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The future of nursing 2020-2030, charting a path to achieve health equity report released in early May. The report bills on progress nurses have made over the past decade since the last report on nursing. We have strengthened education , advanced practice, promoted leadership and increased workforce diversity. And I might add, we are still building capacity. We will not stop doing that. Has the largest and most trusted segment of the healthcare workforce, nurses are well-suited to help advance health equity, but nurses need more support from the system to educate, employ and enable them to do this critical work. We have a great lineup of speakers today who will cover nursing practice barriers and how payment models can enable nurses to impress health equity. So first, I would like to introduce Dr. Mike Rowe. And the first report came out in 2010. Julius B Richmond.

As Sue mentioned, we have made substantial progress. I would like to focus on the specific issue of the scope of practice of nurses. The original future of nursing study which was released in 2010 from what was then referred to. One of his principal recommendations that nurses be permitted to practice to the top of their certification licensure and training. That would imply that they would be able to prescribe medications, diagnose patients, provide treatments without the presence of a physician

directly supervising them. At that time, the full scope of practice was available in 13 states. And in the District of Columbia. It is currently available in 23 states of the District of Columbia. And in fact, Delaware recently passed a law to permit which is awaiting signature by the governor. So we have made progress. We are only halfway there. If you look at this map, you can see in the blue, the states that have full scope of practice, you notice a lot of them are those rectangular states in the upper West side. There are not a lot of people in many of those states. So the actual proportion of the population that have full scope of practice permitted without restriction is well less than half. Now, a very important part of this dialogue has to do with the evidence. When the Institute of medicine reviewed over five years of papers 11 years ago, it was very clear that fully prepared and certified licensed nurses are provided the same quality of primary care as primary care physicians. That was really the basis of the recommendation for enhancing the scope of practice.

Since that time, the evidence has continued to grow. The scope of people living in states. Significantly greater access to primary care, twice as much actually as people living in strictly restricted states. The wait time in 2017 to see a provider fell from 16 days to 3 days. And in addition to access is clear evidence of quality as well. Particularly the case with respective -- The full scope of significantly reducing costs.

The publish study in 2017 was significantly lower. Imaging the tests and fewer referrals to specialists, etc. And there was a very significant saving at the national level for Medicare, cost savings well over $40 billion. Now, interestingly, during the COVID pandemic period, 8 states temporarily lifted the practice barriers for nurses.

Florida, Kentucky, Louisiana, New Jersey, New York, Wisconsin. Some of those red states, some are blue states. I named them for that reason. What's not really clear is whether or not that lifted the restrictions is going to be made permanent in any of these states. We would hope that that would be the case. Reverting to the previous era of restriction was certainly the wrong side of history here. And a step back. And lastly, I just want to mention, I think that much of the data, many of the studies, a lot of the discourse has been with nurse practitioners. We are really talking about all nurses. All nurses. And if we can increase the scope of practice of all nurses to the level of their certification and education, that will be a tremendous asset to patients and their families.

This will particularly be the case in geriatric care. We all know that there's a tremendous short flow of physicians trained in geriatric

individual's health and wellness needs across multiple settings. And through sustained relationships with patients, families and communities. It should no longer be fragmented care. We approached primary care as a common good that it has high societal value. And its highly valued, but it's in a precarious state. And we focused a lot on public policy around primary care. How we can provide oversight and actually monitor progress in this area. And nurses play a critical role in the provision of this common good that we call primary care. And as Jack mentioned, yes it is nurse practitioners, but it also involves all nurses that are part of this team. That our focus really needs to be on strong efficacy. Organized leadership and public awareness. So -- Next slide, please. So these are the 5 objectives for achieving high-quality primary care. That I think line up so well with the future of nursing report. One, pay for primary care teams to pay for people. Not doctors to deliver services. There's clear resonance between these two reports there that are reimbursement models need to be changed to reimburse all members of the team and not just to funnel all the payment through doctors to delivering services. Such as to ensure that high-quality primary care is available to every individual and family in every community. In 2019, 30 million Americans , nonelderly Americans locked health insurance. Individuals live in communities that have a primary care health professional shortage. And so, we know that primary care is the only part of the healthcare system that results in longer lives and more equity. And so, it is critically important that work towards primary care and recognizing the contributions of nurses go hand in hand. The third recommendation was to train primary care teams where people live and work. This is a real challenge. I have already mentioned to you about these high shortage areas. So how, in most of the care, most of the educational preparation, a primary care team member

takes place in healthcare systems. Academic health centers. How do we get them to the communities where people live and people work? So that is critically important. And then, the fourth objective is digital health. The 1996 report did not talk about digital help at all. Such a big change over the last few decades. And we know it is [illegible] now part of how interprofessional teams collaborate and work together. And then, the fifth thing is okay, how do we, if we know our goals and where we want to move, how do we get there? Next slide, please. So I pulled out some of these recommendations that are layered in the report.

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to ask these sites to take interprofessional teams and students. These

but for the most part, it's myself with all of the services that we are getting ready to offer in almost all of the rural areas no. There still physician shortage in the rural areas. When I say shortage, I just want to further define that as physicians who will go into the home. Okay. So

yes, there may be a slight shortage in the areas. But when you start to drill down a little more and say a physician or healthcare provider, nurse practitioner or P.A. who is willing to go the extra level and see a patient who is homebound

by all of the laws, meaning that they cannot walk or get out of the home without much assistance, it becomes an issue providing care for them and it's an issue getting physicians or healthcare providers who want to provide care to the vulnerable populations that I served. So let's get into the barriers. Well, one of the first barriers is having to have a collaborating agreement in the first place. It's tough. We are working on it here. But we still have it as do most states, have that antiquated law of needing to have a collaborating physician in order to practice. And I have several points in my career of having this private practice have been faced with possibly needing to close the practice because I could not find a collaborating physician. And now that I am double boarded in family practice and psychiatry, I am now tasked with always having to have, not one, but two collaborating physicians, which is creating more stress, and it's something that I have to deal with. This is a collaborative state, right? That's a major barrier for my practice and definitely is a barrier to health equity for all of the residents that I see who are truly homebound and in many cases, bedbound. I address the laws, and I address the physician shortages. But let's talk about the fees that nurse practitioners have to pay to collaborate. This is not free. We have to pay physicians for their services. So as I said earlier, with me now adding the other specialty of psychiatry, I now have to employ to physicians to work with me in my practice because of the collaborative agreement restrictions in the state of Louisiana and this is the biggest issue I have and is the biggest barrier to health equity for the residents of Louisiana that I serve. I can say so much more, but I don't think that I have the time today. So Sue, I will turn it back over to you. Thank you all for having me.

Think you, Charmaine. Thank you so much. Nothing like a frontline provider. Right? Love having you, Dr. Lawson. I just want to clarify too. We will get to the Q&A's leader. I know you mentioned that collaboration is a barrier. And I think to clarify, I know you, and you collaborate very well with physicians all over the state of Louisiana and New Orleans. It's the financial barrier that is put upon you through a contract is what you are talking about as a challenge. Right? I know you are a big collaborator.

The contract necessitating that I collaborate, because we are going to collaborate. We all believe in team-based care . That is definitely the standard for advanced practitioner nursing. But having to have a contract, stating that you are unable to practice unless you have this contract is a barrier. And it's becoming an unnecessary expense that in some cases, if I can't afford it, that means that I may have to

close my practice. Then it is a barrier because those patients that are on the panel will not get care.

So we are going to move on, but I know a lot of people don't realize

Medicaid and innovation. She will discuss designing better payment models as it relates to social determinants and health equity. And I might add that even though Dr. -- Is not on this committee, I will tell you that she is always helpful to the national Academy of medicine in every way, shape and form and really served as a very valued colleague and consultants to me as I was on the study director for the first future of nursing report. So thank you for that, Dr. Whelan. Take that away.

Thank you, Susan. Thank you for inviting me to be on this panel and also for inviting me to participate when some of the work that you're doing with the future of nursing. So today, I want to talk about designing better payment models that will maximize, we hope will maximize the nurses contribution to healthcare in order to improve the health of the nation as well as looking for ways to help address equity. I guess I will just note 1st, here I am sitting at CMS. As a nurse practitioner, I never imagined that I would be working on payment policy. I will just note, a couple of the issues that happened during my clinical work that helped direct me to think that maybe this is something that I wanted to do, work in the federal government, because it relates to some of the barriers that nurses are having in fully trying to contribute to the healthcare system. And other clinics, I was able to dispense the medication directly to the patient. And that was in part because of certain federal policies that were paying the clinic's. So I could not even sign my own prescription in the place that I could dispense the medication. And second is similar to Charmaine's story. I was able to start an adolescent primary care clinic in a community center in West Philadelphia in the mid 90s in part because of federal payment policies that allowed direct reimbursement. I was one of the first Medicaid , one of the first nurses to be able to get Medicaid reimbursement. But the process that I went through and the things that were coming up as we tried to do this made me think who is making these policies. And is there a way that I can -- So here I am, doing this clinical practice. I'm thrilled to be able to look at some of these issues from the federal policy level. So to follow what Dr. Chen just talked about, I'm going to talk about moving away from fee for service into alternative or value-based care. And I will not go into many of the problems with fee-for-service. I'm sure that everyone who is watching better understand some of the issues that are happening that fee-for-service or paying for individual services over and over again. There was never a payment policy. Never an I to improve care delivery. It was really just looking to pay for the services delivered. And of course, because of that, we got more services delivered and not necessarily improved patient outcomes. So as we now at CMS, Medicaid and the innovation centers, we are looking to design new alternative payment models and I want to just mention three things that I think, three issues that we can address through the movement from fee-for-service tube value-based care. The first is actually having payment models help change the care delivery model. I think that's really important. We are not doing new alternative payment models is to come up with a new way of paying. What we are trying to do is look to see what is not working now in the care delivery model and how do we create a payment model that supports the care delivery model that we think will improve outcomes. And of course, as we are looking

to see what kind of a care delivery model improves outcomes, the role

these parties thing that we value equity. We value the patient experience, there's unfortunately some concretely baked into our systems that actually create the incentives so that our healthcare system is truly geared towards improving patient outcomes and patient experience. So for example, the various clinic -- That the public and private payers use to reimburse providers in these payment systems, again do little for incentivizing or addressing in terms of health or holistic needs, so as Ellen Marie said, the key is not payment reform for payment reform's sake, but payment reform that will support and incentivize the types of care delivery systems that can reach the outcomes that we need. We know from evidence based, this is robust evidence. Nurses play a key role in all of those. Addressing social determinants of health. These are all things where if we are intentional about our Northstar goals, and a continuous link for the evidence-based critical goal. And we read the metrics and financial systems that incentivize us, that's the way to get there.

Dr. Whelan.

Yes, I will just follow-up on the importance of nursing, which I did not focus on as much. I think to Marshall's point, I was needing a learning collaborative with pediatric awardees at the innovation Center who were serving kids with medical complexity. In the intervention across the board was not a critical issue. It was not a new medication. It was how to better coordinate care. Every single one of them came in the model that they wanted to promote was how to do a better job coordinating care. I think that's common across all of our payment amounts. Weathered primary care specific or broad. That is what nurses do. That's what nurses are doing to help coordinate that across. That is what I think is part of what we want a payment model to support. In terms of measurement, if we are paying based on what outcomes, we have to make sure that I'll those outcomes are something that is affected by the intervention. Sometimes, it's easy to say we have a measure, so therefore we will use it. But is it something that we really can move any line? I think a lot of nurses are doing some research on what quality measures should be used. Should they be used in payment? Should they be used just a monitor? Should they be used for research? And in different training that is going to be really important in the future because if we are saying that certain payments will be made based on really tracking the care delivery model. Some outcomes are easy to pull a bus out and immunize folks. That is not sure that we have transformed the care delivery model. A challenge and opportunity for the future.

Thank you. So I want to harken back now to the scope of practice area. I think Dr. Road, Dr. Lawson, Dr. Collin all talked about what the barriers were. We had a lot of questions come in on line ahead of this webinar asking for

tips on how to get the scope of practice laws modernized or authorized, if you will. Dr. Roe, we can start with you. You are a prominent physician in a healthcare administrator. We know that's some of the issues of that, but what tips do you have for allowing the modernization of the scope of practice? What tips do you have?

Well, I think that we have to recognize the resistance to modernization. It largely comes from a subset of -- But not all parts of an organization. So for instance, if you are in a college of physicians, which I think is actually more members than the American Medical Association has been strongly supportive of the recommendations for the 2010 commission report. And so one of the things that I think is important is to identify and collaborate with elements of medicine of physicians and physician organizations and local physician champions in states that are very respected. It might be the CEO of a hospital or a very respected physical -- He said he thought we should do this. I think that that's one tip that I would put out. I think that's another side of the coin. I don't know if you want to -- Or not at all. But that is that it's not just limitations. It's over practice at the regulatory level. Or institutionalized within hospitals. And that's different for a different strategy. Looking at --

board members for a health system or hospital they are talking with the executives at the health system and they can mention, oh, we have this prepared nurse who is the Dean of -- School etc. etc. The other way is to talk to people who are on boards. So I will give you a specific example. I recently left the board of a very very large healthcare company. That owns over 200 hospitals in the United States and other countries. I will not mention the name of the company, but it's a very big company. I was a clinician on the board. And I left the board after many years. And I said to the CEO, I think you should replace me with a nurse. And here are a couple of nurses who are teams of elite schools. And why don't you interview them. In the interview them and they put one of them on the board. There you go. So we didn't get a nurse from the hospital doing that. We got a nurse from 200 hospitals doing that. So I mean, I think that's another approach is talk to people who are on boards who might be sympathetic and talk to the chairman of the board and not every hospital uses these search firms. Right? At Mt. Sinai, we had no shortage of people who wanted to be on the board. So that was you know, it's not like we had to go looking for people. Many hospitals are looking to fill diversity inclusion related slots. You might consider this part of their diversity and inclusion.

So thank you very much. One thing I want to mention before calling on Dr. McAuley and Dr. Whelan is that a number of years ago, the nursing community knew this was an issue. So some of us started an organization called nurses on boards coalition. And nurses coalition.org they are an organization that will help with this. So Dr. McAuley, Dr. Whelan, how do you get nurses. We'll talk about nurses on boards. But if you want to add on to this. Dr. Whelan, I've heard the two worked on the help. How do we get nurses working on the ?

Well, so I think it's as an educator, I think I hope to own some responsibility with this. I think historically, we all recognize it's important to have the nursing lens on boards. That is truly important. But the nurse that follow board has to brought in their lens. And when you're on the board, you have to be able to apply things other than nursing. And that might be being a huge advocate for social determinants of health, vulnerable populations. It might be understanding reimbursement models as well as the decisions sitting next to you. It may be understanding laws and policies that affect practice as well as the attorneys sitting next to you. From my experience, we need to start approaching nursing in addition to focusing on practice competencies, we need to get serious about this area of policy and how you begin to introduce -- The policy is different than advocacy. That our curriculum needs to talk about the laws that impact whether people can pay for their medications. Every student needs to be able to tell us, recite that math that Jack showed in terms of still scopes of practice. We just don't spend enough time and I would say that something that also we could do a lot more in this area. I had an MPA MD student say once I had to go to the School of Public Health to get an mph to understand the industry that I was entering into practice for the rest of my life because his medicine education was so focused on the care of patients and not that broader lens. So I'm hoping with the new nursing essentials competencies we

way that they are so critical. The evidence-based just doing so well with that. So there are some North stars.

Right. Dr. Whelan, go ahead.

I would add the additional perspective. I agree with what Marshall said. For the industry, when you said what is the industry think about including payments for nurses? From the point of the health insurance industry, there are some small companies that are emerging startups. They are very weary of getting on the wrong side of the medical associations. They don't want to get locked out by the state medical society and the board members that such and such company is doing such and such with nurses. So there's a little politics there. But for the bigger companies, that's not so much of a problem. Particularly in states which are not restricted and have full practice is already. Because they have big enough market share and the physicians are not going to -- So when I was the CEO, I had maybe 23, 24 million customers. And if you took the Fortune 100 companies, 86 of them were --

They don't always know how and we are working with that. It's not an easy next step. But I will also add, just one quick addendum to that. If we put the patient first, sometimes the patient will want that. And they will go back to either their employer or perhaps their state. That example that I was so struck by four years ago now was a group of very big employers, Fortune 500 were talking about what they could be doing. They wanted access to midwives and could not figure out why midwives were not better access there. So there was the big, big employer saying why is the insurance company not allowing this to happen? So using that force as a stakeholder, big employers to be critical. I think having patients be able to articulate what they want, that's our job to make sure that they understand what good care is and then whoever it is providing that with the federal government. Of its Medicare, Medicaid.

Okay, so we just have a few minutes left. I'm going to ask that -- Will be very very succinct and can take a long answer. I realize that. Then I'm going to ask the entire panel in summary, this second report on the future of nursing was about how nurses can achieve health equity. What is the role of nurses in achieving health equity. Okay? So I'm going to ask for your most salient, most important point, and I'm just going to go being, being, being and that will bring our session to a close. But Dr. McAuley, I'm going to asked you to be very succinct. How can we work together to promote this energy points of this future of

working with your clinic or hospital, organization? Whether that's to join Ellen Murray in Washington and work on legislation and all, working with education institutions to change the narrative about importance. In this critical role, hopefully over a career, people feel comfortable and sees the opportunity.

Okay. Dr. Whelan, quickly?