Past Event: 2022 NCSBN APRN Roundtable- National APRN Workforce: Strengths and Challenges in an Emerging Post-Pandemic "Normal" Video

amounts of insurance, and those individuals who are qualified for both Medicare and Medicaid, the dual eligibles, very poor individuals, often with very complicated, numerous comorbid conditions that are difficult and expensive to take care of.

I've got a reference here at the bottom of the screen, that at the end of the presentation I've included three or four slides that list the references to studies that backup this third strength, and also this fourth strength.

Well, we'll get to the fourth strength, I've got one more slide before there. This is data from the "National Sample Survey of Registered Nurses" that was conducted in 2017 by the Health Resources Services Administration, and the Census Bureau. So, what was found is that NPs, 71% reported that at least a quarter of their patient panel were among racial and ethnic minority groups.

That was the terms that were used in this study, so I've just provided them here to be as completely accurate as possible. Twenty percent of NPs said that at least 75% of their patient panels were from racial or ethnic minority groups.

And then about a little more than a quarter of NPs said that 25% or more of their patient panel had limited English proficiency. So again, NPs providing a lot of care to vulnerable populations. Here's the other strength that I wanted to note.

And I wanted to bring this information to your attention. It's been my experience that when you talk with APRNs, and particularly nurse practitioners, they're well versed around the strength and evidence around quality of care. And I wanted to just, you know, kind of provide some other information that expands our awareness of the contributions of nurse practitioners beyond quality.

So, I want to go through these. And again, you'll see these slides will be referenced at the end of the presentation. But this first one, decrease in the number of payments made by physicians for malpractice rates. This is a study that Ben McMichaels did, that showed that in states that had less restricted scope of practice laws, the malpractice payments made by physicians decreased by as much as 31%.

Tell that to our physician colleagues, that might get their attention. With regard to the lower rate of use of emergency departments, we knew that as the ACA was passed, and that states were going to expand their Medicaid coverage, that there was a chance, a good chance that use of emergency departments would increase.

In fact, the studies have shown that's what happened. McMichaels shows that the increase in ED use was lower in states that had no restrictions placed on nurse practitioners.

So, ED use went up across the board, but it was lower in the states without restrictions. Now, McMichaels also did an analysis of more than 70 million births in this country over the past 18 years and found that states without restrictions have lower caesarean rates. So, powerful information there.

The fourth one on the slide about access to rural and vulnerable populations, we've talked a little bit about that already. But a study by Wendy Xu at Ohio State University was able to identify that the dual eligible population is clustered in southeastern states in rural counties, the very areas where there are physician shortages, and the most scope of practice restrictions on NPs.

And finally, with regard to improvement in mental health, a study done by economists at the Federal Reserve Bank of Chicago, looking at 24 years of data, and identifying independent prescriptive practice authority by nurse practitioners, particularly those in psych and mental health, showed that in states that did not restrict the practice, the very favorable outcomes in terms of self-reported mental health was

practitioners, we could be at a point where now that those emergencies are leaving, or are no longer in existence, we could return back to imposing scope of practice restrictions.

And this would be a really regressive move. And I would just simply say to you who may be in that situation to ask for the evidence where people were harmed or died as a consequence of nurse practitioners being allowed to practice without these restrictions during COVID shows that evidence.

This was a natural experiment, and they won't be able to show that evidence. And so, why would we want to go backwards versus going forwards? So, I really think it may also be a time where the leaders of our APRN organizations and particularly nurse practitioners may want to develop some television advertising on this issue for national audiences, bringing in states that have had the benefit of lifting scope of practice restrictions to weigh in on the experiences, the positive experiences that they've enjoyed, why shouldn't this occur throughout the rest of the country?

Maybe we need to sit down our leaders with the editors of "The New York Times" or the "Wall Street Journal" or the "Washington Post" or others and have a conversation about what's happening with the nurse practitioner workforce. I think we're just at an opportune time to make significant change, so that in a few years we won't have to be looking at these maps as we progress through this decade ahead.

All right, the fifth challenge is a challenge that I think you're familiar with, and that is the challenge of growing demand for healthcare originating out amongst society, pressing in on our healthcare delivery systems, our physician workforce, all other workforces, including nurses, particularly.

And sort of the basic point here is that we just don't have the numbers of APRNs, and for that matter, the nursing RN workforce who are trained in the right specialties and providing care where they are needed most.

And this gap is not new. But I think we've not paid much attention to it with COVID, understandably, but now, here it comes again, and we need to be taking, I think, a more firm stance at addressing these gaps, because this will require some tough decisions that I want to just speak to a little bit about, which

First of all, on the growth in demand, we have 70-some million people in our population born in the baby boom generation or earlier who are ageing. And you can see some of the information here on medical visits that have increased over time. Before the pandemic, it was an estimated 40 million people had diagnosable conditions in mental behavioral health.

I've seen estimates where that's doubled as a consequence of the pandemic. We have an estimated 80 million people without adequate access to primary care. And then, with regard to high maternal mortality, it was just beginning to drop a little bit before the pandemic, but I just saw some recent evidence that suggests that it increased again.

Since then, so now, if you look at the supply of nurses, and I included RNs as well as NPs on this slide, you can see we're not able to provide the numbers of RNs or NPs in geriatrics, in mental or behavioral health, and in primary healthcare even though we've done a lot here, still not enough.

And we have a slow growth of certified nurse midwives that we really need to ramp up as well. Now, I feel that we need to close these gaps. This is what societal health needs are going, and we are lagging behind. And I think to address these, we've got to look at what educators value.

Do we value producing a workforce that addresses the needs of society, or do we value more producing a NP or APRN workforce that fulfils professional interests? So, it's a question around values.

It's also a question about balance. It's not to say that we should not be educating specialty care NPs or others, that's not what I'm saying. But we do need to look at the balance, are we producing enough who will be able to be in working productively and effectively in multiple community settings, non-acute care settings? So also, I think that we may be really at a point where we need to hold nursing education programs accountable.

There is a lot of money that has come into the health workforce community over the past couple of years, thanks to COVID, and some of the bills that have been passed by Congress.

And it's a huge amount of money. We need to hold not just nursing but all of our workforce accountable to producing nurses that will be able to respond to primary care needs, geriatric care needs, our growing population, behavioral and mental health, the challenges of maternal health care, how to better address social determinants and health equity.

If our workforce is not prepared for this, and we already saw evidence from the 2018 survey that NPs feel they don't have that preparation, why should we fund our education programs? So, I think this is a serious challenge, and I want to be firm about them.

Now, if we're going to take on the challenge of narrowing the gaps between the demand for healthcare and what nursing is producing, it'd be a lot more effective if our education practice research and policy approaches integrate what we know about social determinants and achieving health equity.

I think that is happening, you see a lot of good signs of that, so I think we're moving along in the right direction there. If you haven't seen the report, there's lots of information on how that can be achieved in our education settings, and lots of recommendations for practice and research and leadership as well.

Now, the last challenge, before I conclude, is what I want to talk about is sort of the wise use of our comparative advantage, What I was talking about earlier. Now, we have this shift away from fee for service payment towards value-based payment. This shift has been endorsed by both Republican and Democratic presidents over the past 10 years, and it has been enjoyed bipartisan support in Congress as well.

And the movement is slow but steady and going to be picking up pace. And this is going to be increasingly affecting where NPs work in hospitals, non

This can be exploited for the benefit of the workforce and also to the benefit of the populations that