



**The Health Workforce Dream Team: Who Will Provide the
Care?
Alliance for Health Reform
December 2, 2010**

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ED HOWARD: Well let's get started. I'm Ed Howard with the Alliance for Health Reform. I want to welcome you on behalf of Senator Rockefeller and Senator Collins to this program continuing our look at how health care workforce may meet the likely increases in demand from the results of the reform legislation and the aging of the Baby Boomers into their Medicare years.

Last month we held a briefing on the supply and distribution of physicians. Today we're going to turn our focus to nurses, and other health care providers will be depending on the answer to that question as the title of the briefing says: who will provide the care?

We know that even the current health care system can't be sustained without attention to the number and the quality of nurses who are available to deliver care. Throw in 30 million-plus more in newly insured Americans over the next few years and the additional Medicare beneficiaries and the extent of the need is pretty apparent.

When you stop to think about it, when we refer to nurses even to registered nurses, we could mean people with any of several levels of education and training and preparation. Then add the millions more of the direct care workers some of

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whom aren't classed as nurses and you realize the picture's a pretty complicated one.

Today's program is going to help you sort – going to help me sort – all of that out. How many and what kinds of nursing and other human resources do we need to deliver the care, and how does the Affordable Care Act respond to these needs? In an era when everyone talks about the need for health care teams, who's on the team? Who's the captain of the team? What roles should the nurses and other providers play? Fortunately our panelists and my co-moderator actually are well equipped to give us guidance on these and related questions.

Our partner today, as it was in the physician briefing last month, is the Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to promoting health and health care. We're pleased to have with us today to help me co-moderate Sue Hassmiller who's the senior advisor for nursing at the Foundation.

She also spent the last couple of years running the RWJ initiative at the Institute of Medicine on the future of nursing about which you will hear more today. I want to thank Sue and Brian Quinn and their colleagues at the Foundation for their support and help in assembling this briefing today. Sue, let me turn to you at this point.

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SUE HASSMILLER: Thank you Ed. It's my great privilege to be here with you today to co-moderate this panel. I think that probably almost everyone in the room knows that our mission is to improve the health and health care for all Americans. We fund and create social change in many areas including childhood obesity and transforming public health but we're here today to talk to you about a large part of our portfolio and that's called human capital.

We invest quite a bit, at the Robert Wood Johnson Foundation, in building leadership capacity in our health professions in this country, physicians, community health workers, and nursing as well. We are currently funding nursing to the tune of a little over \$200 million. So we care quite a bit about nursing and the role that they play in transforming health care in this country.

My president, Risa Lavizzo-Mourey is fond of saying that we need to improve quality of care in this country but we really can't get there until we first address the nursing issues. We were very, very proud most recently to work with the Institute of Medicine on a brand new spanking report called "Leading Change, Advancing Health".

It was about the future of nurses and about how this country should really be doing more, policy makers in this country should be doing more, to effectively use and

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efficiently use nurses so that all of our citizens can get the health care that they need and deserve in this country.

We're just fresh from launching a very big, very big and successful summit. We had a summit over the last couple of days at the Grand Hyatt, over 500 people, who came from multidisciplines because I just like to say that even though we did a report on the future of nursing, we do believe this is a societal issue that every one of us should care for.

Just as we care about the teachers that our children have in school, we should care about the nurses that care for us and our family members. So we had a big summit, we web cast the event all over the country and we are ready to start something that we're now calling the Robert Wood Johnson Foundation Initiative on the Future of Nursing: Campaign for Action because now what we want to do is ensure that every one of those recommendations that Linda Burnes Bolton will talk about gets implemented, eight big categories, 43 subcategories and I think we can get started. Thank you.

ED HOWARD: Thank you Sue. Linda Burnes Bolton has told us that she can cover all 43 subcategories in eight minutes. So that's something to look forward to. Let me just do a little housekeeping here. Those of you who have been to these briefings may have heard this before but as they say on the airplanes, you never know when you're going to need this

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stuff so pay attention. In your packets, you're going to find a bunch of important information including biographical information on each of our panelists and Sue – much more extensive than you're going to hear from either of us.

The Power Points are in there. We had sort of a difficulty with our AV contractors. So there is kind of the mini-me version of a screen over there that I'm sure you're going to be able to see from the far edge of the room but follow along with your hardcopy you have in your packets please.

Everything that's in your packet and things that we didn't have room for in the packet are at our website, allhealth.org, for you to use for further investigation after this briefing. There'll be a web cast posted on – both through our website and at the Kaiser Family Foundation website kff.org. Thanks to them for doing that service. We will make arrangements to link to your conference web cast as well, the web cast that Sue just made reference to so that you can see the underlying conversation about that initiative.

There'll be a transcript available in a few days on allhealth.org. You'll be able, also once we get through the presentations, to ask questions. There are microphones here if you can crawl over to them to my left and my right and green cards you can use to write them down. We'll bring them forward

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and the blue evaluation, the ubiquitous blue evaluation form that we would love for you to fill out so that we can improve these briefings as we go along.

Let me get to the program. We have an incredibly knowledgeable group of panelists today, very broad range of experience. We're anxious to hear from them so I'm going to shut up. Leading off is Joel Teitelbaum who's on the faculty at George Washington's School of Public Health and Health Services. He also directs GW's Hirsch Health Law and Policy Program. He's a lawyer by training.

He's won several awards at GW for excellence in teaching qualifies him for this panel absolutely. He's also an expert on what's in the ACA. We've asked him how to start us off today with an overview of workforce aspects of the new law and some of the related policy questions in their implementation. Joel thank you.

JOEL TEITELBAUM: Thank you Ed. Good afternoon everyone. Thanks to Alliance and to the Foundation for inviting me this afternoon. It's a pleasure to be here. I'm going to take just a few minutes and provide some overview and some context to the discussion that you're going to hear in just a little bit.

As you all know probably, trying to distill the ACA down to something meaningful in just a few minutes is not an

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easy task. It's quite a bear of a law obviously but I've done my best to try and get this down to five minutes.

A couple of background items: the first is that there are lots of different ways you can cut this material. I could have done it by provider type. I could do it by topical area. I thought I would take the path of least resistance and do it in the order in which and the way in which it is presented in the law itself. I think given the time constraints, it probably makes the most sense.

The other thing is I've focused just on that section of the ACA that is targeted toward the workforce. There are lots of provisions in the law obviously outside of that section that deal with workforce issues whether it's reimbursement rates and other issues, for example, community health center expansion, lots of other things that will deal with the workforce but again I wanted to stay focused on just those provisions again with time constraints. So it's really a thumbnail sketch and really an overview.

So a couple of background and context items and then the ACA breaks up the workforce provisions into five areas really. I've condensed them into four. The first is what they call innovations. The second is increasing supply of the workforce, education and training is actually set up separately in the law from supports but I've included it there,

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strengthening primary care, and then finally some key implementation questions, which I'll lay out at the end of my presentation. I assume we'll come back to them at the end. I don't know if you want to take questions during or if you want to hold them all until the very end.

ED HOWARD: Why don't we hold them until the end?

JOEL TEITELBAUM: So beginning with some background and context, obviously given this year's scope of provisions that are in the ACA, strengthening and modernizing the health care workforce was a key goal of the law itself. In addition to the focus on quality, the ACA is really concerned with three things primarily when it comes to the workforce. The first is to alleviate shortages. The second is to help with the maldistribution both geographically and specialty areas of the health care workforce and then finally to produce more diversity in the workforce.

There seems to be two different views as to how the workforce provisions are viewed. The first is that all it really does, the ACA, is tinker around the edges of the problems. It does a little bit of tinkering with the market. It does a little bit of tinkering with scope of practice. It does a little bit of tinkering with thinking about how we can maybe think more nationally about our workforce policy in this country.

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The other view, which is very different, which is: it's a new era. It ushers in a new era of collaboration of thinking about how to improve the workforce both in terms of its numbers, its distribution, and its quality and which one turns out to be the correct one remains to be seen certainly. I know the other panelists have their own view but if you do any reading now about the interpretation of the workforce provisions. It really is breaking down along two lines.

Finally I wanted to mention a project that we have in the Department of Health Policy with the Hirsch Health Law Policy Program. It's also an RWJF-sponsored program. That is called Health Reform GPS. Some of you may be familiar with the project. It is a website that is dedicated to all things implementation of the health reform law.

We do original content analysis of the law but we are also pulling in all of the proposed regulations, all the final regulations, whatever bills there may be proposed to try and scale back some of the ACA. It's supposed to be a place for one-stop shopping with both original content analysis and also everything else that's going on around it. You can see the website there but if you can't see it, I'll read it once. It's healthreformgps.org, healthreformgps.org.

Okay moving on to the provisions themselves, the first one is what the Affordable Care Act calls innovations. I tend

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to think of these not so much as innovations but rather beginning to create a system in which we can think about national policy with respect to the workforce.

So three key things with respect to the innovations section of the ACA: the first is the National Health care Workforce Commission, which is supposed to encourage innovation around the country. It is supposed to be presenting back to Congress and the administration its views on where we need to go next. The members of this 15-member commission were announced back at the end of September.

If you want to see who is on that commission, you can simply Google it or you can go to the GAO website. Whether the commission will have the resources it needs to do its job in the coming months remains to be seen especially given that they are supposed to produce their first annual report by the end of April of 2011.

The second thing is the National Center for Health Care Workforce Analysis providing comprehensive assessments and creating data reporting systems working in conjunction with the Commission of course. The law also sets up state and regional workforce centers like this one to work along with the national center.

Finally state health care workforce development grants, these are both planning and implementation grants. We're going

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to hear a lot more about the grants and later on from Bob.

These are administered by HRSA in consultation with the National Commission.

Increasing and redistributing the supply, the key for the ACA in this regard was incentivizing individuals to take jobs in fields where there is high demand and also in places where there is high demand. They tried to achieve this in four main ways. The first is through amendments to existing educational loan programs, again something we'll hear more about, authorizing educational loan repayments in various programs, the one for pediatric specialists and public health workers specifically have gotten a lot of play.

Third our grant programs to establish, for example, and operate nurse-managed health centers. Back in September, I believe, HHS announced \$14.8 million for this program. Another program is scholarships for mid-career allied health professionals who would like to advance their educational training in their chosen field and then finally they amend the Commissioned Corps program.

It removed the 2,800-person cap that currently exists with respect to the Commissioned Corps. It also established the Commissioned Corps Ready Reserve, which can be called into action by the Surgeon General in the event of a real national crisis or emergency to assist the regular Commissioned Corps.

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Education training and other supports, an obvious and major focus area of the ACA, there are a lot of grant opportunities. There was a lot of thinking about how much money we need to create the kind of system we want. They were focused very much on education and training and other kinds of supports.

For example, and there are far too many to discuss in any detail here, in the coming months on the GPS website, we're going to have an issue brief that is dedicated to several of these programs but for example, primary care, direct care, oral health specialists, geriatric education centers, behavioral health, and so on. It's varied. It's broad but again far too many go into it at the moment.'

Secondly the U.S. public health sciences track, which is aiming at training physicians and others in things like team-based service, public health, and epidemiology. What this does is provide tuition remission and stipends for individuals who would then serve in the Commissioned Corps. I've been told I've got three minutes left. We can't forget primary care. I should have put that first just in case I ran out of time.

Four main areas of change in the ACA with respect to primary care, the first one, as I mentioned, this idea of financial incentives for providers who choose certain practice

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and specialty areas, for example the 10-percent boost in Medicare Part B payments to primary care providers.

Secondly revisions to graduate medical education in the form of redistribution of unused residencies across the country to various hospitals and also a fund for teaching health centers to expand and for those who don't have it to establish residency training programs.

Third, a new primary care extension program to provide support and education to primary care physicians around the country. Finally again new grant programs, for example, state demonstration projects to develop core training competencies and the like. Okay, two minutes left and I can get to my implementation questions.

The one that is on everyone's mind at the moment is whether there will be funds available to do much of anything in the ACA, workforce provisions and otherwise. Obviously there are authorized funds in the ACA. Even if we don't achieve the full authorized funding, there is perhaps maybe less funding that could still achieve much of what we would like to in the workforce provisions. How that is handled going forward remains to be seen and I think is the \$60,000 question at the moment.

Secondly, assuming we are moving forward at something close to full speed, will the necessary data information

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infrastructure be developed? Both to determine what distribution is exactly where we need more of, what types of providers we need and where, but also to measure whether any of the demonstration projects that we have in the ACA are effective.

So it's not just measuring what we have now but figuring out a way to determine whether what they have come up with as a policy matter is effective. What kinds of performance measures will be developed to measure the success of the programs, how will they be coordinated with current HRSA monitoring, what standards will be used in the awarding of the workforce grants are all key questions.

Another big one for me is what's going on at the state level? What policy and cultural differences at the state level will have on the implementation of the workforce provisions? For example, Maryland has already moved way up in front of really most of the other states in a commission that they have that is explaining to the Governor what they believe needs to happen in the state of Maryland not just with respect to workforce but including workforce provisions.

You can compare that with what's happening in so many of the other states, for example, they're looking to derail implementation and you can see there is such a huge range of how the states feel about the law obviously and what they will

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do with respect to implementation, how hard they will work at implementing versus how hard they will work at derailing it. So there could be very, very uneven implementation of the law across the country at the state level.

Will the ACA affect a discussion around scope of practice and if so how? Will the ACA lead to truly national health care workforce policy making because prior to the ACA, there was no single national approach to thinking about these issues and finally, will the Affordable Care Act alleviate the twin problems of workforce shortages and uneven distribution? I think I may be right on the button. Excellent, thanks.

ED HOWARD: Thanks very much Joel. Now let's turn to Bob Konrad. He's a Senior Fellow at the Cecil G. Sheps Center for Health Services Research at UNC Chapel Hill and a former co-director of its program on health professions in primary care. You may think that we're sort of establishing an underground railroad between here and the Cecil G. Sheps Center just because a couple weeks ago, we had your colleague, Tom Ricketts on panel who's a member of that workforce commission that Joel just mentioned. So, we're very pleased to be able to mine that particular load.

Tom is deeply involved in evaluating a national Robert Wood Johnson program as a matter of fact aimed at improving careers with so-called direct care workforce that includes many

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people with many varied skill levels. He's been a leader in workforce studies for the better part of four decades and we're very pleased to have another Cecil G. Sheps faculty member with us.

BOB KONRAD: Thank you very much and I appreciate the opportunity to be able to address this group and the support of the Robert Wood Johnson Foundation as well as the Alliance. The view I'm going to give you today is really from the frontlines about—so the frontline workforce in our health care system is about 50-percent of the people actually employed in the health care center, these are people who constitute a workforce that has a very high level of direct care service but their compensation levels are generally much lower than what we think of when we think of physicians and nurses.

They have a median annual wage level of under \$40,000 a year. Their requirements for education are a bachelor's degree or less and many of these are not licensed but are certified and often receive a significant amount of training on the job.

These are people who, with minimal training, don't necessarily have stable career paths or they're unclear but this is half of our workforce and what is interesting about the current law is that these people are, for the first time, being recognized by the federal government as a group of people that are important for the implementation of health care reform.

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On the commission, for example, there are one or two members on the workforce commission that essentially represent this category of worker.

Now who are these workers? Well in a report that was done about four years ago by the Robert Wood Johnson Foundation entitled "Workers Who Care." ["Workers Who Care: A Graphical Profile of the Frontline Health and Health Care Workforce" prepared by Health Workforce Solutions, LLC for the Robert Wood Johnson Foundation]. This is on our RWJF website if you just look for workers who care. There are 32 occupations that have been identified with the characteristics I just described.

They work in long-term care, in community health, public health, substance abuse, and addictions treatment, primary care offices, and hospitals. They're the core workforce that do the hands-on care under the supervision of physicians, nurses, and therapists, a variety of assistants, aides, and auxiliary health workers.

What's interesting is that this act did show some concern for these workers and in your packet, I think there's three documents. This, which outlines the provisions and the two pieces from the Paraprofessional Healthcare Institute, PHI, gives some more details of important segments of that workforce particularly those that are working in long-term care.

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As you can see, the demographics of this workforce are such that they're about 80-percent female, about a third are minority, and the average age of people in this workforce is relatively high. We're going to require 10 to 12 million new and replacement workers in these categories over the next 10 years. Why are they important?

Well with an aging workforce and increasing levels of chronic disease, we're going to need more stable workers in these positions to assist in the management of these conditions and working with these populations. This is true as well as in community health and in behavioral health.

These are workers who very substantially, again as Joel pointed out, there is a lot of variation across states not only in how health reform is going to be rolled out but in how these workers are treated or licensed or recognized. For example in New Hampshire and in Vermont, nurse aides are licensed. In very few other states are nurse aides licensed, but various kinds of aides and assistants are quite a bit of variability.

One of the unique aspects of our federal system is that despite the fact that so much of our care is paid for by federal sources, the licensure of people varies so much from one state to another and how they're supervised and how tasks are delegated that's all state level legislation but we're going to have a need for a number of these workers.

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So for example, what we call direct care workers, those who work in long-term care, in nursing homes, in adult care homes, and in home health agencies, we're going to need another in the next 10 years an increase of over a third of that workforce. Clearly we're going to need more nurses and physicians and other allied health professionals but in long-term care that is going to be especially important.

Now when you look at these direct care workers compared to others, we're going to need 3.2 million registered nurses over the coming decade but we're going to need 4.3 million direct care workers to meet the needs of the aging and disabled population. So let's get more concrete now in terms of key provisions in the Affordable Care Act. I've broken this down to amplify some of Joel's points by the kind of workers we're talking about.

So for example in these direct care workers, there was an authorization and an appropriation for personal and home care attendance that PHCAST grants, six states have already been awarded these grants and North Carolina's one of those. We're hard at work developing the standard curriculum and implementing that, field testing it, and evaluating it so that we have the uniform standard for personal care attendance and personal care workers in home health and home care agencies.

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So that part has already been authorized and appropriated but there are also enhanced training through college-employer partnerships that will be granted to states and partnerships throughout, I think there's 30 or 40 of these that have already been funded. There will be authorized but not yet appropriated demonstrations to engage TANF recipients to move into these careers. So this is again a jobs program and a health care program. Then finally there will be a personal care workforce advisory panel and that's already been appointed.

Now for public health workers, there's also a loan repayment program that will feature three-year service obligations, mid-career awards for allied health workers, and then perhaps an expanded definition of allied health so community health workers will also figure into the Affordable Care Act's medical home legislation.

So there's a lot of room there for frontline workers in primary care. In the mental and behavioral health area, there are training grants that will focus on involving underserved populations and focusing on care for youth and adolescents. There's a special focus here on historically Black colleges and universities as training sites and a specific authorization for paraprofessionals.

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Again this has expanded the traditional federal workforce beyond nursing and medicine but perhaps the most important impact of the Affordable Care Act will be to give a million new low-income health workers health insurance, something that will keep them in the workforce.

Finally, where we see the action in the future will be the states. The states will have to watch closely and comment during the rule making process to make sure that these kinds of workers are represented in the grant process. There will be available federal resources for better data about local needs; it's important for states to use those resources to figure out what they need.

For example, in North Carolina, one of the things that we do periodically, in fact annually, is link the nurse aide registry data to the employment data so we know what people are making and when they're leaving the workforce what other occupations they are going to.

So there are resources now from the federal government to do this partnering with local and national foundations to leverage these resources will be an important thing that states can do and then capitalize on the grant demonstration funds. Hopefully they will be available to really reshape their workforces to meet the needs of their citizens. Thank you very

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much, and I appreciate the work that PHI has done and the Johnson Foundation has done on this.

ED HOWARD: Thank you Bob. Sue?

SUE HASSMILLER: I'm going to introduce the next two speakers together and set this up a little bit. I told you about the Institute of Medicine report that just came out October 5th.

You can find everything you want to know about the report and much more on the campaign on thefutureofnursing.org, thefutureofnursing.org, all one word. On this committee, we were very privileged to have a chair who knows her way around Washington quite a bit and is quite a champion of nursing and that was Dr. Donna Shalala. The Vice Chair of the Institute of Medicine Committee Leading Change Advancing Health was Linda Burnes Bolton.

Linda Burnes Bolton, if you don't know her, you should know her. She's one of our nation's greatest leaders in the country. She is the Vice President for Nursing and Chief Nursing Officer at Cedars-Sinai Medical Center in Los Angeles. I would say thank you Linda for being here. Linda's going to go over the recommendations quite broadly, and Catherine Dower was on the committee. There were actually just a few nurses on the committee, which is typical of an IOM committee, just a few

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nurses. Here you see one nurse and here is an attorney. So we had quite a robust committee.

Catherine Dower is the Associate Director for Research at the Center for the Health Professions at UCSF and she codirects the Health Workforce Tracking Collaborative there and was quite active on the committee especially around scope of practice. It is an area of great expertise to Catherine. That's what Catherine will go over today. So, Linda and then Catherine.

LINDA BURNES BOLTON: Thank you Sue. Good morning to all of you, well good afternoon I guess it is. Yes it is morning in California. I requested you take out this document because it has the detailed, not all 43 subgroup recommendations but it does have the highlights of the report. This report, a landmark report, in fact over the last several weeks since the report's release, individuals have likened this report for nursing to what the Flexner Report was for medicine. It turned, the Flexner Report turned how physicians in our country would be trained and projected what was needed to be able to have a medical physician workforce to meet the needs of our nation.

I begin there because I want you to know that this report, this landmark report, wasn't done solely to address the issues of nurses or the shortage of nurses, which has been

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around for many decades and continues. This report was a blueprint for action about how do you take the largest professional section of the health workforce and provide them with capacity to be able to meet the current and future needs of our country in terms of health care.

So our center always remained about what is it that we could do to strengthen our ability to meet the health care needs of our nation. That is, center nurses, not only because they are a part of the human caring professionals in our country, are positioned to be able to do that, but they needed some help and our recommendations are aimed at that. So it's a milestone report about how we can achieve high quality, patient-centered, equitable, equitable health care but it can't be done unless we do something about nursing.

The committee came away with four key messages that capture the recommendations. The first message is that nurses should be able to practice to the full extent of their education and training. To that end, the report recommends moving scope of practice barriers and I won't speak about that because Catherine will and also implementing nurse residency programs that will help to transition novice nurses as they come out of school just as pharmacists, physical therapists, physicians, and others as they come out of school for the first

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time to practice that they have a transition program that enables them to practice safely.

We had solid evidence, if you're familiar with the Institute of Medicine process, you know that it must be evidence-based that it goes through a rigorous review, solid evidence that if we increase the number of nurse residency programs in this country, we could achieve two very important outcomes.

First decrease the incidence of hospital-acquired conditions, hospital-acquired conditions cost money. Having a hospital-acquired pressure ulcer, for example, costs \$44,000 per episode. So just think about that in terms of and the investment in nurse residency programs and what that could do.

The second that it would reduce turnover in America's hospitals, which also costs money because every time you turn over a registered nurse in our country, it costs \$66,000. So the opportunity to achieve both improved clinical outcomes and effective efficiency was why that recommendation was made. The second key message that we had is that nurses should achieve higher levels of education and training but in transforming the system that prepares nurses and promoting seamless academic progression, seamless academic progression.

So we recommended that they increase the proportion of registered nurses that have an earned baccalaureate degree from

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50-percent, which is what it is now, to 80-percent over the next 10 years.

We also recommended that we double the number of nurses with a doctorate degree by 2020 to increase the number of individuals who can serve in faculty roles and nurse scientists and that we engage nurses in lifelong learning.

The third key message is that nurses should be full partners with physicians and others in redesigning the United States health care system. While the Affordable Care Act has done a great deal in relationship to improving access to care through the provisions to increase the number of individuals – we have funding for that care – we still have a lot of work to do in terms of the system delivery and to that end, the report recommends expanding the opportunities for nurses to lead and diffuse collaborative improvement efforts and that we prepare enabled nurses to lead change to advance health.

The final message is that we need to have more effective workforce planning and policy making and we need more data. Even though we looked at a lot of evidence, there was so much data that is still needed about the workforce and so we made recommendations about building an infrastructure to collect and analyze the health care workforce data.

I want to leave you with that this study is monumental in that it was represented the first time, the Institute of

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Medicine had a partner, Robert Wood Johnson Foundation, in fact my very dear colleagues, Dr. Sue Hassmiller was loaned to the Institute of Medicine. So that was unique in itself. The Institute of Medicine, one of the nation's most respected bodies, put its stamp of approval on this recommendation.

So they're not coming from nurses. These recommendations are coming forth from a very eclectic group of 18 individuals representing consumers, physicians, social workers, all kinds of individuals including attorneys who came together, reviewed the evidence, reviewed the evidence, reviewed the evidence and said there is a significant amount of evidence to support these eight recommendations and the 43 sub-recommendations.

That if we do this or when we do this, when we implement this that we can bridge the gap between insurance coverage and the availability of primary care services that we can actually produce a significant gift in what some are saying is how in the world will we care for 32 million more Americans in our country and that we must work at implementing these recommendations including the outdated regulatory barriers that prevent advanced practice nurses from being able to provide the care that they are trained to get. So thank you and I know Catherine will now talk more about this last recommendation.

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SUE HASSMILLER: I just wanted to add that I have two colleagues in the room, Brenda Cleary and Andrea Brossard and we talked a lot about implementing this report, which is quite something for the IOM and the Robert Wood Johnson Foundation but just as we partnered with the IOM on this report, we're now going to partner on an implementation campaign to assure that these recommendations get out with AARP and our own center to champion nursing in America at AARP. Catherine?

CATHERINE DOWER: Thank you. Thank you Sue and thank you very much to the Alliance and to the Robert Wood Johnson Foundation for having me here today to talk about scopes of practice and the role that scopes of practice play and will play in preparing and having a health care workforce that can deliver care appropriately in the United States.

So as most of you probably know, licensing, regulation, and determining practice authority, also known as scopes of practice or who may, not who can but who may deliver which services to whom in which settings is done by the states, specifically is done by the state legislatures. It's not done by any technical group or bureaucratic organization. So practice acts are politically decided. It's a political decision.

So there's three key results that come from that. One is that you have state variability and just to strain your

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eyes, we've put this little tiny map over there. Sorry about that but the point is that there's extreme variability. This is an example of nurse practitioners' practice authority in the 50 states and D.C. looking at whether they need to have physicians who provision or collaboration or can practice relatively autonomously.

You can do maps like this for virtually all the professions as Bob indicated. There's are a few that are exceptions but, dental hygiene is, physical therapists, PAs, nurse practitioners though are probably one of the best examples of a core match. It's hard to find any correlation.

We tried to do overlays with red/blue states, with urban/rural states. There's no correlation between any of the usual suspects that you would think. You come away from these looking at these maps with the conclusion that these decisions are political compromises that are not based on the evidence regarding, in this case, nurse practitioner competence.

The second result is of the state-based decision making is you end up with unnecessary limitations on professional practice because the nurse practitioners in this case are trained to a higher level of practice than what they're permitted to do, which limits access to care. Again this has been documented. The IOM report is a nice study that documents all the research about that.

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The third result is that, and I think this is probably the most troubling, is that these politically charged decisions are exacerbating into professional tensions. So you've got more and more tensions between and among the professions, which we don't think leads to good collaborative care.

These state variations do work for some people so it works for the nurse practitioners who are fortunate enough to be practicing in the dozen or so states that have relatively autonomous practice for them but it doesn't really work for any NPs that are going to these, the many more NPs that are going to nationally accredited schools to learn how to practice autonomously and interdependently with physicians and other practitioners and receive national certification but who practice in one of the states with restrictive practice acts.

This process also doesn't work for the nurse practitioners who may work part-time in a hospital and then work part-time in a clinic across town or across the state line that has different practice act for them.

So when they cross that state line, although that individual's experience, training, expertise doesn't change his or her practice, authority changes. It's really troubling in some communities such as Kansas City where they can actually go from one part of the city to the other part of the city and the practice act changes for them.

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It doesn't work for health care employers and payers that try to operate in multiple states. It also doesn't work for individuals, patients, consumers who move to a new state or who seek care across the state line. It doesn't work for those of us who ever get sick because intraprofessional tensions don't contribute to strong patient-centered health care teamwork. So it doesn't really work for most of us.

So looking at solutions, to address the variability as long as we're going to maintain state-based licensing, we need standards. We need to move towards national standards. This has been elusive for many years but recently, relatively recently, a consensus model was put forward. It is a consensus model on APRN practice. APRN stands for Advanced Practice Registered Nurse, so that's the umbrella term that refers to nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists. There's four groups in APRN.

So now we have this consensus model and that was developed by a number of stakeholders in the nursing profession that came together, worked on it for many years and agreed to these standards. It can be used by the states now. It will go a long way towards eliminating this variability across the states.

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So that was one of the main recommendations in the IOM report regarding scope of practice is that states move toward adopting practice acts that are consistent with this APRN consensus model that will help with the variability and will also help with the unnecessary limitation on practice and the unnecessary limitation on access to care that that creates.

The IOM committee that did a limited scope of practice recommendations just to the states, this is a multifaceted national issue now. That's one of the themes that we see in the ACA is taking on some of the duties that the states have all traditionally done but making some national points about it. So the IOM committee also recommended that Congress looked to expand or amend the Medicare and Medicaid policies to recognize and pay NPs appropriately.

One of the key recommendations that tied with that recommendation that states adopt the APRN consensus model is that federal funding for nursing schools be conditioned on states in which the school is located adopt the APRN consensus model. So that's one of the disincentives that the IOM recommended to try to get the states to go along with the standards. There's also a recommendation for CMS to clarify hospital participation requirements so that APRNs are eligible for clinical privileges, etc.

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One of the, let me just go back for a second to one of the big differences, the variability across the states, some of the details you can't see on the chart like this but it's things like they can't have hospital admitting privileges in some places. Sometimes they're limited to prescribing just for a 72-hour supply of the medication or a 30-day supply.

In some cases, there's a difference between a nursing diagnosis and a medical diagnosis although it's never clear what that really means for a patient. In some cases, nurses are not permitted to, they can assess but they can't diagnose. That's a key distinction in many states.

So they cannot diagnose death for example. They can assess it. They can say this patient seems dead [laughter] the patient sounds dead but there's a very bright line in some states that they're not allowed to actually diagnose death and many other things.

I mean I say that one because it's a little bit funny, you get a chuckle but it's a problem across the states for patients and for nurse practitioners. So, some of the recommendations in the IOM report are very specific. The recommendation also for the Office of Personnel Management requires insurers participating in the federal employees' health benefit program to include and directly pay APRNs.

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There's a requirement or a recommendation that the FTC and the Antitrust Division of the Department of Justice take a look at what's going on in the states and make sure that there's not anti-competitive behavior going on.

So as I said before while reforming scope of practice is absolutely necessary, it's not sufficient to truly improve health care. The whole scope of practice issue pales in comparison to this goal of creating intraprofessional collaborative teams but I think that I do believe that the IOM is on the right track with recommending that we do need to address the scope of practice issue as part of that effort to chip away at the divisions between the professions. So I will leave it at that. We have time, plenty of time now for Q&A and I appreciate your time and attention this afternoon. Thanks very much [Applause].

ED HOWARD: As I mentioned, there are microphones. At least one of us has discovered that independently [Laughter]. I would ask if you use the microphones to ask a question that you identify yourself, keep the questions as brief as possible and in this case, exercise just a little bit of patience because let me intervene here.

I just wanted to pick up on the theme that Catherine and Linda have sounded on the scope of practice laws. Someone remarked to me at our last briefing that every profession wants

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to, how is the recommendation phrased, every profession wants to practice to the full extent of their education and training and wants none of the professions below it on the professional scale to be able to do the same thing.

I wonder how do you sort out where the line gets drawn and are there lines between nurses, APRNs and other nurses and direct care workers that are going to have to be sorted out if we're going to get these teams done in a coherent way.

CATHERINE DOWER: Yes. I would just say that there are lines and that we often joke at our office that the loudest sound you hear after one profession gets a new or expanded scope of practice is not the popping of the champagne cork but the slamming of the door to keep everybody else behind them, not letting anybody else come in but it's not up to the incumbents what the others get to do.

It's up to each profession to demonstrate through evidence that they have the education, training, testing situations, testing new organizations in place, and competence. They've got outcomes measures in place to demonstrate that they're able to provide the services that they are providing.

The other professions are invited to comment to help develop those educational programs, develop the tests, they might want to comment on it but it's not up to, from a perspective of the analysts and the researchers, it shouldn't

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be up to the other professions to determine what another profession is doing in terms of the legal scope of practice.

LINDA BURNES BOLTON: In some states, it's very prescriptive in relationship to whether or not one group of individuals who are prepared to do X can also do Y and Z, so some of that is in at the state level. What's important and one of the things that we recommended in the work is competence.

That's what's important: competence and the ability to assure that you not only have competence just when you graduate and you receive your license or your degree but that you maintain competence to be able to deliver safe quality care.

BOB KONRAD: I'd just like to make a comment from the viewpoint of the frontline worker who is below the nursing level and are referred to generically in many nursing practice acts as unlicensed assistive personnel. That's sort of a triple negative. You're unlicensed.

You're defining in terms of what you're not instead of what you are. You're assistive because you're not helping the client or the patient. You're helping the nurse and you're personnel, you're not people or a fully recognized worker. So I think the nursing practice acts may need to expand their vision.

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I mean we've focused a lot on where nurses are relative to physicians but I think it's really important to recognize where the frontline worker is relative to the other health professions and within each of these professions, you've got physical therapy aides in addition to assistance.

You've got a whole stratum of unlicensed, unrecognized people that are shadow workers in the health care system. We've got to think about these because they're the people that are actually laying hands on and it's just a lot of work needs to be done.

ED HOWARD: Yes?

JULIE CANTOR-WEINBERG: Hi I'm Julie Cantor-Weinberg with the College of American Pathologists. One thing totally absent from the discussion today is the laboratory workforce and about 70-percent of the data in patients' charts come from laboratories.

Our members largely run those laboratories and yet we hear constantly that they're not able to find sufficient workers for those labs and that ranges from everything from the lowest paid phlebotomist to PhD workers. I think there's less of a shortage on the PhD side. They're not singled out anywhere in ACA. So I wondered if you had any thoughts on that. Thank you.

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CATHERINE DOWER: I'll take a first stab at it and then pass it to Bob. I agree with you. It's a very important workforce. I happen to be here today because I happen to be on the IOM committee on nursing and I agree with Bob but if I was here for another group, I don't have a dog in the fight about nurse practitioners and physicians.

So I've been talking about any other group that they shouldn't be controlling the scopes of practice but in terms of laboratory personnel, extremely important shortages in many of the states right now. We're trying to document it.

We actually have a grant right now from the California HealthCare Foundation trying to document the issue in California changing educational requirements, changing regulatory requirements, and because of all that, it's sometimes we've already got shortages and then the changing requirements are making it even harder for people to meet the requirements and to take the physicians where they belong. So I fully agree that that's an issue, a problem right now and it needs to be additional attention both on documenting the shortages and figuring out how to increase the supply.

BOB KONRAD: Yes. I think the superordinant professions, the pathologists and people who are responsible for the employment of these individuals have to take a more active role in defining competencies and figuring out how to

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construct effective and meaningful career ladders for these people.

Part of the labor issue in these auxiliary and ancillary health professions is the stability of the work. Many times you can recruit these people but you can't retain them because you don't have a career ladder. You don't have a good starting wage.

So figuring out how to create a career ladder and in the long-term care field, we see this a lot in nursing shortages, a part of the problems in LPN and RN nursing shortages could be made up if we could get people from the frontline workforce to move up that career ladder.

MIKE BARTH: Mike Barth, independent health consultant. This is for Mr. Teitelbaum. At the present time, what authority does Secretary Sibelius or any other part of HHS have to increase, to positively influence the scope of service rules so that nurse practitioners and other mid-level professionals could increase the amount of services they provide?

JOEL TEITELBAUM: Honestly not a lot. Certainly around this specific issue that you mention there is not a lot that grants new authority to the Secretary to define the scope of practice issues. So it doesn't really exist.

ED HOWARD: Sue you have some questions from cards?

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SUE HASSMILLER: Yes. I have one. It says what barriers to the IOM recommendations exist within and from the physician community? In other words, is the entrenched resistance stemming from competition, professional hubris that may prevent progress toward full integration of PAs and NPs and changing scope of practice laws.

CATHERINE DOWER: Well there is opposition for some of the things the IOM has recommended but there has been a lot of support also. I'm not sure how to take that question. I'm going to assume that the question was referring mostly to the NP scope of practice issue.

SUE HASSMILLER: Yes, what are the barriers to full scope of practice and particularly from the physician community?

CATHERINE DOWER: I would say I can't speak for the physician community. I would say I can't say that in the work that I've done in the states some of the organized medical groups have come out against expanded scopes of practice for nurse practitioners and PAs and other APRNs and they base it on concern over patient safety and quality of care. That's the stated opposition and concern.

The nurse practitioners have documented and that's one area that we know pretty well from having done the study that documented pretty well that quality and safety are not

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compromised and that access can be improved. So there's very good solid evidence on those points. I think I'll stop there because I can't speak for the physician committee itself.

ED HOWARD: Linda.

LINDA BURNES BOLTON: Well I certainly can't speak for the physicians either. I will tell you that as Catherine indicated, there have been physicians group who've come out in support and that's because there is so much work to be done. There is so much work to be done. We need the physical therapy aide. We need the home care worker.

We need the community health worker. We need nurses. We need physicians. There's so much work to be done that there's not any one group who will be able to do all that work and that just as Bob indicated, there are opportunities, for example, we know in nursing that if we can take certain parts of the work and give it to this group then nursing can do its part in relationship to its education and practice.

The same is true in relationship to physician practice so other crossover areas and that's what this report speaks to is the crossover areas where nurse practitioners are working particularly in primary care and to address the fastest growing issue in our country in terms of what costs in the delivery of care and that's chronic health. Managing chronic health requires that we have many more individuals who can deliver

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primary care. We need physicians. We need nurse practitioners. We need physicians' assistants. We need them all.

ED HOWARD: if I can interrupt for a commercial, we're going to do a briefing on Monday the 13th – is it? – of this month specifically looking at primary care and the changes and the delivery and payment systems that might alleviate some of the problems that Dr. Burnes Bolton was talking about. Yes, go ahead.

ARTEM GULISH: Artem Gulish with Citizen Advocacy Center. My question is what role do you see in defining this new roles for different health professionals for consumers and the general public and also how do you see mechanisms for communicating to consumers what health professionals are available to them and what they can do for them in this changing health care workforce?

ED HOWARD: Very good question.

CATHERINE DOWER: Can I start? First of all thank you. That's a terrific question and I know you, Citizen Advocacy Center has done a tremendous amount of work trying to make these issues known to public groups and public advocacy groups. That's a good start getting public members on the boards, on the state boards, tremendous work over the past couple decades.

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I think that getting the AARP involved as a partner in implementation plan is a phenomenal way to get, for the first time that I'm aware of, a major consumer group involved in a health workforce implementation plan. It's really impressive. So I think that that will go a long way in trying to get the word out to the patients and consumers about what's going on.

I think that everybody involved in health care has a role in getting the word out about these issues to consumers because I think it is, I agree with you that many consumers don't know about the variation across state lines until they try to move.

It's really surprising. They don't know about the lack of continuing competence requirements. There are so many things that consumers don't know until they're faced with a crisis and that's the worst time that you want to learn about something like that so good point. I think that we're making some steps in the right direction but I think there's a lot more work to be done in that area.

JOEL TEITELBAUM: One comment, it may be a little obscure for most consumers is commenting on proposed regulations. The law itself, the statute itself is about 2,300 pages long. In a normal world I mean if it were really moving with full implementation that would probably generate almost 15 or 20,000 pages of regulations.

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So what the ACA means is really yet to be determined and that will be determined in large part through federal regulations. So to the extent that people can be alerted about and tuned into and commenting about the proposed regulations could go a fair way in having them have some ability to influence what will happen going forward.

BOB KONRAD: Yes. I think also the personal care workforce advisory panel would be a good channel to focus some of those comments, essentially the CLASS Act, which was part of this legislation, essentially empowers people to hire their own caregivers if they're at home and receiving care.

The biggest growth in the long-term care sector in the frontline workforce is going to be in home and community care. Institutional care will not grow as rapidly. So figuring out how those particular caregivers can be qualified and how in some states family members are empowered to take on these roles and those two things are very closely intertwined.

We found in North Carolina that 15-percent of our new frontline caregivers were, actually, came to that through care of an aging relative and then realize they were good at this and moved into this as a full-time career.

LINDA BURNES BOLTON: I just wanted to add that the members of our committee really saw consumers as being part of the health care team. They're not outside of it and we had

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many examples of how consumers working at the local level and state level as well as national programs like the nurse-family partnership, which is a good example of how consumers have worked with nurses in terms of the delivery of care.

ED HOWARD: Let me just ask, are there consumer, did I hear someone say there are consumer representatives on the workforce commission or not?

LINDA BURNES BOLTON: I don't think so.

BOB KONRAD: There are members of lower level occupations on the commission but not consumer representatives I don't think.

JOEL TEITELBAUM: No, in fact there are, the statute does set out the categories that have to be represented on the committee and representatives of consumers is one of them.

ED HOWARD: So that may be another channel for informed comments from a consumer point of view. Thanks Joel. Yes go ahead.

PATRICK COONEY: Well first of all thank you for this briefing. It's been very important and helpful. My name is Patrick Cooney. I operate the Federal Group and we represent a number of the health professional groups that you've been speaking of, American Physical Therapy Association, American College of Nurse-Midwives, American Academy of Audiology, [American Academy of] Clinical Lab[oratory Physicians and

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Scientists], [American College of] Radiology, a number of them and I'm struck by I guess a couple of comments.

Well first of all I want to say the Institute of Medicine's support of the future of nursing is fantastic and I commend all the work of the various people in this room that worked on that. I think it's a really important report because what it does is it highlights the barriers to practitioners working within their existing scope of practice.

I was struck by, like Catherine's comments about scope of practice, I think the challenge is not so much to, there are still some work that probably needs to be done in the states on specific scope of practice laws but the bigger challenge or opportunity that I see across the many professions is to allow the federal government to allow these health professions to operate under their existing scope of practice.

I'll just give two examples. One of them was addressed within the Accountable Care Act nurse midwives have been reimbursed pitifully low under Medicare for years and years, 65-percent of what a physician would receive for similar services. So the ACA corrects that by now bringing them up to 100-percent reimbursement.

So as of January 1st they'll get full reimbursement for the services they provide but because Medicare was paying them at such a pitifully low rate, Medicaid plans have been as well.

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So about half the states paid midwives 100-percent equal to their physician counterparts but the other half of the states pay somewhere between 65-percent and 95-percent.

I think there are numerous examples of this where these are not major changes in law. They are modest changes that actually don't cost a great deal of money that could allow these health professionals to operate within their existing scope and then hopefully provide a wider array of professionals to address this expanding population that we're going to need to serve. So I just wanted to throw that out to you.

ED HOWARD: Comments, questions, responses?

JOEL TEITELBAUM: Okay, can I make one point? It's interesting that you chose that provision. In the entire statute that is the only place where the term scope of practice is used. One time in 2,300 pages of the statute and it is only used because it wanted to make clear that by virtue of that reimbursement change, they were not doing anything to affect the existing scope of practice.

So it had nothing to do with expanding it but making sure that it is not expanded. So that gives you a sense, I should have mentioned this in my response to the [inaudible] gentleman who asked about the scope of practice in the ACA. It's all handled at the state level and the new federal law does nothing to change that.

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ED HOWARD: Thank you, yes. Let me just follow up if I can ask your forbearance for a minute because it ties in, this question that was submitted on a card ties into some of the remarks that Bob was making about the state's roles in addressing these problems.

The questioner writes given the political sea of change at the state level on November 2nd, i.e. 18 state legislatures going from Democratic to Republican and 29 Republican governors now, how will the repeal effort on Obamacare or the starve effort play on the implementation at the state level including scope of practice laws. Any speculation?

CATHERINE DOWER: Well I can't comment on the whole legislation but in terms of scope of practice, I think that there's enough momentum now going on because of the APRN consensus model. That's going to be moving forward independent of the federal legislation that was passed this year. So many of the states, five states have already passed legislation consistent with that consensus model. I understand 18 states are considering legislation. As I said when I had my map up here, these decisions don't break down by Democrat/Republican. It's not a partisan issue and it's not rural versus urban. There's no classic distinction.

So I mean some of you might have some thinking about which way to lean one way or the other but we really do have

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examples of states where you've got very conservative legislators and conservative governors who have progressive scopes of practice; it's not a partisan issue.

So I think that the scope of practice issue has become more of a concern about access to care and this lack of consistency because we have intrastate companies now, health care systems and insurers and others who are, and we also have telehealth, which no one's mentioned but we actually have the ability to practice across state lines and a lot of people are using that now. So these other drivers are going to push that move towards standardization independent of the health care legislation.

Although I think that one of the roles that the health care legislation will play is that there's money and support for innovation. I think that that concept of innovation just testing new things out will help drive some of the changes but I do think that this path is already taken and people are moving along it.

BOB KONRAD: I agree with Catherine. I think one of the issues that is more consistent with the Republican position is issues of health care liability and insofar as liability issues have to do with task delegation either from physicians to nurses or from nurses to nurse aides, I think the liability issues may affect how these things get played out but it's up

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in the air and courts decide those things as well as legislators.

ED HOWARD: Okay. While we're reading the 27 cards that just got forwarded up here, let us turn to our microphone.

MARY MULLANEY: Hi, my name is Mary Mullaney. I work at CMS but I'm talking as having been a bedside critical care nurse for many years. I'm curious what the panel thinks about nurse to patient ratios. With respect to your comment on competency, I think we need to be cautious in that nurse competency is one thing but unrealistic workloads are another.

If you have six patients on day shift and you have one patient that goes bad and even if it's just that they need a couple of pints of blood, the day is over candidly. How do you think that one thing, but how do you think also the nurse-patient ratio issue will affect hospital-acquired conditions and readmission rates, which is now come through the Affordable Care Act and could potentially negatively impact hospitals on a financial aspect?

ED HOWARD: Presumably Linda.

LINDA BURNES BOLTON: Yes. First of all, the report does not address nurse to patient ratios. There are a fair amount of studies that have been done on that including some that I've done. The report did take a look at the issues of the nursing practice environment, which includes not only how

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many patients a nurse has assigned but whether or not that nurse has an environment that is safe that he or she can provide care in.

We gave examples of what should be in those environments and the recommendations about nurses being engaged to lead change in their institutions address that because in those institutions where the practice environments have changed and where there's excellent physician nursing relationship and where there's significant amount of support for nursing autonomy of practice, which includes decisions about staffing that you actually had better outcomes.

So I'll refer you to a couple of articles in that. The special edition of the *American Journal of Nursing* that was published in October of 2009 where we made the business case and it happens to be in the state of California, which does have ratio law that if you could improve the amount of time nurses spend with patients so that they're not running around, they're not spending so much time in, for example in documentation, which in our country as 30-percent of the nurse's time.

If you could undo that, you actually could decrease the incidence of hospital-acquired conditions including the admission rates, infection rates, medication errors, so forth and so on. So the practice environment is where we went to

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instead of the ratio. Ratios are just part of that practice environment issue.

SUE HASSMILLER: We have a lot of questions still on scope of practice. I'll squeeze one in for you sir if I might. Under the, everybody has patients that are in medical homes on their mind and this is a question in regard to that, under the patient-centered medical home model, primary care physician practices are and/or will be required to integrate health coaches.

These health coaches positions are and will be filled by mostly by RNs or MAs, medical assistants I would assume. Do you think the model will allow RNs to utilize their licensure to the fullest extent or require them to undergo more training to be part of the medical home? Does this model have the potential to change the future of nursing and strengthen primary care in the meantime?

LINDA BURNES BOLTON: Well I'll take a first stab at. While our report doesn't address that specifically, we did address the issue of the importance of intraprofessional collaboration in the design and the delivery of care.

So we would say that the medical home or some are calling it the health home will require that we have both nurse practitioners and physicians and others to be able to do that. If you look at some of the models that are already out there,

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so you could integrate delivery system models like Geisinger and Kaiser and Cleveland Clinic. You say well that begins to get at it.

How do you take that and expand it? You can only expand that if you allow all health professionals including nurse practitioners, to practice to their full scope. So that was our recommendation not necessarily to say indicating what role nurses would play in that.

The fact that your question says nurses or MAs is an interesting one. In the oncology world, the navigators that exist don't come from any one specific discipline. So the idea of being able to help people as coaches isn't limited to any one title of the health professions.

BOB KONRAD: Yes. I think that's really important and there are provisions in the legislation for patient navigators with the oncology people got in there. Again states and institutions should be very creative in interpreting this but I think for the frontline health worker the idea of identifying and certifying very specific competencies and getting people recognized for having those competencies, having a career path, having a training, having periodic recertification, all those things will enhance quality and create clarity for those frontline health workers so they can actually move through the system.

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More and more chronic disease management requires long-term personal relationships between someone on the care team and that individual. You're going to prevent those hospital readmissions. It doesn't take an RN necessarily to remind somebody to take their medicine or to help them if they have congestive heart failure to weigh themselves every day.

It could be a person with very little training but very focused skills and competencies.

CATHERINE DOWER: I would just add a couple of points. I agree with that, Bob, that in our work looking at primary care new practice models using medical assistants in particular, they are often choosing, the employer's choosing medical assistant over the RN because the RN would be not practicing to their full scope in that particular environment.

So that's different from the NP practicing as a clinician in those settings but in terms of the RN practicing in the role of an MA, often they're using MAs instead and that the focus will be on competencies and identifying the services that need to be delivered whether it's primary care services or educational services or whatever it is and identifying the people that can best provide those services based on competencies rather than looking at numbers of professionals by profession.

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Then just one final comment, the IOM report did recommend that we have these residencies, these transition-to-practice residencies so that we are moving to new models, innovative practice models such as the health home or some other such thing. RNs and others, well RNs in particular in this case would be trained to move into that new setting because it would be significantly different.

So the IOM envisioned some sort of a transition to practice residency program to help people move into those new environments.

DAVE MASON: Thank you. Dave Mason representing three different nurse practitioner organizations, the American College of Nurse Practitioners, the National Association of Pediatric Nurse Practitioners, and the National Organization of Nurse Practitioner Faculties and first of all, I want to join in thanking IOM and Robert Wood Johnson for such a visionary report and pathway to the future. Along that pathway, I know the report addresses issues that the Accountable Care Act raises in terms of interdisciplinary care and innovative models of service delivery, medical homes, health homes, and accountable care organizations.

In terms of what the report says about leadership and nurses being in interdisciplinary leadership positions, can you speak more to what we need to move forward on areas that we

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need to move forward on to make sure that nurses have that role in those kind of innovative models?

LINDA BURNES BOLTON: So the report addresses, I will tell you that at one point in time, we were throwing around themes about what the report should be called and one theme that got thrown out on the table was nurses must lead. What's behind that theme is first nurses themselves must take up the mantle to lead.

So when you say what does the report say, it says come on, while we believe that this is a societal issue and that everyone should be helping nurses to be able to do their best work, nurses first themselves must say I'm standing up. I'm going to help lead that change. So that's number one.

Second is that we must do a better job of preparing nurses to assume leadership roles. That comes in not only in terms of what happens in nursing education but also what happens in terms of nurses being placed into positions where they can lead. Leadership is a practiced art. You do it once, you get better at it.

So continuing to support nurses being placed in not just leadership roles when you think of, like in acute care organizations, where someone's a chief nursing executive like me but more let's get more nurses who are taking their knowledge, who are sitting on insurance boards, who are sitting

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on banks, who are sitting on all other kinds of those in society to be able to talk about the work that we do of human caring.

So first nurses themselves must lead. Second nursing organizations like the three that you talked about, which were participants at our summit working together and not being so diffuse and then nurses must be prepared to lead in a variety of ways not just in health care.

ED HOWARD: Bob?

BOB KONRAD: Yes. There was a movement a few years ago among the boards of nursing to specifically recognize, if not mandate, competencies in supervision and improving and capitalizing on a coaching style of supervision for both registered nurses and even LPNs vis-à-vis the nurse aide has proven to be a really important element in strengthening the quality in long-term care. We have emerging studies now showing that nurse leadership in that particular area is leading to better quality outcomes in the management of long-term care.

Particularly where you're trying to supervise nurse aides or home health aides and you can't be there in person, you've got to have a very strong relationship with that nurse aide. I think that's an area that we really have to look at and strengthen.

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SUE HASSMILLER: I'd like to add something and that is we are in an era of innovation and change and the ACA has afforded us the opportunity. I think this report and other reports have afforded us this opportunity and I think that there should be pressure on the CMS Innovation Center in particular to really look at new ways, new models of providing care in this country.

I think if anything, there is a lot of pressure to keep things as it is. We have the opportunity to give advice to the CMS Innovation Center at this time and I would behoove everyone in this room to think creatively out of the box and give them ideas. They are open to ideas at this moment. They are getting some but from what I heard, it's a lot of the same old same old. Let's be creative.

ED HOWARD: Okay, Sue has a number of questions on cards and we have only a few minutes left. Let me just say as you listen to the question and the response, you might be filling out those blue evaluation forms so that we can make these programs better for you in the future. If you're absolutely hell bent on making sure your question gets asked, you'd better come to a microphone in the couple of minutes we have left. Sue?

SUE HASSMILLER: So considering that this might be the last question, I'm not sure, it seems like it's an appropriate

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one for every single panelist here. So I think it's a really terrific question. We've heard a lot about problems and achieving an optimal workforce, I'd appreciate the panel's view of what constitutes a dream team, the name of this panel today. Panelists?

BOB KONRAD: Well I think the dream team is one that recognizes foremost the central role of the patient in that team. That's somebody who isn't at the table here today in any explicit way but I think if in every decision that's made and every judgment about the composition of the team, the welfare of the patient is central, I think that will be what will guide us in constructing the appropriate team for every particular circumstance. That's a little vague but I think it's really true.

LINDA BURNES BOLTON: Well I think that the dream team is going to vary based on the patient populations. So if we're talking about someone who is a quadriplegic that dream team member, besides having a physiatrist and perhaps having a physical therapist but also who has a personal health worker who is able to assist them in their home. If you're that new mom with triplets and your mother lives way across the other way about 2,000 miles away, your dream team might consist of a nurse midwife, a lactation consultant, but again someone who's going to be in that home.

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So my point is that it is not cookie cutter. The dream team must first be able to determine what is it that that consumer needs and then how can I provide it in the most efficient and most effective way, defect-free, that would be good and be able to have it when I need it, so the right amount of care, right type of care at the right time. That takes a variety of team members based on different populations.

JOEL TEITELBAUM: If you ask me, clearly what we need are more lawyers [Laughter] but actually I'm not completely kidding. I'm going to pick up on a theme that the two of you mentioned is what we didn't talk about today.

I actually don't say this with any real dog in this fight either but there is a growing movement toward the idea of a medical-legal partnership centered around the patient. The idea being that there are many conditions that you can treat but not fix or cure unless you address the underlying cause of that. A lot of those causes stem from home environments and other environments where the clinician of whatever type cannot actually effectively deal with.

For example, if there's a child who has chronic asthma and that asthma's being exacerbated or caused by conditions in the home, whether it's a lack of heating, whether it is vermin, whether it's any other number of things, that child can keep going to the physician and can keep being treated for the

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asthma but unless you bring in an advocate, a legal advocate who can help address the underlying problem, you're never going to be able to truly get at the root cause of that.

So there is actually a movement, there is a national center being run out of Boston right now called the National Center for Medical-Legal Partnerships.

They have actually had quite a bit of success in the last few years. They have been very successful in lobbying Congress for some money for a demonstration project. It looks like they're going to be successful, fingers crossed, but anyway the idea being focused on the patient but also that there are additional members of the dream team that perhaps we didn't discuss.

CATHERINE DOWER: That is great. I love that idea [Laughter]. No it is really good. I was going to add, I wasn't going to add the attorneys because we've got enough of it but I was going to add we look at all 200-plus recognized professions in this country, we're very fortunate in this country to have that many recognized professions but it also creates some havoc and some lack of understanding, some distrust.

I think whoever's on the team needs to trust each other, know what each other does, understand what each other's capable of doing. I mean those are the key things. It's like

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cultural competence with the patient. You need to understand the patient and you also need to understand the people with whom you're working.

I had the fortunate and unfortunate circumstance, recently my son was hospitalized. It was rather a scary, traumatic situation because they didn't know what was going on and unfortunately at one point because the medical professionals could not all decide what the situation was for the first 48 hours, the groups divided up into teams.

The different doctors and nurses and aides all divided up into their own teams. Each team had its own thought about what was going on with my son. That was not a dream team [Laughter]. I've gotten more gray hairs than I needed to get over these past couple weeks.

So it's not about dividing up into little teams that you're going to play against each other as on the playing field. It's a group of people working together for the interest of the patient. So I mean the dream team concept, the wording is good in some ways but I also, I just caution us to make sure that we're not setting up teams of professionals who then are going to fight against each other. We need to again develop a group of people who can work in the patient's interest. Thank you.

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ED HOWARD: Good summary comments. All I can say is I know that the dream team is neither the Wizards nor the Redskins [Laughter]. I think we have just about run out of time. I want to distribute some thanks. First of all the Alliance staff did a terrific job in scrambling to make this briefing [Applause] come off both in the long-term preparation and the short-term execution of some last minute additions. I commend to you the webcast that'll be available tomorrow on the Kaiser Family Foundation, kff.org, website.

I want to thank the Robert Wood Johnson Foundation again particularly Sue Hassmiller for literally helping shape this briefing and give us the grist about which we could talk. I want to thank all of our panelists but I want to say a special word about Linda Burnes Bolton who is not only a brilliant scholar and an eloquent speaker but a new member of the Alliance for Health Reform board.

So she's a particularly welcomed guest today [Applause] not to say that all of the other panelists haven't done us a great job and I ask you to join me in thanking them for helping us do that [Applause]. So we'll try it again next Monday on primary care.

[END RECORDING]

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