



The *North Carolina Medical Journal*, the official journal of the North Carolina Medical Society, published by the North Carolina Institute of Medicine and Duke Endowment, dedicated their July/August issue to the [Future of Nursing in North Carolina](#).

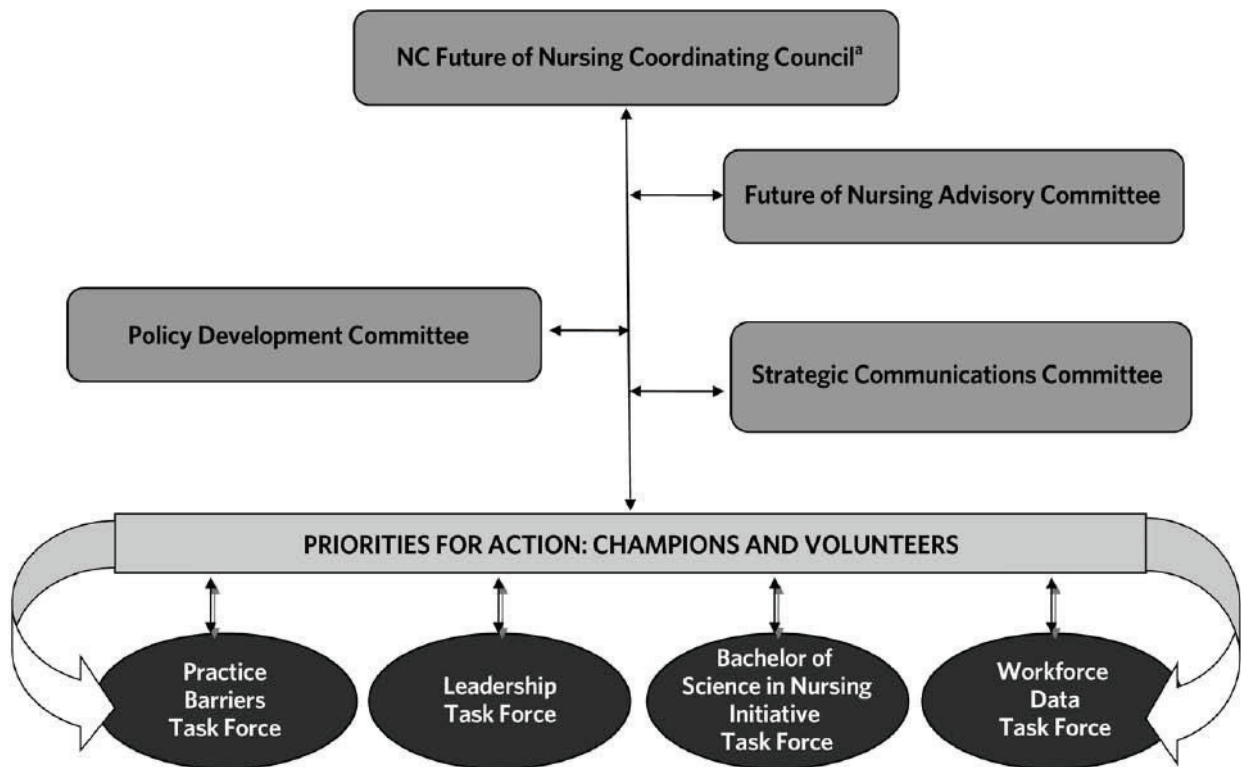
[Thomas C. Ricketts](#), editor in chief, NCMJ writes that “Nurses seek to rise to the challenge society has given them to improve health care amidst the realities of the complex economics of health care. The aspirations of nurses and nursing have changed dramatically in the recent past and are beginning to converge with medicine. This convergence is due to the shared need to bring the best and most-efficient means to making a healthier society when many forces run counter to that goal. Nursing is rising to the challenge”.

[Sue Hassmiller](#) provided “The National Perspective on the Future of Nursing: Where We Are Going” and described the five goals of The Future of Nursing: Campaign for Action to strengthen nursing education, enable nurses to practice to the full extent of their education and training, advanced interprofessional collaboration, expand nurse leadership, and improve collection of data about the health care workforce.

[Peggy Wilmouth](#) summarized the April 11 Statewide Summit for Creating the Future of Nursing and Health Care in North Carolina. The Future of Nursing Coordinating Council will be leading the way in North Carolina to ensure that

- (1) North Carolinians will have an effective, educated nursing workforce;
- (2) Education for nurses is accomplished through a seamless educational process;
- (3) Nurses can practice to the full extent of their education and training;
- (4) Nurses are full partners in redesigning health care in North Carolina; and
- (5) There is an effective and comprehensive health care workforce planning system in the state

FIGURE 1.
Organizational Structure of the North Carolina Future of Nursing Action Coalition



^aCouncil members consist of the Foundation for Nursing Excellence, the North Carolina chapter of AARP, the East Carolina Center for Nursing Leadership, the North Carolina Board of Nursing, the North Carolina Nurses Association, and the North Carolina Organization of Nurse Leaders.

Four articles address advancing nursing education transformation.

[R. Scott Ralls](#), president of the North Carolina Community College System, describes how North Carolina redesigned the ADN curriculum and encouraged partnerships for seamless transition to more-advanced nursing degrees.

[Polly Johnson, Vincent Hall, and Brenda Causey](#) describe the Western North Carolina Regionally Increasing Baccalaureate Nurses (RIBN) Project, which adapted the Oregon Consortium for Nursing Education model for dual admission of qualified students into a community college and a 4-year university, yielding a seamless, 4-year educational tract.

[Elaine Scott & Helen Brinson](#) discuss barriers and facilitators to advancing nursing education for associate degree graduates.

TABLE 2.
Barriers and Facilitators to Progression From the Associate’s Degree in Nursing (ADN) to the Bachelor of Science in Nursing (BSN) and/or Master of Science in Nursing (MSN)

Area	Barrier(s)	Facilitator(s)
University	Limited number of advisors for nursing students at both community college and university	24/7 online technical support Computer literacy aids
	Wide variability in university and nursing program requirements related to transfer credits and general education courses	Designated RN-BSN coordinators who are accessible to current and prospective students and who collaborate statewide Offering separate courses for RN students
	Barriers and issues associated with online courses	ADN program directors who encourage educational continuation and exposure
	Communication between students and faculty	Articulation agreement between the NC Community College System and the UNC System related to nursing
	Limited financial aid for part-time students Requiring timelines on transfer credits	Community college transfer counselors that understand RN-BSN education College Level Examination Program examinations Waiving timelines on previous course work
Employment	Employment situations that are not supportive of furthering education	Employers who provide tuition reimbursement and upfront financial aid or loans
	Inadequate tuition support or loans for returning to school	Increased RN salaries for additional degree attainment
	Limited rewards for educational progression	Educational requirements at the BSN or MSN level for nursing leadership roles in health systems
	Lack of standard educational requirements for varied nursing roles, such as nurse manager, administrator, and vice president of nursing	Educational cohorts in health systems that have release time, support meetings, and mentors Celebration and acknowledgment of RNs who achieve higher degrees
	Health systems disregard for evidence-based practice standards in nursing staffing	
Personal	Balancing priorities	RN-BSN inclusion in the North Carolina Nurse Scholars Awards
	Financial obligations	Internet-based modules on time management, financial aid, balancing work and school life, and school expectations
	Family responsibilities	RN-BSN/MSN mentors
		Online forum for RN-BSN/MSN students to discuss issues and share ideas that are successful

Note. RN, registered nurse; UNC, University of North Carolina.

[Eileen Kohlberg](#) outlines the contribution of nursing education programs to the implementation of the Affordable Care Act in North Carolina.

Barriers to advanced practice registered nursing care in North Carolina is also covered in this issue

[Bobby Lowery and Deborah Varnam](#) describe how required physician supervision of nurse practitioners in North Carolina limit consumer choice and access to health care. Two illustrative tables are copied below.

Table 2 Case Studies of Adverse Outcomes Associated with Physician Supervision and Insurance Reimbursement for Nurse Practitioners

Variable	Case Study
Physician Supervision	A thriving NP-owned practice in rural western North Carolina, with 2,000 patients is managed by 2 NP partners and a small staff of 8 employees. The practice is the only practice in the small, rural town. The NPs contract for physician supervision, as required by North Carolina statutes. The physician is remotely located and visits the practice for the twice-yearly meetings required for the quality improvement process. The practice manager drives 60 miles roundtrip once per week to deliver and pick up paperwork that requires a signature from the physician who supervises the NP-delivered care. The physician is paid \$25,000 annually to supervise the NP practice. During a busy practice day, the NP practice receives notice from the North Carolina Board of Nursing that their supervising physician no longer has an active medical license and that the practice has 30 days to find another supervising physician or they will have to close their practice. The NP practice is threatened with closure because of the absence of statutorily required physician supervision. Two thousand health care consumers are threatened with loss of access to health care and choice of healthcare professionals. A new supervising physician is secured only 5 days before the office would have been forced to close.
Insurance Reimbursement	J.D., a family NP, owns an established, rural primary care practice in North Carolina that serves Medicaid, Medicare, and indemnity plan clients across the life span. J.D. contracts with a physician for supervision, as required by North Carolina statutes. J.D.'s supervising physician decides to relocate and gives notice that he will be resigning as the supervising physician for the practice. A different supervising physician is hired, requiring another contract with the indemnity insurer. The insurer refuses to renew the contract with this NP and practice, although many of the clients in this practice are covered by the plan. When the insurer is questioned about why it will not renew the contract, it replies that it does not contract with NPs. The insurer is unable to explain how the NP had been able to contract with its office previously. The clients with this insurer have to find another health care professional or pay out of pocket for their care at J.D.'s practice. The viability of the NP practice is threatened by inconsistent reimbursement policies that tie the NP to physician practice and limit consumer choice.

Table 3 Common Reimbursement Barriers to Nurse Practitioner Practice and Forms Requiring Physician Supervision

Variable (statute)	Barrier
Physician supervision	Physician supervision is linked with more-restrictive reimbursement policies
Handicap placards (20-37.6)	Commonly used in primary care: delays care for consumer and increases cost by physician involvement
Private provider vaccine agreement (130A-152)	Required for childhood vaccine administration
Physicians' request for medical exemption of vaccines for children (130A-156)	Physician signature required to order
Medicare home health/hospice	Physician signature required to order
Variability in insurance reimbursement	Specialty rates charged to consumers seeking primary care services from pediatric nurse practitioners; increases cost

[Eileen Kugler, Linda Burhans, and Julia George](#) describe how the four advanced practice registered nurse (APRN) roles are currently regulated in North Carolina and efforts to implement the [Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education](#). In North Carolina, “each of the 4 APRN roles is regulated in a different manner. NPs are jointly regulated by the North Carolina Board of Nursing and the North Carolina Medical Board and are required to have physician supervision. CRNAs are regulated by the board of nursing, with no requirement for physician supervision. CNMs are regulated by the Midwifery Joint Committee, with independent statutory authority; however, CNMs are required to have physician supervision. Last, CNSs are not regulated and do not have title protection.”

Transforming leadership is a key message of the IOM report. [Connie Mullinix](#) describes the reasons nurses have not been leaders and calls for nurses to become full partners in redesigning health care in North Carolina. “The reasons for nurses not taking on leadership roles are thus steeped in gender and history and are hard to overcome. ...If nurses continue to subordinate their talents and insights and fail to help create solutions to these problems, it will only perpetuate the current, substandard level of care that is in desperate need of improvement.”

Recommendation 8 of *The Future of Nursing: Leading Change, Advancing Health* is to build an infrastructure for the collection and analysis of interprofessional health care workforce data. According to [Erin Fraher & Cheryl Jones](#) , “North Carolina has a long history of collaboration around the collection of nursing workforce data and is considered a national leader in this regard. However, a more comprehensive, systematic, and enduring interprofessional system is needed to measure, monitor, and evaluate the state’s nursing workforce within the context of other health workers.”