[Captioner Standing By] >>

collaborated with ALP and launched the future of nursing campaign for action, which included action coalitions in 50 states. To implement the recommen dation of the report. We have seen a lot of progress in the last 10 years. The United States has removed major barriers to practice, the advanced practice of registered nurses and 22 states and D.C. gift will practice authority to nurse practitioners. That also includes the federal level. CMS issued in 2012, the final rule that broadens the concept of medical staff permitting hospitals to allow other practitioners, for example pharmacists and PAs and RPMs to perform all of the functions within their scope of practice. This increased diversity with a number of minority students enrolled in advanced nursing education and the number of men enrolled is also increasing. Today's report presents a 10 year follow- up of the 2010 report and chart the course for nursing for the next 10 years. Since 2010, we know a lot has happened. Many of you have lived through these last 10 years. Challenges and new challenges and demographic changes. A growing, aging population, increasing ethnical a nd race populations. There is nursing burnout and the Kinyoun continued uncertainty of the healthcare act. Technology advances and is telling medicine in the rise of big data and AI is sure to transform the practice environment for nurses. In Portland, as this report was being developed the committee members will tell you that they found themselves in the midst of COVID 19, which certainly is important because it is given an additional perspective. COVID has highlighted deep inequities in the health system. Inequities in both health and access to healthcare associated with the social determinants of health. In my opinion, health equity has emerged as one of the most important issues in health and healthcare and addressing inequity requires addressing social determinants and requires people to understand, have knowledge, experience for the entire workforce close to the patient and close to communities. This is why I believe nurses are so important. They play such an important role. For more than one century, nurses have worked to build cultural health where people live, learn, work and play. Today, nurses reach out to people of need, visiting them in the inner- city, high rises, public library's, barbershops and beauty salons. Indeed, the largest and most trusted segment of healthcare workforce is nurses. They play a critical role in achieving health equity. To fully contribute to achieving this goal, nurses need robust education, supportive work environments and autonomy. I think it is in this context that this report is so timely. We are so grateful to L WJ to request us to do the study. It is aimed at charting a path to the nursing profession and to help create a culture of health and reduce disparities in people's ability to achieve their full health potential. The report, as you will hear identifies a number of priorities to meet the needs of the U.S. population and the nursing profession for the next decade. You will hear the outline of nine recommendations for providing a comprehensive path forward of policymakers, nurses, educators, health care system leaders, researchers and payers to help enable and support today's in the future of nurses to create a fair and just opportunity for health and well- being for everyone. This committee report comes at a critically important time for our nation for our nation's healthcare and for nursing. So, to conclude nurses are powerful. The world needs their dedication and persistence more than ever. The pandemic has taught us that healthcare organizations will be

made stronger when nurses knowledge, skills and contributions are valued and appreciated and where they are given the tools, resources

This is the set of study staff and advisers who were absolutely instrumental to the production of this report and who also stayed working with us on the final project. We are most appreciative of having their exceptional expertise to inform our thinking during the development of the report.

We will now turn to the statement of task. This was the statement of task that was provided by the Robert Wood Johnson Foundation. It is the road map that the committee followed in executing this work. This overarching aim for the study really focuses on how and what the nursing profession can contribute to reducing health disparities, to improving overall health of the nation and to creating a culture of health. You will hear and read today as you look at the report the attention the committee pays to significantly strengthening and resetting the professions focus. In the areas of education, practice, research, all taken together and designed to build a path toward achieving health equity. More specifically, the report looks at the role of nurses in addressing issues such as, the opportunities and barriers to achieving, for example I diverse working nurse force. And to better addressing health disparities and more broadly achieving health equity. The report explores opportunities to strengthen the perforation of nurses to substantially contribute to achieving health equity. We talk about strategies that address nurse well- being and resilience, an area of concern before the pandemic exacerbated by the pandemic. And, given that nurses are typically key players in addressing emergencies, public health emergencies, and disasters and saying the disproportionate impact of public health emergencies most recently, COVID- 19 on vulnerable po pulations we were asked to consider how to strengthen the role and capacity of nurses in these circumstances. So, what you will hear about through the remainder of this presentation is a focus on all of these different and important areas. All with the aim of improving health and health equity by furthering the nations nursing workforce. To summarize, and as I noted this statement of task was's whipping, as you can tell based on my description and we will now turn to achieving health equity and equity in healthcare. And, with a lens on issues associated with health equity. I will now turn to my colleague, Dr. David Williams. Dr. Williams?

Thank you so much, Mary. I want to give you a sense of the challenge the committee wrestled with as we looked at what the contribution of nurses could be. Compared to other developed countries, the United States has the highest poverty rate, the greatest income inequality and some of the poorest health outcomes. Prior reports of the National Academy of Medicine indicated that even the best Americans are not achieving a level of good health that is possible today. The COVID - 19 pandemic did not create health inequities, it just shown a bright light upon them. People of lower socioeconomic status, people who reside in rural communities, people who belong to communities of color experience a higher burden of poor health relative to those of higher socioeconomic status. Of urban residents and the white population. This scientific evidence is very clear. Individuals without health insurance are much less likely to receive preventive care and care for major health conditions and chronic diseases. But, science is also clear that

as health care access and healthcare quality moves forward, it is not important alone. Research shows that persons of higher income home education, and wealth who are better positioned to address the social determinants of health in their lives enjoy lower rates of mortality, higher life expectancy, slower declines in physical functioning, and decreased risks of smoking and other health behaviors. Research also

particularly to improve abilities to advance health equity and to address social determinants of health. As Mary mentioned, well-being is a critical issue for nurses and we can do better as a system in improving the well-being of nurses. Nurses have a key role in emergencies, such as the COVID-19 pandemic and national disasters, such as hurricanes. We need to do a better job for preparing nurses for these roles. If you move down, in the middle is a light blue box that says, determinants of health divided into medical determinants and social determinants. Each of these are on individual levels and structural levels. Picture, for example a patient with diabetes. Nurse taking care of that patient can address medical determinants and help that patient better manage their insulin. That nurse can help with structural medical determinants, such as helping to organize and lead the team of clinicians and staff that are caring for that patient, the other nurses, medical assistance, social workers, health educators, physicians and as a team to care for that patient. For social determinants, that nurse may screen that individual patient for social needs, such as food insecurity and help that patient with food insecurity. The nurse might also, with the clinic and hospital partner with community-based organizations to address the problem of food insecurity in the community. I am on the south side of Chicago and we

health equity. These restrictions are limiting access to quality healthcare services. They limit access to care generally and high-quality care offered by advanced practice did registered nurses. When I say APRN , I include many categories. Removing these barriers will increase the types and amount of quality healthcare services that can be provided to people who are experiencing complex health and social needs, improving both access and health equity.

While we have made considerable progress over the past two decades in lifting state- level regulations that restrict nurse practitioners scope of practice there are still 27 states that do not allow full practice authority for nurse practitioners. So, on this map on this slide we depict the scope of practice for nurse practitioners by state. You can see the states that have either a reduced, shown in the yellow color or restricted, shown in the orange, as well as those that have full practice authority, which are blue. Full practice authority for nurse practitioners allows them to do things, like prescribed medications, diagnose patients and provide treatment without the presence of a physician. In other words, they are doing the things they are educationally repaired to do. In the 23 states and the District of Columbia where full practice authority is allowed, evidence has demonstrated that people have significantly greater access to primary care services relative to those living in states where there is restricted scope of practice. Evidence also shows that these states have longer wait times for access to care and a lower supply of providers in historically marginalized communities and underserved populations. Not permitting nurses to practice to the full extent of their license and education decreases healthcare services that could be provided to people who need this care. These artificially imposed reductions in capacity have significant implications for addressing the disparities in access to healthcare between rural and urban areas. So, until all nurses are permitted to practice to the full extent of their education and training, we will continue to see significant and preventable gaps in access to care. Meaning, essentially that millions of people who need healthcare will be unable to obtain that care as readily as others who happen to live in states where nurse practitioners scope of practice is not restricted. So, for many people this is going to translate into delays in obtaining care, which can lead to worsening of symptoms, disease progression, later diagnosis, which we know influences outcomes, and all of this will ultimately affect the cost of care when it is provided. One important note, during the COVID- 19 pandemic eight states took emergency action so that nurse practitioners could practice to the full extent of their education and training. This expanded access, not only provided care to COVID- 19

This slide outlines a recommendation, the committee's recommendation on nursing scope of practice. This is really that all organizations, state and federal entities as well as employing organizations should enable nurses to practice to the full extent of their education and training. We can do this by removing those barriers I was talking about before. Which allows them to address social needs and social determinants of health and improve health care access, quality, and value. These barriers include things that are outlined on this slide, regulatory and public and private payment limitations. Restrictive policies and practices, including within organizations. And, other legal, professional, and commercial impediments. Things that are in place that we need to eliminate. The committee believes that by 2022 all changes to institutional policies and state and federal laws that were adopted in response to the COVID- 19 pandemic, that expanded scope of practice, telehealth eligibility, insurance coverage, and payment parity for service provided by advanced practice registered nurses and registered nurses should be made per minutes. Since government leaders concluded that removing these restrictions was beneficial in expanding the public's access to care during the pandemic, it seems counterproductive to reimpose those barriers. Some states have already moved to make these changes per minutes. With that, I will turn it back over to Dr. Chin. Thank you, Marshall.

Thank you, Regina. Our sec1.154 TD itr pathetdicw5es isctnurses cnstrbtutions.
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understanding that is really important , the foundational understanding of health equity that we think is necessary to prepare nurses to do the work in a wide variety of settings and roles that are envisioned in this report. So, these concepts need to be integrated and sustained throughout the nursing school curriculum. In addition, they need to be paired with community- based experiential opportunities. So, academic content alone, the didactic piece is not adequate to provide students with the knowledge, skills and abilities they need to have two advance health equity. Increasing experiential learning opportunities to nontraditional context, for example homeless shelters, federally qualified health centers, public housing sites and residential addiction programs is important. So, moving away from the more traditional hospital dominant models is an important way to gain experiences in this phase. These expanded opportunities are absolutely critical to bill the competencies necessary for nurses to be effective in the health equity arena. Students need to actively engage in these experiences that will expand and diversify their understanding of this nursing practice. We know that students, clinical experiences influence their choice of where they might work. So, we feel like this is important and may have implications for increasing interest in community roles.

Our recommendation with regard to strengthening education, recommendation number seven

is that nursing education programs, including continuing education, so we know that nurses make a commitment to lifelong learning and continuing education needs to be called out here. As well as accreditors and the national Council of State boards of nursing should addiction prllwd tsestelycaAemng lege natianonti01576.5 (ph for)]TJ 0 -1.catioen numbJ 0 -1.ts I ml

nurse scientists are competent to design and implement research that addresses issues of social justice and equity in education and healthcare that can be used to inform relevant policy and also build the critical evidence base in this area. We also must prepare all nursing students to use their voices to advocate for health equity through a variety of vehicles, including things like civic engagement, engagement in health and health related public policy and communication through both traditional and nontraditional means. Such as, social media and mu lti sector coalitions. There is a lot more on this subject

nurses to provide high- quality person, family, and community centered care effectively and safely. Establish a culture of physical and psychological safety and ethical practice in the workplace, including dismantling structural racism, addressing bullying and incivility, using evidence based approaches, investing in organizational structure, such as resilience engineering and creating accountability for nurses's health and well- being. It is also a call to support diversity, equity and inclusion across the nursing workforce and identify and dissemination eliminate discrimination in the nursing profession. We also call to practice and invest in evidence- based mental, physical, behavioral, social and moral health intervention including reward programs that are meaningful to nurses in their diverse roles and specialties. And, to promote nurses health and well - being and resilience within work teams and within organizations.

We want to emphasize that nurses need to leverage their own power to advance health equity by making sure they are well prepared to bridge medical and social needs, taking care of their own mental and physical health so they can care for others, and advocating for policies that address poverty.

With this slide, I will take the very last slide. The recommendation for nursing organizations to create a shared agenda . We point out that by 2021, all national nursing organizations should initiate work to develop a shared agenda for addressing social determinants of health and achieving health equity. I will say just a little bit more about this particular recommendation, and this is the last recommendation we are sharing with you this afternoon, although as was indicated at the top Dr. Williams, there are other recommendations we just don't have time to get through. The actors in this recommendation that the report talks about include, for example the tri- Council for nursing and the Council of public health nursing organizations. We recommend that they, with their associated members should work collaboratively to leverage their respective expertise in leading this agenda setting process. The committee notes that there is relevant expertise that exists across the many, many nursing associations. From the state level through the national levels. We suggest that they should collectively share their national nursing organizations expertise, including organizations engagement such as the federal nursing service Council and the national coalition of ethnic minority nursing associations, bringing their expertise and their knowledge to bear associated with this recommendation. We also say that this action of nursing organizations coming together to create a shared agenda should be done with the support from the government, from payers, from health and healthcare organizations, and foundations to implement this shared agenda. It should also have associated timelines and metrics for measuring impact. There are specific actions that are called out in the chapter and we don't have time to get into them here. I should say associated with this recommendation. We don't have time to get into all of them, but let me make a few comments. We have actions that are targeted toward nursing associations and organizations within their structure. We have actions that are identified to be deployed across nursing organizations. And, we have actions related to this recommendation that speak to external organizations, organizations external to

nursing associations. I will give you just a flavor of a couple of them. With regard to actions within nursing organizations, we recommend that the assessment of diversity, equity and inclusion within nursing associations and where they exist, the elimination of policies, regulations, and systems that perpetuate structural racism, cultural racism, and discrimination with respect to identity , place and the circumstances. Specific actions, as I mentioned are also targeted across nursing organizations, and they include action such as developing mechanisms for leveraging the expertise of public health nursing. For example, in areas like population health, their expertise in addressing social determinants of health. Community level assessment, and so on. We also talk about public health nursing and nursing associations serving as resources to not just nursing organizations, but also to the broader nursing community, health plans, and as a resource for health systems, as well as public policymakers in advancing this agenda of creating a path toward achieving health equity. We also indicate that across nursing organizations there should be developed mechanisms for leveraging expertise of relevant nursing organizations that specialize in care coordination and care management. Those care coordination and care management principles can be applied to inform new cross sector models for meeting social needs and addressing social determinants of health. And finally, I mentioned that one of the areas of focus is on actions external to nursing organizations. So, we have actions articulated designed to address developing and using, for example communication strategies to amplify for the public, for policymakers, and for the media nursing research and expertise on health equity and related issues. With that, for our concluding statements and before we go to Q&A, I will turn it over to my colleague, David Williams.

Thank you so much, Mary. We want to let you know that we have a range of dissemination activities planned for this spring and summer. There is a three part webinar series that will target various stakeholder groups and will go more in depth on different topics, such as payment, workforce, well- being and education. Staff will also work with professional podcast company to produce an eight series podcast. We are also planning to have an online to get with all of the products that have been developed. So, stay tuned there are many dissemination activities coming up. Finally, we want to put you in touch and have the contact information here of our key staff who have done such an admirable job throughout this process. You can reach out directly to Suzanne or Jennifer on the staff team contact information available on this slide. Thank you so much for your time and attention today.

Thank you to the committee for a very thorough presentation. We Mary.iMt Ie5 (pWe r6 (ismx 0.t)7p(tne ,series i
directly for nursing care, specifically within hospit

interdisciplinary teams are an important concept to think about, we are
really talking now about inter- sectorial teams. That is working with
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early, right? In the report we address a couple innovative programs that have looked at strategies to do this effectively. Although, they have been done only on a small scale. They are, some of these programs make use of having focus on people when they are very young, talking about grammar school and high school. So, programs that look at increasing the amount of science that is taught in grammar school and moving into high school. Actually, as we were doing the research for this report we did look at a number of exemplars. There was an extraordinary example in the state of Rhode Island we looked at. There was a high school that was very, very focused on training the high school students to become nurses. There was a very significant focus on underrepresented minorities in that group. And, a very successful graduation rate and going on to become nurses and beyond. It is innovative programs like that that look at this process very early on and generate interest in nursing among different groups. We also talk a lot about nursing leadership, diversity in nursing leadership and diversity in nursing faculty. I would say these things are really hard. We have made strides, as David suggested but, it is hard. These are complex issues and they involve making sure that you are very deliberate in your recruitment process. But, not only that, but in the organizations where these nurses are leading or serving as faculty. There has to be appropriate supports in place for them to be successful. Same with students. You need to be looking for a way to create a learning environment and a practice environment and a work environment that is conducive and addresses some of the prevailing paradigms, the structural racism issues that are embedded in so many organizations that Dr. Williams talked about earlier in his comments. So, making sure that we have the right support, that people don't have what we described in the report as a diversity text. There is a lot we need to do in order to bring those close to fruition. And, it is hard work and we need to advance it. I don't know if anyone else has anything else additional on that.

This is Marshall and I will add onto those great remarks by David and Regina. First, it is important to realize that when you diversify the nursing workforce everyone benefits. The patient's benefit in terms of having Amar a more diverse workforce who can understand diverse patients. The underrepresented students benefit also, where if you are a small minority, when you have more numbers of similar students it becomes a safer and more comfortable environment. In the case of racial ethnicity white students benefit in terms of being able to understand these particular issues and some of the patients and relationships they encounter of diverse patients. Regina had a great list of internal things that need to happen within the profession. One of the common themes to me is that there needs to be a voice better heard of those members of the nursing profession and those populations who have an underrepresented image. What are the biases implicitly and structural that are built into the process, like recruitment criteria, safe environments, etc. that Sam would not be aware of would not necessarily prioritize unless there is the voice of people that have not had as strong a voice as they should have.

I will just add one more point, thank you Marshall. Going back again, to the leadership chapter where we talk about these competencies, we

call out the need to create this culture of inclusion, a culture of diversity and talk about the competencies associated with that. There is a lot more detail as you look through that chapter on some of these issues that might be helpful.

Thank you. that some would not be aware of Does this report how to fix the funding gap? Does it make recommendations on expenditures or the amount of money or funding that should be given to public health nursing? And also, a major deterrent to nurses pursuing careers in public health nursing is salaries. How could we better recruit and maintain nur ses in the public health field so their salaries reflect their values? Has this been addressed? And also, school nurse salaries are another example of this. >> Marshall, you will want to step in on this one. I would just make a general, overarching comment. Yes, there is a fair amount of content in this report that lifts up and examines issues around salary and the need for recruitment into public health nursing, into school nursing, as well as a call for reimbursement that is significant enough to attract nurses into those particular specialty areas or disciplines. That is absolutely essential if we are going to achieve health equity in this country because of the work that the nurses who operate in those areas do. They are front- line and influencing and informing issues around social determinants of health, whether they are dealing with a child, a child in their family, issues regarding food insecurity, transportation, etc. Th6.5 up asmoing a

system. We have recommendations regarding enabling school nurses to

country that were all part of this process, it became fairly clear to us that that focus is inconsistent across nursing education settings. And, that there are opportunities to markedly strengthen this at all levels of nursing education so that we get a consistent and very high standard of sustained focus within academic nursing. That doesn't answer the how, but it does tell you what our literature told us, what are site visits told us, and what is some of the basis for our associated recommendations. I defer to Dr. Williams, if he has something else to add.

I would just want to emphasize something that Regina made earlier on. One of the problems we have with the curriculum currently in nursing, on both health equity and the social determinants of health is that it is not integrated, as a central part of the nursing curriculum. It is off to the side. It is a course here or a course there, as opposed to something that is integrated into all of the work. That is one of the key recommendations of making the health equity and the social

The short answer is, yes. There is emphasis on exposure of students to public health policy and public policy. And, the importance of nurses engaging. You heard the reference earlier to civic engagement and I think my colleague, Dr. Williams had mentioned that. The basic civic engagement on the part of nursing students and nurses is important. Involvement at the local level in local, city policy, whether that is elected or takes on other forms. If you look back to the framework that Dr. Chin walked us through at the beginning of this presentation, you saw that significant emphasis on regulation, legislation, etc. in the policy domains. And, the importance of nurses engaging in those policy domains. It is about elective office and there are other ways of serving, as well. We certainly didn't just focus on elective office. That would be a narrow focus, albeit an important one. We also talked about nurses serving in other capacities, from a local to a national level. You find that all the way from the framework in the beginning two references throughout the report.

Again, I will add a little bit to that because, of course we did certainly cover that and it does directly influence this work, for sure. Again, there is some specific discussion in the leadership chapter. We encourage nurses to start early in terms of thinking about that, not just about the elective level, as Mary mentioned. But, nurses who are working in any practice setting have an opportunity to influence policy. They have an opportunity to influence what is going on in their organization. It doesn't have to be through a formal leadership role. It can be informal and nurses do it at every level and across every setting. They have the opportunity to be that voice and to get involved in shaping how things work within the organization or the community or more broadly, in society through the legislative process or through the elected official process. I just wanted to add that.

Our next question is, can you address the role of the nurse licensure compact going forward, which allows for nurses to have one multistate license?

I can talk a little bit about it. Then, I will ask others to join. The nurse licensure compact is something that allows, I think now 25 states to have a common license. It makes it easier for nurses to practice across state lines. You then, don't have to apply in every single state for reciprocity, which is a regulatory burden. It has particular relevance as we think about things like telehealth, where patients might be seen that are far away or in different states, depending on your geography. You may easily be crossing state lines, for example I am in Philadelphia and we care for a lot of patients from outside of the state or the Commonwealth of Pennsylvania. That compact is one of the things from a regulatory perspective that looks at making the licensure process smoother. Again, I don't know if anyone wants to add into that.

Just as Regina said, the point she made are highlighted in the report. We talk about the importance of state compacting to facilitate exactly the circumstances , and other circumstances Regina discussed. I think that probably covers it, Regina. You will find content on that with the

focus on it, a directional focus on it in the committee report from the committee's perspective. Yes.

I think, also I would just add, thank you so much Mary. The other piece, which is mentioned is about the advanced practice registered nurses, which currently they need to have a license in each individual state. They are looking at something similar, according to the national Council of State wards and nursing. That may be something we see in the future.

We have time for one last question and this is a good one following on our report on high- quality primary care last week. With the emphasis on insured professional practice, how can we improve nurses relationships with physicians and other vital members of the care team? And, how can we really seize this moment to move those dates with restricted practice laws to and powerful practice and unleash the power?

I can get us started on this and others can join in.

To the second part of your question, how can we use this moment as a catalyst? I don't think there could be a better moment, to be honest with you because we had a natural experience happen in COVID- 19 around scope of practice. We had states that completely relaxed and gave full practice authority. We had other states that put waivers out for certain subsets or different parts of nursing practice. And, we have seen some very early evidence from that that showed, as I suggested in my remarks that there was not a negative impact in any way on that. We have seen an early study recently published that has come out that is not included in the report because it was just published that looked at mortality rates associated with states that had waivers put in place. I think we can point to the evidence that is going to come out from that natural experiment as a platform, a really important platform and have those conversations with legislators and other policy groups and possible associations in the state that still have restricted scopes of practice. I would just say that. With regard to the interprofessional work, it couldn't be more critical. Mary mentioned before about how that teaming has been a focus of the IOM and other groups for many years. Going back to what are the essential competencies people need