American Association of Colleges of Nursing

Senate Health, Education, Labor and Pension Committee

Hearing on the *Affordable Health Choices Act of 2009*

Testimony Provided by

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June 11, 2009

Good afternoon distinguished Committee members. I am Dr. Fay Raines, President of the American Association of Colleges of Nursing and Dean of the College of Nursing at the University of Alabama in Huntsville. The American Association of Colleges of Nursing (AACN) is the national voice of baccalaureate and graduate nursing education, representing over 640 schools of nursing that educate approximately 270,000 students and employ over 13,000 faculty members. Together, these institutions produce about half of our nation's Registered Nurses (RNs) and all of the nurse faculty and researchers. It is my great honor to testify before you today on the *Affordable Health Choices Act of 2009*. First, let me commend and congratulate Chairman Kennedy, Senator Enzi, Members of the Health, Education, Labor and Pensions (HELP) Committee, and their staff for drafting this legislation, which promises to reinvigorate our country's healthcare system. I am pleased to offer AACN's insights on this comprehensive legislation.

TITLE IV-HEALTH CARE WORKFORCE
SUBTITLE D-ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING
SECTION 438, ADVANCED EDUCATION NURSING GRANTS

AACN commends the Senate HELP Committee's work to reauthorize Titles VII and VIII of the Public Health Service Act (PHSA). These programs are vitally important to the efforts of nurses and other health professionals to address future workforce needs. As the Committee is well aware, our nation's 11-year nursing shortage persists, and more positions continue to open for RNs across the country. The U.S. Bureau of Labor Statistics (BLS) recently reported that the healthcare sector of the economy is continuing to grow, despite significant job losses in nearly all other major industries. Hospitals, long-term care facilities, and other ambulatory care settings added 23,500 new jobs in May 2009, a month when 345,000 jobs were eliminated across the country. As the largest segment of the healthcare workforce, RNs likely will be recruited to fill many of these new positions. Moreover, according to the latest BLS projections, more than one million new and replacement nurses will be needed by 2016.

The nursing workforce is not growing at a pace that will adequately meet long-term needs, including the demand for primary care, which is often provided by Advanced Practice Registered Nurses (APRNs). This challenge is further compounded by the number of nurses who will retire or leave the profession in the near future, ultimately reducing the nursing workforce. The supply of nurses nationwide is stressed due to an ongoing shortage of nurse faculty. The nurse faculty shortage continues to inhibit nursing schools from educating the number of nurses needed to meet the demand. According to AACN, 49,948 qualified applicants were turned away from baccalaureate and graduate nursing programs in 2008 primarily due to a lack of qualified faculty. Of those applicants, nearly 7,000 were students pursuing a master's or doctoral degree in nursing, which is the education level required to teach.

AACN commends the Committee's efforts to include effective strategies in the *Affordable Health Choices Act of 2009* to address the nursing faculty shortage. Yet, we are concerned that one measure, which has no associated costs, was not included in the text of the bill.

- **Therefore, we strongly suggest that the 10% cap imposed on traineeships awarded to doctoral students under the Advanced Education Nursing**

Grant program be lifted by striking section 296j(f)(2) of the current Title VIII authority.

Failing to remove this cap may significantly limit the number of APRNs, as well as doctorally prepared nurses who can serve as faculty in the very near future. The need for nurses with doctoral degrees is growing at an exceedingly high rate. By 2015, nursing education is moving toward preparing all new APRNs and other nursing specialists in Doctor of Nursing Practice (DNP) programs. According to AACN, between 2007 and 2008, the number of new DNP programs and enrollments more than doubled. Additionally, graduations from these programs in that time span nearly tripled. Neglecting to remove this cap will cause significant strain on the educational pipeline of future APRNs and other nursing specialists.

Furthermore, this cap inhibits the expansion of the doctorally prepared nurse faculty population. The need for nurse educators is acute as schools reported last year that more than 50% of the faculty vacancies required a doctoral degree. Unfortunately, schools are not preparing enough doctorally prepared nurses. According to AACN's 2008-2009 report, enrollment in research-focused doctoral nursing programs were up by only 0.1% or 3 students from the 2007-2008 academic year. With increased access to these traineeship funds by removing the 10% cap mentioned above, more doctoral nursing students can be supported. This critical edit will directly impact the supply of nurse faculty and primary care providers.

TITLE IV-HEALTHCARE WORKFORCE
SUBTITLE D-ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING

As evidenced by the rapid growth in nursing school enrollments, nationwide attention to the nursing shortage has sparked the interest of thousands of men and women across the country. However, nursing schools are struggling to overcome a variety of barriers beyond the faculty shortage that preclude them from further expanding student capacity and increasing the pipeline of registered nurses. Thousands of potential nursing students are being denied the opportunity to pursue a nursing education despite the high demand for RNs.

Each year, schools of nursing turn away tens of thousands of students due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Although, schools pointed to faculty shortages as a major reason for not accepting all qualified applicants into nursing programs, many schools of nursing are literally crumbling since Congressional funding for infrastructure ceased in the mid-1970s.

Compared to other academic disciplines, the cost of nursing education is relatively high, like medicine, which further increases the financial burden on nursing schools. Schools require specialized laboratory equipment, computer software, and simulated hospital units to prepare students to provide lifesaving nursing services in a complex healthcare system. Moreover, nursing education is also faculty-intensive with a high ratio of faculty to students, on average 1:10, as mandated by state registered nurse practice acts.

From 1971 to 1978, Congress provided Capitation Grants (formula grants based on the number of students enrolled) to schools of nursing in support of nursing education. These grants have had a stabilizing effect on past nursing shortages by addressing the financial

obstacles of nursing programs. Notably the Nurse Training Act of 1971 (P.L. 92-158) and the Nurse Training Act of 1975 (P.L. 94-63) facilitated increased enrollments in schools of nursing and helped resolved nursing workforce shortages.

The March 2002 Health Resources and Services Administration *Tenth Report to Congress on Health Personnel in the United States* recommended Capitation Grants funding as a strategy to expand the nursing workforce pipeline.

- **Therefore, AACN respectfully requests that the Capitation Grants program outlined in the *Nurse Education, Expansion, and Development Act of 2009*, (S. 497), which was introduced by Senator Richard Durbin (D-IL), be included in this section of the bill.**

Just as in the past, today's schools of nursing need additional resources, particularly nurse faculty, to educate the next generation of nurses. Capitation Grants would complement and expand the existing authorities under Title VIII of the PHSA by providing nursing schools with the opportunity to improve the structural and programmatic conditions that inhibit student capacity growth. For these reasons, Capitation Grants would provide a flexible funding stream to meet the fiscal barriers faced by schools of nursing.

TITLE IV-HEALTH CARE WORKFORCE
SUBTITLE D-ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING
SECTION 432, TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS

Section 432, Training Opportunities for Direct Care Workers creates "Primary Care Training and Enhancement" on page 493. While this program includes physicians and physician assistants, AACN is concerned that this program does not include APRNs such as Nurse Practitioners (NPs).

There are over 125,000 NPs practicing in the United States today. Of those NPs, 66% serve in at least one primary care setting. Therefore, approximately 82,500 NPs are practicing in primary care. According to the American Academy of Nurse Practitioners (AANP),

- 39% of NPs hold hospital privileges; 13% have long-term care privileges
- 96.5% of NPs prescribe medications and write an average of 19 prescriptions/day
- NPs write over 513 million prescriptions annually
- 62% of NPs see three to four patients per hour; 12% see over five patients per hour
- Malpractice rates remain low; only 1.4% have been named as primary defendant in a malpractice case

Nurse Practitioners are widely used as primary care providers, with outcomes equivalent to their physician and physician assistant colleagues.

- **AACN recommends that the "Primary Care Training and Enhancement" program, under Section 432 of this bill be expanded to include APRNs such as Nurse Practitioners.**

TITLE IV-HEALTHCARE WORKFORCE
SUBTITLE B-INNOVATIONS IN THE HEALTH CARE WORKFORCE

SECTION 411, NATIONAL HEALTH CARE WORKFORCE COMMISSION

AACN supports the development of a National Health Care Workforce Commission. Quality data on the national healthcare workforce is critical to ensure that care is comprehensive and coordinated and all providers are used to their full scope of practice. This can only occur with the collaboration from all healthcare providers in the planning and development of national standards for data collection and analysis.

- **AACN recommends that the membership of this commission has an equal representation among health professionals.**

TITLE II- IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE
SUBTITLE B- HEALTH CARE QUALITY IMPROVEMENTS
SECTION 212 GRANTS TO ESTABLISH COMMUNITY HEALTH TEAMS TO SUPPORT THE MEDICAL HOME MODEL

AACN and numerous nursing organizations commend the use of "community-based multidisciplinary teams" to support primary care through the Medical Home Model. For the reason cited earlier, AACN firmly believes that APRNs should be clearly identified as primary care providers and authorized to lead Medical Homes. However, we are concerned that the current language under Section 212 suggests that APRNs could not lead a Medical Home.

- **AACN strongly suggests using the language defining Medical Homes from the Schwartz-Cantwell bill, *Preserving Patient Access to Primary Care Act of 2009* (S. 1174, H.R. 2350).**

The purpose of the Medical Home speaks directly to the skills and education APRNs receive.

TITLE IV-HEALTH CARE WORKFORCE
SUBTITLE D-ENHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING
SECTION 455, PRIMARY CARE EXTENSION PROGRAM

AACN and members of the Nursing Community are pleased to see the inclusion of the Institute of Medicine's definition of primary care and commend the Committee for the emphasis the legislation places on delivering primary care and preventive services under a reformed healthcare system. However, we feel that the definition of primary care providers, as noted on page 573 of the legislation, could be unintentionally limiting as it describes the clinician as providing preventative and health promotion services for "…men, women, and children of all ages…". This suggests that a single primary care provider must offer care to all three populations and would indicate that certified nurse-midwives, pediatric nurse practitioners, pediatricians, and other specialists would not be viewed as a primary care provider since they serve a subset of the population.

- **If this is not the intent of this language, we suggest its removal or clarification. A viable option would be to incorporate the definition of primary care providers from the Schwartz-Cantwell bill, *Preserving Patient***

***Access to Primary Care Act of 2009,* with the inclusion of certified nurse-midwives.**

OVERALL COMMENTS

NURSES AND QUALITY MEASURES

Nurses are a central element in healthcare quality and safety. It is clear that the Committee recognizes the fundamental need for accessible quality care and understands the connection nurses will make in ensuring the provision of the bill are implemented. The *Affordable Health Choices Act of 2009* details new and expansive quality programs in Titles II (Improving the Quality and Efficiency of Health Care) and III (Improving the Health of the American People). These programs will expand the role of and need for nurses as they will be critical to collecting and implementing established quality indicators. Therefore, AACN is appreciative that Section 442 (Authorization of Appropriations for Parts B through D of Title VIII) of the bill seeks to increase funding for the Title VIII programs to ensure that more nurses are educated to address the need for emerging nursing positions.

THE FUTURE HEALTHCARE TEAM

AACN is pleased to see that the Committee thought broadly about healthcare providers when drafting this legislation. Use of the terms "provider" and "practitioner" demonstrates a commitment to a new model where quality care is delivered by a team rather than any one provider. We encourage consistent terminology, where applicable, throughout the legislation.

CLINICAL EDUCATION FOR APRNS

We would like to suggest that as an adjunct to the important work the Senate HELP Committee is doing regarding expanding nursing education, parallel efforts be undertaken with the Senate Finance Committee to expand clinical education for APRNs. AACN suggest a modification of the Medicare funding for nursing to include funds for training APRNs. In hospitals, the vast majority of care is provided by nurses, yet nurses receive little federal funding for clinical training. Unlike the Graduate Medical Education program that has been the primary vehicle for physician training in hospitals over the last 40 years, nursing education programs have not had the support or the funding to sufficiently provide nurses with the training needed for the complex healthcare environment. Because of the critical role nurses play in quality care and patient safety, nursing clinical education should be viewed with the same importance as medicine when reshaping healthcare and move toward system-wide reform.

CONCLUSION

The *Affordable Health Choices Act of 2009* offers numerous programs that would augment the nursing workforce for the benefit of American patients. For example Section 412, State Health Care Workforce Development Grants; Section 428, Nurse-managed Health Clinics; Section 429, Elimination of Cap on Commissioned Corp; Section 430, Establishing a Ready Reserve Corps all have the potential to improve the health professions workforce and directly impact the quality of patient care. AACN would like to reiterate our appreciation to the Senate HELP Committee for the significant efforts to draft such a comprehensive piece of legislation. AACN looks forward to working further with the Committee to address the concerns raised above during the legislative process. Thank you for the opportunity to testify and offer our comments on this momentous piece of legislation.