribution problems. Dr. Anderson added that nurse educators also have to know how to use new technologies "if that's what is expected of nurses in the workplace"; in addition, the educational facilities have to be given the necessary resources to help the faculty.
- **Impact of technology on costs** – Mr. Levin commented that unlike in other sectors, new medical technology "doesn't replace people" but it "drives inflation" and "doesn't bring any efficiency to the system."
- **Nurses' salaries** – Mr. Supplitt raised a question about the effect of nurses' long-term career earnings on the nursing supply. More nurses are being trained at the baccalaureate level but wages have remained relatively flat, without adjustment for inflation. "The standard for professional nursing has been raised considerably with no return for that" – that's going to influence one's career choice, he said. Mr. Levin would like to see how nurses' average real salary compares with other professions—"is this a special case in nursing or just another example of how a certain large segment of the population has not really advanced in terms of inflation and adjusted income?" Dr. Anderson added that salary comparisons should include professions that are not female dominated, such as accounting and engineering. Dr. Bolton said that the cost performance assumptions should take into account the cost of employee benefits, not just wages. She also noted that major insurers, in addition to managed care organizations, are reducing the funds they provide to hospitals and other agencies for wages.
- **Projected nurse supply and need** – Pointing to the graph on projections of RN supply and need (slide 10 in Dr. Maddox' presentation on assumptions), consultant Dr. Atkinson said the graph suggests that currently there is an oversupply of nurses, but need will exceed supply beginning around 2008. Dr. Bolton noted that the graph depicts the national nurse supply in all settings, but in the hospital setting alone, all states except Montana now have a shortage of RNs. Dr. Maddox confirmed

that the graph provides a national viewpoint of nurse supply and need in the aggregate, while particular settings and particular locations may show a "very different picture."

Revision of Planning Assumptions

Dr. Wakefield and Dr. Maddox

Dr. Wakefield and Dr. Maddox then led the panel members in further discussion of the proposed planning assumptions, asking them to recommend specific additions, deletions, or modifications to the list. As. Dr. Wakefield explained at the outset, the list is in draft form; after the panel makes its revisions, the technical team will again fill in the data to support the assumptions, and the panel will then have an opportunity to review and revise the assumptions again at the next meeting. The major topics panelists recommended adding or highlighting include:

- Impact of an increase in the uninsured population on health care costs and nursing supply
- Impact on costs of nurse practitioners providing primary care directly to uninsured population
- Educational infrastructure, including aging of faculty and shortage of nurse educators
- Need for nurse educators to be skilled in use of new technology and opportunity for distance learning to extend nursing education to rural areas
- Effect of workplace environment on nursing supply
- Impact of increasing chronic conditions and co-morbidities associated with aging population on demand for health care services
- Impact of rising cost of higher education on enrollment, particularly among students from racial/ethnic or disadvantaged backgrounds
- Possible trend toward increase in inpatient days, hospital admissions and overall inpatient utilization, but flat length of stays
- Data on other settings of practice for nurses in addition to hospital inpatient, or on specific nurse specialties, including community health/public health, long-term care, nurse anesthetists, primary care with nurse practitioners.
- Impact of increasing workforce disparities in race, ethnicity and gender

SPECIFICATION OF TITLE VIII GOALS AND TARGET OBJECTIVES

Dr. Wakefield, Dr. Maddox, Dr. O'Grady, and Mr. Chinoy

Dr. Wakefield first reviewed the procedures and criteria the panel should use to identify specific Title VIII program goals for Parts B, C, and D. As recommended by Dr. Nichols in Phase I of the project, the criteria for the goals are:

- Must be quantifiable (to monitor degree of progress over time);
- Should be linked to a population or health delivery system need (to ensure goals are defensive outside the nursing profession); and
- Must be placed in the context of explicit assumptions about the evolution of population and health system needs over time.

Dr. Nichols' reasoning for using these criteria, Dr. Wakefield said, is to formulate outward-oriented goals – to ensure that the panel is "not taking a self-interest perspective" so much as making sure that a particular need is being met and can justify this goal, that assumptions underlie the goal, and that it can be measured. The goals should be "potentially evolving over time as health care delivery systems change." Then the panel will determine relative priorities within each part and across all parts; this is a "value-laden," subjective process, but one that links goals with facts, where possible. The goal statements and priorities are preliminary, she emphasized, and can be revised later.

After Mr. Chinoy further explained the procedures for establishing preliminary goals, he led the panel through the process, with Dr. O'Grady first giving an overview of each part, starting with Part C, followed by Parts B and D. Panel members suggested specific goals for each part, and each proposed goal was discussed and tested against the three criteria. Each goal cited supporting data sources, where possible, and was linked to at least one population or health delivery system need; in some cases target objectives were

identified but for most goals, the targets are still to be determined. After the list of goals was developed for all parts, the panelists went back and considered the relative importance of each goal in addressing overall workforce needs and demands. The preliminary goals identified by the panel are listed below, in order of importance within each part (for a more complete description of the draft goals, see the meeting summary, pages 4-7):

- **Part C: Nursing Workforce Diversity**
  - C1. Increase in the total number and percentage of ethnic/racial minority nurses
  - C2. Increase the cultural competency of RNs during the educational experience and in the workplace
  - C3. RN population to be reflective of the racial and ethnic diversity of the U.S. population by 2020
  - C4. Increase in the total number and percentage of male nurses in the workforce
- **Part B: Advanced Education Nurses**
  - B1. Increase the total number and diversity of advanced education nurses
  - B2. Increase the cultural competence of advanced education nurses during the educational experience and in the workplace
  - B3. Increase the number of nursing faculty in advanced nursing education
  - B4. Improve the distribution of primary care and specialty advanced practice nurses (CNM, CNS, CRNA, NP) in underserved and rural communities
  - B5. Increase the number of advanced practice nurses (NP, CNS, CRNA, CNM) who care for underserved and rural populations
  - B6. Increase distance education to increase advanced education nursing opportunities

- **Part D: Basic Nursing Education and Practice**
  - D1. Increase the supply of nurses by 2008 to avoid predicted shortage
  - D2. Improve the diversity of the basic nursing workforce
  - D3. Increase the cultural competency of RNs during the educational experience and in the workplace
  - D4. Improve the distribution of basic education nurses to better served underserved populations and rural communities
  - D5. Expand the number of basic nursing program graduates
  - D6. Expand the basic nurse education capacity through distance learning
  - D7. Increase the number of career ladder opportunities for basic nurses
  - D8. Stimulate the preparation of post-baccalaureate education specialty nurses in practice settings

After the panel completed its preliminary work on the goals, Dr. Wakefield explained that the technical team's next task is to review and fine-tune the draft goals, especially the high priority ones. The team will try to fill in missing data to better quantify the goals, strengthen the focus on population or health care delivery system needs, if needed, and match the preliminary assumptions agreed to earlier in the day with the appropriate goal statements. Panel members will then receive a revised draft document that will be open to further consideration at the next meeting.

PUBLIC COMMENTS

The following members of the audience gave brief comments:

- **Marion McCartney, American College of Nurse Midwives**
  - Key points:
    - The number of uninsured – now around 40 million – will probably increase as insurance rates rise and employers reduce or eliminate benefits. As a result, more people will visit emergency rooms. How will that affect nursing care?
    - A major barrier for nurse midwives, nurse practitioners and nurse anesthetists to practice in rural areas is the inability to get hospital privileges.

- Telemedicine in rural areas would allow nurse midwives to collaborate with physicians.

- **Melinda Ray, Association of Women's Health, Obstetric and Neonatal Nurses**
  - Key points:
    - When a nurse with many years of experience leaves, "you don't just lose one person" who can be replaced with a new graduate. "You lose all that expertise."
    - Continuing education is needed to help keep nurses already in the field up to date.

- **Erin McKeon, American Nurses Association**
  - Key points:
    - Does the definition of nurse with a small "n", as opposed to RN, include LPNs and nurses aides?
    - Perhaps it would be helpful to synthesize into one program the separate ideas of career ladders, advanced versus baccalaureate degrees, and distance learning.

- **Kittie Werner, National Organization of Nurse Practitioner Faculties**
  - Key points:
    - NONP and the American Association of Colleges of Nursing are preparing a report on a nurse practitioners curriculum survey; a draft will be made available soon. The report also includes data on enrollment and graduation for all nursing programs.
    - NONP strongly supports the panel's decision to incorporate diversity across all three parts and to include the goal of fostering cultural competency along with increasing diversity.
    - It may be necessary in some cases "to [step] back and say that the data isn't there to fully support" a stated goal.

- **Lorraine Jordan, American Association of Nurse Anesthetists**
  - Key points:
    - There is a severe shortage of nurse anesthetists. The turnover rate for program directors and assistant program directors is "amazingly high" – 15 to 20 percent. In addition, the number of faculty at the doctorate level is decreasing: "people are leaving faculty positions because clinical positions are really so lucrative." That is "a continuing theme for all of nursing."
    - On the issue of program capacity, it was surprising to hear that baccalaureate programs, like nurse anesthetist programs, often have to turn away applicants, but the panel never followed up on this point.
    - Since technology probably increases costs to patients and the cost of education, shouldn't those increased costs be taken into account? Some advances, such as pulse-oximeters, clearly have reduced mortality and morbidity rates and increased care across the board, not just for nurse anesthesia. But what is the effect on nursing of adding these new technologies -- "will we have to create different levels of nursing just to keep up with technology?"

- **Marjorie Chisholm, International Society of Psychiatric Nurses**
  - Key points:
    - Mental illness occurs throughout the life cycle, from infancy, childhood, adolescence, to old age. People with mental illness are no longer found so much in mental hospitals; "they are in our nursing homes...in our school settings...in our justice system" and they "need exquisite and expert mental health care." What we need to address the problem is advanced education programs that combine cross-training in mental health and primary and preventive care to treat mental illness, prevent complications of mental illness, and care for the persistently ill population to keep them from going back into hospitals.

CONCLUSION

Following the public comment period, Dr. Wakefield adjourned the meeting until the next session, scheduled for April 5, 2002.

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