



What Could Nursing Be?

Reflections on Our Future

NCSBN World Café Education Meeting

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Key Question

- What could nursing be *when* (not *if*) education, approval and accreditation are (a statement of optimism) *fully* aligned (not *partial* and a statement of expectation).
- I would add: What could nursing *contribute to the public's understanding and acceptance when education, approval and accreditation are aligned?*

The Future is Framed from the Past –
and the Social Desire to Move
Personal and Institutional Boundaries –
Are We Ready to Move?

**ACCREDITATION,
REGULATORY AND
EDUCATIONAL
ALIGNMENT**

The Call for *Simplicity* (John Maeda Laws of Simplicity)

- Simplicity = Sanity!
- 1. The simplest way to achieve simplicity is through thoughtful *reduction*.
- 2. *Organization* makes many seem like few.
- 3. Savings in *time* feels like simplicity.
- 4. *Knowledge* makes everything simpler.
- 5. Simplicity and complexity need each other (*differences*).

The Call for *Simplicity* (John Maeda Laws of Simplicity)

- 6. What lies in the periphery of simplicity is definitely not peripheral (*context*).
- 7. More *emotions* are better than less.
- 8. In simplicity we *trust*.
- 9. Some things can never be made simple (*failure*).
- 10. Simplicity is about subtracting the obvious, and adding the *meaningful*.

Positive Deviance – Jerry Sternin

- Solving intractable problems *with no added resources*.
- PD emphasizes *practice instead of knowledge—the “how” instead of the “what” or “why.”* The PD Mantra is: *“You are more likely to Act your way into a new way of thinking than to think your way into a new way of acting.*
- From the Positive Deviance Field Guide retrieved online.

Positive Deviance – Jerry Sternin

- The problem is not exclusively technical but also relational and requires behavioral or/and social change.
- The problem is complex, seemingly intractable, and other solutions haven't worked.
- Positive deviant individuals or groups exist solutions are possible.
- There is sponsorship and local leadership commitment to address the issue.

The STRETCH



Protect the Public

- Practice is predominantly within pre-defined geographic boundaries
- Practice acts guide individual practices
- Regulatory model is based on state-based limitations on scope of practice and payment or reimbursement policies

Protect and Advance Public Interests

- Practice has permeable geographic boundaries
- Regulatory model aligns with practice and reimbursement models
- Create space for innovation across new care continuums
- Practice acts accommodate team care

Current Reality → Future Needs

The Practice of Medicine

- “A person is practicing medicine if he does one or more of the following:
 - I. Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means of instrumentality;

The Practice of Medicine

- “A person is practicing medicine if he does one or more of the following:
 1. Administers or prescribes drugs or medicinal preparations to be used by any other person;
 2. Administers or prescribes drugs or medicinal preparations to be used by any other person;
 3. Severs or penetrates the tissues of human beings.”

Safriet, B.J. IOM report, Appendix H

Not New: Pew Commission, IOM - 1998, 2001, 2010

- “Traditional boundaries – in the form of legal scopes of practice – have blurred.”
- “Some scopes of practice conferred upon licensed occupations & professions are unnecessarily monopolistic, thereby restricting consumers’ access to qualified practitioners & increasing the cost of service.”

Not New: Pew Commission, IOM - 1998, 2001, 2010

- “Clinical practice is no longer based on exclusive professional or occupational domains.”
- “If someone is competent to provide a health service safely, and has met established standards, then he or she should be allowed to provide that care and be reimbursed for it, even if that care was historically delivered by another profession.”

Not New: Pew Commission, IOM - 1998, 2001, 2010

- “Demonstration projects[can] provide an empirical basis for rational development of legally defined scope of practice provisions, which reflect evolving clinical competence, and make optimum use of skilled health care practitioners.”

IPE is the beginning – is the regulatory and practice environment ready to accept, promote, and advance the education provided?



INTERPROFESSIONAL EDUCATION AND PRACTICE

Interprofessional Practice

- Core courses in common
- Core *experiences* that reflect decision-science and “team” behaviors toward quality and safety
- Shift in evaluation of learner attainment



Interprofessional Practice



- Is *not* the ‘homogenization’ of the disciplines
- Team care may not be universally possible
- Education and regulation must be scalable across geographic boundaries

Can we move rapidly enough to realistically meet the needs of aged and chronically ill persons – promoting health and abating disease advancement?



SHIFTING PUBLIC EXPECTATIONS AND NEEDS



Aging and Chronic Conditions – the Plight of Families

How will nurses educate, develop, and lead the Future of Health Care in a country fragmented in its beliefs?

Can the nursing workforce
remain gender and
culturally imbalanced?



**WORKFORCE DATA
AND INFORMATION –
ASPIRATIONAL
GOALS**

Supply and Demand

- Supply data is just being uniformly collected in nursing
- Supply data in the health disciplines is marginally available and does not account for overlap
- Demand data is institutionally based – but does it reflect the population needs?

Competencies and Staging

- Leveling of competencies to mesa or macro level is needed across certifying agencies
- Minimum or optimum competencies?
- How will the workforce be staged – analytic job analysis is needed for an adequate workforce plan and is unavailable

Workforce Data – What Predictive Capacity is Possible?

Learning communities to practice communities – is structural realignment needed and possible in highly bureaucratic structures? Where is flexibility most likely to occur?

**EDUCATING TO
NEW REALITIES –
DOCTORAL AND
PRELICENSURE**

The Academic Culture for the Future

- Geographic and online access to education
- Faculty readiness
- Academic structures and capacity for leading organizational change
- Gender and ethnicity – is balance possible?
- Testing new models of care – who can and where should it be achieved?

The Academic Culture for the Future

- PhD and DNP – coexistence and complementary?
- Will the DNP shift the academic culture and faculty shortage?
- Flexibility in who can teach – IPE
- Science development – will that include education, organizational systems, workforce development?
- New models needed

So – What Could Nursing Be?

- If we continued to use the IOM Future of Nursing Report as a blueprint for action?
- If we unified around permeable geographic boundaries to address “communities of interest”?
- If we tested new models of LACE and care that were scalable?
- If we sharpened our interprofessional lens?

So – What Could Nursing Be?

- If we used predictive analytics to provide direction to the workforce and work environment?
- If we loosened structural elements and focused on key functions, ergo, less regimented solutions?
- If we acted with a level of unheralded urgency to ‘catch up’ to shifting demographics?

That Would Depend on You and Conversation Café Outcomes!

