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

Event
2022 NCSBN APRN Roundtable

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Presenter
Peter I. Buerhaus, PhD, RN, FAAN, FAANP(h), Professor of Nursing and Director, Center for Interdisciplinary Health Workforce, Studies College of Nursing, Montana University

Greetings, everyone. And thank you for the introduction. And I want to begin by just saying thank you to Colleen and to Michelle, for all their help in making this presentation possible.

I want to just acknowledge the agenda here that I want to move through. We'll first of all talk about some strengths of the APRN workforce. You'll note that I'll be concentrating much of the time on nurse practitioners, this is because we have more data to work with.

So, it's not that I'm ignoring the contributions of other APRNs, it's just we have more data to work with with nurse practitioners. We'll then also move into the challenges facing the workforce as we think about a post-pandemic world. And then hopefully, we'll have a few minutes for some conversation at the end. Now, I want to disclose the funders and my relationships with boards and other organizations.

None of these relationships in my mind bias my comments. I'd also like to acknowledge my teammates from four different interdisciplinary research teams. And there's too many individuals to identify and name, so I'll just say thank you to all of them, and we'll move forward.

So, here we are, the strengths of the APRN workforce. Now, there's five of them that I've listed here, we could add to those, but I wanted to pull out the five that really stand out in my mind. They're all listed on this one slide, but we're going to go through each of them one by one. Now, the first strength is that we have increasing numbers of APRNs.

These are data taken from "The Future of Nursing" report, 2020 to 2030. And it's a little difficult in a way to provide numbers of APRNs, because so many are prepared in more than one role.

So, I've listed both at the top all APRNs prepared in a single role, and then added those that have other roles as well. And you can see that by 2018, we have a considerable number of APRNs, around 373,000. That number is probably pretty close to 400,000 today.

And then at the bottom half of the slide you can see the numbers of NPs, clinical nurse specialists, certified registered nurse anesthetist. And I forgot to put in certified nurse midwives, but that number is right around 12,500. The workforce is projected to grow rapidly as we move through this decade.

This is some data that we published in the "New England Journal of Medicine" a few years ago. And you can see the rapid growth of nurse practitioners from 2010 through 2016. But then as we project forward, that number will double from 157,000 in 2016 to almost 400,000 in 2030.

So, this is a large increase in our NP workforce. These projections were done prior to the pandemic, but you can see NPs are projected to grow by about 6.8% annually compared to physicians at only 1.1% and physicians' assistants at 4.3%.

So, strong numbers now and growing numbers in the future. A second strength of the APRN workforce and particularly with nurse practitioners is the growth in employment. And if you go back to 2010, to the left of the slide, you'll see that there was less than 100,000 nurse practitioners employed in the U.S.

Today, that number is around 241,000, at least by 2020. This is a very rapid growth of the workforce. So, a pretty strong achievement here. The yellow line below the top blue line, that corresponds to nurse practitioners working in physicians' offices, so, about 110,000 NPs in that setting.

Below that is the grey line which corresponds to hospitals. And you can see about 93,000 NPs working in hospitals as of 2020. And then the line at the bottom corresponds to all other settings where NPs are working, and that totals around 38,000.

Let me provide a little bit more information on both hospital employed and non-hospital settings. I'll pause a little bit and have a drink of water while you take a look at the slide, and just get a feel for where our nurse practitioner workforce is employed. All right, so moving from employment, we'll look at inflation adjusted earnings.

And this chart shows how earnings have increased from 2010 particularly up through 2015, nice inflation adjusted earnings growth. After 2015, you see that earnings have sort of plateaued, they haven't gone down.

Had they decreased, that would be an indication that maybe the supply of NPs exceeded the demand, and therefore wages and earnings would fall. We're not seeing that, what we're seeing is a nice employment growth and that employers are finding the NPs that they need given current earnings.

A third strength that I'd like to mention is the growth in the amount of care that NPs are providing to vulnerable populations. Now, I think you are aware that a number of studies has shown that compared to primary care physicians, primary care nurse practitioners are more likely to work and practice in rural areas.

This is an area where we are getting increasingly concerned about the physician, the adequacy of the physician workforce. And we know that there are many, many vulnerabilities among rural populations, including insurance, low insurance levels, isolation, loneliness, mental behavioral health, older populations, etc.

We also know that primary care NPs are more likely than physicians to take care of other vulnerable populations, women, people of color, the poor, the disabled, people who have no insurance or very low

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 better.

There was decreases in mental health-related mortality, including suicides. There was improvements in access to mental health services as well. So, these are some powerful examples of the full extent of contributions made by nurse practitioners, above and beyond that, of lower costs and higher quality.

Now, a fifth strength is the comparative advantage that has developed for many nurse practitioners over their colleagues and primary care physicians. And the way to think about this is to think about value. And value is really, from an economic perspective, sort of, the outcomes that are achieved by patients, divided by their cost, the cost of resources to produce those outcomes.

So, you think of what are the outcomes, how much did it cost. And what we see from the studies and that you're well aware of is that the outcomes produced by nurse practitioners are as good or better than those of physicians but at lower costs. So, this gives nurse practitioners a comparative advantage over many primary care physicians.

So, that is a set of strengths that I feel is important for us to be aware of as we move our mindset forward into a post, past pandemic future. These are all strengths that are just blowing wind at the back of our workforce, and they're important, and we should leverage them to the full extent that we can.

Now, on to the challenges, I've listed six. Some of these are not new, and you'll see what I'm talking about in a moment. All six are listed on this one slide, and we'll take them one at a time. So, the first one is really about a more racially diverse APRN workforce. Now, I'm not going to go into this because I know that Margo will be coming on a little later this morning or this afternoon, and talking about this in depth, so I won't go into her topic.

However, I do want to say that if you look at the registered nurse workforce, and you compare that to the APRN workforce, you'll see that the RN workforce is more racially diverse than the APRN workforce. So, we do have work to do there.

At the same time, I would just also ask that we remember that the APRN workforce that we have is taking care of a lot of individuals, people of color, and other vulnerable populations. Now, the second challenge is what I would say is sort of closing gaps in our preparation.

The NPs were asked in the 2018 "National Survey of Registered Nurses" about what topics would have helped them do their jobs better, if they could look back and say, "What were the topics that I wish I had more of that would have enabled me to do my job better?"

And nurses working in public health and community health, ED and long-term care settings, selected the following areas would have helped them do their jobs better. Social determinants of health, mental health, working in underserved communities, and providing care for medically complex/specialty needs patients.

So, our own workforce is identifying we need help in these areas. Now, another challenge for our workforce is to deal with the growing challenges of providing rural health care.

These challenges are going to grow as we see more physicians retiring over the decade. This is some data that was published from a study of ours, it was published in the "New England Journal of Medicine." A lot of lines and figures here. But the main thing to do is look at the right side of the slide, the top line.

And this shows a projected decrease of 23% in the number of physicians per 10,000 population through this decade. This is because of a retiring, older physician workforce in rural areas, and not enough younger physicians being educated to replace them.

So, we'll see a net decline in the physicians for rural population. This is an opportunity and a challenge for nurse practitioners. And fortunately, we have from HRSA a number of opportunities and grants to help increase the rural readiness of the APRN, and particularly the nurse practitioner workforce, which we need to take advantage of.

But we're going to also need to deal with restrictions on our scope of practice. And here's some data that comes from a study that we published in 2015. And this, I think makes the case pretty clearly that we are aware of the top lines or top bar chart shows the restricted states.

The middle bar is the reduced practice states. And the full practice states are at the bottom. And you can see that for the restricted practice states, people living in those states, about 34% say they have access to primary care. But when you get down to full practice states, you see that 63% of people living in those states have good access to primary care.

So, we know that lifting these restrictions increases access to care. But I have to say, I'm getting a little tired of these maps, not because this is an outdated one, and I just decided the heck with it, I'm not going to update this because I'm getting tired of updating these maps.

And I wonder, at what point will we have to be relying on these maps when we talk about our practice? I want to get rid of these maps. And look at this map, which is admittedly a little out of date. But the circled area is the southeast states, and extending into sort of the north central and east central portions as well.

This is where Wendy Xu, who I mentioned before at Ohio State, identified the concentration of dual eligible beneficiaries in rural areas, and in states where there are concentrations of physician shortages, and the most restricted scope of practice restrictions.

This just has to change. And I feel that, you know, maybe we have reached a period as we are moving from the pandemic into a post-pandemic world, where we should pause, and maybe consider some different approaches to, you know, move more decisively in eliminating these barriers that are bringing about real harm and decreasing access to care.

And it's not just the state scope of practice, but these barriers occur in our organizations, and healthcare delivery systems, and among payers. So, maybe we need to be looking at new models of care that are more cost effective and more in line with the care that can be provided by nurse practitioners.

Maybe we need to be looking at different sorts of partnerships with local businesses, with local community organizations, with organizations that are very motivated to address social determinants and health equity. But there's something else I think we should be taking advantage of, is, as we know that during the emergency declarations declared by a number of states around removing the barriers to nurse

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 is that… Well, let me make the case a little further.

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-hospital settings, and in private practice as well.

And what this all means is that if you are a provider or an organization, and you are producing high-value care, really good outcomes at lower costs, you'll receive higher reimbursements. But if you're producing just okay, average outcomes, or below average outcomes, and your costs are high, you'll get less money.

So, there is an incentive for organizations to employ individuals and practitioners who can contribute high value. This is going to help stabilize their reimbursement and their economic health. Now, already sort of established that nurse practitioners have a comparative economic advantage over many primary care physicians, because their outcomes are high, their costs are low.

Going forward into this decade, it will be critical for NPs and any other APRN to avoid anything that lowers their outcomes or increases their cost, because that will harm their comparative advantage.

Now, I want to be careful on this slide because I understand that this could be a little touchy. But what I run into oftentimes are nurse practitioners who insist that no matter what, they want to be paid at the same rate as physicians.

Now, I'm not saying this is all NPs or even a majority. But I get a little concerned about that because it seems that when I ask about what's going on in their local marketplace, what is the state of value-based payment, they are unaware, and they have not done enough research to know if insisting on being paid at the same rate is viable.

Because what you do, if you insist to be at the same payment rate as a physician, you've just given up your comparative advantage. You've upped your cost to the organization. And so, now, don't get me wrong, equal pay for equal work, that's what I aspire, and I think that should be where we are at.

But it could be that not in all situations, in all marketplaces is that a viable option for some NPs. So, just be careful. Be thoughtful. Get information about what is the state of the marketplace, where is value-based payment at, how is it being received, how are organizations looking at this, because you don't want to inadvertently give up your advantage by raising your costs.

Because if you do, an organization may say, "Well, the two are pretty much the same, I'll hire the physician over the NP." And if that happens, you're not employed, you're not in the organization where your value can be observed, and you can up your earnings over time, and you can use, sort of, if you will, carry the cause of how nurse practitioners increase value.

So, think about it is what I'm saying, we need to think about it and learn more about value-based payment, because it's here to stay and it will be developing more so over this decade. So, let me wrap up and just say that we have a number of strengths that are blowing at the backs of our APRN workforce.

We talked a little bit about them. Don't forget about them, find ways to leverage them. Moving forward, we have work to do to increase the racial diversity of our APRN workforce. We have some gaps in our educational preparation that need to be addressed by our education systems.

We have new opportunities and new challenges to address access to care for rural populations and other vulnerable populations, particularly dual eligibles in rural counties. We think or at least I think that we are at a point where we may need to just pause and rethink and restrategize about how can we go about removing these barriers to practice among payers, among our organizations and among states.

Will we have to go through another decade of slow change or is there something that we can do to speed up this change? Given all the demands that are coming down on society, arising from primary care, geriatrics, mental and behavioral health, women's health, etc, we need to quickly get that workforce effective and distributed and able to address those societal needs.

And in all of this, realizing that we're moving forward into a different payment environment, one that is quite attractive, and will favor those NPs who have a comparative advantage, that is, their outcomes are as good or better than physicians, and their costs are lower.

This can be exploited for the benefit of the workforce and also to the benefit of the populations that nurse practitioners serve. So, I'm going to stop there, and I'll pause, I know we're going to have some discussion here. But I just wanted to be sure that you saw this...

I've included some references to the fourth strength that I mentioned earlier about terms of this broader base of evidence above, not just about quality of care but other areas. And so, here are the references. So, I thought I would give those to you, because I think these are points that could be made when you're talking with Republicans or with Democrats, with policymakers, members of governor staffs, or the private sector and the public.

So, let me say thank you very much, and I look forward to having a little discussion with you. And, again, thanks very much.