



George Mason University

Division of Nursing (HRSA) Funding Methodology Public Comment on the 1st Expert Panel Meeting on Testing a Funding Allocation Methodology, October 31, 2001

This document contains a summary of the public comment received in response to the 1st expert panel meeting on Testing a Funding Allocation Methodology for the Division of Nursing, held on October 31, 2001 in Arlington, Virginia. A total of eight responses were obtained via a web-based survey, e-mail, and by fax. The instructions and summary notes provided as guidance for public comment may be found in the Appendix at the end of this document. Following, are specific comments obtained during the public comment period between November 5, 2001 and November 29, 2001.

Anonymous Submission

- 1. Please enter your Public Comment on the priority ranking of Title VIII programs.**
 - Underserved Rural
 - Aging population
 - Decentralized surgical Centers.

- 2. Please enter your Public Comment regarding the 10 factors to consider in testing the funding allocation model.**
 - Needs Assessment to meet population's health care concerns, increased demand for nursing services, increased demand for cost effective providers, increased need for services regarding surgery and pain management, decentralization of surgical services to improve cost effective delivery of care.

- 3. Please enter your Public Comment regarding key data needed and identified data gaps for testing a DON funding allocation methodology.**
 - Implications of the aging population regarding demand for health care services, which will require additional health care professionals.

Deborah A. Chambers CRNA, MHSA

President, American Association of Nurse Anesthetists (AANA)

This document addresses the need for substantial funding requirements for APNs (especially for Nurse Anesthetists based on the shortage of CRNAs). The shortage of CRNAs presents patients, health care facilities, and health payers such as insurance companies, employers and workers with real and growing concerns regarding access to health care and health care costs. The methodology that the Title VIII Funding Project agrees upon should recognize that increased funding for nurse anesthesia education represents a fiscally conservative, highly cost-effective means to increase the number of safe anesthesia providers in the United States at a time of evident and growing shortage.

Demographic characteristics of CRNAs

Nurse anesthesia can be seen as one of the available and promising career advancement options for nurses, one that has a high retention rate of practitioners working in the provision of direct health care services. As of 2001, of the 28,000 practicing CRNAs in the U.S, 59% are females and 41% are males. The average age of the practicing CRNAs falls in the range of 45-49 years old, with those over 45 years of age comprising 60% of the current workforce of 28,000. About 38% of this active CRNA workforce will be eligible for retirement in the next 5 years, aggravating the current shortage of nurse anesthetists.

In terms of employment, 33% of CRNAs are employed by hospitals, 37% belong to physician-CRNA groups, 20% belong to CRNA only groups or are self-employed, and 10% are employed by other settings e.g. ambulatory surgery centers or military. Hospitals with 250 beds or less employ 55% of the CRNAs, and those with over 250 beds employ the remaining 45%.

Nursing Shortage and Nurse Anesthetists

Access to anesthesia care in rural areas is a challenge that is growing, not shrinking, as an aging CRNA population is concentrated more in non-urban areas than in urban areas. While only a small percentage of anesthesiologists serve in non-urban areas, approximately 23% of all CRNAs provide services in non-urban areas. Approximately 29% of CRNAs ages 55 and older provide services in non-urban areas. As these CRNAs retire, it remains unclear what will happen to anesthesia services in these non-urban areas without continued incentives such as the Title VIII funding.

In about 70% of the country's rural hospitals, CRNAs are the sole anesthesia providers working with the local physicians, and nurse midwives to provide anesthesia and trauma stabilization services. It is more cost-effective for rural

hospitals to avail themselves of CRNAs' services since CRNAs' salaries are significantly less than those of anesthesiologists, while providing the same quality of anesthesia care.

Following is a brief overview illustrating the current nurse anesthesia manpower shortage using data from the 1990 HHS Division of Nursing's workforce study:

	<u>2000 Projected Need</u>	<u>Actual</u>
Practicing CRNAs	30,315-37,943	28,307
Graduates per year	1,700	1,000
Vacant Positions	>1	1-12

In a 1998 National Workforce Survey conducted by the AANA's Administrative Management Committee, 43% of nurse anesthetist managers reported 1-12 open positions in their department, and 59% reported that they were recruiting more CRNAs. A more recent 2001 AANA survey of CRNA managers finds the number of CRNA vacancies, and the length of time required to fill them, climbing dramatically. In 2001, some 57 percent of CRNA managers reported an average 3.5 FTE vacancies – a striking two and one-half-fold increase in the average number of CRNA vacancies since 1998. Three-quarters of the managers reporting vacancies said it takes them an average of six months to fill them. One-third of CRNA managers reported an increase in the number of CRNA positions available in their departments. A more recent nurse anesthesia workforce study done in North Carolina found 82 vacancies of CRNAs in 1999, and projected an staggering 133 vacancies by 2004.

Like other nursing specialties, we are preparing for an increased number of CRNAs to retire just as the number of baby boomers reach Medicare eligibility. The number of Medicare-eligible retirees is projected to increase, from some 34 million today, to over 40 million just ten years from now. They will need more health care, as will the aging workforce that will be caring for them.

Lastly, for what it costs to train one anesthesiologist, ten or more CRNAs can be trained for the same task, at the same superlative level of safety, which prompted the Institute of Medicine in 1999 to note anesthesia is 50 times safer today than 20 years ago. Relatively modest investments in advanced nursing education can and will help alleviate the shortage of anesthesia providers while preserving quality during a time when Americans are rapidly growing into their golden years.

Title VIII Funding Limitations

The current nursing shortage provides testimony that individuals and the community at large have not been able to fully fund nursing education. To illustrate the effect of insufficient financial support on nurse anesthesia teaching programs, we provide you with data showing the decline in nurse anesthesia programs over the last 15 years. A review of CRNA teaching programs from 1980 to the present, show that over the last 20 years, the total of nurse

anesthesia programs have declined from 147 programs (1980) down to 83 (2001), a 44% drop. Some of the main reasons cited by nurse anesthesia teaching programs for this decrease were:

- 1) Lack of financial support from hospitals, colleges or other institutions,
- 2) Lack of federal and state reimbursement for clinical costs, and
- 3) Lack of qualified faculty.

AANA's own 2001 survey of 83 nurse anesthesia graduate programs shows that an average of 23 qualified students per program have not been accepted due to the fact that the programs have reached their maximum enrollment. As you can see, the availability of financial support for nurse anesthesia educational programs is a primary concern in the continued availability of qualified nurse anesthetists. The average cost of training a nurse anesthetist to provide anesthesia is \$59,153 per individual, compared to \$635,348 to train an anesthesiologist.

Since 1994, over 75 percent of CRNA students have received student traineeships. For 1999, the Division of Nursing reported that 7 nurse anesthesia programs received grants for development of accredited programs or establishment of new programs. In addition, 7 faculty members received money through faculty fellowships and 69 programs received nurse anesthesia traineeships for students. Out of the 62 new grants awarded in 2000, 3 grants of around \$200,000 each were awarded to nurse anesthesia programs. A study conducted by Dr. Kathleen Fagerlund, which reviewed the costs of nurse anesthesia programs - both to the institution and the student nurse anesthetist - reveals that in 1996, the average Student Traineeship Fund received under Title VIII of the Public Health Service Act (PHSA), was \$1,000, 40% less than what a student would have received in 1985.

Thus, the existing allocation for nurse anesthesia education of four percent of total Title VIII program funding has proven effective at strengthening nurse anesthesia education programs –but only in those programs which have successfully secured funding. The amount of money available can be described as insufficient to meet demand. Clearly, more funding for nurse anesthesia education through Title VIII would help remove the bottleneck that is today restricting nurse anesthetist schools' ability to graduate a sufficient number of CRNAs to meet the growing demand.

Nurse anesthesia programs provide a rigorous course of full-time study averaging some 27 consecutive months in duration and do not allow students the opportunity to work outside their educational program. A nurse anesthesia student incurs an average debt of \$38,200 for their nurse anesthesia education. Therefore, nurse anesthesia students rely heavily on federal funding to assist them in meeting financial obligations during their study. Without this assistance, the number of nurse anesthesia graduates would surely decline. A decline in the

number of nurse anesthetists would then result in a decline in the accessibility to services, primarily in rural and under-served areas that depend on nurse anesthetist for the majority of their care. This important funding source needs to be maintained in 2002 when the Division of Nursing will implement a new method of awarding funds.

Shortage of Qualified Faculty in CRNA Teaching Programs

As cited in Dr. Denise Martin-Sheridan's study of CRNA programs above, the lack of faculty presents a serious challenge for program start-up or expansion. The salaries of teaching faculty have not been competitive with the clinical salaries offered by the industry. Teaching programs have not been able to match the higher salaries offered by the industry due to their own program funding limitations. Moreover, as discussed in the following section, the current Medicare payment policies for non-physician teaching faculty have also created a disincentive for clinical faculty to be involved in teaching nurse anesthesia students.

Med PAC Report on Utilization of Advanced Practice Nurses

The report presented by Medicare Payment Advisory Commission (Med PAC) staff in the March 15, 2001 meeting, supports AANA's statements over the years that access to care and the quality of care is as important to individuals living in rural communities as it is to those living in urban areas. As MedPAC's data shows, there is an increasing reliance on advanced practice nurses and other allied health care professionals to meet the health care needs of the rural population. The report also shows that Medicare beneficiaries are equally satisfied with the level of care provided by their local health practitioners. Anesthesia services are integral to the provision of surgical and obstetrical services. In a majority of rural communities, it is the CRNA who works with the patient's physician to provide anesthesia for inpatient and outpatient procedures as well as ancillary services in relation to trauma stabilization, emergency airway management, and pain management. The volume of outpatient surgical procedures has significantly risen over the volume of inpatient procedures. As more and more Medicare beneficiaries utilize outpatient surgical facilities, critical access hospitals and physician offices, the demand for CRNA services will continue to increase.

Recommendations for CRNA Education Program Funding

We commend the Expert Panel for inviting members of various nursing specialty organizations to comment on the Funding Allocation Project. The testimonies received from other advanced practice nursing groups attest not only to the critical role advanced practice nurses play in meeting the health care needs of the population, as well as the essential need for significant federal funding. Hence, we recommend that the Expert Panel consider the significant shortage of

CRNAs, and increased decentralization of anesthesia services, as well as the increase in the aging population requiring surgery and anesthetics in developing the Title VIII funding allocation. It is vital to ensure sufficient funding for nurse anesthesia education to continue providing quality anesthesia care to United State citizens.

When treated as a social investment, Title VIII funding of CRNA programs have a high return on the government's financial investment. This can be illustrated by the fact that since 1989, the retention rate within the specialty for nurses who have graduated from nurse anesthesia programs is 98% i.e. CRNA programs have graduated approximately 10,691 students out of which 10,484 (98%) are still actively certified and practicing as a CRNA. Moreover, as the previous paragraphs have illustrated, CRNAs remain in this profession for a long period of time, until retirement. With their current income levels, CRNAs more than repay Title VIII funds invested in their education through the tax dollars that the government recaptures.

We support an equitable methodology for distributing federal nursing education funds. Distribution should be based on demonstrated marketplace need and educational costs. Educational costs should be compared with the cost of producing other competing providers, including physicians.

Anne Davis PH.D, R.N., C

Department of Nursing, East Central University

My comments are related to funding allocation for Basic Nursing Education, Workforce Diversity, and the Advanced Education Nurses. Please, please make funds available for additional faculty development within the grants. Rural nursing schools are desperate for masters prepared nursing faculty. While many nurses are obtaining advanced degrees at higher numbers than a decade ago, most of those nurses are becoming nurse practitioners. We need expert clinical practitioners, but we also need nurses who have graduate level courses in nursing education to prepare for teaching.

Perhaps adding funds which target nurse educator development to the three programs would be a start to addressing this potentially alarming situation. I fear we may soon have a crisis in filling faculty positions with qualified Masters level nurses. Thank you for providing this forum.

Linda Hodges RN, Ed.D

College of Nursing, University of Arkansas for Medical

1. **Please enter your Public Comment on the priority ranking of Title VIII programs.**
 - I am most surprised by the ranking of the categories for funding methodology. Also I am perplexed that there is no mention of one of the key issues that will determine the future of the nursing workforce. This issue is the numbers of prepared nurse educators and the future production of the same. Clearly, a well-educated nursing workforce is essential to meeting system and population health care needs. Across the nation we are experiencing an unprecedented shortage of nurses that appears to potentially become worse in the next two decades. Unfortunately, the priority ranking does not take into consideration the need to make graduate education and the preparation of nursing faculty or other key providers such as nurse anesthetists a major priority. The data on the nursing faculty shortage and the projected numbers of nurses being prepared to teach the future nursing workforce needs to be reviewed in setting Title VIII funding methods priority ranking. A recent survey we conducted at the SREB Council for Collegiate Education in Nursing to assess the status of the schools of nursing both associate and baccalaureate and higher degree, pointed to a dismal situation with regard to the numbers of faculty with minimal credentials, the rate of retirement and resignation, and the match of specialty preparation particularly as it relates to the needs of the population in the 16 Southern states and the District of Columbia. For example, the Southern region has the highest percentage of older adults of the four geographic regions in the nation. A large percentage of this population is poor and resides in rural areas with limited access to health care providers. When looking at the numbers of nurse educators with a specialty in geriatrics, this group represented only 3.2% of the entire faculty in the reporting schools. We had a 56% return rate on the survey, with a spread that was fairly even among associate degree, baccalaureate and higher degree faculty. Thus we believe, the findings can be generalized to the schools of nursing in the SREB region. The data showed that if the numbers of resignations, retirements, vacant positions and newly created positions remained the same or as projected by the respondents, thousands of nurse educators would need to be hired in the next 5 years. The area hit the hardest on a percentage basis will be those with doctoral degrees. Yet among the SREB schools of nursing with doctoral programs, the numbers of graduates produced in the past year was less than 100. The SREB region is comprised of many states that have vast regions that are rural. The data showed few faculty prepared in rural or public health nursing. The SREB or Southern geographic region has also experienced a huge increase in the Hispanic or Latino population

in the past decade yet our survey showed a very small proportion of students and faculty from this important cultural group. It will do us no good to recruit students into nursing that are from diverse populations or put money into basic nursing if we have no faculty to teach them. I think it is vital that we look at the way the funding is allocated for advanced nursing. We need to shift more funding from the NP programs and make the programs for faculty preparation both at the master's and doctoral level a priority. We also must put additional funding into nurse anesthesia programs. There is a critical shortage of nurse anesthetist and in fact this shortage will be the deciding factor in the demise of many rural hospitals. The income that keeps many rural hospitals alive is generated from surgery. Most if not all the anesthesia given in small rural hospitals is provided by the nurse anesthetist. This population of providers are even older than the staff nurse and the statistics on projected retirements are frightening. Please check with the American Association of Nurse Anesthetists for their data. In addition, among this group, a problem exist with increased retirements of anesthesiologists. Since this area saw the number of residents declining since 1992, the lack of adequate numbers of anesthesiologist only compounds the shortage of nurse anesthetists. I would urge you to reconsider the priority ranking of the funding methodology. We must solve the faculty shortage if we are to solve the nursing workforce shortage, particularly as the baby boomer nurse educator population nears retirement. An overwhelming number of doctorally prepared faculty are in there 50's and our data shows the average age for retirement to be 58.

2. Please enter your Public Comment regarding the 10 factors to consider in testing the funding allocation model.

- Again funding needs must consider unmet needs such as preparation in public health, nursing education, geriatrics. We need faculty role models that are from culturally diverse groups if we are to recruit and retain students from minority and disadvantaged groups.

3. Please enter your Public Comment regarding key data needed and identified data gaps for testing a DON funding allocation methodology.

- We have very poor data on nursing faculty. AACN has good data on the baccalaureate and higher degree programs; however, it is difficult to get data on the associate degree faculty or to know what is happening in a given region that takes all levels of the nursing workforce into consideration. The National sample survey is good but it is not conducted often enough to inform health policy decision-making particularly at the state or regional level. We need a way to look at each state comprehensively. A method must be found that will allow us to look at the nursing workforce from the LPN to the PhD level. This includes

application, admission, retention, enrollment and graduation rates. We need to know comprehensively what the faculty profile at all educational levels is so we can project the needs in the future. Our graduate programs supply most of the associate degree faculty and those in at the baccalaureate and higher degree level. I would be happy to provide information or testimony on the findings from the SREB CCEN survey of nursing education programs. The core findings have been made available in a news release today and should be available on the SREB website. The full report will be available by the end of December. We have looked at these findings, which includes information on distance education, and have matched it to selected population morbidity and mortality statistics from the 2000 census. This beginning study has already pointed to major problems we need to find solutions for in our region. Clearly we are most interested in the priority rankings of funding methodologies for Title VIII funds since many of our schools have been privileged to receive these to help us in our mission to educate the nursing workforce in the past. Again I appeal to the expert panel group, to reconsider the priority recommendation and seek additional data particularly as it relates to the compliment of nursing faculty in our nation. The nursing education process is the link between getting new recruits into the profession and producing the needed workforce. The machinery for making his happen is adequate well prepared faculty. Thank you for providing this website for comment.

Melinda Ray

**Director, Health Policy and Legislative Affairs
Association of Women's Health, Obstetric and Neonatal**

On behalf of the Association of Women's Health, Obstetric and Neonatal Nurses, I am pleased to submit comments concerning priorities within the funding methodology for Title VIII programs under the Public Health Service Act. AWHONN supports the three areas considered in the methodology: Advanced Education Nurses, Basic Nurse Education and Practice, and Increasing Diversity in the Nursing Workforce. As three priorities may diffuse the impact of limited funding for the development of the profession, we offer what we hope will be a meaningful alternative to three distinct priorities and suggest the combination of these into two priority categories. AWHONN is a membership comprised 22,000 registered nurses and advanced practice nurses. We support efforts to develop a methodology that recognizes the funding needs of these nursing communities. However, we recognize the value and the unquestioning need to include diversity as a priority that underlies the basic and advanced practice nursing education. We propose that diversity be a priority that is threaded through the other two when developing the funding methodology. The members of AWHONN recognize that birth, as well as the larger context of health care; can be an intensely culturally significant occurrence in an individual's life. As the racial and ethnic makeup of our country changes, our profession still suffers from a critically low number of ethnic and racial minorities among our ranks. As we develop a methodology, we need to be sure that we are taking significant steps to meet the challenges of providing culturally competent health care in this new era. Additionally, we must be mindful that we must support diversity throughout the nursing continuum, from basic nurse education to advanced practice nurse education. Within the methodology, we believe that there should be a reasonable needs-based distribution of funds targeted to both basic and advanced practice nurse education. We also believe that the methodology should be structured in such a manner as to emphasize the necessity of diversity in these programs. This can be done by requiring that a percentage of each allotment be designated to support diversification efforts. For example after the distribution of funds have occurred; a mechanism could trigger a requirement that a minimum of 15-20 percent of the funding has to be spent on diversity within that area. AWHONN strongly supports the development of such a model with the full involvement of the minority nursing associations in order to ensure that any concerns related to levels of funding are addressed.

Karen S. Fennell RN, MS

**Senior Policy Analyst
American College of Nurse-Midwives**

We have several concerns that relate to the public document and the approach being used by the facilitator to bring about consensus. We understand that we are very early in the process, and that as the expert panel proceeds our concerns may be addressed.

The Process:

At the October 31, 2001 meeting, members of the Expert Panel voted on priorities without having key facts and data available to them. We therefore find that the rating of priorities is premature. The American College of Nurse-Midwives would like to assist the staff in their collection of data needs.

The Content:

We are also dismayed at the fact that the findings of the October 31, 2001 meeting focused on workforce needs versus population needs. The statute clearly states that the methodology should stem from population needs and then add other factors to be considered.

Jan Towers PhD, NP-C, C.R.N.P, F.N.P

Director of Health Policy American Academy of Nurse Practitioners

1. While we realized that this was the first meeting of this group, we have concerns regarding the process of establishing preliminary priorities before examining information related to the issues to be studied. Data related to the psychology of persuasion document the difficulty individuals and groups have with change of focus once one is committed to particular lines of thinking, even as preliminary priorities. The intent of the legislative language was to examine the health care needs of the population, and from there prioritize needs for funding of nursing education. We hope that the intent of the statutory language will be respected and followed in the processes utilized to arrive at decision regarding how these very inadequate funds are to be spent.
2. The legislative directive specified the health care needs data that was to be used to determine how funding should be allocated to nursing groups under Title VIII. It is difficult to determine if or where there is a plan to utilize these data in making such determinations in the materials disseminated and the discussions undertaken thus far. In fact, in the framework under consideration and in the list of 10 factors to be considered, the use of these criteria seems to be absent.

In addition, in the proposed processes, the quantitative section appears to dismiss the use of these data because there is not a “specific link to nursing workforce needs”. While there is more evidence of the utilization of these data in the recommended qualitative process, it still would be very easy to rely heavily on traditional staffing needs to make determinations about the funding of educational programs under Title VIII, and not pay attention to health care needs that would be met by other nursing entities such as nurse practitioners in primary care settings, nurse-midwives in community settings, or community health nurses in community settings, to name a few. Since the purpose of educational programs is to prepare nurses for the future, it is important that funding be geared to potential nursing roles based on national health needs, rather than stopgap measures that would deal with current staffing shortages in hospitals.

3. In the analysis of the data needs among the 10 factors identified, there appears to be little data identified from the primary care and community health arena, particularly in sections 7, 8, 9 and 10. Since a large portion of health care needs are met in these settings, it is important to include data regarding nursing practice such as that of nurse practitioners, nurse-midwives and community health nurses in those sections.
4. It is both unfortunate that diversity in the workforce is seen as a separate issue from the preparation of nurses both at the basic and advanced level.

As the health care needs of the population are reviewed, it seems that diversity would be a funding criteria for nursing education at all levels and in all specialties, rather than being separated out as a distinct funding entity as appears to be the case in the materials disseminated and in the outcomes of the preliminary discussions. Funding priorities for all programs regardless of health needs being met could and should encompass a focus on diversity.

Kitty Werner MPA

Executive Director The National Organization of Nurse Practitioner Faculties (NONPF)

The heart of the discussion of establishing a funding methodology surrounds nursing workforce issues. For NONPF, the preparation of the future nursing leadership is the priority issue related to nursing workforce, practice, and education. The nursing leadership pipeline must remain open to enable basic nurses to progress into graduate education and then into leadership positions. Nurse practitioners (NPs) now constitute 64.5% of all master's program graduates, and as such we can expect the NP preparation as a foundation for a great deal of nursing leadership in education, research, practice, and health care systems. While the current nursing shortage has highlighted predominantly the shortage crises in hospital settings, the reality is that without change this shortage will reverberate throughout all practice settings and at every level of nursing education. NONPF is pleased to see that the Expert Panel will be reviewing data from a multitude of sources to assess workforce issues and trends.

The ten factors identified for testing the methodology appear comprehensive although certainly represent a significant undertaking for collecting and reviewing all related data. A challenge in this activity will be keeping the eye to the future. Relative to future workforce needs, NONPF has noted that the Expert Panel scored Part B (Advanced Education Nurses) of Title VIII significantly lower as a priority in funding than Part C (Increasing Diversity) and Part D (Basic Nursing Ed and Practice). This priority order raises a significant concern for NONPF in light of funding challenges for advanced practice nursing educational programs and other challenges for advanced nursing education, notably the faculty shortage.

As well, this ranking is further disconcerting in light of the historic role of the Division of Nursing in promoting advanced practice nursing to its present national stature. As the Division Director Dr. Denise Geolot recognized in her opening remarks of the meeting, Division funding for early nurse practitioner programs demonstrated that "nurses with advanced preparation, working in different settings, could improve the quality and increase access to care." The Division funding has been invaluable in helping to build quality nurse practitioner programs across the country that increase access to care for rural and underserved populations. Many nurse practitioner programs have academic nursing centers and faculty practice sites that directly provide care to these vulnerable populations while also serving as models for exemplary nursing leadership.

As the panel considers the future workforce needs, it may be useful to consider the following thoughts from the NONPF leadership on key issues concerning the future of NP education: the nurse practitioner will be in demand to fill a multiplicity

of roles. Len Nichols reported at the NONPF 2001 annual meeting that the number of nurse practitioners practicing in hospital practice settings has increased by higher levels than those in ambulatory settings. These other settings provide NPs the opportunity to bridge gaps between different providers and to build new models of provider teams. The roles of NPs in hospital settings are not limited to acute care practice but include comprehensive and focused assessments of client and family, primary care during acute illnesses, and care management for clients with complex health needs.

Nurse practitioner education will require a paradigm shift to accommodate the increasing demands for NPs in multiple roles. Nurse practitioner programs must prepare qualified health care providers who can identify where care is needed and fill these roles across settings. NP educators will be challenged to create more flexible curricula for NP roles, accordingly.

As well, NP programs will need new resources to complement the flexible curricula of the future –and will especially need a strong cohort of faculty. With the aging of the nursing educator workforce, we must allocate resources for faculty development and continue funding of NP Programs as a proven method for ensuring the future nursing leadership. NP education must include sophisticated experiences in collaboration and team building across disciplines. The interdisciplinary approach to education and collaboration will require reconfiguration of some of the current models in NP education. Analysts are predicting that nurse practitioners may be the primary care provider of the future.

To meet the needs for access in the health care system, we will need to prepare a higher number of nurse practitioners. Better primary care will lead to less hospitalization. We are just beginning to utilize NPs for home care, also leading to less institutionalization.

A key point raised towards the end of the Expert Panel meeting was the importance of studying the sources of funding for nursing workforce, education, and development. NONPF strongly concurs with the significance of including this assessment in the process. Unlike other areas of nursing, advanced practice nursing mostly relies on federal funding from Title VIII for programmatic support. Limited funding may be available from states and foundations, but Title VIII is the primary source of support available for advanced practice nursing program development. In example, the amount of state support to Nurse practitioner programs has previously been shown to benefit very few nurse practitioner educational tracks. In 1997, the National Conference of State Legislatures (NCSL) released their report entitled: Training Nurse Practitioners and Physician Assistants. How Important is State Financing? In this study, the NCSL surveyed 66 NP tracks about the level of state grant support they receive. The tracks were identified as those receiving state funding support based on nurse practitioner program data collected by NONPF and the American Association of Colleges of Nursing and represented less than 8% of all nurse practitioner master's and post-

basic RN certificate tracks. Of the 66, only 59% responded. The report indicated that these 38 tracks receive a range of \$30,000 to \$2.4 million in funding from states. As well, 44% of these tracks also rely on federal funding. While we can glean from the report that state funding was identified as very important to the existence of the 38 NP tracks, we can also recognize that state-level funding is limited to a very few tracks and does not eliminate the need for federal-level funding as well. Although NONPF is urging the Expert Panel to reconsider the level of priority it has assigned to the advanced education nursing program area of Title VIII, we do not want to diminish the significance of promoting increased diversity in nursing. We recognize how important it is to recruit students into the leadership pipeline who reflect the diversity of our culture. In fact, NONPF has established a priority goal in our three-year strategic plan to foster a culture of diversity throughout our organization and nurse practitioner education. We contend, therefore, that the Division should emphasize diversity throughout all program areas of Title VIII.

The current Part C predominantly addresses support of pre-entry preparation into nursing for disadvantaged students.

Appendix: Instructions and Summary Provided for Public Comment

Instructions for Offering Public Comment

A summary of the meeting activities and discussion is posted immediately following the meetings and prior to transcripts being posted. The transcripts of the 1st Expert Panel Meeting will be available at this website on or about **November 14, 2001**. The public may submit comments on the areas of interest from each meeting via web survey. The comment period for the first meeting will be available for comment November 5, 2001 through November 29, 2001. Comments may be posted anonymously.

To submit your comments, please click on the Submit Comment link at the end of this meeting summary. To refer back to this summary, you may either print this page from your browser, or, use "Back" and "Forward" buttons in your browser to move between the public comment survey and this summary.

1st Expert Panel Meeting of the project to Develop and Test a *Funding Allocation Methodology for Title VIII Funds*

I. Preliminary Discussion of Title VIII Programs

Panelists received a report of Phase I of the Project that developed the funding allocation methodology to be tested in this phase (Phase II). After receiving an overview of the project charge, discussing Phase I of the project and Title VIII programs, Panelists were asked to rank the 3 parts of Title VIII, based on population/system needs. Using a variety of processes, panel members arrived at an initial ranking of the 3 parts (Part B, Advanced Education Nurses; Part C, Increasing Diversity in the Nursing Workforce, and; Part D, Basic Nursing Education and Practice) of Title VIII. The purpose of this preliminary ranking was to stimulate thought and facilitate discussion about the different purposes and impact of Title VIII. As this project is iterative, panelists' priorities are expected to change as the methodology is tested via simulations. Preliminary rankings were developed to focus initial discussions about Title VIII. The **preliminary** results were as follows, listed in priority order:

Increasing Diversity in the Nursing Workforce (Part C)
(High Priority)

Basic Nursing Education and Practice (Part D)
(Middle Priority)

Advanced Education Nurses (Part B)
(Lower Priority)

PUBLIC COMMENT on the system/population needs and the priority ranking of Title VIII programs may be made via the link at the end of this summary.

II. Identification of Factors Important for Testing the Funding Allocation Methodology for Title VIII

The Expert Panel identified that the seven proposed factors* which are influenced by the composition and adequacy of the nursing workforce broadly, were important for inclusion in testing the methodology. After discussion, the Expert Panel added an additional three (total 10) factors to be considered in testing the methodology proposed in Phase I. Panelists will be asked to revise and weight these factors in future Expert Panel meetings. The factors identified as important for testing the proposed funding allocation method (not in priority order) are as follows:

1. Funding Sources for Nursing Workforce, Education and Development (both public and private, other than the Division of Nursing). [added by panelists]
2. Health Professions Workforce (other than nursing) Supply and Demand Trends [added by panelists]
3. Public Health Trends (including Health Promotion and Disease Prevention)
4. Socio-demographic Trends
5. Socio-economic Trends
6. Health Care Financing Trends
7. Health Services Delivery and Organizing Trends (including work environment)
8. Nursing Outcomes and Quality (including quality of nurses' work environment, errors and patient safety) [added by panelists]
9. Nursing Supply and Demand
10. Technological Trends and their Impact on the Nursing Workforce

* The original seven factors can be seen in the proposed framework --- [Executive Summary: Developing a Methodology for the Allocation of Funds: Phase II, see page 10.](#)

PUBLIC COMMENT on the 10 factors to consider in testing the recommended funding allocation methodology may be made via the link at the end of this summary.

III. Important Sources of Data to Operationally Define the Factors

Expert Panelists discussed important data for consideration in general and related to each of the ten factors. A compilation of data sources (approximately 123 sources, 90 of which are unduplicated) were identified and distributed for review. See project website for the initial compilation of data sources. Panelists discussed potential data gaps and requested additional data, research, and reports be added to the compilation in order to facilitate discussion and decision-making in future meetings (particularly where data gaps were identified). Data that are both quantitative and qualitative will be used to operationally define the factors and to define scenarios to conduct simulation testing. Source data to be used for these purposes will be determined by the expert panel at the next meeting (January 2002). Prospective data of interest identified by panelists, related to each factor follows. An asterisk (*) indicates areas where the Expert Panel acknowledged data gaps may occur.

1. Funding sources for nursing workforce, education and development (both public and private, other than the Division of Nursing)
Key Data Needed:

Source of funding and level of nursing education (Diploma, AD, BSN, MSN, Doctoral) by:

- a. States **
 - i. State Government
 - ii. Industry
 - iii. Geographic Distribution (e.g., Rural vs. Urban)
 - iv. Total number of nursing education programs and dollar amount for each education level
 - b. Federal Government
 - i. Agencies such as Department of Education, VA, IHS, HRSA (excluding Division of Nursing)
 - ii. Medicare
 - c. Private Foundations
 - i. Helene Fuld Foundation
 - ii. Hartford Foundation
 - iii. Others
2. Other Workforce (other than nursing) supply and demand Trends **
- Key Data Needed:**
- a. Currently funded research on the workforce of other health professions.
 - b. Research on the relationship between nursing workforce and other health professions
 - c. Availability of other health professions and their impact on the nursing workforce (e.g., Intensivist in ICUs, impact of hospitalist physicians)
 - d. Supply and distribution of other health professions
3. 3. Public Health Trends
- Key Data Needed:**
- a. Healthy People 2010 Goals
 - b. Current events/shifts (e.g., impact of bioterrorism)
 - c. CDC and HRSA Reports on Public Health infrastructure
 - d. Degree to which health promotion, disease prevention activities are conducted by nurses
 - e. Council on Education for Public Health/American Public Health Association
 - i. Definitions of health
 - ii. Major Public Health trends
4. Sociodemographic Trends
- Key Data needed:**
- a. Census Data
 - b. Healthy People 2010 health disparities by;
 - i. Age
 - ii. Ethnicity
 - iii. Geography
 - iv. Gender
 - c. Current career choice data for women (especially into other professions) - BLS
 - d. Generational Values (what different generations find appealing)
 - e. Uninsured/underinsured
5. Socioeconomic Trends and Predictions
- Key Data Needed:**
- a. Widening income gap data by population groups
 - b. Census data
 - c. Workforce participation data
 - d. Uninsured/underinsured data
6. 6. Health Care Financing Trends
- Key Data Needed:**
- a. Number of small employers who have stopped providing health insurance to employees

- b. Medicare and Medicaid's role in financing nurse education
 - c. Managed care penetration and retreat patterns
 - d. Private payer data
 - e. Migrant and Community based clinics financing nurse education and ability to attract health workforce
 - f. Uninsured
 - g. How health care financing trends influence supply and demand (i.e., home care financing's influence on supply of home care nurses and how reimbursement for services affects demand)
7. Health services delivery and organizing trends (including work environment)**
- Key Data Needed:**
- a. Setting and location of health services
 - b. Organization of care
 - i. Skill mix/staffing mix
 - ii. Anecdotal Models of care delivery
 - iii. Horizontal and vertical integration of delivery systems
 - iv. Corporate culture (e.g., whether magnet hospital nurses are involved in decision-making at all levels)
 - v. Shift from primary nursing
 - vi. Paperwork
8. Nursing Outcomes and Quality (including quality of nurses' work environment and errors and safety)**
- Key Data Needed:**
- a. Nurse Staffing and Patient Outcomes in Hospitals, Needleman, Buerhaus, Potter, Mattke, Stewart, Zelevinsky. (Feb 2001)
 - b. HEDIS (nurse case management as it relates to improved outcomes)
 - c. IOM Reports, To Err Is Human (1999) and Crossing the Quality Chasm (2001)
 - d. Research on how different health professions affect health care outcomes
 - e. Pharmacy Data on medication errors.
9. Nursing Supply, Demand and Distribution **
- Key Data Needed:**
- a. Supply, demand, and distribution of nurses by education level, practice site, ethnicity
 - b. Reference HRSA supply and demand models
 - c. Indices on retention and turnover
 - d. Vacancy Rates
 - e. Nursing satisfaction
 - f. Research on scope of practice and impact on access to care
10. 10. Technological trends and their impact on the nursing workforce **
- Key Data Needed:**
- a. Degree to which technology is being used across settings to ease nurse workload
 - b. Empowerment of nurses
 - c. Influence of technology on distance education for nursing
 - d. Computer literacy for RNs
 - e. Curriculum trends
 - f. Impact of regulation on use of technology

PUBLIC COMMENT on key data and data gaps relevant to testing the recommended funding allocation methodology may be made via the following link.