# *2019 NCSBN APRN Roundtable* Lessons from the Graduate Nurse Demonstration Project Video Transcript



**Event**
2019 NCSBN APRN Roundtable

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**Presenter**
Barbara Todd, DNP, ACNP-BC, FAANP, FAAN, Director, CMS Graduate Nurse Demonstration Project, University of Pennsylvania

So it's nice to see everyone today, a lot of familiar faces. Also, I want to acknowledge some of my partners who participated in the Graduate Nurse Education Demonstration Project, not only from my University of Pennsylvania project, Dr.

Sullivan and then also Dr. Powell and her colleagues from Neumann, but also I see some from the Texas Gulf Coast as well who participated in the project. So, as Maureen said today, we're going to talk a little bit about the GNE Project and just give you some updates. One, you know, some of the background and context for the project, as well as also talking about the evaluation of the project, and then, what do we do next?

So the objectives for the next 40 minutes or so, are really to talk about the policy rationale for the GNE Project, what were some of the lessons that we learned, and some of the challenge, those related to the project implementation, and really to discuss the formal evaluation that was done by external evaluators on the project. So first, the policy question.

The overview of the project that we had in the Greater Philadelphia region, the evaluation report, as well as, like, the lessons learned and next steps. So just by way of background and context, as many of you in this room may be aware of, the GNE was part of the ACA.

Back in 2010, there were many coalition stakeholders who came together to really pursue the policy reforms, which included the GNE Demonstration. There was $200 million, which was allocated for a 4-year project, which was to run between 2012 and 2016. Because they were, like, funds that were left over, after 2016, the project was extended for an additional two years.

So, in fact, the GNE Project ran for a total of six years. As you can imagine, there are many rules around that two-year extension period and I'll talk a little bit about that. You know, but prior to the GNE

Demonstration, there really had never been funding that had been allocated for nursing education. Everyone was very familiar with the medical model, and where Medicare paid hospitals for residents and residency training.

So the GNE Project, we felt, was really innovative, and really was like a first time that we saw an opportunity to really look at the clinical education around APRN training. So, just by way of description, as I said, it was mandated as part of the ACA.

It was administered by the CMS Innovation Center, focused on primary care transformation, and there were five sites that were selected nationally to participate in this project. With the primary goals being, one, to increase the provision of quality training for APRNs, with a focus on chronic care management, primary care, and, really, transformation.

And really to test the feasibility. Could the money that was allocated for clinical training really, in fact, increase enrollments and ultimately graduates and put them out into the workforce to really do primary care transformation? So, the Affordable Care Act, as everyone knows, also extended insurance coverage to a number of people.

There was a ongoing cry that there was lack of primary care providers. And if you pick up any article related to primary care, you'd constantly see about the number of shortages that exist, not only with nurse practitioners in primary care, but also physicians and other providers. And, you know, there has been ongoing evidence repeatedly that advanced practice nurses can provide safe care in most cases comparable to other providers and sometimes superior to those providers.

What we also heard in our beginning stages is that nursing schools really felt that they were at a disadvantage in terms of increasing enrollment, particularly in APRN programs, because of the lack of clinical training opportunities, inability to find preceptors. Because preceptors were facing increasing competition in their work areas. Also, there was increased demands on productivity, which really, sometime, you know, was a barrier to them taking on students, which sometime would increase the amount of time that they needed to devote to students and ultimately decreased productivity.

So the funding that we were able to give to the schools as well as to the clinical training partners, was to really to try to offset that productivity drag that's associated with training APRN students. So some of the questions that were being addressed across the demonstration sites early on was, did the Medicare payment policies geared to licensed physicians, was it feasible for APRNs?

Will the CMS incentive to increase graduates through paying for these incremental students...and that was a very complex methodology on, you know, which students could be paid for. And it created a lot of dissent in the community because from a provider perspective, they were training students.

They had no notion of whether students were incremental or not, or could be included in the payment counts. And will it result, really, in a significant number of APRNs? And we think that answer was yes, during the demonstration. Will it result in more quality placements? And I think that was a lot of our aha moments as well as we really engage with the schools in our region and we saw the wide variation that was going on as it related to clinical training.

And more importantly, do the graduates that, you know, graduated as part of this program really work with our most vulnerable populations where that is desperately needed? So the design was that the Medicare paid to the hospitals. As I can tell you, the project was quite complex. We have a person who handled on Medicare billing, he was instrumental to helping us operationalize this project and really understand the project, particularly from a cost report perspective.

The only costs that were allowable were related to clinical education. And there were two streams of money, there was payment to the schools of nursing and then there were payments to the clinical training partners or the preceptors to offset the loss in productivity. And the payments were based on this formula related to incremental students. It was a delta between the baseline year students, which was a period of 2006 to 2010, and based on the number of students who were actually enrolled at a given university during the demonstration year.

All APRNs were eligible. There were a couple caveats. You had to be a first-time APRN. So, if students were there and they were previously an FNP and now they're going back to be an acute care NP, those students cannot be included in the counts.

But if you were a previous administration student and now you're coming back to be an APRN, those were included. Also, the BSN to DNP, if that was the entry to APRN practice, but, of course, post-master's DNPs who were already APRNs could not be included. And then the other criteria that we had is that all of the training... 50% of the training had to be conducted in community-based sites.

And all of the sites really were able to achieve that without difficulty. So in terms of the two models with the GNE Project, there were two models that really emerged. One was a single-hospital system in the academic institution. And those included the sites from Duke as well as Rush, which is local to here.

And then there were the consortia models that emerged, which were three sites. One was the one we had at the hospital, the University of Pennsylvania. Then there was the Memorial Hermann, Texas Gulf Coast Demonstration, and then there was Honorhealth, Banner Health. They've changed their name a couple times, but it was in state of Arizona.

And that really expanded the state and probably had more of a state reach than our other two projects, because ours really concentrated in the Philadelphia region. So the consortia model, I think, there were a couple of interesting things about that, working with various universities, all who were essentially competing for similar students, all similarly competing for a similar clinical training sites.

But I think the consortia model, there was a lot of anxiety and angst at the beginning of the model. But I think people came together and worked together to achieve the goal of increasing more APRNs. And I think the other thing that we learned is that you really need a major infrastructure to handle all of the complexities that were associated with the GNE project.

Because of the managing all of the contracting, the payment, the intersection with Medicare, I'm really being able to understand the complex auditing that also took place as a result of the demonstration. In terms of the demonstration landscape, there were 19 participating universities and schools of nursing.

The ones in the red were the ones that are part of the Greater Philadelphia GNE Project. We had nine schools that participated, the Texas group had four, and Arizona had four, and then there was Rush and Duke that had the one. And our goals were similar to what the goals were kind of set forward as a result of the GNE, was really to focus on providing increased care to Medicare beneficiaries, to create, like, partnerships...

create a partnerships that could be collaborative, to look at the ways in which we approach clinical training, and were there ways that we could work together in a different way to achieve the same goals? Also, we did a lot of exchange of information, trying to demonstrate best practices, and really to emerge from the demonstration with the new way of thinking about clinical training.

In terms of the Pennsylvania landscape, as many may know, it's a very densely medical community, you know, within our immediate reach. If you think about Pennsylvania in general, there's like... I think Philadelphia, Pittsburgh, and then there's the rest of Pennsylvania, when you think of all of the concentration of, like, the medical services.

But there are lots of hospitals, as you can see, in the state of Pennsylvania, you know, many emergency room visits on any given year, lots of admissions, ambulatory visits. And there's a projected shortage of physicians in our state, which is probably comparable to most states across the nation. And then when you kind of drill down and you come to the Philadelphia region, within our immediate area, we have five medical schools.

We had 9 schools of nursing that produce APRNs, all within, like, a 30-mile radius, with 8 physician assistant programs, and we actually had 2 PA programs that emerged during the course of the demonstration. And we have thousands of students, all who are competing for similar types of clinical training opportunities.

So if you look at our GNE project, the schools there are listed, the nine schools of nursing. Over 50% of the programs had CRNA programs. All the programs had nurse practitioner programs. Over a third of them had acute care nurse practitioner programs, about a third of them had CNS programs, and only one had, like, a nurse midwifery program.

And I think we were the only nurse midwifery program in the whole entire demonstration. But, as you can see, with the different types of APRN students, that created lots of different opportunities related to the types of clinical training opportunities that they would need to complete their degree. Our footprint in terms of the demonstration, we worked with many clinical training partners across the Greater Philadelphia region to, one, to increase the awareness about the need for APRNs.

A lot of the places were already taking APRN students, so it was kind of a education to demo what the GNE Project was about. But also, you know, we created new partnerships and new contracts with other agencies, particularly working with the National Nurse-Led Consortium Clinics and trying to ensure replacements for students at the NNCC.

But we worked a lot with our Federally Qualified Centers, which actually had a lot of challenges in terms of just working through the contracting, retail clinics that, based on the students and the curriculum, were able to be placed there, and then a lot of our university-based practices. And what we

also saw during the course of the demonstration is that many of the sites that were previously private practice had really been brought up by major health systems.

And then that also changed the dynamic in terms of thinking about the clinical training because now we had to work through gatekeepers to sometime try to secure student placements. So some of the early challenges was related to the payment methodology. And as I already alluded to, the payment included, there was a baseline number that each school had in terms of their baseline APRNs.

There was what their current enrollment was and their current number of students in clinical training. The graduates at the baseline as well as their prior year graduates was all factored into this very complicated formula to come up with what was the increment. And that was very confusing to the schools as well, particularly to the large schools where perhaps...you know, some of our smaller schools had really, like, 100% percent growth, 200% growth, but a lot of our larger schools probably had in the range of anywhere from 30% to 40% growth.

So that still left, essentially, about two thirds of students in any given semester, where there was really no...essentially, no payment. So being able to message that and communicate that was quite a challenge and they didn't understand it. And then most of the sites felt that if they have received payment once, they should receive it every semester.

So also being able to message that. So my finance guy say it only takes people a short time to get used to money. It's like you give it to them one time and they're looking forward forever. But the incremental payment methodology, if I had to do it all over again, I really would advocate that that one looks very differently. And we actually tried to work with CMS and Innovation Center to change that, but it didn't move.

So we actually were stuck with this incremental methodology for the entire demonstration. Then the contracting. The contracting also was really complex in that, not only did the schools with the clinical training site had to have a contract related to their students being in the site, but now they also had to have a contract related to the GNE Demonstration.

And that contract was actually between us as the hospital system, and now the clinical training partner. Because of the payment exchange, that contract had to be put in place. And that was often sometime confusing to the vendors as well. Also early on, there was confusion around whether it's really primary care, you know, versus specialty care, versus ambulatory care.

And we worked a lot with the CMS folks about that as well. And then just increasing the clinical training capacity. And some of the challenges we had there was the wide variation from school to school. In terms of the number of clinical training hours that were needed, I would go into negotiations with some of the clinical training partners to talk about increasing capacity, but I may have 100 hours over here that one school needs, I might have 240 over here that the other school needs, and then I have 360.

So it was very difficult to message, manage, and contract with agencies to increase students with the wide variation. They really were asking for consistency on the way that we place students and the

requirements that they have. And the one of my notions that I had when I came into this project is that clinical sites wanted students every day.

I quickly found out that wasn't the truth. And, you know, we really thought, you know, let's give them that immersive experience that we see with other disciplines. But a lot of partners told me they didn't want the student every day, but they wanted some consistency on how students kind of entered to our agency. The other concern to us is sustainability. We're starting to think about that now.

You know, the project is over, essentially, we're kind of in the final phase of the auditing of it. So, you know, what is the next steps? And I don't think that we've seen the true fallout, if you will, from the GNE Demonstration, because I think there's still some lag from Year 6. So I think next year as we look at the... particularly the schools that are in our geographic area, we'll really be able to get a true sense of what the impact will be now that we don't have the funding associated with the student placements.

And as I said before, you know, I think the schools initially were resistive, but they came together and really formed a nice partnership around thinking about clinical education. And I was actually speaking with someone last night even about the way that we think about, like, evaluating students because that, too, was a challenge when working across nine schools of nursing, trying to work with a single agency to take more students, I had nine evaluation forms.

I had nine evaluation forms, I had nine syllabuses, I had different expectations when, ultimately, the end product was going to be the same. But to the clinical training site, that was really quite concerning to them, and very frustrating, and sometime led to them not being willing to take students.

So some of our strategies toward increase in clinical training was really guided around a couple of principles. Was really to try to increase the continuity of the experience, trying to ensure that there was consistency on how the clinical training took place, try to decrease the fragmentation. I once said it was like putting a quilt together.

Like I felt that I was putting different pieces together, but they were all very different, but you still came up with a good quilt. But the way the clinical training looked was very fragmented. Also trying to develop new preceptor relationships and trying to educate to some sites, they had never had students before.

So it was really educating them about the value of APRNs and then, ultimately, maybe they would hire them. We looked at sites with capacity to accept more students, particularly if you look at huge medical systems, they have more capacity to take students than, say, a small FQHC, where perhaps there's not enough exam rooms, not enough computers, not enough providers to provide the oversight.

We also worked with our retail clinic partners also to look at different clinical training opportunities. But there's wide variation there too, in terms of the number of students and the number of available opportunities for learning. We looked at interprofessional opportunities, particularly in our general med clinic.

And then with some of our acute care students, we also did IPE opportunities, with the overall goal being to really start to look at different ways to think about clinical capacity and change the notion that

there's this scarcity to abundance. And I think that's one of our challenges. And I think things that we can think about and talk about today, how can we start to think about clinical precepting and clinical training in a different way?

Because, ultimately, we are going to continue to see enrollments, not only at our APRN schools, but also at some of the other schools, the PA Programs, the medical programs, the medical students. So is there a different way that we could start to look at these clinical training sites and think differently on how we place students actually into sites? And is there a different way to think about what that training opportunity might be?

And this is just one example that demonstrates that. In terms of increasing capacity, we recruited facilities that had no APRNs. We explained to them what the benefit of taking APRN students, so ultimately, that facility that had no students ends up taking students. We placed the students in the facility, we paid those facilities to take the students.

And then ultimately, they saw the benefit of having them. And ultimately, they hired them. So I think, in some ways, it created a nice pipeline strategy for some of the clinical training sites to think about opportunities for how they could increase access to care by having more of APRNs in their settings. Just in terms of looking at the...from the Greater Philadelphia region, this is our enrollment that we saw across the demonstration, the baseline years being an average, as I said, of...2006 to 2010 was the baseline year average.

So you have a little bit over 1,100 enrolled. And then by Year 6, we had over 2,200 enrolled with a 96%increase in enrollment over the baseline. So there was growth. One of the questions that we're constantly asked is, and I'm sure this audience will ask, would there have been growth regardless of whether there was the GNE Project or not?

And I think that's really unknown. But, you know, with the project, we did see this growth that took place. Aside from the enrollment, you know, the more important thing, I think, is the graduates and, you know, who do we put in the communities and in the clinical training sites? And from our baseline graduates being a little less than 400, and by Year 6, we were at 752, which represented a 91% increase in graduates over the baseline.

We had a drop-off between your five and your six, because we did have some concerns at the schools of nursing, based on whether they would be able to get their students placed knowing that the GNE Demonstration Project was coming to an end. But overall, as you can see, I think that's a pretty good impact that we had a 90% increase in graduates. And this is just a breakdown by advanced practice nurse role.

And it's no surprise that the biggest increase was related to nurse practitioner graduates and much smaller numbers with the other APRN programs. We also participated in alumni survey with the universities. I think the first year, I got a 20% response rate.

And many of the universities told me, "Don't be concerned about that,"I said a 20% return rate just seemed way too low. But then as we did the alumni survey, and in our fifth year, we're right now

collecting data for the sixth year of the study, we had probably over a 60% return rate with the alumni survey. And that increase in the alumni occurred through a lot of different mechanisms.

Ones was like personalized messages. So the alumni survey didn't come from me, but it came from the individual universities, they create a personalized message out to the graduates to really try to secure their return on the survey. And as a result of that, they also text the survey, because everybody lives on their cell phone.

So we found that to really be quite effective in terms of increasing the alumni return as well. What we found, also, which I think is also a success story, is that over a quarter of our students are really employed at places where they did clinical training. And this is just with the Philadelphia GNE. Many of them also stayed in the state of Pennsylvania and 20% of them were from underrepresented minority groups.

And this is of the folks who answered the survey. So we're just pending now with the demonstration Year 6 data and that survey will close out shortly. We timed it to happen essentially about six to eight months after graduation because then most of them would have had positions at that point. Next, I want to transition into the GNE evaluation report.

And I see Kathy Delaney just came in as well from the Rush Project. And a final evaluation from the GNE, and this was conducted by audit... excuse me, by researchers that were contracted by CMS to conduct this external report.

And a final report will be due in the fall of this year. And some of the research questions that were, you know, answered by the GNE evaluation were a couple, and very similar to what we embarked on at the beginning of our project for the Philadelphia group was, one, you know, how was the GNE Project implemented? And, really, the researchers really wanted to know how that unfolded and how did that look different based on the different regions of the country that the project was actually enacted?

So, what were the characteristics of the network? You know, how did the demonstration projects get operationalized? What were their processes? You know, what were successes, what were some of the challenges? And then, did the networks really have any plan for sustainability of this project? And how did it differ based on our precepting opportunities and what was available based on whether we had sites that we were paying versus sites that we were not paying?

And did we really increase the growth in the APRN market? What was the effect on the overall growth? What was the effect on enrollment? And ultimately, was there any spillover effect or unintended consequences to other schools that were in the same regions where the GNE Projects were situated? And then, ultimately, also, to look at what was the cost of the project?

So I think, you know, the final conclusion of the evaluation report, there's a couple of pointers here that I think are really important to take home. We, one, did realize that it was possible and feasible for hospitals and major health systems in collaboration with universities to really be able to operationalize this project, and to be able to do all the multiple contracting to pay all the various clinical training sites that needed to be accounted for as a result of the project.

Also, we found that we could really place students in community-based settings. And I think that was a lot of concern early on. Also that, you know, students came from diverse backgrounds. The amount of data that we had to collect doing this project was really staggering. We had to hire coordinators, I think, at just about every one of the demonstration sites to just collect the data.

And so the amount of data that they were able to secure was tremendous in terms of trying to assimilate it and distil it into this report. And one thing, I think, that we also found is that there was increased demand at the precepting organizations, and also that we were able to create pipeline opportunities.

I know within our own institution, we have grown exponentially over the last five to six years. You know, the demonstration came about, but also the growth, and the number of folks that we have in our health systems that are APRNs has grown. And I think that the demonstration was a nice feeder and it really allowed us to really grow in our health system as a result of being able to prepare so many quality APRNs.

So looking forward, you know, we use the success of the demonstration to continue to have further national discussion about what's next related to the project. We really need to engage with, you know, all the major health systems, I think the payers, organizations such as yourself, I think the nursing organizations, to really ensure that we understand what is next and how do we try to pursue other avenues of funding given that the funding for this project has ceased.

I think a couple of other questions was how effective was the GNE in increasing the growth in the APRNs. And these next few slides really represent the entire demonstration, not just the project that we had in Philadelphia. And what's shown here is kind of pre-implementation and post-implementation from a comparable sample of non-GNE schools. So what it shows is that there was more growth in the GNE schools into the...I think, it's the fourth year of the project, which was 2015, the third year of the project.

So this represents 3 years worth of data, from the Demonstration Year 1 through Demonstration Year 3. So it shows even before the project was implemented, there was growth at the GNE schools as it compares to the non-GNE comparison group that was chosen. And some of this data comes from the audit reports, the semi-annual reports that we had to do, as well as AACN data.

The other was looking at the enrollments in GNE schools versus non-GNE schools. And the red represents the GNE schools, once again with the comparison sample. And you can see that there was more growth in the GNE than non-GNE schools. Comparably, if you look at the graduation rate from GNE Demonstration schools, the blue represents nurse practitioners, the yellow line represents all.

And, you can see, as compared to what happened with our Philadelphia project, most of the growth was with nurse practitioner programs. Also in terms of looking at the number of clinical training hours that were completed by the incremental APRN students, once again, this was the first three years of the demonstration project, with the yellow line representing the community-based training opportunities, and the blue representing the hospital-based opportunities, you can see that the students are completing more hours in community-based settings, which is appropriate, depending on the type of APRN program that they're engaged in.

And then this is just another way of looking at that same kind of data, which shows that from the first three years of the demonstration project, that most of the clinical training is happening in the community-based settings. And this is just a diagram showing the scattering of the clinical training sites. And you can see that we really had a national footprint there with clinical training taking place pretty much across the country.

And the purple dots representing employment opportunities, which also kind of shows a little bit of convergence of where the clinical training was taking place, and also where the graduates were ultimately employed once they finished their APRN program. So it was quite a saturation of the demonstration graduates. And then if you, you know, think about each one of the separate demonstration sites, it probably looks, you know, similar.

We had a lot of folks across the country from our site, because of one of our programs was the distance learning program and they had students across the nation. And this data includes everyone except for the Duke employment data. But aside from that, all of the five sites are represented. So one of the next questions asked was, how was the GNE Demonstration project implemented and operationalized?

And as I had said earlier, particularly with our project, there was wide variation across the five networks. There were, you know, rural and non-rural clinics, particularly in the Arizona Project, they had more of a rural concentration. The startup of this project was very slow, particularly in Year 1. And that's why I think we had funding left to do the two additional years, because a lot of the money was not spent in the first year, because schools couldn't get contracts together.

Some universities would not let them retro pay for the clinical training, because in that first year of the project, we got the funding in July. And I think before we finally had a finalized budget, it was like right at Thanksgiving time. So it was November before we even got our first budget to even move forward. And students were already in clinical training in that's fall semester of 2012.

And some universities would not allow the schools to go back and pay the clinical training sites from the fall semester. So that's why we had the residual money. And all the places also had different infrastructures to operationalize the project.

There were a couple different approaches. Even though we still had to work from that baseline methodology, there were still various approaches to how that was approached and ultimately, the numbers of the number of incremental students. You know, there was, in some sites, as few as 25 incremental students and some of our sites an upwards of 400 incremental students in a given semester.

And then there was opportunity, I think, for innovation, particularly around interprofessional education. And looking at the cost data here for the first four years of the project. And this is broken down by direct and indirect cost, as well as cost at the school of nursing in terms of payments, as well as to the community, the CCSs which were the community sites, and then the total cost.

As you can see that in Year 1, which reflects what I was talking about with the startup of the project, the cost in Year 1 was, like, $17 million, whereas the cost in Year 4 of the project was like $41 million. So, as you can see, I think in our last years, we spent less because we were really, at that point, only dealing with students who had already been there.

We could not count any additional new students for the fifth and sixth year of the project. So it had to be students that were still in the program from the first four years. So in terms of successes and challenges, I think there was increased awareness about the need for APRNs.

As you can see from the slides that were presented, enrollments and graduates ultimately did increase. The implementation, as I alluded to, related to the payment methodology, I think, was really a challenge, not a success. And then some of the qualitative data that was obtained from the evaluation had a couple of quotes that are listed here, relating to collaboration, concern for what happens when the GNE money is no longer there, some of the variations in which preceptor incentives actually take place, the relationships with the school of nursing and the project didn't...I think worked to strengthen the academic practice partnerships in the selected sites.

And then the opportunity to partner with community health centers, which also then led to increase awareness about the GNE Project and what APRN graduates can do. So some of the key results, we think that the demonstration was a success. As I said, there was growth in enrollment and graduates.

The training took place in community settings, which was the intent of the demonstration. The cost, as best we could tell from the data that was obtained, it's about $30,000, and that's only focusing on clinical training, the cost for clinical training. And there was a similar health teaching grant also at the time and the cost there for residents were about $150,000.

We also noted that the more schools that were engaged with the health system for the project, the cost of the incremental students went down, as there were more schools involved. Also, we believe that the graduates are now deployed in places where they can work with the most vulnerable of populations.

This also gave us an opportunity to look at how we support our preceptors, and are there different ways that we could think about supporting preceptors, particularly as we try to grow our APRN programs? And then importantly, also creating that workforce pipeline, which also enables us to develop the partnerships with our academic and clinical partners.

So, in conclusion, I think some of our key learnings was this was a very complex demonstration. If we were to have another demonstration, it would really have to be simplified. And I think the notion of an incremental student would have to be removed, because that's just...just doesn't work for a lot of variety of reasons, and just created more confusion, and I think, also created a lot of ill will and bad feelings, I think, in the community among our preceptors.

You know, repeatedly, we'd have calls...people...every semester, it was like clockwork. I would get a call, like, "Where is my check?" And, they may or may not have had a student, but it was clockwork, what I heard. And then a lot of... you know, I think we really have to be mindful from a university perspective is the impact that students and the preparation of students really have on clinical productivity.

And we hear that repeatedly from our preceptors. And some of the things that we heard, too, and you...probably, you'll find this amusing is that a lot of the sites don't want first-semester students. It's

probably no surprise, right? Every site that we tried to partner or engage with, "I'll take your students, but I want them in their last semester." But everybody wants that.

But I think the other thing that we note, and this is probably no surprise, is that there's increasing competition for these really great clinical training opportunities. And so how do we start to think about that and start to think about the clinical training opportunities in a different way? Because we had, aside from like the nine schools of nursing that we have, and we're actually working on publication right now, we did a survey of our preceptors.

And our preceptors precepted in just our small little catchment area. Forty other APRN programs they were actually precepting for. So we had nine schools that we were working with. But when they wrote in their comments on our survey, there were 40 additional schools that they were precepting for, and some of them or a lot of them were online programs, or people that worked in their, you know, particular setting that perhaps are going back to school and actually seeking clinical training opportunities.

[inaudible] I think from what Maureen told me the purpose of this conference is to be provocative. So I think we really have to think about our clinical training model. And I think it really has to change if we are going to be able to sustain, if we are going to be able to increase enrollments, and we're going to be able to increase graduates.

And we have to have quality, clinical training opportunities for students. It's just not okay that we are not preparing...making sure that our students are really having quality experiences. And we can't leave it to the students to find their clinical training opportunities with limited oversight or input from academic partners.

And in our region, we tried to test a model of matching. And I haven't given up on that yet. So I'm working with our innovation center to see, is there a way that we can come together as a region and really think about all of the clinical training opportunities that are needed in our region?

Is there a way to think about a matching system, very similar to what happens in medical education and with medical resident placements, to really start to... it would require a lot of collaboration with all of our universities in the area, but there has to be some regionalisation. And with that, I think comes the standardization that's really needed for clinical education.

And, you know, lastly, is disseminating what we've learned from this project, so that, hopefully, that does start the beginnings of the discussions of what needs to happen next, as it relates to APRN education. So, at this point, you know, thank you for your attention this morning and for allowing me to share the findings of our project.