

Hettie Garland

Q: Please tell us about the early NP movement.

I think part of that was also part of the national trend in the mid to the late '60s, really trying to respond to the need of access and coordinated primary care for all people, not only in this area, but nationwide, that from healthcare's perspective, particularly from physicians, the physician workforce, that there had been a lot of emphasis on specialists and sub-specialist care, but less emphasis in primary care, a coordinated system of care that took care of all people in the family from birth until death with one provider depending on whether a family moved around or not, but could really have life-long care. It also, I think, coincided with increased recognition of the skills and knowledge of professional nursing and that the nurses had already demonstrated their excellence in practice in a variety of ways in critical care, in emergency rooms, no matter what level of practice that they may have had. So being able to marry two skilled professionals in physician and nursing and really enhancing what nursing does innately in providing comprehensive care looking beyond just the treatment of an acute or chronic illness, but really tending to the family as a whole. And with that, the NP movement began to spread across all of this country and NC was in that pioneering movement in the late '60s and early '70s, already was developing a variety of programs and courses, particularly at UNC-CH to really enhance, expand and advance the practice of nursing. So coupled with increased need for access, coordinated system of care that tended to other things beside disease and treatment of signs and symptoms, it seemed a natural marriage for NC to be part of the leadership in developing educational programs for NPs. Particularly in focusing on rural, underserved areas where nurses participated in a collaborative relationship with each other as well as with physicians to provide care. From a research study/evaluation perspective, coupled with the movement, was also a lot of focus on quality of care and patient satisfaction, and all of the studies that emerged out of the movement in the '60s '70s and even those that continue today, indicate that NPs can take care of 75, 80 even 90% of primary care practice, as well as their quality of care measured with anybody in healthcare has always been at least the same, if not exceeded some of the standards.

Q: Why was NC so far ahead in the NP movement?

I think the blossoming partnership between the academic health centers and the communities in NC, it was a combination of vision, of leaders both in nursing and medicine and other professions within healthcare, it was timed with trying some new and different ways for health profession education in looking at moving the education and practice, particularly in the clinical areas, outside of the academic health centers into the communities. Also in the '60s as people nationally as well as in this state were focusing on the distribution of the health profession, particularly in rural and underserved areas, there were some initiatives, particularly again out of UNC-CH both in the school of nursing and the school of medicine to move part of the academic course work and particularly clinical practice outside of the academic health centers into the communities working with experts within the communities who had just as much skill in being able to

work with students, to teach and to provide that level of supervision with students. There were some forerunners in the state, the Regional Medical Program in the '60s also looked at different models of education, particularly outside of degree programs, what we now look at in a variety of certification programs, both at the state and national level, taking working professionals and placing them in expert clinical situations where they could develop the kind of clinical skills in the area. So the RMP in NC was already evolving into a national model. You've got national initiatives with Carnegie Commission's report about the nation's health and ways again to enhance health professionals, particularly in rural and underserved areas in primary care and in some specialty and sub-specialty care, but primarily a focus in primary care. You had the opportunity for some grant funds that Congress appropriated in the early '70s. You had NC already at the forefront with the RMP and was beginning to think outside the box in community-based activities that outside of the academic health centers and then the opportunity came along to write the grant for the AHEC's initiative. The vision in NC from the very beginning was a statewide system, not just located in either the East or the West or the Central or the sound hills, the Sandhills, but it was a statewide vision of area health education centers that developed and maintained partnerships between the academic health science centers in the communities, not only the agencies of healthcare, but the professionals working and practicing in those communities. NC was the first statewide program, the only statewide program funded as a part of that AHEC pilot project from Congress and was with by about 2 and 1/2, 3 years after its establishment in '72, we had that statewide system that built on the politics, the education, the practice needs and all of those forces coming together from some real visionary leaders in our state at that time.

Q: Obstacles to NP movement?

Some of the obstacles, I think, was the belief that this was an appropriate role for nurses, particularly for those that viewed it as the practice of medicine and that being with solely and historically within the purview of medicine and medical practice. There were educational obstacles, in terms of even though our history was rich in beginning to think about health professions education and nursing education in a different kind of way, there was that forging of partnership between the academic health centers and the practitioners in the communities. There was the usual, when you are trying to create at the same time you are trying to provide, it was kind of a continuing evolution of what is the role, particularly of NPs. There were some that felt that it was just a quote unquote glorified public health worker, there isn't anything that wasn't a negative in terms of public health nurses, but it was hard for people to catch on to the vision that nurses with an appropriate education, but didactic and clinical background, could assume additional and more autonomous responsibility for patient care and really work in a collaborative relationship. I think that symbolically in terms of the nurses and physicians role in the delivery of health care, for nurses to increase their decision-making in the diagnosis and treatment of disease, whether acute or chronic illnesses, was hard for people to imagine what that practice might be like because of the history and the way in which nurses and physicians have worked together. There were political obstacles. There were perception of encroachment on practice, in the late '60s and early '70s out of other NP models across the country, some of the research was beginning to involve that nurses actually in some

areas of healthcare could do a better job than their physician colleagues may have done, again looking at research and the evaluation studies that were beginning to evolve. That's not always something that you want to hear, that there is another group of healthcare providers that may be able to reach a similar skill level in providing particularly comprehensive care. There were economics, there were issues of how NPs economically would survive and thrive, what kind of impact this might have on traditional models and my opinion about the physician colleagues is that they were kind of 180 degrees apart. There were those who were dead set against anyone being able to practice aspects of medical practice that the NP role encompassed. And then they were the champions and the advocates who viewed healthcare and collaboration in a very different kind of way, but very few people in the middle of the evolution of all of this in the '70s.

Q:

The success in NC in the advancement of the education and practice of NPs really hinged around both physician and nursing champions, visionaries and what I think over time have become one of nursing's icons and that is Audrey Booth. Audrey was the first graduate of the master's program at UNC-CH and stayed with the school of nursing in her professional role. She was part of the creation and moving forward of the vision in the '70s of NPs and NP's providing a greater role in the delivery of health care. She was chairman of the BON at the time of the enabling legislation that really created the joint subcommittee of the BON and Medical Examiners at that time and was the first chair or really co-chair with our physician colleagues of that joint subcommittee. It was her political savvy, her commitment and dedication to the role of NPs and the nursing profession in general, that really led the movement in laying the foundation in both a legal and collaborative relationship. I think Audrey she has as I say a lot of political savvy. She knows how to bring people together, to be able to move beyond differences and focus on a common vision. And those are the skills that she used not only at the BON but particularly in forging a relationship with the Medical Board which we did not have that kind of collaborative, either professional or legal relationship with our physician colleagues. Audrey was also one of the visionaries and creators of the NC AHEC program...Sorry...

She was one of those designers of the both the NP program at UNC-CH in the school of nursing but also the NC AHEC program. So she was able to marry a vision from a variety of different directions, bring people together those who were both sold on that vision as well as those who were not so sold on that vision and enable them to focus on what was the common goal and that was the delivery of high quality comprehensive care to the people of NC.

Q: Prospect Hill?

Prospect Hill was one of three clinic under the Orange Chatham Community Health Services, well really 4. There were....

Prospect Hill was also one of those visions of meeting health care needs particularly when communities like Prospect Hill had maybe one physician and no other immediate access to care without coming out of Prospect Hill into the big cities. If that physician either left the community or became ill or for whatever reason was unable to maintain medical practice, then the communities were left holding the bag and worked very hard to recruit another physician or another combination of health care providers into that community. One of the, part of the vision of increasing access to care were community-based health centers and Prospect Hill in NC is also one of those icons of another movement that was sweeping nationally to enhance the availability and accessibility of care. That is another example of many forces, community needs, educational vision, foundations that had already been laid like the RMP or NP program at the school of nursing at Chapel Hill that came together to meet this need and to be able to develop that in the true sense of the community health center that really was the community health center, it was theirs, it was in some way corporately related to some other places within the community depending on what kind of resources the community may have. It provided a perfect model for collaborative practice between NPs based at the clinic full-time and a collaborative relationship with physicians either at the university or within the surrounding communities. And it is another icon of the way in which creative thinking can enhance the ?, really a model practice as the enhancement of primary care the collaborative practice of physician and NPs grabbing both national as well as state attention any time anyone wanted to come and see how this really worked, there was Prospect Hill providing not just treatment of illness, acute or chronic disease, but really tending to the family and the community.

Q:

Within about a year, after the program at UNC-CH opened in the early '70s, the demand fro that program that they began admitting 2 classes a year. And the visionaries for that program, for community-based health care, Prospect Hill, the education and practice of NPs were also part of the visionaries and the crafters of the AHEC grant that was kind of symbolic of community and health professions education and practice and they began to look at how to meet this escalating need for access to the NP program at CH which was the only, Cindy Freund actually coordinated a pilot NP program in collaboration with Area L AHEC in 1973, '74 to kind of test the model that had been developed in CH with community-based education - taking nurses from that area that of the Eastern part of the state and providing the same NP program educationally that they would have received at the University. At that time, by that time, the AHEC grant that established the NC AHEC program had been funded and Area L was one of the first 3 AHECs established with that grant and by 1974, all of the other 6 AHECS for the 9 regional centers had been developed so that NC had a complete statewide program. It was felt that ECU, the school of nursing there, in collaboration with the AHECs in Eastern NC would open a NP program to take care of the needs educationally much closer to home than Chapel Hill for the nurses in the Eastern part of the state. Mountain AHEC also assumed the same responsibility for a Family NP program that served the Western part of the state. So in Oct. of 1975 on the very same first Monday in October, the FNP at MAHEC and the program at ECU in collaboration with those Eastern AHECS opened the first class of NPs

in now this statewide program. There were no national educational or really practice standards at that time other than what NC was establishing through the enabling legislation, Audrey Booth's leadership. So the faculty of these 3 programs, the foundation of the program established at CH and now the 2 regionally-based programs developed their own, our own curricular standards in developing a core curriculum that all NPs in NC had as part of the educational process. We developed common evaluation tools to measure not only competence in clinical practice, but typical classroom measurements of tests, clinical competency or logic problems in what has what we now have available through computers to be able to develop clinical scenarios and identify approach to maintaining health. In 1978, the program at CH, the NP program began its evolution into the graduate program at CH. Eastern AHEC closed the NP program in 1982 and the certificate program at MAHEC stayed until January of 1990, graduated our last class, all of those programs paving the way for graduate education for NPs in advance practice.

AHEC was based and continues to be based on the foundation of developing partnerships between the academic health centers and the local communities and the NP program was a perfect match with that educational and practice commitment of the NC AHEC program. It provided affordable and accessible education within a reasonable and both travel and work distance for the health professionals that worked in those communities. There were many communities both in the far East and the far Western parts of this state that could well-utilize the kind of care that NPs provided in those communities. But to travel to CH for 6 to 8 months of basically full-time study and then to continue to go back and forth for during the clinical preceptor phase of the programs as we knew them particularly in the '70s and early '80s provided a real hardship for nurses who lived and worked in those communities. So it was the premise of maintaining the commitment to the educational quality both from a classroom as well as a clinical practice, but bringing that educational program to where the nurses lived and worked. We knew that they were going to remain in those communities because of the commitment that they already had, both personally and professionally. In order to enhance the availability of the programs, bringing it out of the academic health centers into the community greatly enhanced meeting what those educational and practice needs were. The quality of both the faculty that were recruited into the AHECs to be able to provide the educational framework and the quality of the practitioners in those communities, not only in the West and the East, but throughout NC were able to make the clinical practice, and the supervision real because it was community-based at the same time providing the same level of academic excellence that you would find anywhere in a formalized educational program.

Garland 2

Q: NP program expansion

The demand for NPs extended from the very beginning from Murphy to Manteo, all across NC, so the way to be able to most effectively meet that demand was to establish regionally-based programs both in the East to reach the far corners of the Eastern area

and also in the West to reach the far corners of the mountains, working collaboratively with the established program in Chapel Hill was the best way to be able to meet the demand that was really blossoming across the state of NC

Q: Why?

There was no question about the contributions that NPs made to the delivery of comprehensive healthcare, even in the face of controversy with some practitioners there was no question that the quality of care and the collaborative relationships they were able to develop throughout their communities was of the highest caliber. So the best way for nurses, uh, communities to get their healthcare needs met was looking at new models of care and the NP was right at the core of that care. So once the models had been established, they just began to proliferate throughout the state as a way of enhancing care, enhancing availability and accessibility at the same time maintaining the highest quality.

Q: Leaders of NP movement

The, again, in the absence of any kind of national standards, especially with this statewide program, with this regional program stretching from Murphy to Manteo and the established program at Chapel Hill, there was the commitment from everybody involved to develop a focused approach. It answered part of the needs of “if we do the education, say, in the MAHEC region for Western NC, will we be able to maintain the same quality so that the program at.....

It was very exciting to be involved with the education and practice of NPs in the beginning because there were no educational or national models at any other place in the country with the innovation of the program at Chapel Hill, the programs in the East or the West. And again, through the leadership of individuals such as Cindy Freund and Audrey Booth and Glenn Pickard, the people who were involved in all of the NP educational came together to be able to develop a common curriculum, common standards for measuring clinical competence and when there isn't anything there and you unleash the kind of creativity that the leaders of this movement, then anything is fair game. So it was really taking what we knew would work in the delivery of health care and being able to mold that into any way you wanted to be able to mold it from an educational and practice perspective, so that has to be exciting to be involved where you have a clean slate of developing both an educational and a practice model and experimenting in an appropriate and educationally sound kind of way with different curricular and practice models. We also had a lot of fun at the same time because you just unleashed whatever creativity you wanted to be involved in the development and evolution of this program.

Q: AHEC and nursing

AHEC and the nursing within the AHEC system provides part of the core services of meeting the educational and practice needs for nurses in any setting in NC, in any

particular role or area of expertise, provides educational mobility which means it enhances the ability to provide RN to BSN and Master's programs off-campus, once again the AHEC model of maintaining academic quality, but providing those educational programs in the region to make them more affordable and accessible. AHEC provides 100s and 100s of programs in continuing education, all of which are developed using nurses to help identify what their educational needs are at the moment to stay on the cutting edge of their practice, allowing nurses to again to remain within their communities but to move back and forth in the continuing education programs that they need to help keep them sharp in the whatever areas of practice they may be involved in. AHEC also provides consultation and technical assistance, particularly in workforce times when like we are right now when the nursing workforce is really at the critical stage of being able to meet the supply and the demand issues for highly qualified nurses in any setting in any level of practice. The AHEC nurses are really part of the cutting edge in nursing and health care in NC, not only in legislative initiatives such as the RN or Master's off-campus programs, but RN refresher courses for nurses who have been away from the clinical setting for a period of time and being able to re-up their skills to enable them to enter the workforce again in whatever practice setting they choose. AHEC and AHEC nursing reduces professional isolation, particularly in some of the rural communities of our state because the continuing education and the consultation and technical assistance or particular special nursing projects don't just take place like for in the mountains at the AHEC center in Asheville, but those programs also take place throughout the communities in the particular area that an AHEC may serve throughout NC.

Q: AHEC superlatives

The NC AHEC was the only statewide program funded in the by Congress in the early '70s. It has been able to articulate a common statewide vision, but regionalize that vision to where health science students and health professionals live and work. It has been able to work in a variety of ways in partnership in the community. AHEC doesn't come to a community and say, 'This is what we have for you.' AHEC goes to the grassroots of the community saying 'What are your needs? What do you need to help you be the best that you can be in your practice as a health care professional?' It brings high quality, affordable and accessible programs at the community level based on the needs that are articulated by the health professionals living in that community. It has been able to maintain kind of this 3 way partnership with the NC AHEC program and the 9 regional AHEC centers, the partnership with all 4 of our academic health centers in NC, and the individual communities no matter how big or small to make sure that the health professional's needs in that community are met by the people who are providing care.

Q: Nsg to AHEC

Nursing was an integral..

Nursing was part and continues to be part of the vision of the NC AHEC program. Again, one of our icons, Audrey Booth, was the first director of AHEC nurses who were based in each of the 9 regional centers, both meeting with them in those regional AHECs as well as bringing them together statewide to develop a way to meet what the educational and practice needs of nurses are and were and will be in the future in those communities. The AHEC nurses have also provided part of the leadership in nursing throughout NC, supporting legislative initiatives that enhances programs such as the off-campus, both undergraduate and graduate degree programs for nurses in communities where they would be unable to access those programs, providing a statewide, coordinated system for nurse to be able to enhance their practice throughout NC, no matter what community they may live in.

Q: Obstacles to NP?

One, it was a new model of healthcare, heretofore, the only person who could really deliver the kind of healthcare that we now know that NPs can do, were physicians. It was a new model of looking at maximizing the care available in the rural communities that also being a new model of healthcare, there were those who were politically, legally and economically and educationally opposed, who did not believe that one, it was an appropriate role for nurses to assume or may have had lack of confidence that nurses were capable of delivering that kind of care, of achieving that kind of educational and practice standards. Part of it was politics, part of it had to do with turf and historical turf boundaries between the practice of nursing and the practice of medicine. It had to do with developing new educational models - how do you lay the foundation for building on the expertise that nurses have already demonstrated in practice, but what kind of skills and knowledge do you teach nurses to be able to assume accountability for a level of care that has historically been part of physician and medical practice. It was economic. How do you pay NPs? Are they salaried employees or are they fee-for-service like physicians have been in historical community practices. And it was also beginning to look at new health care delivery models, for instance in community based health centers that may be primarily staffed and managed by NPs utilizing physicians in a consultative role which was a brand new model for the traditional medical model of private practice, or group practice which may have existed in the community.

Q:

I thought some about this in terms of trying to think ahead to this time is that nursing in NC is not just a job and it's not even a career or a profession, but nursing in NC is a passion. And it is a passion of nurses everywhere across this state for the health of all people and the critical role that nursing plays in accomplishing that vision for all persons no matter where they live and work or what their health or illness challenges might be, and

this first century of nursing in NC has played its a wonderful foundation, but I can promise you with the success of NC, that the second century of nursing in this state is

even going to be more exciting than we can imagine in this point in time. It is. It is a passion.