

## The Future of Nursing

*From a report released on October 5<sup>th</sup> by the National Academy of Science's Institute of Medicine, widely considered the nation's top scientific experts on health: "The Future of Nursing, Leading Change, Advancing Health" (visit [www.iom.edu/nursing](http://www.iom.edu/nursing) for more information):*

"In 2008, The Robert Wood Johnson Foundation (RWJF) and the Institute of Medicine (IOM) launched a two-year initiative to respond to the need to assess and transform the nursing profession. The IOM appointed the Committee on the RWJF Initiative on the Future of Nursing, at the IOM, with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing."

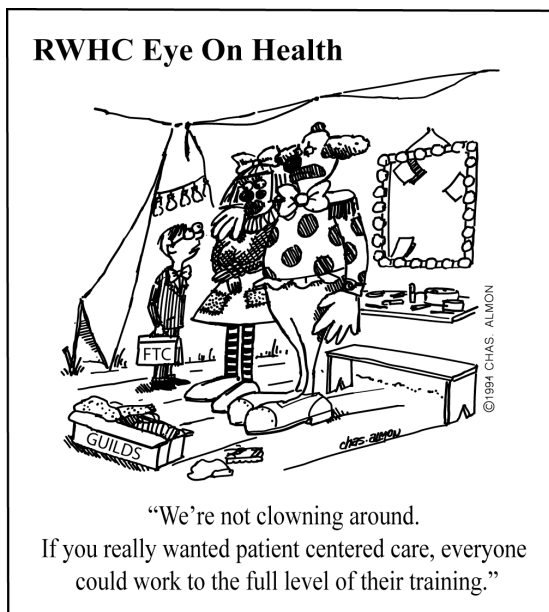
"Nurses practice in many and varied settings, including hospitals, schools, homes, retail health clinics, long-term care facilities, battlefields, and community and public health centers. They have varying levels of education and competencies—from licensed practical nurses, who greatly contribute to direct patient care in nursing homes, to nurse scientists, who research and evaluate more effective ways of caring for patients and promoting health. The committee considered nurses across roles, settings, and education levels in its effort to envision the future of the profession. Through its deliberations, the committee developed

four key messages that structure the recommendations presented in this report:

1) **"Nurses should practice to the full extent of their education and training"**—While most nurses are registered nurses (RNs), more than a quarter million nurses are advanced practice registered nurses (APRNs), who have master's or doctoral degrees and pass national certification exams. Nurse practitioners, clinical nurse specialists, nurse anesthetists, and nurse midwives all are licensed as APRNs. Because licensing and practice rules vary across states, the regulations regarding scope-of-practice—which defines the activities that a qualified nurse may perform—have varying effects on different types of nurses in different parts of the country. For example, while some states have regulations that allow nurse practitioners to see patients and prescribe medications without a physician's supervision, a majority of states do not. Consequently, *the tasks nurse practitioners are allowed to perform are determined not by their education and training but by the unique state laws under which they work.*"

2) **"Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression"**—To ensure the delivery of safe, patient-centered care across settings, the nursing education system must be im-

proved. Patient needs have become more complicated, and nurses need to attain requisite competencies to deliver high-quality care. These competencies



include leadership, health policy, system improvement, research and evidence-based practice, and teamwork and collaboration, as well as competency in specific content areas including community and public health and geriatrics. Nurses also are being called upon to fill expanding roles and to master technological tools and information management systems while collaborating and coordinating care across teams of health professionals.”

3) **“Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States**—Efforts to cultivate and promote leaders within the nursing profession—from the front lines of care to the boardroom—will prepare nurses with the skills needed to help improve health care and advance their profession. As leaders, nurses must act as full partners in redesign efforts, be accountable for their own contributions to delivering high-quality care, and work collaboratively with leaders from other health professions.”

4) **“Effective workforce planning and policy making require better data collection and an improved information infrastructure**—Planning for fundamental, wide-ranging changes in the education and deployment of the nursing workforce will require comprehensive data on the numbers and types of health professionals—including nurses—currently available and required to meet future needs. Once an improved infrastructure for collecting and analyzing workforce data is in place, systematic assessment and projection of workforce requirements by role, skill mix, region, and demographics will be needed to inform changes in nursing practice and education.”

**Conclusion**—“The United States has the opportunity to transform its health care system, and nurses can and should play a fundamental role in this transformation. However, the power to improve the current regulatory, business, and organizational conditions does not rest solely with nurses; government, businesses, health care organizations, professional associations, and the insurance industry all must play a role.”

“The recommendations presented in this report are directed to individual policy makers; national, state, and local government leaders; payers; and

health care researchers, executives, and professionals—including nurses and others—as well as to larger groups such as licensing bodies, educational institutions, philanthropic organizations, and consumer advocacy organizations. Working together, these many diverse parties can help ensure that the health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health.”

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## Boomer Retirements to Hit WI Nursing Hard

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*From the press release “Department of Workforce Development, Wisconsin Center for Nursing Jointly Announce Results from Survey of State’s Registered Nurses” on 10/7/10:*

“Wisconsin Department of Workforce Development (DWD) Secretary Roberta Gassman and Wisconsin Center for Nursing President Dr. Ann Cook jointly announced the results of a survey of the state’s 77,500 registered nurses. The findings will be used to strengthen the state’s health care workforce.”

“ ‘This survey provides valuable insights into Wisconsin’s nursing field, which includes the largest group of health care workers in the state,’ DWD Secretary Roberta Gassman said. ‘We know there will be a need for over 8,000 new health care workers per year through 2018 to fill new jobs, and nurses are in the greatest demand of all occupations in the state.

**RWHC Eye On Health** is the monthly newsletter of the Rural Wisconsin Health Cooperative, begun in 1979. RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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Blogs: [www.ruraladvocate.org/](http://www.ruraladvocate.org/) [www.worh.org/hit/](http://www.worh.org/hit/)

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with subscribe on the Subject line*

*The information from the survey tells us nurses are significantly older than the general labor force, so we must keep advancing strategies to address these future labor shortages.’ ”*

“The Center for Nursing’s Dr. Cook added: ‘On behalf of the Wisconsin Center for Nursing, I’d like to thank registered nurses for their cooperation in completing the survey. The data collected are critical to the future of nursing in Wisconsin. The data also are critical to the well-being and health of the citizens who rely on registered nurses who perform in a variety of roles including direct patient care provider, policy leader to health care manager, and nurse educator.’ ”

“Findings of the 2010 Wisconsin RN Survey include:

- Wisconsin registered nurses are predominantly female, well-educated and older than the workforce as a whole.
- The median age of registered nurses is 45-49 years old, while the median age of the state’s workforce is 40-44 years old. Additionally, 46 percent are 50 years or older.
- Less than 50 percent of registered nurses work in hospitals; other workplace settings include ambulatory care, nursing homes and extended care, public health, and academic education.”

“These and other findings can be found in an ‘at-a-glance’ document on the DWD WORKnet website at [www.worknet.wisconsin.gov](http://www.worknet.wisconsin.gov).

The findings were also presented as part of the Wisconsin Nurses Association’s annual conference in Madison at the Monona Terrace Community and Convention Center.”

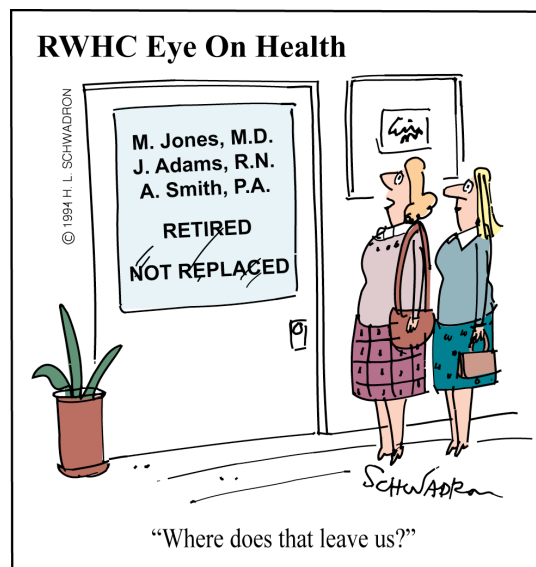
“The 2010 Wisconsin Registered Nurse Survey was conducted as a component of registered nurses’ biannual license renewals earlier this year. The state Department of Regulation and Licensing (DRL) administered the survey online and in paper format, and DWD

received and began initial analysis of the data in consultation with the Wisconsin Health Workforce Data Collaborative and the Wisconsin Center for Nursing.”

“The project is being funded in part by the Healthier Wisconsin Partnership Program, a component of the Advancing a Healthier Wisconsin endowment at the Medical College of Wisconsin. State Senator Judy Robson was instrumental in securing funding for the survey through the legislative process.”

“State Department of Regulation and Licensing Secretary Celia Jackson said, ‘The license renewal process provided the means to reach as many registered nurses as possible. The Department of Regulation and Licensing felt it was important to assist in this important initiative.’ State Department of Health Services Karen Timberlake said, ‘An adequate nursing workforce is vital to the health delivery system and the well being of Wisconsin residents. Thanks to the 2010 Wisconsin Registered Nurse Survey, we have accurate and comprehensive workforce data on RNs licensed in Wisconsin. This is a critical component to understanding the nursing supply and demand and allows us to better plan for the future.’ ”

“Wisconsin Nurses Association President Carolyn Krause said, ‘Our organization has been very engaged and supportive of this historic project. We look forward to partnering with all of the key stakeholders in gaining more information and developing a strategy for assuring that the people of Wisconsin have access to a competent, committed and caring nursing workforce for the future.’ ”



“The survey was developed through assistance by DWD’s Division of Employment and Training and Office of Economic Advisors, and further supported by the following organizations: **State agencies:** Departments of Regulation and Licensing and Health Services; **Educational Institutions:** University of Wisconsin System—Schools of Nursing, Wisconsin Association of Independent Colleges and Universities and the Wisconsin Technical College System;

**Nursing Organizations:** Wisconsin Center for Nursing, Wisconsin Nurses Association and the Wisconsin Nursing Coalition; and **Health Care Organizations:** Rural Wisconsin Health Cooperative, Wisconsin Hospital Association, Wisconsin Medical Society, Medical College of Wisconsin and the Wisconsin Area Health Education Center (AHEC) System.”

“A survey of Licensed Practical Nurses is slated for 2011, and will be administered by DRL as part of license renewal. Once all survey data are analyzed, the Wisconsin Center for Nursing is charged with developing a statewide strategic plan to address nursing workforce needs in Wisconsin. The plan will analyze and seek resolution of regional and specialty shortages; monitor and evaluate trends in nursing supply and demand; develop recruitment and retention strategies across the continuum of care; and, support expansion of capacity in nursing education programs. The plan is due to the Legislature in September, 2011.”

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## New Physician Shortage Forecast Skyrockets

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*From an Association of American Medical Colleges (AAMC) press release, 9/30/10:*

“The AAMC Center for Workforce Studies has released new physician shortage estimates that, beginning in 2015, are 50 percent worse than originally anticipated prior to health care reform.”

“The United States already was struggling with a critical physician shortage and the problem will only be exacerbated as 32 million Americans acquire health care coverage, and an additional 36 million people enter Medicare. Some key findings include:

- Between now and 2015, the year after health care reforms are scheduled to take effect, the shortage of doctors across all specialties will quadruple. While previous projections showed a baseline shortage of 39,600 doctors in 2015, current estimates bring that number closer to 63,000, with a worsening of shortages through 2025.
- There also will be a substantial shortage of non-primary care specialists. In 2015, the United States will face a shortage of 33,100 physicians in specialties such as cardiology, oncology, and emergency medicine.
- With the U.S. Census Bureau projecting a 36 percent growth in the number of Americans over age 65, and nearly one-third of all physicians expected to retire in the next decade, the need for timely access to high-quality care will be greater than ever.”
- “The number of medical school students continues to increase, adding 7,000 graduates every year over the next decade. However, unless Congress supports at least a 15 percent increase in residency training slots (adding another 4,000 physicians a year to the pipeline), access to health care will be out of reach for many Americans.”

“To Ensure an Adequate Physician Workforce, the Medicare Freeze on Residency Training Must End. Because of the concern with likely shortages, the number of medical schools is increasing, and there will be an additional 7,000 graduates every year over the next decade. Still, there can be no substantial increase in the number of residency training positions supported by the federal government:

- Medicare’s support for physician training has been frozen since 1997. Unless the number of residency training positions expands at the nation’s teaching hospitals, the United States will face a declining

### “Primary Care Well Beyond ‘Rural’ ”—RWHC Video Visit with Dr. Linnea Smith, Yanamono Medical Clinic, Peru

<http://mediasite.rwhc.com/mediasite/SilverlightPlayer/Default.aspx?peid=c260fbf10ae6464b8139c5bda7865ae1>

Dr. Smith graduated from medical school at the University of Wisconsin in 1984. She completed additional training in Internal Medicine in Madison, became board-certified in that specialty and then went into a small group practice a few miles up the road in Prairie du Sac. In 1990, she went to Peru for the first time, for what she thought was just a vacation in the remote Amazon basin of northeastern Peru. The clinic operates with grassroot support from family and friends and many others. Donations are welcomed c/o: Amazon Medical Project ([www.amazonmedical.org](http://www.amazonmedical.org)), PO Box 194, Mazomanie, WI 53560.



number of physicians per capita just as the baby boomers swell the Medicare rolls.

- Congress must lift the freeze on Medicare-supported residency positions. Because all physicians must complete three or more years of residency training after they receive an M.D. degree, Medicare must continue paying for its share of training costs by supporting at least a 15 percent increase in GME positions, allowing teaching hospitals to prepare another 4,000 physicians a year to meet the needs of 2020 and beyond.”

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## “Geographic” Chasm in Value Debate?

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*This is a brief report from Tim Size, RWHC Executive Director, on an invitational Federally hosted National Summit on Health Care Quality and Value held in Washington, DC on October 4<sup>th</sup>:*

The Healthcare Quality Coalition, with which RWHC is an active participant, is pushing for Medicare to recognize the higher quality and lower costs typical of the Midwest and other areas throughout the country as long noted in the long highly regarded *Dartmouth Atlas of Health Care* available at [www.dartmouthatlas.org/](http://www.dartmouthatlas.org/)

During the health reform debate, Congressman Ron Kind negotiated an agreement with the Department of Health & Human Services Secretary Sebelius for this summit; along with two related Institute of Medicine studies that are now underway. (The first IOM report will result in recommendations to Congress and Medicare re geographic adjustment factors and the second in recommendations re changing the Medicare payment system to reward value and quality.)

There is significant disagreement among providers on this issue, particularly from regions where clinical practice patterns and/or patient characteristics lead to reports of lower quality and higher costs. The summit brought together speakers on both sides of this debate. About 150 people met

for the day in the auditorium at the new underground Visitor’s Center on the U.S. Capital grounds. The audience was primarily congressional staff, federal regulators and other stakeholders.

Both Secretary Sebelius and the Centers for Medicare & Medicaid Services head, Dr. Don Berwick, gave brief keynotes followed by six panels with the speakers being mostly physicians from around the country.

Summit Recap from [www.POLITICO.com](http://www.POLITICO.com)

“Secretary Kathleen Sebelius urged Congress on Monday to turn its attention away from politics and partisan sniping and to focus on how it can successfully reform the nation’s health delivery system.”

“ ‘This is not a political debate,’ Sebelius said of the need to make Americans healthier, before an audience of congressional staff, federal regulators and stakeholders at DHHS’s National Summit on Health Care Quality and Value.”

“ ‘If we have a healthier nation, we will have a healthier work force, and that work force will make us more competitive,’ she said. ‘It has the potential to drive growth and create jobs or be a job killer.’ ”

“Sebelius spent little time on the administration’s favorite health reform subject—wave of consumer-friendly insurance reforms that took effect in September—and instead focused her remarks on the more challenging question of which reforms can improve health quality outcomes while concurrently lowering costs.”

“ ‘Much of the discussion of the affordable care act has been about the insurance market so far, about consumer benefits and insurance coverage,’ Sebelius said. ‘But the underlying bill gives us a brand-new platform, transforming the delivery of care. At its very core, our work today begins that conversation about improving lives and ensuring peace of mind.’ ”

“Donald Berwick, the administrator of the Centers for Medicare & Medicaid Services, also spoke. It marked his first appearance on Capitol Hill in his new position, albeit it with Congress out of session.”

### The RWHC Social Network

(no relation to the movie)

Rural Health Advocate: [www.ruraladvocate.org/](http://www.ruraladvocate.org/)

Rural Health IT: [www.worh.org/hit/](http://www.worh.org/hit/)

Twitter: <http://twitter.com/RWHC>

## Apparent Agreement Amongst Participants

Don Berwick previously led for many years the Institute for Healthcare Improvement (IHI). His comments after lunch were mirrored by panelist on both side of the geographic variation fight throughout the day:

- “Our Triple Aim is to improve health, improve care and reduce cost.” (From the IHI Triple Aim to (1) Improve the health of the population; (2) Enhance the patient experience of care (including quality, access, and reliability) and (3) Reduce, or at least control, the per capita cost of care.)
- “Variation means that we can and should learn from those providers who are having the best outcomes.”
- “No matter what subset of providers you identify, there will be variation.”
- “The risks of transparency are worse than the risks of hiding; we need to learn our way to a new future of health care.”
- “We are all in this together, it is not just an issue for CMS but public and private, urban and rural.”



- Accountable Care Organizations under the current rules are significantly less appealing in markets with less “fat” (without agreement re what is “fat”).
- Quality improvement requires that providers have real time data.
- Providers are generally willing to be accountable for their own behavior and adequately risk adjusted patient outcomes but are not willing to take on the volatility of “insurance risk.”
- A core challenge is to change the very culture of how health care is provided.
- Medicare and Medicaid needs to pay for the right tests and right treatments as opposed to more tests and more treatments.
- Recognition that payment systems are a big part of what drives physicians re how and where they practice medicine.
- If held accountable for outcomes, providers need the flexibility to do what is needed for the patient whether or not it is a covered service.

## *Common threads amongst the panelists:*

- CMS needs to start recognizing value in how it pays for care.
- Known innovations need to be driven to scale.
- Providers need to shift from provider centric to patient centric.
- Coordination of care is the key; corporately integrated delivery systems are not the only approach.
- Care management and medical homes need to be locally run, not held within a regional call center.

## Apparent Disagreement Amongst Participants

*Positions with which areas designated by Dartmouth Health Care Atlas as “low value” disagree:*

- That Wisconsin and other high quality, lower cost states are disadvantaged by Medicare compared to other parts of the country.
- ***That when Medicare beneficiaries move from low cost areas to high cost areas they rather quickly collect more diagnoses and have more procedures done to them, and vice versa, with no improvement in health.***
- That small numbers are a problem when evaluating quality and cost—whether it be publishing out-

come measures for individual physicians or risk adjusting small hospitals and clinics.

- That it is appropriate to create financial incentives for people to stay healthy and use the healthcare system appropriately.

*Positions with which areas designated by Dartmouth Health Care Atlas as “high value” disagree:*

- That some states are shown with higher utilization and lower quality, even after the data is risk adjusted, is primarily due to variation characteristics of the patients and not due to variation in regional practice patterns.
- That all of America’s center is “rural” and doesn’t face real challenges like New York, Florida, Texas and California.
- That Medicare should not pay for value until there are better measures (with no sense of irony regarding the flawed measures currently used for geographic payment adjustments.)
- That providers are not forced to cost shift to commercial payers due to Medicare or Medicaid underpayment (arguing that higher than necessary costs drives the cost shift).



chapters draw from published research and from information gathered during site visits to rural South Dakota and rural California.”

**Home and Community Based Care for Rural Seniors**—“The elderly population in rural America is growing at a rapid rate. An estimated 69 percent of people turning 65 years old will need some form of long-term care in the future. Studies show that seniors are happier remaining in the home as long as possible, but too often seniors are ushered into retirement homes without being offered an alternative. Allowing seniors to age-in-place is more difficult because the existing infrastructure and available resources are concentrated on supporting nursing home care.”

“The Committee believes that options for home-based care need to be expanded in rural areas. Barriers such as geographic accessibility, ineligibility, workforce shortages, and limited awareness of options all affect seniors’ decisions when choosing care. The Committee’s recommendations to the Secretary include evaluating current laws prohibiting payment to family members for care and coordinating with the Secretary of Transportation to ensure seniors access to care.”

**Rural Primary Care Workforce**—“Declining interest in primary care has most notably affected rural communities. An aging rural population and a retiring medical workforce exacerbate the shortages rural America already faces. Additionally, fewer medical school graduates are interested in practicing in rural areas. There are 55 primary care physicians for every 100,000 people in rural areas, compared to the 95 per 100,000 that are needed. An expansion of health care insurance would intensify the unmet demand for primary care in rural America. The Committee recognizes the importance of not only attracting primary physicians to rural America, but in utilizing physician assistants and advanced practice nurses who can act as the sole primary care provider in a community. The Committee recommends that the primary care system be strengthened through local leadership, an emphasis on preventative measures, and by attracting and training a workforce dedicated to care in rural areas.”

**Rural Health Care Provider Integration**—“The majority of patient care in the United States is uncoordi-

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## Annual National Rural Report Released

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*The 2010 Annual Report by the National Advisory Committee on Rural Health and Human Services (NACRHHS) has just been released. A complete copy is available at <http://ruralcommittee.hrsa.gov/> Below is the Executive Summary:*

“This year’s report examines three key topics in health and human services and their effects in rural areas: home and community based care for rural seniors, rural primary care workforce, and rural health care provider integration.”

“All are pertinent and timely issues that the Committee chose during its February 2009 meeting. The

nated due in large part to an incomplete transfer of important patient information between providers. This fragmentation of care is acutely problematic in rural areas, which face higher rates of chronic diseases that require greater managed care. This is cause for concern since 88 percent of Medicare spending is concentrated among only 25 percent of beneficiaries, 75 percent of which have one or more chronic diseases.”

“The Committee believes that the quality of care and efficiency of delivering care will both increase if integration—seamless patient and information flow among providers—is achieved. In this report the Committee recommends specific ways to achieve integrated care. These recommendations include fixes to Stark regulations to prevent hindrance of provider integration, and a call to include rural providers in future demonstrations of Accountable Care Organizations bundling, and patient-centered Medical Homes.”

**19<sup>th</sup> Annual \$2,000 Monato Essay**

A \$2,000 Prize for the Best Rural Health Paper by a University of Wisconsin student. Write on a rural health topic for a regular class and submit a copy by April 15th. Info re submission is available at [www.rwhc.com](http://www.rwhc.com)

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## Wisconsin Hospitals Community Benefits

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The Wisconsin Hospital Association (WHA) annually surveys its 131 member hospitals and asks them to describe and quantify the programs, services and activities that they provide at or below cost, solely because those programs fulfill a health need in the community. The hospitals reported that in 2009 they provided nearly \$1.18 billion in community benefits and more than 735 patients per day received their hospital care free of charge. Altogether, Wisconsin hospitals provided nearly \$226 million in charity care to 268,568 individuals last year.

WHA’s new web site [www.wiServePoint.org](http://www.wiServePoint.org) is designed to familiarize the user with the services, programs and assistance that hospitals offer at or below cost. The WHA Community Benefit Report describes and quantifies these services, but most importantly, it tells the true life stories of how hospitals help people live safer and healthier lives. Visit ServePoint to review the 2010 report with more than 100 patient stories and descriptions of free and reduced cost services that hospitals provide in their communities.

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