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Dr. Scharmaine Lawson ([00:16](#)):

To obtain their licenses, nurses go through years of training, education and clinical experience. Advanced practice nurses go through even more extensive training. And with this education and training, they have the authority to prescribe medications, diagnose and treat illnesses and manage chronic diseases. Nurses have substantial expertise and this expertise can help more people access high quality care.

But there's a problem in many places in the United States. Even though advanced practice nurses have the training and education to do things like assessing people, diagnosing, prescribing medications and conducting telehealth visits, they often aren't allowed or aren't paid enough to do so.

Dr. Mary Joy Garcia-Dia is the President of the Philippine Nurses Association of America and has specialized in nursing informatics. Throughout her career, she's received a lot of feedback from fellow advanced practice nurses who weren't allowed to practice to the fullest extent of their education and training even though they were equipped to do so. One story stuck out to her from a nurse practitioner named Dr. Danilo Bernal.

Dr. Mary Joy Garcia-Dia ([01:31](#)):

Dr. Bernal, he decided to work in a emergency room after experiencing burn out from working full time in another facility. He was surprised that doctors in this new hospital refused to let him work in the main emergency department area. But instead, he was assigned to work mostly in rapid care or urgent care area.

When he asked the reason why he cannot work in the main ER despite his previous training and experience, he was told that he is not a physician and that his training, education and background is not enough.

Dr. Scharmaine Lawson ([02:13](#)):

It didn't matter that Dr. Bernal had the proper qualifications to work in the emergency department. The hospital saw him as unqualified simply because he wasn't a physician. Unfortunately, this is the reality for many advanced practice nurses. And when nurses aren't allowed to practice to the full extent of their training, a lot of people miss out on access to high quality care.

This is The Future of Nursing, a series from the National Academy of Medicine based on the recently published report, The Future of Nursing 2020 to 2030: Charting A Path to Achieve Health Equity. I'm Dr. Scharmaine Lawson. I'm a nurse practitioner and I'll be taking you through the stories of nurses confronting health inequities. And together, we'll learn how nurses can use their unique skills, knowledge and dedication to address health inequities and overall improve the health and well being of the nation.

Right now in America, there are barriers that keep nurses from practicing to the top of their education and training. In this episode, we're going to learn how these barriers impact health outcomes, how they can be removed and why it's critical to remove them if we want to advance health equity.

A nurse's scope of practice varies from nurse to nurse. It all depends on what kind of licenses they've earned. And what kind of training and education they've received. Dr. Ashley Darcy-Mahoney is a nurse practitioner and she gave us an example of what her scope of practice allows her to do.

Dr. Ashley Darcy-Mahoney ([03:59](#)):

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I am a neonatal nurse practitioner. And so one of the things about scope of practice for me that's important is that as a nurse practitioner, my scope of practice is for children, aged zero to two years old. Beyond two years old, I would not practice under my own license or education and training because I was not educated and trained to be a nurse practitioner for people beyond the age of two.

I am also a registered nurse. As a registered nurse, I can provide care across the life span under the scope of practice as a registered nurse. Which means I could provide nursing care as an RN to somebody that's an adult or a teenager, but I could not do that under advanced practice license.

So I would prescribe medicine, for example, to a 20 year old. But I could prescribe and do prescribe medicine to infants in a hospital.

Dr. Scharmaine Lawson ([04:51](#)):

Dr. Darcy-Mahoney is allowed to prescribe medicine to infants under her advanced practice license. This is one example of what a nurse's scope of practice can entail. What's important to acknowledge is that there are certain health systems and certain regions in the country that still would not allow Dr. Darcy-Mahoney to practice in this way.

There are a few reasons why advanced practice nurses are restricted from practicing within their full scope of practice. One reason is that some public and private health systems refuse to recognize the qualifications of an advanced practice nurse.

This is what Dr. Bernal experienced. However, Dr. Bernal had a very different experience at another health system, even though he had the same training and qualifications.

Dr. Mary Joy Garcia-Dia ([05:35](#)):

He also experienced and had the chance to work and be trained as a family nurse practitioner for over four years in another emergency room department. And it is a training and teaching hospital. And this is why after he completed his family nurse practitioner program, he was able to practice in the main emergency to eval with patients, diagnose, order and interpret diagnostic tests. He was able to initiate and manage treatment, including prescribing medications and controlled substances, doing admissions, transferring and referring patients under the supervision of his attending physician.

Dr. Scharmaine Lawson ([06:17](#)):

In this particular setting, the physicians and health system had a much more inclusive perspective and team based approach that supported the role of advanced practice nurses.

Dr. Mary Joy Garcia-Dia ([06:28](#)):

He was very lucky that the physicians that they had worked with incredible group of doctors who were not only working as clinicians, but educators as well. They treated him as one of their colleagues and he was afforded the respect of a medical provider and being part of the care team. He said that he would love to work in an environment where doctors respect nurses and treat nurse practitioners as a team member, allowing them to practice at the top of their profession and education.

Dr. Scharmaine Lawson ([07:00](#)):

Dr. Garcia-Dia remembered another story where another health entity attempted to restrict a nurse practitioner.

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Dr. Mary Joy Garcia-Dia ([07:07](#)):

One other example that Dr. Eliza Green, another nurse practitioner that we have had experienced is while she was trying to order a cat scan of the abdomen and pelvis with contrast to her patients. The facility refused to do it and demanded that the script be written by a doctor instead of a nurse practitioner as they do not recognize nurse practitioner in their diagnostic facilities.

Fortunately, the doctors that she worked with are very supportive and told the manager of the facility that they do not nurse practitioners, they will send their patients somewhere else. From there, they have changed their practice since then. And now included nurse practitioners as recognized providers in their facility.

This example, Eliza have always learned from it and teach her student that if they're going to work for a practice, to make sure to investigate if the doctors are supportive of nurse practitioners.

Dr. Scharmaine Lawson ([08:09](#)):

Public and private health systems often have the power to recognize the qualifications of advanced practice nurses. When they do this, they can then allow these nurses to fully practice in what they have been trained to do. But this is only part of the problem, because while health systems can lift their own restrictions, this can only be done if there are no state or federal laws that put those restrictions there in the first place. And unfortunately, there are many states in America that have these barriers.

Dr. Ashley Darcy-Mahoney ([08:41](#)):

We have, across the United States, a group of states, 20 plus states and the District of Columbia that have scope of practice laws that don't require nurse practitioners to practice in collaboration with or under a physician colleague.

We have another subset of states who have other collaborative agreements. And finally, a third set of states who have what we would call the most restrictive laws that require nurse practitioners to practice under, I would say, the authority of a physician. And those can be challenging in some ways for patient care, depending on what laws entail.

Dr. Scharmaine Lawson ([09:17](#)):

When laws restrict nurses scope of practice, patient care is heavily impacted.

Dr. Mary Wakefield ([09:23](#)):

More than 80 million people live in areas of the United States that have been designated shortage areas of health professionals.

Dr. Scharmaine Lawson ([09:30](#)):

That's Dr. Mary Wakefield. Dr. Wakefield has spent much of her nursing career working in public health policy at the federal level. And she's witnessed the impact scope of practice laws have on communities.

Dr. Mary Wakefield ([09:42](#)):

The research is so crystal clear about the quality and the accessibility that advanced practice registered nurses provide to the communities that they serve. It is so crystal clear that in those places where these

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advanced practice registered nurses do not have the ability to practice fully to the top of their education is a lost resource to individuals and families and communities.

These restrictions are really an artificial artifact of regulation and law that stands in the way of individuals and communities having full access to clinicians. In this case advanced practice registered nurses who can provide a wide array of health care.

And in the process, providing some of the very best care that can be available. So removal of those restrictions critically important to expand access for the millions of Americans that currently don't have it to the extent that they should.

Dr. Scharmaine Lawson ([10:49](#)):

To make these restrictions even more complex, the scope of practice laws vary across states. This can really create challenges, especially during a public health emergency.

Dr. Mary Wakefield ([11:01](#)):

So this business of having an artificial difference applied from one state to another is just that. It's an artificial restriction, a difference that really can create challenges, especially in areas that need nurses and need them quickly, like traveling nurses.

That was the case with COVID last year where some of the governors of some states recognizing that they were totally overwhelmed in their hospitals with inadequate numbers of nurses given the patient loads that were coming in and setting up tent structures, et cetera, had to build out more beds for patients.

The rate limiting factor often wasn't whether or not they could create more space with a bed in it. The rate limiting factor to provide care was did they have registered nurses licensed in that state to provide care? Did they have sufficient numbers?

Dr. Scharmaine Lawson ([11:51](#)):

The COVID pandemic forced many states to examine their policies that restricted nurses from being able to practice.

Dr. Mary Wakefield ([11:59](#)):

I think that it really took the pandemic to lift up the challenges of state by state licensure and the inefficiencies of getting a license rapidly to be able to practice in another state. I think it took the pandemic. And the reason why, perhaps, it took this pandemic was because a lot of disasters that we've seen in the United States play out historically have been local or regional.

So for example, flooding or a tornado or a hurricane where a city or a state or, perhaps, a couple of states are impacted. But in this case, we had the need for nurses all across the United States in state after state where traveling nurses were moving quickly.

And there was a real challenge as states were competing for those nurses to get them to the locations where they were needed to practice most expeditiously. So I think the pandemic put a very sharp focus on this challenge.

Dr. Scharmaine Lawson ([13:01](#)):

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The lifting of restrictions because of the pandemic revealed this: the barriers that restrict nurses from fully practicing, they can be removed.

Dr. Mary Wakefield ([13:09](#)):

So some governors stepped forward and lifted those restrictions and basically said, "We'll accept nurses who are licensed in another state." And they applied much more efficient processes of then going through the process of getting a license from the state needed that nurse. They really removed barriers state by state when they were being overwhelmed by patients diagnosed with COVID-19.

So there are ways around this. The governors have moved restriction in emergency situations. But it should not take an emergency to help facilitate nurses getting to patients and populations and locations where they are needed.

Dr. Scharmaine Lawson ([13:50](#)):

Like Dr. Wakefield mentioned, these barriers to nursing scope of practice mean that communities, especially underserved communities, do not have equal access to high quality care simply because there aren't enough clinicians.

And while some states lifted these restrictions because of the pandemic, these barriers need to be permanently removed.

Maureen Bisognano ([14:16](#)):

We saw eight states expand the scope of practice for nurse practitioners.

Dr. Scharmaine Lawson ([14:21](#)):

That's Maureen Bisognano. Ms. Bisognano is the President of the Institute for Health Care Improvement. Throughout her nursing career, Ms. Bisognano saw more and more why it was so important for these restrictive barriers to be removed.

Maureen Bisognano ([14:34](#)):

But we still have 27 states that have restrictive practices for nurse practitioners and midwives. We need to take that barrier away for two major reasons. The first is right now we've got dire shortages of staff, particularly in rural settings. And particularly midwives.

So if we want to produce the kind of health equity across the country, we've got to take away those barriers of scope of practice.

What we are finding is that nurse and midwives are producing excellent results in expanded scope of practices where they have it and we need to take away those limitations.

The second is the power of relaxing these scope of practice restrictions. A recent Milbank study showed that increasing the scope of practice for nurse practitioners generally decreases the number of opioid prescriptions. There was a fear that if nurses were able to prescribe opiates that the numbers would go up and it's already a devastating problem in our country.

But the study found that nurse practitioners prescribed less opioids and decreased the amount of opioids that patients in their population were taking. That's a demonstration of the way that nurses think. We look at other ways to treat patients and families, not just a prescription. And I think that's one

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very powerful way for us to begin to lobby at a state and then a federal level to take away these restrictions. It will improve health and health care across our country.

Dr. Scharmaine Lawson ([16:11](#)):

Expanded scope of practice made a big impact on the opioid crisis and a lot can change with just one piece of legislation. What this showed is that removing restrictions on nurses can actually help to advance health equity forward.

Dr. Ashley Darcy-Mahoney ([16:29](#)):

One thing that many of us has heard about is to address the opioid crisis as one, perhaps, example as we think about health equity. In 2017, a federal waiver allowed nurse practitioners to prescribe buprenorphine to patients. And this significantly increased access to care in some rural communities and kept many people who were experiencing addiction safe.

Dr. Scharmaine Lawson ([16:51](#)):

The Comprehensive Addiction and Recovery Act of 2017 increased the number of nurse practitioner and physicians assistants who could safely prescribe buprenorphine. From 2016 to 2019, the amount of clinicians per 100,000 people in rural areas increased by 111%.

Dr. Ashley Darcy-Mahoney ([17:10](#)):

And so that's an example of a health equity issue right? Maybe those families and those patients, those people couldn't access a particular prescribed medication that they needed to be able to treat their substance use disorder and, therefore, didn't have the same kind of equitable access to care that other people may have, perhaps, in an urban environment.

Dr. Scharmaine Lawson ([17:33](#)):

The country's needs are evolving. There's an urgent need to address substance use disorder, but there are also many other needs. By 2030, over 20% of the population, which is 73 million people, will be over the age of 65. And older people have a higher prevalence of chronic illnesses like diabetes, heart disease and Alzheimer's disease.

There are increasing rates of maternal morbidity and mortality, especially among black and American Indian and American native women. In all of these areas, nurses can help provide treatment and help alleviate provider shortages.

These are just a few, but urgent, reasons why it's absolutely critical to remove nursing scope of practice barriers.

Maureen Bisognano ([18:22](#)):

When nursing scope of practice barriers are removed, we certainly see nurses practicing in rural underserved areas and in urban underserved areas. Nurse practitioners are there already. But this really encourages and makes possible nurse practitioners to engage that entire array of services that they provide, whether that is diagnosing and treating an illness, prescribing medications, practicing with autonomy.

Certainly held accountable as all health professionals are. But practicing often in places that are remote and underserved. Remote in terms of rural, frontier areas, and remote in the sense of working in underserved urban areas where that ready access to health care services doesn't always exist.

So this is really about a world where nurse practitioners and certified nurse midwives, nurse anesthetists and so on have barriers removed that allow them practice, especially in communities that have historically been marginalized with regard to access to health care.

Dr. Scharmaine Lawson ([19:33](#)):

Policy makers need to permanently lift the barriers that restrict nurses scope of practice and, consequently, limits people's access to high quality care. When organizations and state and federal entities remove these barriers, they enable nurses to better address factors that negatively affect the health of the individuals they care for.

And overall, this enables nurses to improve the value and quality of health care. As we advocate for these restrictions to be lifted and engage in discussions on removing barriers, we need to center our conversations around one thing.

Dr. Ashley Darcy-Mahoney ([20:09](#)):

I hope that when we think about the barriers that exist that we begin to keep the patient at the center of that conversation, rather than thinking about it like a turf war which I think is often how it's thought of.

Dr. Scharmaine Lawson ([20:21](#)):

Removing barriers to nursing scope of practice should not be about just who holds the most power and authority, rather we should remove barriers to develop a system that relies on team based care where all kinds of clinicians work together to deliver the best quality of care to people.

Dr. Ashley Darcy-Mahoney ([20:39](#)):

For the most part, my physicians colleagues and I practice in a way that's extraordinary collaborative. We all know what our strengths and our weaknesses are and how we can work together as a team to bring those strengths to our patients. I think all clinicians: nurse practitioners, physicians, pharmacists. All of us want what is best for patients.

And in most cases, team based care is what is best for patients. Operating as a team. Operating within the confines of our health system means that we all provide sometimes similar and overlapping jobs, but we also provide different roles for a patient.

And so when you talk about what needs to be implemented to address the scope of practice issues, I think in some ways, taking a step back to see what it is that everyone is capable of doing. What it is that nurses and nurse practitioners are capable of doing in terms of education and practice and where we complement our physician.

Dr. Scharmaine Lawson ([21:40](#)):

When we remove barriers to nursing scope of practice, we're also showing that we value nurses' contributions in health care. Often nurses' contributions are not seen as valuable as, say, a physician's contributions or even a surgeon's contributions.

Maureen Bisognano ([21:58](#)):

I think there is a tremendous amount of improvement potential in recognizing nurses' contributions. I think the hierarchy in health care has been detrimental. Doctors speaking one language and nurses another. Having calling doctors doctor and nurses by their first name.

Every time you walk onto a unit, in my experience, you can tell whether the culture is open to closing that gap or not. And I am seeing some promising changes, but we still have a long way to go.

Dr. Scharmaine Lawson ([22:31](#)):

Ms. Bisognano had a moment in her career where she clearly saw that even though she was a nurse leader, some of her colleagues viewed her a bit differently in comparison to other health leaders.

Maureen Bisognano ([22:41](#)):

When I was first a CEO, my first national meeting of CEOs was me flying to the south part of the United States and walking into a room where I was the one woman and the only nurse. All the other CEOs were men. They were all over 60. And when I walked into that room, I got a very strong feeling of my difference. When I walked into the room, one of the men turned around to me and he said, "Honey, get me coffee."

And I thought this moment is going to have an impact on my career. And so I thought for a moment and I said, "I'm happy to get you coffee. How do you take it? And this afternoon, you can get me coffee and I take mine black." And then everybody started laughing.

And I think that said to him, I'm not trying to be better than you, but I am equal to you. And I think those kind of moments we have as women and as nurses really begin to change the culture and open people to seeing women and nurses in a different way.

Dr. Scharmaine Lawson ([23:48](#)):

When it comes to valuing nurses' contributions, it is important for health systems to recognize that what nurses contribute is just as important as what physicians contribute.

But there's another major component that has the power to truly value nurses' contributions, and that is payment models.

Dr. Marshall Chen ([24:08](#)):

We have a problem with the way the current billing system is set up.

Dr. Scharmaine Lawson ([24:11](#)):

This is Dr. Marshall Chen, the health equity researcher who we heard from in our last episode. Dr. Chen has spent a lot of time looking at how current payment models in health care affect the quality of care delivered to patients.

Dr. Marshall Chen ([24:26](#)):

The current predominant system is fee for service. So this is the system where basically you do a service, you get reimbursed for it. Everyone agrees this is an inefficient system. It basically incentivizes volume, not necessarily quality care or the experience of patients.



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Dr. Scharmaine Lawson ([24:41](#)):

Not only does the fee for service model encourage quantity over quality of care, but it doesn't reimburse equally.

Dr. Marshall Chen ([24:50](#)):

It tends to basically overweigh and be overgenerous regarding things like procedures and surgeries, high tech things and then to under reimburse a lot of these key core nursing functions so things like the time that nurses spend educating patients, coaching patients, working on self management, doing monitoring in between clinic business, working with the patients when they're at home. These are all things which either aren't reimbursed or terribly reimbursed.

So there's a gross inequity that because it's not being reimbursed then there's no incentive for health care systems to do this.

Dr. Scharmaine Lawson ([25:27](#)):

The current health system does not value addressing social determinants of health or value advancing health equity. But this can be changed.

Dr. Marshall Chen ([25:36](#)):

If we value something, we should then back it up in terms of putting our money where our mouth is. If we truly value the patient experience, patient outcomes, we should reward that. If we truly value improving care for marginalized populations, reducing health disparities.

Dr. Scharmaine Lawson ([25:52](#)):

Sustainable and flexible payment models must be established to support nurses to do things like address social determinants of health and health inequities. There are a few different ways that this can be done.

Dr. Marshall Chen ([26:04](#)):

There are ways that we can tweak fee for service to help and support nurses. So one is to make sure that there are billing codes for some of these essential nurse functions that can address medical and social needs. So that there are billing codes to support team based care, care management, care coordination, conditional care.

Dr. Scharmaine Lawson ([26:25](#)):

Current procedural terminology are billing codes that report the kind of medical, surgical and diagnostic procedures and services provided to a patient. These codes are assigned a value and that value determines how much a provider gets paid. In this system, an hour long specialty procedure can be worth three to five times higher than an hour long counseling session where a patient receives health education.

This gives more weight, value and importance to complex procedures. But not for things that nurses do, like providing care management, helping to schedule appointments and providing follow up care, like explaining medications once a patient has returned home.

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There are, however, other ways the payment system can recognize the value of nurses' work and how it impacts people, especially for those who experience the negative impact of social determinants on their health, like working an hourly job that doesn't give them enough time to seek preventative treatment.

Dr. Chen describes how these models are different from fee for service, which is currently how most of the U.S. health care system operates.

Dr. Marshall Chen ([27:31](#)):

These alternative payment models, there is an opportunity then to think about, if you're giving us up front money, there are these terms like global payments, capitated payments or per member per month payments, as examples.

Dr. Scharmaine Lawson ([27:43](#)):

Alternative payment models and value based payments are complicated. But essentially, these models are focused on investing in quality where payment is given up front with the expectation of better outcomes and results. This shifts the incentives for the health care team and system to provide high quality care that achieves better results, rather than incentivizing providing the most expensive care.

Dr. Marshall Chen ([28:07](#)):

If you give us the money up front, that potentially enables you to direct that money towards some of this nurse infrastructure that can address the patient's medical and social needs. Something like team based care, again, it's just generally not well reimbursed, if it all, under fee for service.

But if you can imagine though if you have up front money that you can invest in things like these nurse led care teams or care management programs or other associate personnel like community health workers, that provides you an opportunity to then create more logically designed systems of care that proactively address patient's medical and social needs, of which nurses have a key, if not leading, role.

Dr. Scharmaine Lawson ([28:46](#)):

As Dr. Chen mentioned, if we truly care about the health of the nation, we have to invest our resources into advancing health equity. Dr. Chen mentioned new payment models that can give health care organizations the flexibility to support key nursing roles, including care management and team based care, expanded scope of practice, community nursing and telehealth.

If you want to learn more about payment systems that promote health equity, check out chapter six of The Future of Nursing report where we go into further detail on how to incentivize these changes. These are such important changes to make because when payment models are reformed, nurses in all settings can then address the medical and social needs of the individuals they care for.

Dr. Ashley Darcy-Mahoney ([29:34](#)):

It's about how we value health and how we value health and wellness. And much of our health equity conversation centers around how do we keep people healthy. And we have to be able to provide high quality access to care for people.

What I hope the public feels and what our patients and the community want is that we want to make sure that we can give everyone access to high quality care and there have been and continue to be

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institutional and structural barriers that don't enable us to provide that care. And if remove them, we're hopeful that the nursing workforce can begin to move our country towards better health equity.

Dr. Scharmaine Lawson ([30:18](#)):

Removing barriers to nursing scope of practice and valuing nurses' contributions, these are both part of the larger strategy to advance health equity. And when these things are done, more people across the nation will have better access to high quality care.

There are a lot of key players in this mission to improve the health of the nation. In our next episode, we're going to explore some nontraditional ways that nurses, nurse leaders and nursing organizations can collaborate together to address health inequities. Until then, if you want to learn more about this topic and what your organization can do to remove nursing barriers, check out The Future of Nursing 2020 to 2030 report. You can visit the report home page at [nap.edu/nursing2030](http://nap.edu/nursing2030). And as always, thanks for listening.