Please stand by for realtime captions.

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 medicine. We also know over the next decade that they're going to be about 300,000 more nurse practitioners coming into the field. If we can get a significant number of those in the eldercare workforce, and capable practicing for the folks at that capacity, then that will do a tremendous job to alleviate the critical shortage that we have in the eldercare workforce. Thank you very much. >>> [Silence]

>>> Sue, over to you.

Thank you for getting to that question ahead of time. I want to now bring on Dr. Linda McAuley, Dean of the -- Woodruff school of nursing will discuss how to work towards lifting barriers for nurses in the primary care setting. And I might add, cochair of an extraordinary report that came out at about the same time as our future of nursing report. Hers was on primary care and she is anxious to tell you about that.

Thank you, Sue. Hello to everyone who is listening today. I have to tell you one of the most exciting things is to be involved with the implementing high-quality primary care report. At the same time, at the future of nursing report was coming out. And to have these two phenomenal reports kind of hitting the public at the same time and looking at the points of synergy and I want to, that's what I want to focus on with you today with particular emphasis on the future workforce and how the primary care committee approached the work around the future workforce. This report was very different from a lot of national Academy reports in that we were asked to build on the 1996 report on primary care and to actually address what had changed since 1996. And what were some of the barriers to implementation. And so, the overarching theme was what's stopping us from making the changes? Which I'm sure a lot of you in the audience asked that question all the time, like what is stopping us from expanded scope of practice for nurse practitioners? So the first thing that we did was look at the definition of the 1996 report and there were changes that were important to make. This is the updated definition. And it is very whole person integrated care. Is accessible and it's equitable access.

It is provided by interprofessional teams. We avoided language around provided by a clinician. But now, today, we believe that it's provided by interprofessional teams and that you address the majority of an

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. So a big change over the last few decades. And we know it is all 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.

I think they are most relevant to the discussions we are having today is continued efforts to increase the supply of primary care clinicians. And that is certainly nurse practitioners. It is certainly other members of that core team. It is nurses who work in ambulatory primary care settings. And we need to monitor this workforce. The supply of and the requirements for these primary care clinicians. So do we have the data at our fingertips? We know we prepare a lot of primary care nurse practitioners. But are they working in primary care? Or do they get pulled into specialty care settings. Explore how to alleviate this geographic distribution. In there we go with the fourth one. Amend the spoken practice limitations that Jack has already talked about. And also, how can we incentivize primary care services to support interprofessional education endeavors. We know there is a shortage of primary care training sites for our students. And it's a huge challenge

to ask these sites to take interprofessional teams and students. These are major areas of focus that we need and I have some other things to say, but I think they are going to be covered in our question and answers section. So I think I will turn it over to the next speaker. Sue, if that's okay, so we can move through all of this important content. Thank you.

Wonderful. Thank you, thank you so much Dr. McCauley. Our next speaker is Dr. Charmaine Lawson. A nurse practitioner from New Orleans, Louisiana. And the author of the children's book series no love the nurse. Dr. Lawson will discuss the community perspective and how to work towards lifting barriers for nurses. And before you start, Dr. Lawson, I really want to make a point midway through our presentations today that the future of nursing report, this last one was really about nurses achieving health equity. So everything we are talking about here today would not be in the report if we did not believe that this all lead to health equity in our country. Dr. Lawson.

Thanks, Susan. I appreciate it, national Academy of medicine as well for having me. What an honor to be here. I just want to share a little bit about my practice and some of the practice barriers that I have of providing care here I have the distinct honor of starting the very first nurse practitioner practice in the state of Louisiana. And I am still alive. Yes, I started this practice back in 2005 and as my luck would have me, that was the year of Hurricane Katrina. So my practice went through a lot of changes and unprecedented growth due to the storm. And I was able to successfully navigate it through the use of telehealth, or EH are. I was one of the early adopters, if you will of an E HR format practice and was able to serve thousands of residents of Louisiana with primary care services and also with updated technology. Over the years, as most practices do, we go through changes. And here we are in a pandemic, 2021. In a seriously contemplated closing the practice after all those years because it was just tough dealing with barriers of having to get into having a definitely a continuous and more consistent collaborating physician, which I will get into in a few minutes as far as the barriers. But not just that, it was just with the increased need to have resources. To maintain a practice this large for so long. It was tough, so I contemplated closing the practice in moving to the East Coast, to the land of FPA or as most of you will know, full practice authority, where I don't have to worry about any types of barriers for my practice. Well, let's just say, I decided that maybe I should possibly stay and fight a little longer, because I wanted to add behavioral health to my services. We offer primary care in the home. We have a very very small clinic, because most of our work is done either in the home and now we have moved into telehealth. Thank you, Corona for getting us into in a more acute way into telehealth and telemedicine. But now we offer behavioral health because it just passed my psych and PB boards on Monday. We are now going to be offering behavioral health services. So this is a good time to be in practice. But at the same time, most of my patients still don't get the health that they need because it's really just me. I have another in P that helps out may be part-time,

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 that APRN's, all APRN's, midwives and nurse practitioners, and I would imagine some clinics with specialists really do have to pay. Either out of their own pockets, or their employers pockets to have these contracts. So I think that was an educational point today. So our next speaker, like Dr. Roe was also on the committee. On the future of nursing. Our second report here. And he is the Richard Perrault of family Professor of healthcare ethics of the Department of Health at the University of Chicago. And Dr. Shin will provide an overview of effective care management programs and payment models. Dr. Chin, is it all about the money?

Money is an important driver. So next slide. This slide shows the conceptual model of the future of nursing report. I want to highlight a couple key factors. We will start towards the nurses in a variety of roles impact determinants of health. These are both medical and social determinants. That an individual at functional levels. For example, a nurse may be taking care of a patient with diabetes and that nurse could also be a part of a team creating an assistant for care. Such as patients food insecurity and that nurse might be part of community-based organizations to address the problem of food insecurity in the community. So medical and social determinants of health that the individual at structural levels. At the bottom there, you really see a North Star. I think this has been a themes through all the presenters so far that what drove the report? Really, it's a report for the public and people, the nursing report. But really, Northstar is improving individual and public health. Improving healthcare equity. So if that is the North Star, then it's easy to connect the dots. To get overall great population health. Of a key role for nurses in addressing social factors effectively to a improve equity. So regarding effective care models, there's a lot of evidence regarding the effectiveness.

What these all have in common are that these models address social needs of patients. They involve close monitoring and follow-up of patients and families establishing relationships and trust. And we know that families, this is what they want. They want to have relationships. They want to be respected. They want to be viewed as whole individuals with their medical and social needs addressed. And I have talked about managing practice and telehealth. Next slide.

Here is an example that we cite in our report. The C train. This is what patients from discharge to 3 days post discharge. And involves team base care with an RN and social worker. Helping the patient navigate the healthcare system. Reconciling in the key issue of the complex of listing the outpatient in a setting that may differ. They identify social needs such as food insecurity, homelessness, insufficient clothing , and establish relationships as well as link to primary care, specialist and behavioral health. Next slide. >>> Here's the recommendation. On the left, federal, tribal, state, local and private payers and public 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 on health, and health equity. It's sustainable. It's not like one of these programs. But the base core funding system. Flexible. They're going to be in different context. Needing to be flexible to allow the organizations to best serve the populations. Healthcare, public health, nursing. And again, as you mentioned, the heavy emphasis upon addressing social determinants of health. I will adjust most of the areas on the right-hand side. Next slide. A fee for service. Most people would agree is basically an inefficient, lousy system where we pay for each individual Bill service. This was the first bullet in Linda's slide about the high-quality primary care report. So we have a number of recommendations. As we start this larger system, there was to build a period of time where we have a larger fee for service. In there things that we can do to improve. So first, include current procedural terminology codes for nurses. Such as case management. Care coordination. We heard from Charmaine, the crucial role of the nurses in behavioral health. And health equity. Reimbursing for school and nursing. And as jacket others talked about, enabling the nurses to bill for the next slide. So we are seeing a shift from fee-for-service. Alternate models. Here, these models that reward paying for quality and value, value being messed with outcomes and cost. So the recommendations for the report really focus upon advancing health equity and at the addressing terms of health. Why they are crucial for those particular issues. We recommend using critical -- Support nursing interventions by incentivizing reductions and -- High-quality care for at risk populations. For example, the nurse has a robust literature of how this can be used to advance equity. And the third, incorporate disparity measures that support nursing interventions that advance health equity such as process measures. Or outcomes to avoid hospitalizations. Next slide. Alternative pay models that promote value and cost efficiency. Organizations take on financial risk to deliver high quality care at more cost. An example is -- For the health and cost of a predetermined population of patients. So we recommend that these models provide flexible funding, such as -- Payments, global budgets. Health community models for nursing and infrastructure that addresses social determinants of health. Some plans have for all the beneficiaries a model where there is a fee paid to providers for -- They say that can then be used to support the best care models. For nursing infrastructure that can successfully address social determinants of health. Third, incorporating a value-based payment. Advanced health equity. Next slide. Finally, school and public health nursing, it's a very important part of our over all healthcare system. In terms of attention and funding. So we recommend allowing school nurses to build Medicaid. We recommend financing public health with funding streams from multiple private and public health partners. Across public health and social factors. Leverage the nonprofit hospital community in effect requirement the hospitals have to serve the community. Many of these, if done appropriately could address equity and evolve nurses in key leadership roles. Then, make key roles competitive. Equal pay for same services provided.

Thank you very much, Dr. Chen. So our next speaker is Dr. Ellen Marie -- Who is a chief population health officer at the Center for Medicaid and chip services and senior advisor for the Center for Medicare and

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 of the nurse is critical there. And it's not just the role of the nurse. It's the role of the entire health, clinical team. The whole health team including some nonclinical providers. Fee-for-service to pay individual services. Mostly to physicians for the service they deliver without that improved outcome. This now is looking to pay clinicians, clinician practices held systems based on the outcomes that the patients are having. Better payment if the patient outcomes are better. I was thinking about when I was working in the United States Senate in the early 2000's, it was kind of a novel idea that a new payment policy was announced that was no longer going to pay for a list of never events, including events like amputating the wrong leg. So before that, someone went to get a leg amputation. The patient still that paid. So that would be much more deliberate now thinking what are the outcomes that we are looking for. How do we pay for care. That will support this new care delivery model. And I will just a note the first objective to the primary care report that we just heard presented and I am really thrilled that the very first outcome there were objective there is to pay primary care teams to care for people. Not doctors to deliver service. And that's really what we are all about their. So looking to see how we can maximize the contribution of everybody in the healthcare team to be able to provide better care to improve patient outcomes. The second thing that we are thinking about as we are designing new care delivery models is how we can better address social determinants. We all know, you have all seen the slides, most of what keeps us healthy or makes us sick does not happen in the healthcare delivery system. Not in the 15 minutes that you spend in any clinical office once a month. So in Medicaid, Medicaid is thought of as not just an insurer, but a medical assistance program. So in Medicaid, we are looking to see how we connect with flexibility to address things like expectation. In some parts, housing issues we look to see how we can keep key people in their home and not have the move to an institution. We see --

Alerting states and reminding them of all the things that they have within their existing toolkits that they could be doing to better address the social determinants of health. So that cannot happen necessarily in a fee-for-service system. Much more able to look at those issues and look for ways of supporting payment models that allows those issues to be addressed in value-based care in new alternative models. And the last thing I will mention because it's an important part of this future of nursing moving forward is how we can achieve health equity. A tough nut to crack. Health equity is something we have been dealing with for a long time. We know that the infant mortality rate is much higher in people of color. So this administration is really spending a lot of time trying to think about what we can do as we design new payment models and new care delivery models. What we what can we be doing to make sure that we address equity issues. One of the very first executive orders that President Biden signed when he came into office. Was an executive order on advancing racial equity through the federal government. So we are taking a whole new approach. We are working not just within CMS and the different agencies there. But we are working with CDC. Looking to see what we can be doing if we work together to be able to address this. Within the federal government. But I will also note that we are working outside the federal government. We

know that CMS cannot do this alone. We have to be working with private payers. So number of years ago, as CMS started the advancement away from service, we started to work with the private payers. We are looking to see if they would make a commitment to remove from fee-for-service. Ran out looking to do something similar to address equity. And I will note that there is an agency. An entity that was created called a healthcare payment. Learning and action network which we have called the land. They have been looking to bring the public and the private sectors together to look at moving away from fee-for-service. And we have just created as part of that, the health equity advisory team. And I will say that it is cochair, by our very own Dr. Chen who presented right before me with a nurse cochair and three other nurses on that committee as well. And what we are doing is looking to see what can we be doing as clinicians, as health systems are looking to address health equity. It's not an easy nut to crack. So we are coming together to see what it is that that we can be doing? What are we measuring? What are we talking? What is it that we can do in the primary care space. To be able to look to addressing equity issues. Equity is not the same for everyone. It's those that need more get more and how is it that we can do that in a way that not only we can do within CMS but also with our partners in the private sector to be able to do that as well? So looking. The three things that I think are most exciting, especially in terms of what is being promoted and recommended in this report is moving towards having payment models create a new care delivery model that maximizes the entire health delivery team including nurses and not just in keys. I think RNs are another huge benefit that we can figure out how to do a better job there. The second is how we can use payment models to better support the social determinants of health and last, how we can do a better job of trying to address equity. Another thing that I will flag is if we are paying for outcomes, we have to know which outcomes we are paying for. So that measurement. What are we measuring there? That nurses can help address. So if we are paying for certain outcomes, we have to make sure that we are getting those outcomes right. But I will stop there. Were going to have a really robust question and answer period.

So thank you. Thank you so much. I really appreciate your time. And we are going to get to our questions now. We are going to have a panel discussion. So let's stay on this payment issue for a little bit longer. Shall we? Let me go back to Dr. Chen. And then I'm going to have you see if you might want to elaborate, Dr. Whelan and talk about your measuring outcomes as well. I know that is a cliffhanger for us. I really liked that. So Dr. Chen, where should we start providing? Where should we start regarding the payment recommendation? Where should we start regarding the payment recommendations? If you and Ellen Marie can take them on, I would appreciate it.

So I agree with these. I appreciate the level of detail. I think the first priority is to really be intentional about our goals. In right now, as we said, the goals should be improving individuals and populations of health. Should be advancing health equity. Should be addressing the medical and social factors that affect a patient's care. Should be improving the patient and family experience. If that were Sullivan, the problem is that despite all of the rhetoric by all of

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 --

Absolutely. You were the top administrator. I think you are authorized to talk about this.

I survived 12 years as a president of the -- Medicine and a CEO in New York. So it was one of the largest in the country. So here are the lessons that I have learned. Again, something like this though. Or some other things that we are trying to do. The first is through a lot of processes like this, it has to be inclusive. And it has to have a committee or a group that is led by a clinical champion. Okay? So when I tried to do something not exactly like -- Or it can do this, I did not chair the committee myself or have with my vice presidents chair it even though they may have been a nurse or physician. We will harken back to the physicians after the nurses touch on this one.

I'm going to go first and take a stab at this. Me, particularly the board question, how do we get on board? Will, I have a question. How do we? Who do we talk to? Do we just conduct a board? A hospital that we are interested in? A vendor? A big group? I'm just going to name, Amazon, target. Say hey, I have X, Y, and Z experience. Do we hire an outside group? I've spoken with an outside group. I don't want to say the name but there's a group that I've spoken to and you pay them a fee and they take your CV and they will disperse it to several entities and boards. Is that the right way? There's really no blueprint on how to do it. I am not alone in my desire
to be -- As a nurse. We want to do it. But how? Is there a blueprint?

So Dr. Rhodes is going to weigh in here because he has a way in perhaps.

He does? I need your phone number.

Yes, so I lost the feed for a moment, so can you hear me? You know, I think there are a couple different approaches. But one very important valued approach is to simply go to the executive search firms that populate the boards of hospitals and health systems and talk to those executive firms. Give them your resume. And when they are looking for

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

will get serious about this because you can't just decide at the age of 40 that you want to be on the board if you have not been inquisitive about these larger issues all along.

Right, thank you. To Dr. Wheeler, you have a very prominent position as a nurse. As a policy expert. So how did you get to where you got to? How do other nurses do it and run for office?

Thank you, Sue. I completely agree with Dr. McAuley that having nurses teach policy but also understand how policies are affecting their practice is a really important thing. I'm just going to talk about, it's not just nurses on boards, but it's nurses at the rate tables. There's a lot of tables out there where we need to be represented. There's a saying here in DC that if you are not at the table when you're on the menu. So being at those tables is really important step. There's all sorts of different places that you can see. One of them is for talking about payment models. Many of the payment models have a shared savings model. So the savings come back to healthcare systems based on how well they do with healthcare systems. How did the savings get distributed? To which departments? Who is making those decisions? I guess one of the things is, what are the policies that nurses are seeing that are affecting their practice? I talked a little bit about starting my own practice and I was frustrated I could not sign my own prescription. I was a CFO service provider but I could only get one managed-care place. So what are those policies that are hindering you? Is a better understanding about what? Better understanding your health department maybe the academics side and having students to academic studies with some policymakers at all sorts of different levels. I was fortunate to have a fellowship after had a degree in policy. Really getting embedded into mostly Congress but also in the ministration. Have a student working with me now as a fellow because I'm trying of students better understand what policy means and I was thrilled to see that as part of the curriculum for the doctor nursing practice that policy is a big piece of it and I think one thing that we could do there is not having every faculty member have to create their own curriculum.

Okay, thank you. I want to get to a couple other questions around payment now. Let me ask Marshall and Ellen Marie. What is the industry appetite for payment model recognizing and embracing nursing practice?

I will frame this more widely in terms of the industry shift to social terms in health and health equity. I personally have not seen a lot of industry specific focused on new nursing models outside of that particular element of this new horizon no, shaking the system up here and here, I think again, the key is that three years ago, I don't think -- Were evolved so quickly. Now, is the same discussion as I am seeing where there is no a fairly uniform agreement. There's a lot of well-meaning intent. Through a lot of organizations struggling to be concrete. So I think we are in a state where the will is there and now we have to get concrete evidence. I think if we keep the North Star of population health outcomes, holistic -- And social needs. Nurses in the

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 -- That was my business. Self-insured -- The employers like it. You have to work with the employers. Making sure that the employers understand it and like it. And then -- Don't think that you're trying to give their workers and beneficiaries second-class care. So I would spend a lot of time educating my customers who were my employers about the evidence. It always comes back to the evidence. Paying for 2018. Is less expensive. The nurses no order as many -- For so on and so on. And they are going to save money. So medical costs are an issue for employers. They are for essentially all employers. It's an important part of their budget. They are going to save money for economics. And you focus on the employer. That would be my strategy.

Okay, so Dr. Whelan, going to ask you, I'm going to put a secondary question into your hat here as well. So the question came, how can we create equal opportunities for RNs? For example, nutritionists can build -- Using telehealth, but RNs and CDE's cannot. So there's a temporary override of this during the -- But this is unacceptable. RNs in primary care. So Dr. Whelan?

Thank you. I think that question reinforces why we need to move away from fee for service to value-based care. Because it's random sometimes who gets paid for which services and why. I think if we are looking to improve patient outcomes and looking at that total cost of care model we don't bill individual clinicians so I would say that it is not fair. There are some changes that we made. Some of them we think will stay. But I think if you reinforce why the fee-for-service system is broken. And when we talk about the industry, it's interesting. What I was going to talk about before Dr. Rowe was the purchaser of the healthcare is critical. Who is that purchaser? As Dr. Rowe said, the employer who is invoking that to ensure to manage that, they are the ones purchasing the insurance for the patient in the state. The state is purchasing that health care. If we look to them, the original question was how do we move along this continuum and get into this industry? Do they want to move towards value-based care? The answer is yes, if the person who is paying for care wants to see better outcomes and can see it being done more efficiently, then that's absolutely.

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 nursing report in the primary care report?

So you know, I think we need to get serious about teaching social determinants of health to all health providers and these two reports would be part of the required reading about the complexity of how health professionals can address health equity and access to care. So I think for us to really understand health equity and to really see our role as nurses in providing health equity, we really have to understand social determinants of health. And have it be part of our DNA from the beginning when we begin to study in the health production. So that's just one idea.

Okay, all right. So let's talk about what can we do to create synergy between the two reports?

I think both reports, the health equity is a link, a clear link between those two reports. If we get serious about health equity, it will bring these two reports together.

All right, Dr. Chen, what is your most important point for this audience in terms of how nurses can address health equity? You can stick on this topic if you want. Practice barriers of payment models. What do you say?

When we taught -- About health equity, we found that paradoxically, if we don't talk about solutions and efficacy, then we can get disillusioned and disempowered. So you've heard of -- Over the past hour and a half. I would ask that everybody listen to this webinar and ask themselves where along the spectrum of mobilizing change to advance equity are you comfortable? Weather is an official patient care,

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?

You are on mute, you are on mute.

I muted myself . I would savor every nurse listening, they should do two things. They should think about the impact they are having on the lives of their patients, questions they are asking. All of that goes to the equity issue. Someone gets a prescription, do they have the refrigerator to put that prescription in?

I would also ask them to think about what policies at their institutions, schools, systems, hospitals, what policies are there that are getting in the way of you doing a better job and then being proactive about asking how those policies are made and if there's something you can do to tweak those policies? To do a better job serving the patient's and you are doing a great job serving.

So speak up, it's all about understanding the issues and speaking up. Okay, Dr. Rowe, most important point here.

I think we need a communication strategy. One of the problems with studies from national Academy or otherwise is that they sit on the shelf. When we have the original study, professional Ferman, Julie Fairman and Donna -- The chair of the committee and I have published an article in the New England Journal of Medicine about the study findings and recommendations and it got tremendous response. And then, people started going out and lecturing and having meetings with nursing associations, publishing editorials in nursing journals. I think Sue has Miller should give a talk at every school of nursing in the United States.

I'm trying, I am trying.

And we need, in the problem with communication strategies is that they are never on a budget, right? They are never in the initial study budget and we need to get lucky and have some friend like Robert -- Or AARP to come along and help, but I think we need communication strategies.

Okay, thank you. Linda, anything you want to add to what you just said earlier about working together? And understanding health equity? We have about 30 seconds left here and I have to get Dr. Lawson in.

Let's get to Dr. Lawson's comment.

Let's get the frontline provider in.

No pressure here. So I'm just going to keep it really simple. To all of the frontline workers who are owning their practices and working

particularly in the role , underprivileged areas. For us, the ability to practice at the fullest scope of our practice will directly affect health equity. Directly. So having that ability to do some -- In New Orleans and Louisiana will have a great impact on the Residents in the communities that I am seeing.

Thank you. I want to thank our entire panel. Give everyone a hand. It's absolutely an astounding privilege to be able to facilitate this with you. Thanks to the audience for joining us and we are offering CEU's through the National League for nursing. This webinar will count towards .1 CEU/1 contact hour. The survey link will be sent in an email following this webinar. The slides from this webinar will be available and I want everyone to get on the list serves. I think this slide is up. You can complete the quiz and earn your CEU's. The quiz will be available until August 18. The attendance verification code also on the slide is 721. Thank you, I hope all 1600 of you were able to join for this webinar today. Astounding speakers. We will have two more webinar events that you can register for on the national Academy of medicine website. One on August 4 on nursing well-being. And August 11, diversifying the nursing workforce. Bye and have a wonderful day. Thanks, everyone! [Event concluded]