[Captioner Standing By] >>

Hello everyone, good afternoon. I am Stephanie Miceli, the media officer with the National Academy of Medicine , engineering and medicine. Thank you for joining us today for the recently released report for the future of nursing 2020-2030, Charting a Path to Achieve Health Equity . You can download the report at NAP.edu/nursing 2030. You can also follow the social media conversation on Twitter at the information listed. We will also have this available online in the coming days. For those of you not familiar with us, the U.S. National Academy of Sciences, engineering and medicine are private, nonprofit institution that provides independent, objective analysis and advice to the U.S. to solve complex problems and inform public policy, decisions related to science, technology and medicine. For each requested study, panel members are chosen for their expertise and experience and they serve Bonow to carry out studies and tasks . The reports that result from the study represent the consensus view of the entire committee. And, they must undergo external peer review before they are released, as did this report. Today, we have with us several members of the committee to discuss this report. We will first start off with opening remarks from National Academy of Medicine president,

Dr. Victor Dzau. Then, the committee members will give an overview of the report. We will then, open it up for Q&A. Before I introduce Dr. Victor Dzau and committee members, just a few reminders. This release event is scheduled to last one and a half hours. Again, we will start with opening remarks from Dr. Victor Dzau and transition to princely stations presentations. If you would like to submit a question for the Q&A, you can click the Q&A button on the bottom of your screen. If you have any technical issues during this webinar there is a support number that is 1-888 -799, 8866 and select option 2. With all of that, let me introduce Dr. Victor Dzau, who is the president of the National Academy of Medicine.

Thank you very much, Stephanie. I am so pleased to see all of you here for the release of this very important report, the future of nursing 2020-2030, Charting a Path to Achieve Health Equity . First, I would like to thank the committee cochairs, Dr. Mary Wakefield and David Williams and the entire committee for their outstanding work. Of course, the staff. The work can't be done without the great commitment and energy and effort, starting with Suzanne and her entire team. Let's not forget the Johnson foundation who is a senior scholar resident and adviser to me. We would like to thank the sponsors. This whole area goes back to 2009, when other DOJ foundations partnered with us and the Institute of medicine to launch the future of nursing initiative, which then released the report of 2010, the future of nursing. That is the most downloaded report ever in the history of IOM and AOM and the national academies. Now, the report said division for nursing today in 2020. 14 messages. Nurses should practice to the full extent of their education and training. Nurses should achieve higher levels of education training through an improved education system that promotes seamless academic promotion and progression. Nurses should be full partners with physicians and other healthcare professionals in redesigning healthcare in the United States. And, of course effective workforce planning policies. Require better data collection and information infrastructure. After the release of the report, we

collaborated with ALP and launched the future of nursing campaign for action, which included action coalitions in 50 states. To implement the recommendation 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 and 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 and institutional support. I am confident that the nursing community and other important stakeholders will use the report recommendation you will hear in a few minutes to unleash the power of nurses and to usher in the new era of health equity and well-being. Thank you very much for your attention.

Thank you, Dr. Victor Dzau. You will now hear from members of the committee that wrote the report who are here with us, today. We have one of our chairs, Dr. Mary Wakefield who is a visiting professor at the University of Texas at Austin. We have David R Williams, our other cochair who is Florence and Norman professor of public health at the Department of African and African-American studies at Harvard University. We have committee member, Dr. Marshall H. Chin who is Richard Perillo family professor of healthcare ethics, and the Department of medicine at the University of Chicago. And, we have Regina Cunningham, another member who is chief executive officer of the Hospital of the University of Pennsylvania and an adjunct professor and assistant dean of the school of nursing at the University of Pennsylvania. With that, I would like to turn it over to our committee for the presentation.

Thank you so much, Stephanie. This is Mary. We will go ahead and take up the next slide. As Dr. Victor Dzau indicated, all of us on the committee are appreciative of both the interest and activity in this area as well as their support of our effort today. This is the full committee member for the work we will be previewing for you, today. I should add in that while this project has just been reported out today, in fact it was due out in about December of last year. Just before that, the committee, excuse me the National Academy of Medicine had been contacted by the Robert Wood Johnson Foundation asking that they consider extending this work so that we could reflect the circumstances associated with the COVID pandemic, its relationship to health equity and disproportionate impact on certain populations. And, what we could learn based on evidence about the interplay with the nursing profession. That is what brings us to today, report that is being released in May that was a really projected to be released in December of last year. I am most thankful, as is my committee cochair, Dr. David Williams that the committee members all, to a person agreed to continue this work forward. I also want to call out that as we delved into the impact of the COVID pandemic, both on populations among vulnerable populations across the United States, we of course, looked at the impact on the nursing profession, are working in her nurse force. When you look at the report, you will see a dedication identified at the beginning of that report indicating that the report is dedicated to the scores of thousands of nurses, both in the United States and around the world who lost their lives, who became sick, themselves and whose mental health and physical health suffered as they gave absolutely everything they could to saving countless lives. Often, in the face of incredible adversity associated with the COVID pandemic. And, we pay them tribute through that dedication of this report regardless of where in the world they hail from.

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 populations 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 shows us that racism is an added burden. That structural racism, through contributing to higher levels of residential segregation which determines access to opportunities and support at a neighborhood level profoundly affects health. Another example of structural racism is the highest incarceration rate in the United States. Mass incarceration today is a public health crisis and disproportionately impacts black and Hispanic individuals. The bottom line is that if the roots of social inequities are shaped by upstream structural determinants and understanding and acting on these determinants will help nurses play a pivotal role in improving health equity. Let's go to the next slide.

What was the vision of the committee? The vision of the committee is that the achievement of health equity in the United States is built on strengthened nursing capacity and expertise. We believe that by leveraging these attributes nursing will help to create and contribute comprehensively to equitable public health and healthcare systems that are designed to work for everyone. And, you say why nurses? Nurses have long been advocates for health equity and work to address the root causes of health. Nurses are present in a wide range of settings outside of traditional healthcare facilities, working directly in communities to provide care in schools, in workplaces and in prisons. Nurses make home visits to families, provide primary care to school aged children, administer vaccines, and we are so thankful for their role in administering vaccines, provide health education, coordinate healthcare services within and across settings, and educate people on preventive measures for staying healthy. Nurses also routinely work with people who have had to face adverse life experiences, including not only prior medical challenges, but also social stressors, such as trauma, the lack of food or homelessness. Nurse practitioners working in primary care are often the only providers caring for low income or uninsured people. Medicaid beneficiaries and historically disadvantaged groups in both rural and urban populations who always do not have access to a physician. In so many ways, nurses make a broad range of contributions to healthcare in the United States. Now, I turn to my colleague, Dr. Marshall H. Chin.

Thank you very much, David. This slide shows the framework that guided the report. Please look at the green bar, which says, nursing roles. Nurses have many key roles, including clinician, teacher, administrator, researcher, care coordinator, policymaker, advocate, etc. Above the green bar is a dark bar that says, key areas for strengthening nursing. As Mary said, this speaks to a variety of key areas that impact the ability of nurses to be most effective in their multiple roles. Starting at the far left you have workforce. Workforce issues include the number of nurses, the distribution of nurses across the country and the diversity of the nursing workforce. Nurses can be given additional training to become strong leaders in these important roles. And, the educational system for nurses can be further improved,

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 have a food desert problem partnerships with the healthcare system, nurses and community-based organizations play a major role in addressing the structural social determinants of health, as David mentioned. At the bottom you have the ultimate goal in the dark blue box, to improve individual and population health. And ultimately, to improve health equity and healthcare equity. Really, improve population health, individual health, equity and these are truly the compass of the overall report, the Northstar of the report. And what everything is geared towards, improving our nation's health. On the far right is a bracket that shows key levers, payment, laws, policies and regulations that we will go over in more detail.

So, here are key actions. For our country to advance health equity for all, the systems that educate, pay and employ nurses need to permanently remove barriers to allow them to do this work, value their contributions, prepare them to understand and tackle these issues, and diversify the nursing workforce.

This is a big report. It is almost 500 pages with nine recommendations. We will not be able to go through every recommendation. But, for the rest of the time we will focus on a subset of key messages, conclusions, and recommendations. I will turn it over to my colleague, Regina Cunningham.

Thank you very much, Marshall and good afternoon everyone. As David indicated in the visions slide, one of the aspects that was included in the vision was really, the ability to strengthen our nursing capacity. Our first key message of the report focuses on overcoming the barriers that affect the nursing workforce capacity. The committee views this as a significant challenge facing nursing over the coming decade. We need to permanently remove the barriers that keep nurses from practicing to the full extent of their education and training. Nurses at all levels and in all settings face multiple practice barriers to advancing

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 patients, it helped us with the pandemic. Things like testing and vaccines, as David mentioned before. But, it also extended to other types of care. These states saw no changes in the rates of medical errors, injuries or deaths in people served by these nurses. No changes. And, while the evidence about the impact of these changes in regulation is really still emerging, one study found that states where waivers were granted were able to reduce the death rates from COVID-19. So, in a situation where the public's health was at significant risk, advanced practice registered nurses provided a trusted source of care.

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 second message is to value nurses contributions. Public and private payers need to establish sustainable and flexible payment models to support nurses in healthcare and public health, including school nurses, so that they can effectively address the medical and social needs of people, families, and communities. The key problem is that the current healthcare system does not value addressing social determinants of health nor advancing health equity. We have the predominant fee-for-service system that incentivizes volume, treating acute illness, and prioritizing inpatient hospital care, especially services as opposed to some of the key factors that we know can advance health equity and address social determinants of health well that nurses are so great at in terms of the evidence-based information. These are factors such as prevention, health promotion, primary care, community health and public health. The bottom line is that we need to value advanced health equity in addressing social determinants of health and we need to intentionally design our payment systems to support and incentivize advancing health equity and addressing social determinants of health.

Here is a recommendation for paying for nursing care. Federal, tribal, state, local, and private payers and health agencies should establish sustainable and flexible payment mechanisms to support nurses in both healthcare and public health, including school nurses, in addressing social needs, social determinants of health, and health equity. This universal agreement that the current fee for service system is broken. As we transition from fee for service to alternative payment models and value-based payments, this will take time. The report does have some recommendations for fee for service. We recommend there be billing codes that basically reimburse nurses for key functions, such as care management, care coordination, team best care in areas such as addiction treatment, substance usage treatment, behavioral health, etc.

These are critical for allowing nurses to be fairly reimburse for the work they do. For value-based payment and alternative payment models, there is sometimes this erroneous belief that that alone will lead to advanced equity in determining health. The current systems are not designed intentionally enough and powerful enough for the schools of equity and social determinants of health. We recommend then that clinicians and healthcare organizations and clinics and hospitals be rewarded for successfully advancing health equity and addressing social determinants of health. This means that measuring clinical performance and patient outcomes and stratifying those results by patients social risk factors, such as race, ethnicity and socioeconomic status and rewarding those groups that reduce those disparities between more and less advantaged populations that improve the outcomes in quality of care for the last advantaged populations. This can help support and incentivize the types of evidenced-based nurse interventions, such as care management that we know can successfully advance health equity. Alternative pay models have more flexible funding and it presents an opportunity to direct some of those funds towards these nurse activities and this nursing infrastructure. However, we need to combine these with specific incentives that incentivize advancing health equity and addressing social determinants of health to heighten the chance that these key nursing functions are paid for. It is critical to create a national nurse identifier. One of the problems is that under the current system it is hard to isolate the key contributions and value of nurses in improving quality of care and reducing costs. This is because nursing services are often lumped under a broader category, such as hospital services. Having a national nurse identifier will enable us to better identify and isolate the effects of nurses in improving quality of care, reducing costs, helping to lead to more fair reimbursement systems. Unfortunately, today the funding for school and public health nursing is woefully inadequate. We need to improve reimbursement for school nurses. For example, increasing and allowing school nurses to bill for Medicaid. We also need to be more creative in integrating funding streams of healthcare, public health, and social service sectors to fund public health nursing. And aligning the incentives in the ways in which these different sectors are rewarded. So to and sent everyone's interest in improving the populations health. We need to create partnerships between primary care organizations, public health nursing and social health agencies. I will turn it back over now, to Regina.

Thank you so much, Marshall. Going back to the vision, this recommendation and key message is really around strengthening nursing expertise. In order for nurses to promote health equity and reduce health disparities and improve the health and well-being of everyone, we need to ensure they are prepared to do that. They need to be well prepared. Our third key message is focused on how our systems of nursing education need to evolve to support this work. So, the committees review identified that nursing schools tend to cover the topics of social determinants of health, health equity and population health in isolated, stand-alone courses. Such as those focused on community or public health. But, this material doesn't appear to be well integrated or thoroughly integrated across the curriculum. So, this approach is not sufficient for creating the foundational

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 ensure that nurses are prepared to address social determinants of health and achieve health equity. So, we need to integrate social needs, social determinants of health, population health, environmental health, trauma informed care, and health equity as core concepts and competencies throughout the course work and clinical and experiential learning. These core competencies and concepts should be commensurate and seamless with the academic level and included in continuing education, as I mentioned before. We also need to increase the academic progression for geographically and socioeconomically disadvantaged students. We can do that through innovative and novel academic partnerships that include community and tribal colleges located in rural and urban underserved areas. Also, critically important, we need to recruit diverse faculty who have expertise in social determinants of health, population health, including environmental health and health equity, as well as policy. We need to ensure that students have learning opportunities with care coordination, with working with other healthcare teams and individuals to address family and individual needs, as well as learning opportunities with multi sector stakeholders. That would include a focus on health and all policies and social determinants of health. So, in a community the teams look much different than they might in traditional hospital settings and nurses need help working across these areas. With regard to doctoral education, it is essential that content related to the social determinants of health, population health, environmental health, trauma informed care, health equity, and social justice again, be incorporated into the curriculum. We need to also ensure that our PhD graduates, are

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 multi sector coalitions. There is a lot more on this subject in the education chapter of the report. But, in the interest of time I will turn things back over to Dr. David Williams. Thank you, David.

Key message number four that we want to focus on is that employers must support nurse well-being so they can in turn support the well-being of others. So, we are emphasizing the importance of fully supported nurses. Nurse well-being is impacted by physical, mental, moral and social factors that can originate from a number of sources, from the individual to the system level. Improving the well-being of nurses will require multilevel and multifaceted approaches that address the physical, mental, moral, and social health that can create a safe, supportive, and ethnically ethically grounded environment. COVID-19 has imposed new challenges for well-being. But, COVID-19 has also offered opportunities to give nurses well-being the attention it has long deserved. And, to address the systems, the structures, the policies that create workplace hazards and chronic and acute stress orders. This issue will take on an even more prominent role in the future as nurses are asked to assume a more prominent role in advancing health equity. For nurses to take on the many social determinants that influence health, nurses need first of all, to feel healthy, to feel well and to feel that they are well supported, themselves. Nurse well-being has impacts, not only on the individual nurse, but is necessary for nurses to provide quality care for people, for families and communities.

So, our recommendation to promote nurses health and well-being is recommendation number three. By 2021, nursing education programs, employers, nursing leaders, licensing boards, and nursing organizations should initiate the implementation of structure, systems, and evidence-based interventions to promote nurses health and well-being, especially as they take on new roles to advance health equity. We believe that this can be accomplished by taking a number of steps and I don't have time to outline all of them. But, I want to highlight some of them. For nursing education programs, there is a need to integrate content on nurses health and well-being into these nursing education programs. To raise nursing students awareness of the implementation and the importance of these concerns and to provide them with associated skill training and support that can be used as they transition to practice. There is also a need to create mechanisms, including organizational policy and regulations to protect students most at risk for behavioral health challenges, including those students who may be experiencing economic hardships or feel that they are unsafe or are targets of bias, discrimination, and injustice. Recommendations for employers, including nurse leaders is to provide sufficient human and material resources, including personal protective equipment to enable

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 will now move on to the Q&A period. Again, please keep your questions coming. We will start off with a question that is addressed to you, Dr. Chin and others can feel free to jump in. Unfortunately, we function in a system that is driven by financial goals without reimbursement directly for nursing care, specifically within hospitals. And, the value of nursing will have difficulty truly being measured. Did the report cover this? And, provide any solutions?

That is an excellent question. We have a recommendation that we support the creation of a national nurse identifier that will better enable us to identify the specific contributions of nurses regarding such factors as, reducing costs and improving quality of care. This is one step toward leading to a fair reimbursement system that can justly reward nurses for their contributions. In the meantime, with our existing payment systems we have specific recommendations that, in the meantime do a better job of enabling us to provide those resources and financial support to enable nurses to do the jobs they can do so well, addressing social determinants of health and health equity. On the current fee for system, we can make sure there are reimbursement codes that will enable nurses to be reimbursed for aspects such as some of the care coordination and care management regarding substance abuse disorder or behavioral health or addiction treatments. Another would be that we have adequate incentives in new and alternative payment models that provide incentives for health organizations and health plans to advance health equity to address social determinants of health successfully. Because there is so much evidence for the ways nurses do help attain those goals, financial incentives could be powerful enough and would direct more funding to the types of support for nurses to do this great work in addressing social determinants of health and health equity.

Thank you, the next question is for Dr. Wakefield and Dr. Cunningham. How are we going to collaborate with public health, with social workers to address the social impacts on health while nurses practice across all aspects of healthcare systems. Currently, they lack the systems to integrate their expertise into these institutional settings.

Do you want to start, Mary?

It is a great question. The current structures that we have in place in healthcare don't necessarily facilitate that. One of the things that we discussed in some detail in the leadership chapter were some of the competencies we thought were important for nurses to develop in order to advance health equity. One of those particular competencies was around cross boundary teaming. So, how do we think about working? Mary talked a little bit about this in her remarks. How do we work across sectors, across professions, across groups in order to identify common ground and be able to advance some of these initiatives? Nurses and social workers and many other healthcare professionals work together in many settings, sort of within that setting. But, they often don't work across settings and that is an area where we need to develop expertise. The leadership chapter does a good job of calling out some of these things. It also identifies that this can happen at all levels of nursing. It is not just for people in formal leadership roles that need to do things like this. It is really, every nurse in every setting that has the potential to think about how to communicate across some of the traditional boundaries we have had in order to work on achieving health equity. Mary, I don't know if you want to add anything.

Not much to that rat great answer. I will just reinforce what was just shared with you. Historically, we have focused on the last number of years on teams. On really working hard to leverage in a professional, interdisciplinary and teams. Within this report, while

interdisciplinary teams are an important concept to think about, we are really talking now about inter-sectorial teams. That is working with individuals, just like the individual who asked the question is suggesting. Working across disciplines, locations, settings, all of which together, impact the health and well-being of individuals and neighborhoods and communities. So, just as interdisciplinary teamwork was a major focus since about 1999, with the release of the IOM report, to air is human and Crossing the quality chasm, this is next-generation thinking. Saying that now, our teams are much broader and they need to be broader if we are going to leverage our profession and other professions, as well alongside or with and from other sectors that influence, that impact the health of individuals and the health of populations. That means, during the hard work of looking for opportunities to create course boundaries between specialties of nursing , within nursing, across professional groups. And, as I said across sectors. Community health with acute care nurses, along with potentially transportation, housing to address issues like housing instability or to address food insecurity or to address the inability of a family to be able to get a child to a clinic appointment in a timely fashion who needs to be seen for an asthma checkup, for example. It is really pushing the boundaries out so that we are looking at health and healthcare and health equity from the patient's perspective, the individual's perspective, family perspective, and community perspective. And, to do that work we have to do the hard work of stepping back and thinking about how we link and leverage nursing expertise alongside of other colleagues and in nontraditional settings to improve health equity, as well as healthcare equity. Thank you.

Our next question is about nursing education and also the pipeline. This is for you, Dr. Williams and again Dr. Cunningham. What role does racial and ethnic diversity of nursing students and nurses, themselves play in achieving health equity and how do we promote it through nursing education institutions or schools of health professions?

I will say a little and then let my colleague, Dr. Cunningham respond in depth. Diversity is critical. Diversity is important. There has been progress made in the nursing profession on the diversity front and we have noted that in the report. But, it is a theme that runs through many of the chapters in the report of the importance of diversity at every level of nursing. Certainly, in nursing education and recruitment. We have, in the report recommendations for federal agencies to be more active in providing support and reinforcing support in diversity and enhancing loan repayment programs and other strategies like that. That is a theme that runs through multiple chapters in the report because we think it is critically important in terms of delivering the highest quality care for all of our patients as we live in a more diverse nation.

Thank you, David. I will add a little bit to that. As David suggested, you will see this pop up as a common thread throughout the report. You will see a lot about this in the education chapter, the leadership chapter, the workforce chapter. We need a more diverse workforce and more diverse faculty in order to carry out the agenda we are proposing in this report. I will make a couple comments on this. This starts

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 nurses 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. Those are issues that school nurses wrestle with on behalf of their students. By way of example, they all wrestle with those concrete examples of areas of focus that are critical in this report. Consequently, we have to look at the workforce that is involved in those areas, and what might be limiting nurses from moving into those roles and ensuring that once they are in those roles they are compensated fairly for the incredibly important work they do. We also call out the importance of all professional nursing associations, learning more about some of these key concepts, where there are gaps to be filled, concepts such as social determinants of health, health equity and so on. Learning from the expertise embedded in those specialty categories. There is a fair amount of attention in many parts of the report devoted to those two categories that the questions ask about. And, a specific payment policy chapter that again, focuses in addition to other issues, on those two categories of nursing. Marshall, I don't know if you want to make a comment or two about what we say with regard to the payment side of the equation for public health nurses and school nurses.

Thank you so much, Mary for that great answer. It is another example of, if our country truly valued advancing health equity and addressing social determinants of health, we wouldn't have this two-tiered, second-class system were public health and school nurses have a much lower salary than many other types of nurses. Or, that the same services done by, for example a public health nurse can sometimes be reimbursed at a much lower level. Something like immunization. Why should an immunization given by a public health nurse be reimbursed at a much lower rate then a nurse within a hospital setting? It makes no sense at all. So, we have specific recommendations about both the salaries, as well as the services provided being fair and equitable. We have specific suggestions also, on ways to direct more money into the

system. We have recommendations regarding enabling school nurses to bill Medicaid. We have suggestions regarding enabling collaborations of school nurses with community providers to be reimbursed. We have suggestions about increased public health funding, per se as well as, in reality it is not just the sector, but the healthcare system funding, public health funding, and the social sector funding. There are different funding mechanisms that are blending and combining these funding streams and using them in a flexible way and you are able to allocate an illogical way. We assess the benefit of an overall public health and community nursing activity which payers, for example benefit from that. And, what they pay into the system can be proportional to how much that pay or benefits from that public health or community nursing effort. We have a number of specifics and this is a key issue that frankly, until the payment issue has a sustainable business case for it, it becomes difficult.

What does the report say about how nurses can be better prepared for the next global pandemic, or a natural disaster? And what should a nurses role be? Did the report provide specific examples of how nurses responded to climate disasters, human caused disasters, etc.?

Let me begin and let other members jump in, as well. The report, as Mary explained up front that preparing this report was extended explicitly to deal with this issue of disaster preparedness. And, I report not only has a chapter on this, but this is an issue that cuts across multiple chapters in the report. In short, the report is calling for bold actions that need to be taken to transform nursing education, nursing practice and policies across healthcare and public health systems so that the nursing workforce is prepared to respond to future crises, not only to respond but we also emphasize the importance of responding from an equity lens. Some of the specific recommendations we make is that the centers for disease control and prevention should establish a national center for disaster nursing and public health emergency responses, along with regional centers. This should act as a hub to prepare the nursing workforce. The CDC and the center should create a national action plan to address gaps in nursing emergency preparedness. Another recommendation is that federal agencies should be supporting efforts to develop and support the knowledge base of the workforce on these issues. And, the final recommendation I want to highlight of the multiple ones that are made is that nursing schools and employers need to expand disaster preparedness, educational and training opportunities for nurses at all levels and in all settings while working across sectors to develop emergency response plans. So, we have a comprehensive set with bold recommendations that should be made in this space. >> I think that covers it. Thank you, David.

Our next question is for our chairs. How is nursing education evolved to ensure that nursing students understand the impacts of racism, including medical racism on shaping patient outcomes?

I would just make a general and brief comment about that. Based on our review of the literature, our meetings and town halls across the

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 determinants of health more streamlined, integrated, and a golden thread running through the nursing curriculum, as opposed to an appendage that someone takes here or there.

I will add to those excellent comments. Building upon what Regina said a bit earlier. One of the challenges is that within health professions more generally is that it is still emerging, what the consensus standards can be for topics and best practices for teaching about structural racism and cultural humility. And, making sure there is adequate training of faculty to be able to teach these. There is the structural issues that were mentioned. How do structural racism manifest in the organizations or the community or patient care? As Regina mentioned in her talk, lecturing only go so far. Critical is really experiential experiences and a discussion. There is no substitute for having the trainees go through expert facilitated, guided discussions with their peers and teachers regarding these issues and having them, throughout their training with the field placements in the community experiences, the direct patient and community experience needs to go into an integrated whole. The challenge is that we all need to be working on it now.

If I could just add into this. We can take it a step further and talk about this as a needed focus for testing. For testing associated with licensure of registered nurses, for example. That it is important to lift up the focus and make it consistent across all nursing academic settings. And, that this is core content that the students should be evaluated against as part of their professional licensure processes, for example.

We have a few more minutes, so probably time for two more rapidfire questions. The next one is, this report provided a number of examples of how nurses are shaping health policy. They are wondering, did this committee consider the macro effect on social determinants of health and having more nurses serving in elected office could have on these goals? By encouraging and supporting nurses who run for elected office? Could we have a more direct effect on forming the health policies that affect public health and the social determinants?

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 to advance the agenda, like the one we are suggesting here? Communication, exquisite interpersonal communication skills and the ability to find common ground is critically important.

[Event has exceeded scheduled time. Captioner must proceed to next scheduled event. Disconnecting now.]