FUTURE OF NURSING: CAMPAIGN FOR ACTION

INNOVATION IN HEALTH CARE 2020-2030

WEDNESDAY, AUGUST 7, 2019

Residence Inn by Marriott -- Seattle University District

4501 12th Avenue NE

Seattle, Washington 98105

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(SEATTLE, WASHINGTON; WEDNESDAY, AUGUST 7, 2019)

(3:00 p.m.)

MARY SUE GORSKI: Okay. Well, good afternoon, everybody.

AUDIENCE IN UNISON: Afternoon.

MARY SUE GORSKI: My -- my official duty here is to welcome you all here to this time together. And this is exciting. Hasn't it been a great morning? Oh, my gosh. And in our beautiful state of Washington. So welcome to all of those of you who are visitors, and also welcome to the local people. I know what it means to get on the freeway and -- and wrestle with the traffic to get here. And give up a day in August, too. So. But I tell 'ya, this is an amazing opportunity we're having here to have this dialogue and have this discussion.

Welcome to the Future of Nursing, Campaign for Action, Innovations in Health Care. This is the time when we get to advance our discussion a little bit further, even, specifically around the nurses as change agents and nurses moving forward to culture of health and how they do that specifically.

We are really fortunate to have individuals from 13 different action coalitions here. So we have people from all over the country, mostly in the region,

and then we have many of my colleagues and colleagues from Washington state, too. So welcome and thank you for taking the time to be here with us.

I've been with the Campaign for Action for -- since 2011. Pretty amazing to -- what an opportunity and a privilege -- privilege, really, it has been to work with the Campaign for Action. Really an amazing initiative and a partnership with AARP and leadership with Susan Reinhard and Robert Wood Johnson Foundation with Sue Hassmiller. I get to work with these amazing change-agent leaders in nursing and -- and see the tremendous progress that has happened over these last years, and now we get to continue that progress and even accelerate that progress. Right? In the 2020-2030.

My other great opportunity is to work with the Nursing Care Quality Assurance Commission, Washington State. For the last five years I've been back in my home state and working with the Nursing Commission under the leadership of Paula Meyer, the executive director at the Commission. And we have amazing initiatives there. You'll hear a little bit more about that.

But Washington state is a pretty amazing state. Lemme take just a minute to say that we have a lot goin' on in this state and a lot of amazing nursing leadership that you have already experienced, and you'll

experience even more through the rest of today and tomorrow.

So I'm really looking forward to this, even though I -- my head is swimming. And I talked with many of you, and I think that's the case w- -- our goal is to make it swim even a little more, give you a little more to think about, and -- and also to share with each other. So I'm excited to hear and to hear from all of you and to get started. So. . . .

Pat Polansky's gonna get us started, but just a minute. Lemme tell 'ya a little bit about Pat Polansky.

I -- I don't know -- I mean, most -- many of you know Pat Polansky, but she is pretty amazing, and she has been working -- we've been working together in this -- in this work --

PATRICIA POLANSKY: Endeavor.

MARY SUE GORSKI: -- for -- yeah, this endeavor, from the very beginning. And I just can't imagine a better partner. I mean, she is --

SUE [UNKNOWN LAST NAME]: Mutual admiration society.

MARY SUE GORSKI: I get the mike this time.

But anyway. Just -- just a couple more things, honestly, then we'll get started here, but --

She really has endless energy. She's dedicated and passionate in this work. And here's somethin' that's really important, too: She's a lotta fun. We always seem to have a good time, even though we work really hard.

So anyway. I'm gonna hand off the mike to my colleague, Pat Polansky, to go over the agenda and the objectives.

PATRICIA POLANSKY: Thank you, Mary Sue.

I'm just gonna step behind here, because I have papers to show you and all these good things.

I'm gonna -- I'm gonna start with kind of where Mary Sue kind of ended. You know how in your career sometimes you just collide with people. You don't plan it. You don't know it's going to happen. Sometimes it's through work. Sometimes it's through a friend or something. But Mary Sue and I showed up at the Campaign for Action within two and a half weeks of each other, and we've been colleagues, you know, thick as thieves, I wanna say, we have become. Shoulder to shoulder with all the Academic Progression in Nursing work and the APIN work and -- just this whole time.

And I was trying to think how many meetings she and I have done together in this campaign. It's well more than 40 or 45 at least, believe it or not.

I -- I lost count. But . . . when she told me that you had wanted her to come back to Washington and take the job, my heart was very heavy, but I was like, "You gotta -- I know you gotta go back there."

Because Mary Sue actually came in residence with us for a couple of years, and -- right, Susan? -- that was special time for us. So you are blessed to have her here, I tell you that. And we've been blessed this whole campaign time. And you --

See? Hear them. "We know. We know." Because you know when you got good. And it's terrific.

Okay. So I'm gonna walk you through some important things; points to ponder. The most important thing in the beginning is the wine will be served right outside this room. We're going to have the reception literally right out here, where you're gonna -- where breakfast is in the morning. And there's ice tea and other stuff right around the corner here. Does not bother Mary S- -- Mary Sue or I if you get up in the middle. So we don't have a break built in this afternoon, 'cause we wanna get you out.

And then my disclaimer is -- and I can hear my voice. So those of you who know me every day -- I'm on four hours' sleep, and I'm post six grandchildren since Friday for five days straight. And my husband's been

crooping with acute bronchitis for three weeks, and I've been up half the night because it's one of those things. My nursing brain goes off. So if I start to lose it, she'll hit me, and so should you.

But we're fine. Get up. You know. Be comfortable. If you have to, you know, take a little break.

We wanted -- we didn't wanna do heavy, heavy, heavy, because it's like Mary Sue said, it kinda blows your mind, everything from today and . . . it's kinda blowing our minds. Because we were just in Philadelphia less than a week and a half ago. Right? And these testimonies and stuff, it's just been amazing. I mean, even the student at the end. Was that amazing or what? I mean, it's, like, crazy good; right? So this stuff is all crazy good.

All right. Important people in the room. Because this is all most important. Ana's rollin' her eyes. Did you hear what she said? We have al- -- have fun? What did I tell you in orientation? "I'm gonna work your you-know-what off. You're gonna whatever. I'm gonna work to earn your trust. And we're gonna have fun." I believe in it.

ANA HERVADA: True.

PATRICIA POLANSKY: That doesn't mean that you

be a goofy. It just means that you can't take work so seriously that your brain is fried all the time and everybody who works for 'ya wants to kill 'ya. Now, they may wanna kill me, anyway.

Evan. Evan, wave your hand.

Evan is the man who is in charge with everything at the hotel. The front desk. The van that brought you here. Anything that's wrong with the room. Hot. Cold. The food. This. That. Where's your bag. How do you get to the airport. Whatever. He's the man. He's not gonna be in the room. He's gonna be right outside the room. He comes here from Washington from AARP. And may I be proud to say that Evan came as an intern.

Right?

EVAN NIELSON: Yeah.

PATRICIA POLANSKY: Came as an intern and interned with Kristan, who is an AARP meeting planner. I've said the best meeting planner I've ever met in my entire life.

And you got taught by the best.

A lesson for all of us. And Evan's great. So thank you. So I just wanted you to see who that is.

Ana, wave. Ana's the person that's probably spent 400 hours, God knows how much time, I don't know

how many emails, everything for the meeting. Ana came to us -- and just so you know, Ana's been working with us on our PHIN work. Ana has a master's in social work and a master's in public health. So she's listening, too. And she's been invaluable to us on our site visits and everything we've done before. Was working with Susan on healthy living. And she just one of the key people in our office.

And then Scott. Wave in the back. This is Scott's first --

Is this your first with us, actually; right?

SCOTT TANAKA: Yep.

PATRICIA POLANSKY: So Scott Tanaka's new to the office. He's working with Win. He works on health equity. And you should meet Scott later. I told him you should come up --

And shake your hand; right? Didn't I say that? I did.

(Simultaneous talking.)

PATRICIA POLANSKY: You look very handsome in the shirt and tie.

I told him he needed to wear a shirt and tie. I did. I'll admit it.

So . . . but anyway. Scott has been a tremendous addition to the office in terms of health

equity and all of these issues, so you'll get to learn s- -- meet Scott some more.

Nor. Wave.

Okay. Some of you know this, but the rest of you don't. From your lips to God's ears. She's a court reporter. Not just an admin. taking notes. She's a court reporter. And she's gonna be taking down every word. The proceedings. Why? Because what is going to happen here? This is a wrap-around meeting for the NAM town hall. It's an extension of that thinking. Got your brains going, and we're gonna keep 'em goin' here for the next -- tonight and tomorrow. So she's gonna be capturing all of that, so -- the things we're gonna learn and the people we're gonna be talking to, so we don't lose any of that, and what's of value is going to go forward to them, so we want all of you to know that.

And then Andrew is back there on the AV, in the room. So don't you worry. We're all in good shape here.

So I did drinks. Dut dut. Okay.

The agenda. Your agenda's in here. We -- as Mary Sue mentioned, we invited regional states. So there's gonna be a meeting in New Orleans, there was a meeting in Philadelphia, and this meeting. So we invited states west of Chicago and from California and

the Pacific Northwest on purpose, because there are regional differences and regional things that we believe you can do together. We even one day were sitting in the office and we were thinking maybe we should just -- you know, halfway through the campaign we would clump you into some regions, because -- to help you network and do things together and maximize on stakeholders.

So you're gonna have plenty of time. We're going to have all the states -- we'll have the states on the table. So tomorrow, after you hear everything, you'll be able to sit with them during a period and network tomorrow. And tonight, of course, you have the reception.

Mary Sue mentioned what we decide to do is kind of really do the beginning focus on our host state. NAM did not come here by accident. Came here on purpose. And there were site visits and the meeting and the town hall and the testimony. And we want you to hear the impressive -- underline "impressive" -- unbelievable things that the Washington Action Coalition and now how they have networked across this entire state.

Many of you've been on the phone with me, and I've said Sofia back there, who you're gonna hear from shortly, she was one of the leaders who stepped up, and

when Washington State got its SIM grant, of which was in the Affordable Care Act, you know, $2.1 billion was given out to 37 states, this was one of the states. And Sofia and this group was responsible for getting a nurse on every single work group for that SIM, for the federal government. So they have just spun straw into gold, and we want you to hear all of that.

In addition to that, we asked a couple of states, just in case I might wanna call on you for a couple minutes, and they're gonna be short, so you'll see state exemplars down here. We're gonna have some states share with you what we think are pretty unique things that they're doing. Real short. Five minutes. Just like Sue. [Bell rung.] You go over, I'm gongin' 'ya. And I don't only have one bell. I have two bells. One's there and one's there. We'll have one in the back of the room.

So we really want it short. Make sure -- yes, make sure you tell everybody what -- you know, what we really need to hear. And then there's a lot of time for Q&A and other things later. But we wanna get you up. So we're gonna do that.

So this afternoon we're going to hear from Washington. Coupla state exemplars. Treat, treat, treat. Kristi Henderson here. She and I are gonna sit

up here and she's gonna share with you. She's over with Amazon now and really has a lotta things to share. And I think you're gonna be really happy to hear from everybody. And then we're gonna hear more from the dean and Mary about some really unique things here that you should know about. And then we're just gonna wrap up.

So our job is to keep you energized and keep you up. The room's small on purpose. We really wanted everybody to just talk. And for those of you who have been at Mary Sue and my meetings and any -- any CCNA meetings: No table work. Are 'ya happy? You should be happy. We're not gonna do that. Make a list and decide what you're doing when you go home. We did that. We've done that.

And when we had the five regional meetings with all the states, remember, we had every single state come two years ago, cross the country, and we laid out the Culture of Health Framework; the drivers. 'Member all of that? Linking. Scaling. We're here. We're here. You're gonna be listening to people who are linking, scaling, and jumping over hurdles getting there and doing some great things.

So we hope you get a lotta mental notes. And the whole idea is just -- you know, just to listen to it, kinda take it all in, and you'll be good.

So. Without further ado, back to you. I think I've covered my stuff. We're good.

MARY SUE GORSKI: So first on the agenda is Sofia Aragon. Sofia is the -- the executive director of the Washington Center for Nursing. And she's gonna tell us -- give us an introduction of sort of that -- of the Washington State sort of framework and -- and that kind of thing.

For each one of the individuals that I'll introduce, I'll just give you the name and the background and then have them give you the topic. These are all real short and meant to kinda give you a flavor. Pat and I meant to mention: Everybody's bio and head shot, both the staff and everybody you're gonna hear from, which is in excess of 20 people, are all in here. So we're not gonna go through big intros.

Here's Sofia.

SOFIA ARAGON: Great. Thank you so much, Pat.

So . . . and I have people helping me with the PowerPoint.

So what Mary Sue asked me to do is give a bit of a background and the history of our action coalition. And you'll hear a little bit more tomorrow with colleagues Victoria Fletcher. And I'll just say that Dorene Hersh is in the room, who is our Leadership

Nursing Action Coalition co-chair right now with Katie Eilers, who couldn't join us, and she's in this lovely picture.

And so I'm gonna tell you the story of how we arrived here today. 'Kay. So the nursing influence on Washington State's health policy and workforce development is actually really rich. And when I started developing this PowerPoint, I just really wanted to get to the point of the work today. But I really thought about all of our colleagues in the big policy-making arenas that all of you talk about frequently, and those are our nurses in the legislature. And at one point we had more nurses in the legislature than any other state. We had four in the senate and four in the house.

Eileen Cody, who is chair of house healthcare, is the senior legislator in the house of representatives. So she's still there, wielding a lot of influence and rank.

But when we talk about the culture of health and how nurses can really influence all these other aspects that people don't think about as health, I start thinking about the other nurse legislators that were there. So we did have nurses who were entrenched in healthcare. Eileen was one of them. Tammy Green: Mental and behavioral health. Dawn Morrell was a

critical-care nurse.

But interesting enough, I think about the other nurses. So Judy Clibborn, who just recently retired, she moved on to be chair of the transportation committee for the State of Washington. M'kay. So you think about what kind of lens she had in terms of developing that.

Rosemary McAuliffe was a former school nurse, and she start ser- -- she chaired the K-12 committee in the state senate and had a huge impact in how healthcare is delivered there.

And I also think about Margarita Prentice, who -- actually, her political career started at the school board. For all of you here thinking about, "How do I get my foot in the door?", that's where she started. And at the end of her prestigious career was chair of ways and means in the senate, which means she was in charge of the state budget. And back in the day, when I was an advocate, governmental-affairs person for the Nurses Association, it was a real privilege to just walk in her door and say, "Here's what's going on and this is how we need your help." And she -- a door was always open to us.

So the other pieces of really excellence in nursing education that's been here for a really long

time is our University of Washington School of Nursing. Not only is it highly ranked nationwide, but as you see, Azita's taking it nationally with Nursing Now, so we're moving forward there.

I also want to mention the Council on Nursing Education in Washington State is a major organization here, simply by a fact that our leaders in community/technical colleges and four-year colleges and university get together regularly and share information and from there develop what are some common interests and agenda. So when I talk to other states, the virtue that they just are willing to sit around and talk to each other seems to be a unique thing. We've been doing that for years.

And I'll point out that they also develop together a statement on population health, and that that's where education and nursing needs to go, and that's been a couple of years now. So that's very forward thinking even then.

State agency leaders. So MaryAnne Lindeblad has been a leader in our state for a very long time, leading Medicaid. Also a willing victim here with the legislature from time to time when we talk about . . .

SUE [UNKNOWN LAST NAME]: Raise your hand. This is MaryAnne right here.

MARYANNE LINDEBLAD: All right. Stand up.

SOFIA ARAGON: That's right.

And we have Patty Hayes. I don't think Patty's here today. But she heads Seattle King County Public Health, which, frankly, has a bigger role than the state department, just because of the sheer density of the population here in Seattle King County. And also the -- the amount of social issues public health does have to deal with. We have a severe housing and homelessness issue here in Washington, and public health is very engaged in that.

And we were very excited to see Sue Birch join our agency leadership team in the state of Washington. So she's really -- I don't have, like, time to talk about that. But the way I think she's elevated nursing, and actually brought in a lot of nursing partners in the state and being generous with the Health Care Authority's capacity and structure to move things forward, has been really, really helpful.

And then I wanna say, too, that local health organizations. So Accountable Communities of Health, they cover all of our counties, but there's nine of them, and I want to say that we do have nurses at the helm of those. Dorene Hersh's co-chair was a . . . initial board member of Olympic Community of Health and

really started the ball rolling there.

And then also with health and nonprofit organizations, I wanna recognize that Dorene, again, was chair of the Washington State Public Health Association.

And I served -- because I was inspired by many of you in terms of trying to reach outside of nursing, I serve on what's called the Washington Low Income Housing Alliance, which is a major organization in the state that wants to eliminate homelessness and promote affordable housing in the state of Washington.

So next slide, please.

'Kay. So this slide is prob'ly really familiar with -- to you about the IOM recommendations in the previous report. So those are the familiar pillars. Enabling nurses to practice to the full level of their training. And the last bullet on the previous slide, just wanted to remind everyone, that the nurse practitioners have had full practice authority for a very long time and are very visible in the state of Washington.

Improving nursing education was one of the pillars. Preparing and enabling nurses to lead change, which is the focus of the Leadership Nursing Action Coalition. And improving workforce data collection and analysis.

And -- however, woven through all of these recommendations is to foster interprofessional collaboration and diversity. And I'll just say that one of the things that we would like to see, or I would like to see, is have those two issues moved up and being more visible, particularly because we're looking at nursing's role in health equity.

Okay. So next slide, please.

So the evolution of the Washington Nursing Action Coalitions. About the time that the Robert Wood Johnson Foundation were looking for, you know, action coalitions around the country, my predecessor, Linda Tieman, held a big summit to ask stakeholders, including those outside of nursing, what should the organization be focusing on, and there were four areas that this audience told us to look at. First was interdisciplinary practice, second is diversity, third is nursing education, and fourth is nursing leadership. And so coincidentally, when the Robert Wood Johnson Foundation was looking to see, okay, who -- what type of body would be instrumental in implementing them in different states, because these were already in place, we were recognized as an action coalition.

And so actually, each one of these areas renamed themselves to be an action coalition.

Next slide.

So in terms of convening, what I want to say that was really helpful and propel this forward to make this recipe for innovation is moving from what a lot of us w- -- what I'm hearing and what a lot of us were observing were that we're absolutely good at discussing things, we're good at planning things, we're good at writing them down, but that next step towards action is really the big, challenging part.

So in terms of action, the Healthier Washington initiative -- and I'll just say a story about that, is that Dorene Hersh, through her leadership role in Seattle and King County, heard about the Healthier Washington initiative through her colleagues, and they had this issue of, "This is a really big initiative, it can make a big impact, but we're having trouble getting people to know about it."

And so what does Dorene do? She comes to turn around to her nursing colleagues and says, "How can we help do this?"

And so one of the lead staffers at that time, Dorene reached out and got a hold of her and said, "So how -- how can we help?"

And Dorene, of course, makes the case for nursing. "We're the largest profession. We're

everywhere. We can help spread the word. Just let us know how we could do it."

A funny story about that lead staffer is that her mother used to work for the department of health, and I used to work with her. And so there was that ins- -- I said, "Zeichkin [ph/sp]." I said, "Is your mother named --" and they're . . . so we just clicked from then on.

And then she's like, "Oh, yeah. I know that you guys can do this work."

And so k- -- Dorene got our Leadership Action Coalition nursing members around the table and said, "Okay. They're setting up these different accelerative committees." One was the equities and communities accelerator committee. There was one on social action. One was on behavioral integral health innovation. And we just thought about every single nurse colleague that could potentially make a contribution to it, and we just got on our phones around the table and started calling 'em and said, "You know, we're gonna nominate you for this. Can you do it?" And of course hardly anybody said no.

And so from that, the communities-and-equities subcommittee actually was the only one remaining as the others closed their work, and it's actually alive

well -- alive and well now through every ACH as they're trying to implement their own equity strategies.

'Kay. The other piece is using data, both state and national, to inform policy. And our work with the Nursing Commission is really key in that, in that both of our organizations have a lot of strong ties to our national organizations. For example, for me, the national forum that has templates for data gathering, analysis, and reporting. And so there's a National Council of State Boards of Nursing.

And we've seen that other states in terms of collecting information on what does a nursing workforce look like compared to where we want it to be, the Nursing Commission actually makes an acquirement [sic] now through licensure that we need to answer a set of questions. So now we know the diversity of the nursing population -- or will soon. We're in the analysis -- the f- -- the analysis of the first batch this year. And we'll know how our demographics match up with that of the population.

The other piece that's really helpful is that for major initiatives, such as Academic Progression in Nursing, we have much more precise data. So as some of you around the room through the action coalitions and involved in APIN, we knew that in general, as a nurse

moves along in his or her career, or near retirement, less likely will that person wanna choose academic progression. What we're seeing in the state of Washington is that nurses from the age of 30 and younger, they're actually super close if not already there to the 80 percent BSN goal. It's when they're at age 34 does it start dripping -- dropping off precipitously.

So what that means for the Center of Nursing as an organization that wants to promote academic progression, we can better target the age in which we want to reach out to nurses and encourage them to move on to more advanced degrees.

The other piece I wanna talk about in terms of equity is really tying workforce development to social trends. So there's a major initiative here called the Puget Sound Region Partnership, and because of the incredible economic growth in the Seattle area, we're looking at a need to fill 700,000 jobs within the next five to ten years, and we're struggling with how to fill those jobs. And then when we talked about how do we move forward in this effort, they decided that the healthcare industry was number one and their needs were the most dire, particularly in long-term care. So right now there's a focus on the partnership Healthcare

Industry Leadership Table affordable healthcare, and what did we find that is related to recruitment and retention to not only registered nurses but the healthcare team? Maybe not physicians. That is affordable housing.

So together we're actually mapping out where do nurses live versus where do nurses work and what does the housing pattern look like. And there is data that you can see which neighborhoods or areas of the state have -- are more affected what they call housing burden, or people who spend more than half of their resources on housing.

And so one of the things that we should challenge ourselves as -- what I'm seeing in the workforce world is that there are more demands and challenges on nursing; however, there are some really key roles that are going to be delegated or given to our -- our healthcare team. Who are they? Well, home-care workers. Potentially medical assistants are on your team are gonna do this work. Nursing assistants may be needed in more different areas or may be asked to do more. But at the same time, if you look at their income-earning ability, there's no way that a person in that income level as we know it can even afford to live in the Seattle area.

So you have to think about as a nurse when you're leading a workforce team, or you are a nurse executive and you are in charge of s- -- staffing and hiring, what is our role in making sure we have a fully staffed team to do what we need to accomplish, but is there a question of perpetuating some inequities in the current teams that we have. So I just say that as a provocative question. And I'll say that as a workforce-development community, we're just discovering this and asking ourselves those hard questions.

So the other piece I wanna say is that an example of planning in which the Center for Nursing worked with the Council of Nursing Education, the other stakeholders, was the master plan. And when we looked at, "Okay. The master plan is over a dozen years old, do we need to review it?" They found that there were still a number of obstacles that we hadn't resolved, and that if we were to do it again, we would probably find the same obstacles.

So what happened to that is the Action Now Coalition, led by the Nursing Commission, Washington Center for Nursing, the Council Nursing Education, we also invited stakeholders to join us and how do we tackle these really huge issues.

I'll say that one of the priorities that we

tackle, before I get to what that success was, is that I think -- and I'm gonna look around with my colleagues in the room -- that, as you know, nursing does feel challenged when we have to promote the value and the worth of what we do, and then you layer on the education -- right? -- sector of nursing, in which they see them as a lot different from a hospital nurse. Right? Or someone with direct care. I mean, that's a distinction that other people will draw between us.

But the great thing about the Action Now Coalition was that they took advantage of the state government system, recognize that nurses in that system needed a significant pay increase in order to be competitive for recruitment and retention in nursing, and they took advantage of that momentum and were able to have legislature invest in that same level of funding for our community- and technical-college faculty, and for -- and this is also very rare, that there was funding earmarked just for nursing faculty. So that was a major lift that took a really huge community. So the planning and convening definitely ended in success and action.

And so for the last slide.

So some recommendations for the Future of Nursing, 2030. These are my thoughts looking at the

landscape. Is that in the previous slide you saw that diversity and equity was an implicit goal, and that we'd like to see a more explicit goal to advance diversity, and that to have an explicit statement about nurses' role in equity.

And in terms of improving workforce data, an example of that is that we are celebrating the -- our ability to double our number of graduate-degree nurses, and that's awesome, because that is our pool of nursing leadership in institutions. However, in terms of a dashboard, we should also compare the diversity of those nurses who are also moving up and obtaining more degrees. So are we graduating nurses as diverse as our communities into our leadership, or are there still inequities there that we still need to address?

And also in terms of equity, we would like nurses to be encouraged to develop practice and tools on how to address the social determinants of health. And tomorrow a colleague of mine, Rebecca Pizzitola, will talk about our efforts here in Washington to do that.

And that there should be a statement that nurses should aim to be and are leaders in all practice settings to address social determinants. And I'll say one of the efforts we're making is that for our acute-care colleagues, again, a little over half of

them, are in hospitals. We still work to try to connect the dots for them so they know that they also have impact on the social determinants of health as much as their community-health and public-health colleagues.

So that is your snapshot of Washington.

PATRICIA POLANSKY: There you go.

SOFIA ARAGON: Thank you.

PATRICIA POLANSKY: Fabulous. Your minds blown again; right? Second time -- second time in a day. The magnitude. I just wanna point out --

Can you put the slide back up again, please? That other slide?

Things to ponder that we've been talking about for years. They're branded. You've gotta brand yourself. WCN. CVS. IBM. Everything is short. Amazon. Whatever. It's not "The Company Doo Doo Doo, Inc.," anymore.

The meme. "It's About Washington's Health." You should have a meme. It helps. You used to call it a byline. Whatever. These are memes.

You gotta think about it. You gotta think about it from a marketing. You gotta think about it. What would a nurse think? What do hospital people think? What would the dean of the University of Utah think? What would your grandmother think? What

would -- if she looked that, what would she know that?

I can tell you all of our mothers -- mine, God rest her soul, if I said, you know, "I was out at Washington for a meeting, Mom, and they have a whole thing goin' on, and it's about Washington's health," at 85 she woulda known what that is.

It doesn't have to have "nursing" in it for nursing to own it. Did you hear all the places they've been? Critical.

Policy, policy, policy, policy. We're gonna be talking to you about policy. You're gonna be going, "I can't hear you." Because Sofia pointed out a lotta place [sic] where the work has translated to policy. Get people on those places so that you can do that.

The AC for each. Many of you had work groups. Right? You had a work group for every recommendation. You had -- you know, there were lots of morphs of it. But the idea of an action coalition working on this, that's unique across you. So just something for you to digest. I'm not saying you mimic everything you've heard. But it's something to think about. Or maybe you break one out. You break one out for culture of health or one out for health equity and culture of health or one out for population health.

Holding public office. Moving people to

public office. We heard testimony before about in school we should be teaching these students about policy and public office. And remember, person stood up and said -- and -- and my student said to me, "Yeah, I had, like, 20 of them come up to me. I would love to do that."

We need people to follow us. I am huge about this. Of course I am old now and I'm at the end. No, it -- really, this is so serious. I'm -- I know everybody laughs. I -- you know, it's . . . the thing about getting old that everybody says you hate what happens to 'ya, how you l- -- all that garbage. But what really happens to you is you get clarity in your brain about what's important and what you need to do and what you're gonna spend your time on. And as a professional, separate out who you are. Like me. Grandma and all that balogna. Grandma's a nurse. I don't have any idea [indiscernible]. But I do have one grandchild, a junior in nursing school, so I get credit for one big one. But.

And that leads to NOBC. You've got Kim Harper here, who's been leading this with us since we had the summit in Phoenix. And the Scottsdale in 2014 is when we began sitting down with ANA, that Marla Weston was there, we sat down. Remember? We were in a room. We

had the Hispanic nurses there. And we talked about leadership. And that morphed into 10,000 Nurses on Boards, which was actually birthed here. We were in the room, Mary Sue and I, and we emailed Sue Hassmiller, we showed her all the stuff we had up on the board, and came up with this 10,000 Nurses on Boards. And look where we are now.

But this is critical. Look at all the people that are leading. Look at Sofia leading. It's not a meeting that Pat Polansky's in the room that I don't say the same thing. For the last 40 years. If I ever stop working and I write my book, it's going to be entitled "It's All About Leadership." 'Cause whether it's eight Cub Scouts for the weekend or the President of the United States, or this work, needs to be led. Without leadership, you're not goin' there. It's just not possible. It's chaos.

So, you know, we've gotta take this seriously now 'cause we're in this critical place. That's what this meeting and the next meeting are gonna be about.

And then I heard the term "equity strategy." You're gonna hear from a lotta people. If you do nothing else, either get in your brain or write down these little key words: Equity strategy. Wouldn't that be cool? Think about an equity strategy. Because it's

gonna be different in New Jersey than it is here. It's a different kind of state. Different kind of lens. I'm not saying it has to be an equity strategy, but something like that. Thinking about how to crystallize your work. 'Cause otherwise gets to be kind of a scatterplot.

And then I'm sure Susan, who mentioned today when she testified -- she's a senior vice president of Public Policy Institute. That's the brains in the box that sit and create papers and research and how to think and advise. Not only everybody on the hill and everybody else, but people within AARP about how to think about these big issues. Housing. Transportation. Food insecurity. Social isolation. These are the underpinnings of those social determinants.

So when you heard Sofia talk about housing and the housing burden and how they're looking at that and how they're looking at that for nurses is incredible stuff. Incredible stuff. So there's just a whole bunch.

Tomorrow, during the plenary, Sue Birch and MaryAnne Lindeblad are going to be on that panel with other experts we brought from outside the coalitions for you in the morning. So you'll hear more from them and have that opportunity.

We're right on time.

Next.

We're just gonna jump up and down so you don't nod off.

MARY SUE GORSKI: Great. Thanks so much for that overview, Sofia. And we'll get -- we'll get snapshots and a little bit more detail on lots of those different areas over the next day and a half.

So now we're going to have a couple of brief reviews of some innovations that are going on in other states. So the first is Callie Anne Bittner, project director at Colorado Center for Nursing Excellence.

Is it Callie Anne or Callie?

CALLIE ANNE BITTNER: Callie Anne.

MARY SUE GORSKI: I'm Mary Sue.

CALLIE ANNE BITTNER: Right. Two names is just better.

MARY SUE GORSKI: Yeah.

CALLIE ANNE BITTNER: All right. Yes, I'm Callie Anne Bittner from Colorado Center for Nursing Excellence, on the Colorado Action Coalition.

The COAC, as we call it, has been committed to nursing-leadership development for several years, and we have several unique innovative programs that Susan Moyer, Karen Kowalski, and others have been building out

since the previous set of recommendations.

Today I'd like to tell you about the Nursing Leadership Connection, NLC. We have discovered the secret sauce to engage emerging nurse leaders in personal and professional development through innovation. Colorado followed suit of Virginia and several other states, starting a 40-under-40 initiative, which has been present and growing for a few years, but the explosion of participation was yet to come.

As a nurse leader in the millenial generation, when I joined the Center for Nursing Excellence, my team assigned me to lead this program. When planning the annual event, I began to think innovatively and creatively. The intention of the group is to prepare and enable nurses to lead change, and it needed to have more participation and excitement around it. So I began to develop the secret sauce.

First: Inclusivity. After I got another email asking, "I'm 44 years old. Can I attend your 40-under-40 event?", I realized people felt that this was an exclusive group, which was not only hindering participation, it didn't represent the Center for Nursing Excellence nor the action coalition. At the annual event a few weeks later, I empowered the group to help align the mission and the name, and participants

came together and came up with a new name and slogan: "The Nursing Leadership Connection: Elevate the Leader Within."

I rebranded the group by designing a new logo, advertising the new leadership in inclusivity, and being more intentional about seeking diverse speakers to present at networking and annual events.

The second secret-sauce ingredient is environment. The last thing millenials, Generation X, or any generation wants to do is go to a networking or development event in the basement of their hospital after a long day of work. So I wrote a grant proposal and secured funding through the Colorado Nurses Foundation and the Colorado Organization of Nurse Leaders and began hosting networking events at breweries, wineries, and other hip locations around Denver. With over 400 breweries in Colorado, there's a lot to choose from and it's a large part of our culture.

NLC covers the cost of space and food, while participants purchase their own drinks if they choose. The evening begins with networking, music, and celebrating being emerging nurse leaders and all that comes with that. Networking is followed by a one-hour presentation on leadership topics, and contact hours are awarded for all NLC events.

Before I even advertised for the last networking event, we had 85 people sign up for it. 65 percent of attendees to last year's events stated that that was their first NLC event. When we put out the call for abstracts for the 2019 annual conference, the number of submissions more than doubled from previous years, and the event sold out quickly.

The third secret-sauce ingredient is synchronous and asynchronous activities. With the explosion of popularity, not only did we have more offers from presenters than I have networking events through the year, we also wanna continue to reach more nurse leaders, especially in rural areas of Colorado. So beginning in 2020, NLC is rolling out two new programs called NURSE Talks and Leadership Buddies.

NURSE Talks is our own version of TED talks, and NURSE is an acronym that stands for Nurses Unapologetically Recognizing Self-Empowerment.

PATRICIA POLANSKY: Woo-hoo.

CALLIE ANNE BITTNER: NURSE Talks is where current and emerging nurse leaders can develop their executive presence and presentation skills by creating a short video on their passions; interests; expertise; any innovative idea that empowers them. These will be stored on a learning-management system and will give NLC

participants the opportunity to get feedback and grow from their videos and also discuss content.

Leadership Buddies is a program similar to a mentor program, as far as lending support to one another, but the difference in the buddy program is that it doesn't pair based on hierarchy or expert-novice relationship. Rather, NLC participants can be paired based on a number of things; really what they feel comfortable with. The buddies are given guided leadership, coaching, and reflection questions to ask each other, which help grow themselves as leaders, while gaining experience in coaching as a leadership skill.

Finally, we will be combining our Nurses on Boards coalition efforts with NLC, as they go hand in hand, and young nurse leaders will see board service as part of their career from the beginning.

So using innovation, inclusivity, hosting events in environments that increase participation, and establishing both synchronous and asynchronous activities, the future for nursing leaders in Colorado is bright.

Thank you.

MARY SUE GORSKI: I -- I wanna join. I'm a little older than 44. Is that all right?

KIMBERLY HARPER: But you like breweries.

MARY SUE GORSKI: I like breweries. Yeah.

Wow. That -- that is great. I would challenge us all to think about developing something like that.

Teresa knows she's next.

TERESA GARRETT: Yeah, and it takes me a while to get anywhere.

MARY SUE GORSKI: Sh- -- she's movin' slow.

TERESA GARRETT: I just start.

MARY SUE GORSKI: Great.

TERESA GARRETT: Yeah.

MARY SUE GORSKI: Welcome. You're great.

So Teresa Garrett is next. She's assistant professor at University of Utah College of Nursing, and she's the co-lead of the Utah Action Coalition, and she's gonna give us some snippets here.

TERESA GARRETT: Thank you.

MARY SUE GORSKI: So thanks.

TERESA GARRETT: Thank you, thank you. Yeah, I'm a founding member of our action coalition, back in the day when I was the deputy director of our health department in our state.

So our action coalition, the Utah Action Coalition, was established in 2011. There's a surprise. And over the years we've worked on academic progression,

we achieved our Nurses on Boards goal, and have exceeded it.

KIMBERLY HARPER: You're 172 percent. I just looked it up.

TERESA GARRETT: Thank you, Kimberly. 172 percent.

UNIDENTIFIED WOMAN: There you go.

TERESA GARRETT: Yeah. And . . . working hard on academic progression and entrenching nurse residency and APRN fellowship programs. Those are hard.

And a success we've had, also, is a partnership we have the Utah Nursing Consortium that led to several major policy changes in the legislature and in funding for our universities. Side note.

So recently our diversity-innovation work has really been focused on the nursing workforce and the diversity of our nursing workforce. Our work is funded in part by the Center to Champion Nursing and a broad swath of community partners.

And we have four things that we're working on. We are trying to understand what draws diverse students to a nursing career. We're studying what students and parents believe is their capacity to succeed in a nursing program. We're looking at -- we're conducting outreach to diverse students and their parents, or their

guardians, on the value of pursuing a nursing career, looking particularly at Hispanic communities and several large Native American communities and counties that we have in our state. The third thing we're looking at is how do we reduce ap- -- application barriers. If you're not kind of an average white person, like me, and you look at a college-of-nursing application process, it doesn't look like you. And most of our universities don't say things like "equity" or "diversity" in their mission statements. So we're working to change a lot of that.

Specifically today I'd like to highlight the -- some work we've been doing on motivators and intention to leave of early-career, diverse nurses. Okay. I'll be the first person to say Utah is not a diverse state, and our diversity is growing and we are changing, so trying to help our workforce look more like our population is something we're all trying to achieve.

So we've been conducting some qualitative surveys and research among diverse nurses who are in their first year of employment, and we have some rather . . . shocking -- maybe not -- surprising data that we're looking at in . . . the first set of data they have, 50 percent of diverse nurses considered leaving their unit for r- -- reasons related to the

cultural environment; 30 percent of participants reported feeling uncomfortable due to their race, their es- -- ethnicity, or their culture; and 50 percent agreed that there would be negative consequences if they reported unfair treatment.

And . . . this is just -- I suppose I -- I t- -- I'm trying -- we are trying to rise to the challenge of one of the last speakers of the day today, who said, "It's time for white nurses to start talking about this." We're trying to be white nurses who are talking about this, and trying to get our colleagues to realize that -- that structural racism happens, it's here, and none of us get a pass on this particular issue.

So with this data we're working with our colleagues of -- Utah Organization of Nurse Leaders has an Academic Leadership Council as part of it, where the deans and the directors and -- meet on a very regular basis, and have a long history of collaborating together, to look at how we can do some inclusion in education -- inclusion/education work amongst ourselves and then take that to the hos- -- the unit setting.

So our overriding message in all of this is that we all have to own this issue of equity. I suppose our --

What did you call it, Pat? Our equity . . . strategy?

PATRICIA POLANSKY: Oh, strategy. Our equity strategy.

TERESA GARRETT: Is to say the word "racism" and "structural racism" out loud regularly and start talking about it.

So. I'd like to recognize my colleague, Joan Gallegos, who's the k- -- my co- -- our co-lead of the Utah Action Coalition, who was not able to be here today; and Liz Close, our k- -- Close -- our k- -- ever-present community champion.

And thank you for this opportunity to highlight our innovation-diversity work.

MARY SUE GORSKI: Thank you, Teresa.

PATRICIA POLANSKY: Take your time. Take your time.

TERESA GARRETT: Just give me ten minutes.

MARY SUE GORSKI: While she takes a break here, we wanted to highlight our -- our costumes.

TERESA GARRETT: Oh, yeah. We called each other.

MARY SUE GORSKI: Coordinated. Costumes. "Outfit" I guess is a little better. Oh, I guess black and white is the way to go.

PATRICIA POLANSKY: It was. Whatever it is.

MARY SUE GORSKI: Thank you. That's two great snapshots of innovative things going on in action coalitions.

Now we're going to talk with Kristi Henderson. So you wanna come up, Kristi?

And Pat's gonna be -- sit and talk with Kristi about. . . .

PATRICIA POLANSKY: About . . . we're gonna talk about a lotta things.

Take a chair. Any chair. There you go.

Well, we are really thrilled -- and Sue was whispering in my ear always; right? -- you know, the opportunity we had today to have Kristi Henderson here. And so she and I were on the phone and were talking and we go through the whole thing, you know, "We should talk about this," and she was -- I couldn't write fast enough all the gems that she was sharing with me. And I said, "Well, you know what the real problem is? Everybody's gonna be sittin' in the room, and if I don't ask you this question, nobody's going to be able to concentrate." So the first question for you is: How'd you get to Amazon? Because I think everybody would really like to know that journey and -- and how you ended up there.

KRISTI HENDERSON: A nurse from Mississippi is now working at Amazon. That's pretty interesting story. But -- so . . . this is truly how it happened. It's not too exciting. But I did get a phone call about two years ago, actually, from somebody at Amazon, just starting to talk about what nurses were doing; what technology and healthcare looked like. Somebody there had heard me present at a conference and had told somebody else, "Hey, you oughta call 'em and just see really what's goin' on in healthcare and what you can learn." So this became a dialogue over about two years. And I had no idea -- naive, I guess. But I was just thinking, "Oh, they just wanna learn, and maybe they're gonna sell, like, something, you know, to help us scale healthcare and help us out." Little did I know they had another plan.

But -- so in . . . so fast-forward. I had -- I actually came out here a couple of times and thought I was gonna be doing some consulting for them, and -- and then in January of this year I got a phone call, about two weeks after the beginning of the year, and they said, "Hey, will you come out and talk to us? We want you to come work for us."

So I came out and went through a much different interview process than I've ever seen anywhere

else, for those that have heard anything about their interviews, and -- and -- and wasn't told what I was gonna be doing, and asked if I wanted to come on. So . . . that's interesting.

And I kinda thought and talked -- so my husband and kids are still in Austin. So I'm here, and -- for this bold "maybe." And so when I was interviewing, I said -- I actually asked 'em to interview me again. I said, "Since you can't tell me anything, I need you to really -- lemme tell you more about myself before I make a whole big life move and not know."

So I didn't know what I was signing up for. Of course I knew it was healthcare, and I've had -- I assumed things, because why would they call me unless it had something to do with what I had been working on all my career. And so jumped in and here we go.

Now I'm here and -- moved here in April and -- and we're working on a project that I told Pat I can't tell a whole lot, but I can tell you that I'm working on healthcare, and excited about the possibilities.

PATRICIA POLANSKY: No, it's -- that's cool; right?

So one of the things you said to me when we were talking was -- that you didn't mention just now --

that's part of the theme of all of this work is you never know where you are if you step up and you're talking or you're presenting or you're at a meeting or whatever. That's how they found Kristi. So, you know, doesn't have to be you go on and you're looking for X job. It sometimes finds you. And I think that's, like, super cool.

KRISTI HENDERSON: Yeah, only thing I'd add is during the interview, how many of 'em said, "Oh, I heard you in Florida. I heard you in DC. I heard you in wherever." So it was a -- a very intentional move on their part. So people are watching and . . . maybe listening.

PATRICIA POLANSKY: So there's another keyword to write down: Intentionality. If you're gonna lead, intentionality . . . again, be prob'ly chapter two or three of the book . . . you -- you have to think through what you're gonna do. Where do you wanna go? What do you wanna accomplish? What's comin' out at the other end? What kind of sausage are you making? And then you pick the right people, like they picked you. That's the secret sauce of leadership, I think.

And I -- I'm so excited to hear you. Honestly. See? This is a millenial. This is a millenial. I think okay, I can retire now. 'Kay.

She's gonna take this over. But no. Seriously. You know what I'm saying? That was so impressive what you're saying. And it's the same kinda thing. Because someday you'll be sitting up here.

KRISTI HENDERSON: I wish I was still a millenial. Or young. Maybe I should say I wish I was still young.

But no, it was really good, Callie Anne. I really enjoyed --

PATRICIA POLANSKY: Yeah, it was so good.

Well, how 'bout you just take, you know, a couple of minutes and just share -- I think if you shared with 'em some of the things that are really important to you, the lens and the perspective you have on just nursing and -- and -- and what your feeling now. Again, not talking about what Amazon's doing now. But the bigger, broader, you know, issues. And then we'll talk a little more. Because, you know, we have time.

KRISTI HENDERSON: Yeah. So the -- the whole -- my whole journey in this space was around -- first of all, it started in Mississippi. So . . . workforce, literacy, finance, you name it, every problem you can think of was there. And so we had to get creative. I -- we weren't gonna be able to recruit people. No one wanted to move there. All the

stereotypes of -- of that area. And the unbelievable complexity of healthcare coupled with poverty and food deserts and everything else. And so we had to get creative.

And so we started solving it through things like new members of the healthcare team. How could we advocate for, you know, community health workers was one at that time that we started with, and some others, to be a part of the team, and then how could we use technology to overcome some of the barriers.

And -- and -- and what I loved talking about in this space is that people think there's gonna be a greater digital divide, and that you're gonna actually worsen the disparities and inequity across the system, but I can tell you firsthand in the poorest state that our -- we were able to reach people and make a difference using the technology. And so over the years, all of this has been about solving a problem. Not about getting a new, shiny object or trying to, you know, change a policy for -- for no reason. It was all about, "Okay. We've got a real problem. I don't have another solution. So what -- how can I use the pieces that I have here?" Which were very community-based solutions through strategic partnerships that ended up using technology.

And -- and so moving forward and -- and -- and echoing that and amplifying it, it worked in Mississippi, it worked in Texas, it worked in every state that I touched and -- and -- and started working with them, to really make this, you know . . . person centered and really on things that real -- really economic drivers for the -- each of these areas. I mean, you've gotta have a good healthcare system to be able to attract new businesses and everything else.

So anyway. Fast-forward. And -- and now the possibilities of what could happen at scale are -- are really pretty amazing to think about.

So on my mind is how do we make sure that we don't miss opportunities because of assumptions or stereotypes or whatever it may be. I just think that sometimes when I come forward with ideas that are innovative or new technology, it's sometimes there's walls that come up. And instead of, "Wait a minute. How could this be used? How [indiscernible] how could this enable a safe, quality, connected healthcare ecosystem?" So it's really about really doing safe, responsible care in a modern world and taking advantage of tools that we have.

PATRICIA POLANSKY: I think we all know that when Epic first hit the streets, if you will, nurses

gave a lotta pushback to that new technology. I mean, think we all know that that is what happened. And I -- you know, so in light of that, what are your thoughts on how we can advance the adoption of technology now? And maybe share one or two examples of some successes in any of these states you mentioned.

KRISTI HENDERSON: Yeah, and I think there's -- you touched on one, but there's different categories of barriers to get adoption. There's the obvious system barriers, which are: Who's gonna pay for this? Little, minor things. Policies and regulations to even enable it, you know. Policies weren't necessarily written to prohibit it, but some of 'em just inadvertently do 'cause they're older and -- and these things weren't even available or thought of when policies were written.

So how do we change policy. System barriers. Those are some of the -- the really important ones that you can't ignore. We've gotta figure out how to pay for this, show the value of it, and -- and integrate it into a system of care.

So if you think about telehealth, for example, one of the big challenges is: Who's on the other side? How does it fit into my health plan? How will -- who is it? Are they licensed? You know, all those good

things. So there's this -- that piece that are system barriers.

There -- there are also ones around trust, and -- and just a system of wanting to protect our customer and our patients -- I'm already sounding like Amazon: "customers" -- our -- our patients to really make sure that we answer all those and are -- are not minimizing that relationship, this human touch, this -- you d- -- are -- we aren't gonna be successful just putting technology out there. It's gotta be a relationship and one built on trust. So that's another barrier.

And then the -- the -- the last one is also around just some of the -- the not only policy changes, but us really thinking about making sure it's meaningful and we have outcomes that show that it works. So there's all these hypotheticals around, "If we do this, we'll save a billion dollars and -- whatever, and we'll save Medicaid however much in care." We've got actually do the work and r- -- research that and show that there is a -- a positive return on this investment for technology.

So I think those three barriers are the ones that we have to overcome to get true adoption.

There's still a lotta skepticism and pushback

from the traditional healthcare system, so that includes nurses. We do push back. And -- and -- and a lotta times that's not gonna work. We can't do that. "I wanna do it the old way." So I think a willingness to lean in and be the ones that help craft it so that we do advocate for our patients in a -- in a smart way.

So that's a whole lotta things. I could dig in on any one of 'em for a whole talk. But high level, those are the major issues we're gonna have to address to get through adoption.

PATRICIA POLANSKY: So we're all aware of "Lean In," the -- the book. Right? Sheryl's book. So I'm at CCNA, and this is back whenever Tory [sp] was there and was one of our staff people. And I wanted to have a -- not a lunch-and-learn. I just wanted to sit with them for lunch and -- talk to all these very young millenials. She was, like, 22/23 when she started working for us. And talk to them about "lean in." And you said we have to lean in to that.

Now, when I read the book, I wanted to -- well, I read it on, you know, the lap -- the thing. The Kindle thing. But if it had been a book, I woulda thrown it into the wall, because it made me, like -- like, "What kinda reaction am I having to this?"

I was having a nursing reaction to it, that,

you know, leaning in is harder for us. I don't know why that is. Because we'll never abandon a patient situation. But if we feel we can't win it, so to speak, sometimes, we're angry about it. But we don't always lean into the situation. Like business does. Like what you were just saying. So talk to us about that. 'Cause I -- I think that's another thing that's real. It's real for women and it's also real for nurses in particular.

KRISTI HENDERSON: The leaning-in piece, yeah.

PATRICIA POLANSKY: Whether you're a male nurse or female nurse, there's the hierarchical stuff we always deal with; right?

KRISTI HENDERSON: Yeah, I mean, if I -- when I look back at the journey that it took to get, you know, s- -- one of the first large-scale pr- -- programs that I led was a statewide telehealth program that's now one of two centers of excellence by her, so -- which super proud of. But in a state where you would have never thought that would have happened.

But I -- to the lean-in piece, if I had known what I was going into, I'm not sure I woulda leaned in as much. But I didn't know. So it was this, you know, "We've gotta solve a problem. Let's just keep goin'. Dive in," each -- each thing. When you look back at it

cumulatively, you're like "Wow."

But it was. We had to change policies. We had to testify to -- over and over and over, telling stories that were -- that resonated.

And I'll -- I'll never forget. This is a really good story. So we were doing a statewide telehealth program, trying to change legislation, wanted to get reimbursement for it. Not only for telehealth. We were also dealing with medical nursing board, because we had nurse practitioners alone in communities, and their collaboration was done through technology back t- -- you know, hundreds of miles away, and at that time that was just not even heard of. And then we were also asking for technology in homes so that patients could send in information and we could engage with 'em. So we could overcome some of the transportation barriers.

And so there was -- I remember going into the first legislator's office -- after I got in, 'cause that took forever -- and once I got in and -- and they were almost like w- -- I felt like they were gonna pat my hand. I was like, "Now I'm mad." But . . . going forward I remember them saying, you know, "We can't take this legislation forward. There's just -- we've got so many bigger things."

And I was like, "There's nothing bigger than

this."

But -- so I ended up calling across the state patients, hospital CEOs, everybody I could think of, everybody that had touched our program, that had slowly evolved over many years, and said, "Hey, you know what? I just need you to know this is what's going on, and for us to sustain this and scale it and really make a difference in healthcare, I need you to make a phone call."

They flooded the place.

So it went from no one wanted to meet me to a unanimous vote passing legislation for telehealth reimbursement. And this was before anybody had that. And then we still have one of the leading policies around reimbursement for remote monitoring before there was any CMS changes there. So amazing stories that one voice does make a difference.

But the power of a community rising up to say, "This is what works, what is making a difference. We are saving money for Medicaid. We are making a difference." And having even Medicaid coming around saying, "Hey, we did our own independent analysis, and it works."

So that's the leaning in. And I think that it's just kinda -- some of it is best not to know what

you're leaning into.

PATRICIA POLANSKY: Exactly. Exactly. And I think for the -- again, there are young people in the room, and for those of you go back, you know, whether it's through NOBC efforts or what we've already heard today, from some of the younger people who testified, lean in with them. Teach them how to do this. You know. Give them some affirmation that leaning in is a good thing. A good thing.

So let's talk a little bit about one of the things that every nurse has a concern about. And I -- I think it's the same if you're in rural health or you're on 2-North or an ICU, wherever -- wherever you find yourself. You could be in the armed services and I think, you know, there's patient-safety issues everywhere today. I mean, you know, they tell you, you know, if you go in the hospital, you better take somebody with you. And that's not unreal. I mean, whatever it is.

Talk to us a little bit about how you see this patient safety and technology. Because that's -- nurses are the guardians of -- of families and patients and customers and clients and all the names we have for them depending on where we find them. But --

(Simultaneous talking.)

PATRICIA POLANSKY: -- a really big issue.

KRISTI HENDERSON: Yeah, really is. And I think we have a incredible responsibility here to -- to be the voice and lean in on that piece, as well.

But, you know, there's no playbook. We don't know what -- what works or doesn't work when we start integrating technology. And so I think that there's a responsibility for taking calculated risk and being very transparent with our patients, with families, with everybody that we're touching about the unknown, and being very intentional about, "Okay, here's the risk. This is what I'm gonna do. This is what I'm -- how I'm gonna make sure the patients are safe."

But we just don't even know. I mean, when we start doing care remotely, I talked to my team all the time about the -- the tap on the shoulder. When you're working in the bunkers with people, there's this trust and camaraderie, and you know, "When that person walks in, I know I'm okay," or, "That person's got my back. We're a team."

And so with -- there's all this literature out there on remote workers, anyway. So we're now enabling remote working and remote teams in so many interesting ways that I think we've gotta figure out how to recreate a camaraderie, a . . . I call it the virtual tap on the

shoulder. How do I have a virtual tap on the shoulder or, "Hey, I need your help. Come help me with this. I've never done this before," so that people don't feel isolated and don't reach out and don't -- I mean, takes a team to make sure p- -- care is good and safe.

So I think it's -- one new technology that we've gotta make sure that we're calculated and -- and very intentional about maintaining safety. But then it's this whole remote workforce and teams that are doing things all over the place. And -- and you may not know each other, and you may not -- like you -- like we're all used to doing.

So I think those are some of the things that resonate in my -- in my mind. And -- and it just -- it kinda blows my mind when I start thinking about the possibilities of what we can do with technology. And then there's the question of what should we do with technology and what is making a difference.

And as customers are asking and doing more and more and expecting things faster and -- and have access to things in every other sector, they want it in healthcare, but they may not -- it may not be the best interest.

Matter of fact, I use this a lot, too. So in -- in retail and everywhere else, your

customer-satisfaction scores drive everything. There's literature out there that shows if a customer-satisfaction score is high, mortality and morbidity actually may -- it may be reverse . . . related, so that we actually may have higher mortality and morbidity if we actually have customer service, 'cause we're giving 'em what they want, not necessarily what they need. So just something to think about.

I mean, it doesn't mean that we don't want 'em to be happy, but -- and it may mean we need to think differently. But when you're thinking about a retail or some other nontraditional k- -- entity working in healthcare, it's not the same as selling a Kindle. And so how do I think about that and make sure safety is at forefront and that we're evaluating our customer's voice but also making sure it's making 'em healthier.

PATRICIA POLANSKY: Yeah. Absolutely. It's an interesting lens. You can understand why they tapped you on the shoulder. 'Cause I think -- think about part of how you're saying that, you know, thinking about those kinds of things. Ana and I went -- whenever it was ago; months ago -- to Population Health meeting in Philadelphia. 19 years they've been doing Population Health meeting; right? With David Nash leading that. And so we went to -- we split up and we did everything.

And one of the sessions we went to, they presented, like, these little exemplars. So guess what they were doing? I mean, it blew my mind, because I was a 3-to-11 supervisor and an ICU person, so I'm like, "This is cool. Scary, but cool."

So they have gotten together with the hospitals. Because they're acquiring each other; right? And I'm before telemetry. We had the bird things. You had to listen, you know. If it sounded weird down the hall, we -- everything wasn't wired up. And they have a team developed, an interdisciplinary team, doctors and nurses, and they're sitting remotely -- telehealth, innovation, IT, exactly what this meeting is all about -- and they're sitting there --

I think I pressed something.

-- and they're sitting there, and they are monitoring 16 emergency rooms as their first demo, and now they're doing 30 ERs, and guess what they're doing? Patient safety. I wanna -- if I, God forbid, have a stroke, I wanna be in one of these ERs. Because they're taking the golden hour and using technology and using what used to be -- like I would always say on 2-North of that ICU -- and they are immediately intervening for anybody that comes in that even looks like they're having a stroke.

And every nurse in this room, if you have even worked a week anywhere, you know that that little, old lady or whoever comes in that goes, "I -- I don't know. I just don't feel right. My head. I'm havin' trouble swallowing," they're prob'ly on a litter in another room. They don't get fast-tracked unless they come in lookin' like they're havin' a brain hemorrhage.

And their quality numbers and morbidity and mortality have gone down 68 percent since they're doing this.

So this is the kind of leaning in and what Kristi's talking about: Be not afraid. Remember the old -- be not afraid. Nurses should be championing these things. Right?

KRISTI HENDERSON: You know, it's -- it's interesting, 'cause what you're describing, there's so many different ways this could impact care. So if I think about the example you just gave, where there's this bunker of nurses monitoring or being the second set of eyes to really make sure nothing is missed, there's -- there's a huge benefit in that. And -- and f- -- whether it's an ICU or a rural area or who -- whatever, there's just so much benefit.

We did that, actually, in Texas, as well. And it incorporated even falls prevention. So we were

remotely monitoring people from [sic] falls, as well. So those that have implemented programs like that are -- it's quite amazing.

But then you think about it from -- and this one may rub some of y'all, goin', "What is she doin'? She gonna replace people with robots?" But we -- we -- when I was in Texas, there's just a huge challenge of all the responsibilities that the nurse at the bedside has to do, and as things get leaner and leaner and budgets are cut, people are pulled out. The clerk at the desk is no longer there. The patient-care assistant or tech is no longer there. And so again, work rolls to somebody else.

So we did a study and brought in robotics and let the nurses lead this to say, "Nurses, tell us where you're doing repetitive task. We want you looking eyeball to eyeball with your patients as much as possible. We wanna take this burden out. So let's -- let's train this robot to do things for you. Whether it's go get supplies; whether it's dietary; whether it's linens; whether it's refill the water in room 202. It doesn't matter. Anything."

And so it was interesting, though. So we got a -- they led it. Nurses led all of this. They helped us evaluate it and determine how we train this robot.

It'd get smarter and smarter, so you could tell it what to do and then it would go get it. Looked kinda like a praying mantis, though. We needed to work on that. But . . . it was a little scary.

But I'll tell you there was a ton of backlash around, "You're gonna replace people with robots."

And -- and so, you know, there's gotta be a balance in all this. I don't -- I don't know what it is. It was to -- it's the same around telehealth. When -- whether it's a nurse practitioner, physician, whoever, it's this uncertainty around "What it means for the future of my profession and my -- and my job." But there's also a need for us to figure out how to use people top of license; make sure we're spending our time where they need to be. So there's gotta be a balance in this. And I don't -- I don't know that I've necessarily figured it out. Maybe it's just a consciousness and an intentionality around calling it out that there's a risk here and -- and where have we gone too far. I mean, there's all kinds of articles that are out there around the robots are taking over the world and whatever.

But -- so I just think that there's a lotta responsibility for us to have a voice in that and crafting it and making sure we keep the priorities in focus.

PATRICIA POLANSKY: The good part is if we're helping design it, that's the key. You know. Kind of thing.

A former hospital administrator that I hired, I hired him when he was younger than you. He was, like, 23, I think, he came to me. And when New Jersey got E-ZPass -- so on the east coast -- I'm sure on the west coast, too, you know? -- you get your little thing now, you have your responder, you just fly through, and then you didn't even have to go through a booth. Now the thing's over the highway. Right? If anybody in the room wants to sit in a line with their dollar and a half and have to wait for the guy to ring it up and go through, or do you wanna just drive through at 70 miles an hour?

And I think it's a good metaphor for us. But it has to be safe. And it has to be designed and you have to think how it goes and you have to figure that out; right?

KRISTI HENDERSON: Yeah, and baby steps. I mean, we don't --

(Simultaneous talking.)

KRISTI HENDERSON: -- have to go to what's all possible at the end. Let's go slow. Let's figure this out. Let's be smart about it. So I -- it's a

partnership that we've -- we together and through different people in different boards and associations, coalitions and all, are gonna be a part of redesigning that. But making sure that we are forward thinking and willing and open to consider all possibilities.

PATRICIA POLANSKY: Yeah. That would be the key.

One of the themes, you know, today, and of course all with culture of health, population health, everything that's going on, and a lot of people speaking, too, today, social determinants of health, and when we all define what they exactly are and how we're gonna measure them, but let's -- let's not go there.

But how do you think technology will either help or hurt how we -- the collective "we," 'cause I just don't think that's on nursing's back, to do all that -- toward addressing the social determinants of health in these much larger population-health issues today. And whether it's violence or ACEs -- I mean . . . we're not at a loss for issues to deal with, but --

(Simultaneous talking.)

KRISTI HENDERSON: -- a long list --

(Simultaneous talking.)

KRISTI HENDERSON: I mean, there's so many

different ways to -- to use technology to positively impact those -- the same turn, there's a very possibility of -- of having the opposite impact. And so lemme tell -- maybe answer the story [sic] with a -- an example. And again, I go back to Mississippi, because when I think of social determinants of health, they're -- they're magnified.

So when we were working on a diabetes telehealth program -- and we actually did this with the State of Mississippi Department of Medicaid -- and said, you know, "We need to go into the community and we need to address things -- everything. Everything. Transportation. Housing. Jobs. You know. Environmental issues. Everything." And it was a focus around diabetes, but we wanted to make it around the entire issue.

And so we actually went in, partnered with community health centers; we partnered with pharmacies; we partnered with even the rural telehealth network, as well. I mean, we did all kinds of things. And backed all the way up to really make sure that this was driven from individuals that lived in the Mississippi Delta. And -- and they were sick and they -- and I can still remember faces of them in tears by the end of it. So I'm gonna kinda fast-forward to the design of the

program.

It was community based, and we used technology to bring in the resources that they did not have. And so endocrinologists; diabetes educators. I could go on and on and on and on. And we wanted to bring 'em in and use it, but with their trusted health team locally. We didn't wanna come in and replace somethin', then rip it out and it all fall apart. And when we came in, people in the community said, "We get so many grants. Every grant comes in here and then it stops as soon as the grant ends. So we don't trust you. We're not gonna use this program." That was literally what patients would say. "Great. We're another guinea pig."

And so this is in Ruleville, Mississippi, believe it or not. And -- and so we went in, worked with them, built trust, and let them help co-design that. And the community health workers -- we even trained community health workers to help us stay engaged, use technology in the home, the whole bit.

Lemme fast-forward to the outcomes of the program. So we -- we did a deep dive with the -- our Department of Medicaid and then analyzed the impact of this program. And it ended up still going to this day, and it's now been scaled. But we ended up having an impact on their health to the level of Medicaid

projected $189 million in savings a year just on the outpatient cost -- I mean -- I'm sorry -- the inpatient cost related to diabetes. So that actually drove our legislation change.

But the interesting thing was is the patient stories and testimonies. So where FCC commissioner has flown down there and gone with me on a three-hour drive in the Mississippi Delta. We've had the governor go there, as well, multiple times. And to sit there and say -- these patients are in tears. "I assumed I'd be on dialysis. I assumed my kids would die of this. I assumed I'd have an amputation. I just knew this was my future and this was my -- the cycle that I was in and I couldn't get out of it."

They turned it around. We just enabled that through technology. And it had to address everything from food deserts to jobs to everything. And so it was through partnerships with the extension centers; job centers. Everybody was engaged in this. The whole kinda community rose up and -- and used technology to enable it.

And so to me, it's -- it's really about -- there's not a one size fits all, but it's around each community building solutions and having access to these resources and filling gaps to be able to have something

that's substantial that they own and that they're proud of, and we didn't do it, they did it, that kinda thing.

PATRICIA POLANSKY: Yeah, that's great.

Okay. Before we open up for questions, 'cause we're gonna give you a little time to really just ask her some questions here -- and we've got rest of tonight and tomorrow. So if I were [indiscernible] -- I didn't tell you I was gonna ask you this.

KRISTI HENDERSON: Oh, no.

PATRICIA POLANSKY: If I were your fairy godmother, could give you three [snapping] -- remember me, I took six kids to see "Aladdin." Rub the magic lamp. If I gave you three wishes to transform healthcare and improve health equity -- just quick one, two, three -- what would they be, do you think?

KRISTI HENDERSON: Oh, my gosh.

PATRICIA POLANSKY: In your new lens.

KRISTI HENDERSON: Are these wishes gonna come true?

PATRICIA POLANSKY: Well, I don't know if they're comin' through [sic] in my lifetime, but I'm hopin' they're through in your lifetime --

(Simultaneous talking.)

PATRICIA POLANSKY: -- 'cause you're gonna make sure that happens.

KRISTI HENDERSON: This is for Callie Anne, then.

(Simultaneous talking.)

KRISTI HENDERSON: Now, you know, everybody talks about access to care. And it's about each individual achieving their health goals. And -- and so some kinda preconceived, like, "This is what health is" is not it. It's -- it's what's -- what is meaningful to each one of you all and where you are right now. And so I think that I -- I wanna have a connected health system that takes into account the social services, the local communities, and the health system in a smart way that actually meets people where they are and helps them enable what's their health goals. And so not to predetermine -- it's not just about an A1C at this level. So not it. It's like am I gonna be alive to go to my kid's wedding. It's those kinda things.

And so I -- to me, it's this connected personal . . . connected health system that makes getting healthy easier and takes the hassle out.

Is that three things into --

PATRICIA POLANSKY: Yeah.

KRISTI HENDERSON: -- one big paragraph?

PATRICIA POLANSKY: I think that's good. I think we're all good.

How 'bout we take two quick questions. Anybody. You have to come up to the microphone, though. Be brave. Oh, you must have some questions. Go ahead. Absolutely. Come on down.

SUSAN REINHARD: All right. So AARP thinks a lot about this. And we're hew- -- I wish Winifred Quinn was in the room bek- -- oh, there she is.

(Simultaneous talking.)

PATRICIA POLANSKY: We've been talking health equity the whole time.

(Simultaneous talking.)

SUSAN REINHARD: I know. I thought you were still out there.

Tell a -- but -- but just had a series of three roundtables around this, with part- -- Women for Partnerships and Children and whatever that is. A whole lot of different people. A lot around data privacy and the issues. And I don't th- -- maybe I missed that. But we -- we support technology, we want sharing of data, but under really careful conditions. And then along with that came the selling of data.

So can you just help us feel better?

KRISTI HENDERSON: Wow. That's huge. I'll tell you, that exactly sits on my mind quite a bit. And so I'll just say things that may be on your mind, just

because I think they are on everybody's mind. You know, is Alexa listening to me? Is this data gonna be used for whatever? How is it when I say "X," that that shows up in my search tomorrow?

And what I know is that is at the forefront of every conversation that I hear in any tech company -- and definitely where I am right now, too -- that intentionality around protecting that -- a customer's information is their information, and how do we make sure that that doesn't go across a wall from what I do over here when I'm shopping to what I might or may not do over here in healthcare is extremely important. So there are all kinds of laws about it, but there's really around a philosophical belief an intentionality to make sure that we respect that privacy and that inadvertently partnerships don't use data in the wrong way, as well.

So I mean, this is much bigger than any one company. This is really around we -- you know, you f- -- you push for interoperability so we can share information for continuity of care, and then there's this desire from a health plan or whoever else to really understand their members or their customers or their patients so that you can build programs that better meet their needs. And so it's all well intended, but then there's these -- these -- these other things that

happen.

So I think the comfort should be that it is absolutely the priority of everything that I'm doing is around that trust. You cannot break that trust. And you have to be very intentional about protecting that. And so if you look at even some of the work that's being done and publicly being done with Alexa, with health systems, there are very few that are in a pilot to be able to work on that, and they've now got part HIPAA qualified for providing interactions with consumers or patients in their home. And so it is a long, rigorous process and a lot of testing to ensure that all of that happens exactly what you're talking about. It's -- it's -- it's not taken lightly.

PATRICIA POLANSKY: That's great.

While somebody else is thinking up a question -- you're gonna walk up while I'm saying this. I don't know if any of you saw two or three weeks ago, it's not much more than that, using AI platform to identify potential suicides in the Veterans Administration. And how they're using this. See, again, this is a "be not afraid" thing. But also can you imagine -- because even before HIPAA -- believe it or not; right? -- before HIPAA, you couldn't tell anybody about any -- that had a substance-abuse or

mental-health problem, and that was pre-HIPAA. So boy, that's going to be a thing.

But think about what they're predicting, what they're already seeing, in the reduction of this. I mean, that's that patient safety and why are we here. What -- what are we --

(Simultaneous talking.)

KRISTI HENDERSON: Yeah, I mean, I think about, too, just along that whole -- on AI side, around how f- -- facial recognition and looking at early signs of your mannerisms, changes in behavior, how you move your eyes when you interact, what you post on social media, all of that could be used to improve or save somebody's life. But how do you balance all of that? And I don't know the answer to that, either.

But I've seen some amazing things in early detection of dementia and -- or things like that, and depression, where interventions were possible because of subtle things that we're starting to mine and to use AI for. So I don't know the answer, but it's a -- it's a call out to say we've gotta be a part of the discussion.

PATRICIA POLANSKY: Yeah. Kim.

KIMBERLY HARPER: Thank you so much for being with us. This is an amazing story and I love hearing you talk. I have one burning question, and that is --

we hear you say that you really didn't -- you couldn't ask questions; you didn't really know what kind of a job you were taking. That's guts. That's strong leadership. I'm curious: What was -- what was it about Amazon or the company or the possibilities that made you say yes to a life change for a job you really didn't know what you were gonna do? That just blows me away.

(Simultaneous talking.)

KRISTI HENDERSON: When you say it out loud, I'm like, "Why did I do that?"

Okay. So culturally, I was raised in deep south, in Mississippi, with my family a block away. My kids walked to school. It was a very community -- what you think of in the deep south kinda thing. So I remember 24 years into my career, in academic medical center -- that had a state pension plan, by the way; one year away from retirement -- I picked up and left and went to Ascension because of the possibility to give other people what I saw happen. And I knew the limitations of "Who's gonna listen to somebody from Mississippi from one place? That's just different there."

So I said, "Okay. I've gotta go to Ascension now." And so I convinced my family -- "Husband, quit your job. Kids, pick up and move senior year." All the

stuff that you shouldn't do, necessarily, in the Parenting 101 book. It's not in there. So then I picked up and moved to Austin, to lead Texas initiative, then started leading their national initiative for 22 states, to say does that real- -- are they right? Will that work anywhere else? Maybe it won't work anywhere else. So let's replicate the model and see if it works. Worked in Texas. It's expanded it to 22 states. Worked there, as well. Showed cost return. All that good stuff.

And then I was like, "Ah, it's just not fair that everybody can't have it."

And so when the call came -- so I've been thinking it in my head, but I thought I might wait strategically to f- -- start figuring that out: Where should it be? How sh- -- where should I go? Where can I have an impact? Is it in the policy side? Is it -- wherever.

So when the call came in, I thought, "That's interesting."

KIMBERLY HARPER: It's really big.

KRISTI HENDERSON: It's really big, and --

(Simultaneous talking.)

KRISTI HENDERSON: -- it might do something all over the world. So I almost -- it was almost like

how do I say no? It may not work. I think -- I told some of you all this earlier. In my family, that was the question. "I'm gonna leave you all, and I'll come back a lot, I hope, and you come see me. But this is about this, and this is what I hope it is."

And they were supportive and said, "You j- -- how do you say no?"

And so be a voice. Be there. And if it works, great. If it doesn't, it can't hurt you, except for some time away, and a lot of flights. But there you go.

PATRICIA POLANSKY: Lean in. We are indebted to you. Thank you.

MARY SUE GORSKI: Wow. Wow. My mind is blown. It's racin' around in there. Great new perspective. Thank you so much. That was -- that was just wonderful.

Hang with us. We're almost there. We have another couple of state exemplars and then we'll wrap up for the day.

So . . . boy. I think I can -- I think I can handle just a little bit more innovation in here, but boy, you just about filled it up. So thanks, Kristi.

So. The first . . . we have two Washington state exemplars. Actually, this is officially part two,

because we've -- we've b- -- introduced the Washington state exemplars.

And Mary Baroni?

MARY BARONI: Okay. I'm between -- we're between you -- you and a glass of wine, so we'll be actually fairly quick.

I'm Mary Baroni. Really happy to be here. I'm gonna speak just very briefly about an initiative that is coming out of our Action Now Coalition that Sofia spoke about earlier, and out more specifically from our academic-progression work group that I have been co-chairing for the past two or three years. And we've just been awarded a $50,000 planning grant from Premera Blue Cross here in Washington to support the development of a streamline pathway for LPN-to-BSN academic progression. We have some potential for additional funding, presuming we are successful with this -- which expect to be -- for pilot implementation and evaluation in a -- two or three partnerships between LPN and university BSN educational facilities.

The initiative's really an extension of the work that we did accomplish in our Action Now Coalition and the four years of RWJ Foundation APIN funding that I was co-director of. And in particular -- and in particular outcome of that included the development and

implementation of a statewide direct-transfer agreement to support academic progression for RN-to-BSN progression. And this is statewide. And it assures that all of the credits that people take along the pathway are transferred into the university so that there aren't excessive increase -- repeats of academic credit.

And so this grant would do -- use a similar mechanism, but a very different population, and that's looking at the LPNs.

When we first implemented the RN-to-BSN education, the very first issue that came up from our discussions around the state is, "What are you gonna do about LPNs?" And we weren't really sure. But this is giving us an opportunity to really think about this population as a significantly diverse population that needs to have an opportunity to progress, should they want to, and streamline the entry into practice for -- for that population.

So our first steps are -- we're hosting an invitational, full-day retreat with LPN, BSN, RN, nurse educators, regulators, and policy agencies and practice partners on August 19th. And this is gonna really be to kind of launch the discussion of a pathway development and solicit ongoing support.

We're also planning -- we do have, fortunately, a LISTSRV from the Nursing Commission of all of the LPNs in Washington state, and we're planning on doing a needs assessment to really get a sense of where LPNs are in the state in terms of what are some of the issues; what are the -- some of the incentives; what are some of the interest; what are some of the barriers and -- for possible progression.

We are well aware -- we've done a significant literature review -- we know that other states -- this is not necessarily a new concept. Many states have done this. I know Massachusetts has done a very innovative model, and I've been trying to get in touch with those folks. California I know has done some interesting things. We are trying to learn from them. And again, try to develop this in our own context of Washington state.

So moving forward, this fall, we already have unanimous support from our higher-education stakeholders, who we've worked with several times before. One of our stakeholders groups is a j- -- called a Joint Transfer Council that combines educating -- educator stakeholders from all of our community and technical colleges and universities, both p- -- public and private. And they are willing to

convene a statewide work group to work with us to develop this pathway to approval and implementation.

And that's -- there -- I could talk more about it, but that's just the beginning. And it's another example of Washington state I think really working across settings, practice, education, and with higher-education stakeholders to make academic progression possible for as many nurses as we can.

Thank you.

MARY SUE GORSKI: Great. Just more progress in all of these different areas that we need to get to.

And next we're gonna have a Washington-state exemplar from Azita Emami, the -- and you've all met Azita, the dean at University of Washington. So.

AZITA EMAMI: Thank you very much.

You must be exhausted, but in a positive way. I think that it had been such an ins- -- inspirational day today, and my head is spinning now of all ideas. And, you know, I'm so in awe of all the great works that -- that are done across this country by -- by nurses. It's just unbelievably amazing.

So before I get to -- into sharing with you about some of the exemplars of the good work that is the -- that are done in our state, I just want to give you a very brief background information that, you know,

might give you an insight about why I am pursuing things in the way that I'm doing that, with the -- of course together with all other amazing nurse leaders in our state.

So I was born in Iran, but I lived the main part of my life in Sweden. I moved to s- -- to Sweden when I was very young. So my education and my nursing career and academic career was from Sweden.

When I move to the United States, I was just -- I couldn't really, you know, digest the paradox that I saw in this country. Because United States is known for very advanced, you know, research; knowledge d- -- generation; medical, you know, advancement. The country actually export this knowledge to other countries. And -- but at the same time, when you look at, you know, the -- the amount of money that is used, almost 20 percent of our GDP is used for healthcare services in this country. Compare it with Sweden that is only 11 percent. And compared with to all og- -- os- -- CD [sic] countries, United States has the highest portion of GDP used spent for -- for healthcare. But if you look at the outcomes, the health outcomes, we have almost in the bottom of the list of -- of the OACD.

So I have been thinking about what's wrong. What -- what is that that we do wrong. Because it's not

that we are not knowledgeable or we don't know what to do. Th- -- we actually, you know -- the other countries model the knowledge that we generate. So what -- what -- what's going on? And I have been thinking about, "Okay. Why is that that in Sweden we have such a wonderful, you know, outc- -- health outcomes and at all different areas?"

So I could just, you know, differentiate some things that are going on in the -- in Sweden that we could do better here in the United States that might, you know, help us, you know, improving those outcomes. And of course Sweden has a universal healthcare. We don't have it here. But that doesn't explain everything. So I try that -- okay. What -- what is other, you know, things that are done in Sweden, you know, better, so that we -- we can get those outcomes.

So inter- -- interprofessional collaboration is very, very common in -- in Sweden. So healthcare professionals really, you know, work together in the healthcare settings, and it's a kind of very robust and -- and strong teamwork. And then we -- in Sweden we have integrated healthcare. We call it -- it's -- in Sweden it's *vårdkedja*. The direct translation is "chained care." Chained healthcare. So that once you are born, you get into this chain, and you are never

dropped out of this chain.

And -- and we have also -- you know, Sweden has the most robust patient-data register. They have been, you know, collect data s- -- since 16th century, actually, but not in this -- that s- -- sophisticated way that it is t- -- now. But -- but -- so -- so, you know, we have all this information coming in, and we can really base our, you know, interventions k- -- healthcare interventions based on metrics. Every year.

And the other thing that is also very important is that we have very strong cross-sector collaboration. So that, as an, you know, educator, I was the head of Department of Nursing at Karolinska Institute in Sweden, and when we planned for our, you know, program for courses, everything, we did it t- -- m- -- in collaboration with other, you know, communities of interest, with other public, you know, services sectors. We constantly ask them, "What would we do to improve our education so that it would meet the needs?"

So when I came to the United States, I couldn't wish to come to a better state than Washington, because here we are so collaborative and we support each other so much it's just unbelievable, and I think that that really gave all of us an opportunity to work together and really, you know, remove the -- the

barriers, the silos, break the silos, and work with each other.

So what we have done, and three examples that I want to give you today -- there are many other great works that are done and -- and going on in our state, but three I think that stands out for me. One is that we just recently receive funding from the State, $18 million, to build the Health Sciences Learning Building in University of Washington. And what we plan to do is that we have been very strongly into professional education, you know, for -- for many years. We have been really pioneering that in the -- the country. But that will give us an opportunity to -- to really merge the destructive [sic] innovation, the technology that we talked about all day today, into this learning center. Having all the students from all the six health-sciences schools come together and being in a very, you know, amazing, state-of-the-art, one-stop resource center, to really learn, using technology, using VR, using augmented, you know, reality, using . . . intelligence -- artificial intelligence, to -- to really help us to come together.

But it's not only using technology, but also really taking the interprofessional education, the connection between the s- -- the students to another

level, so that when they, you know, graduate and go out, that they can really work together as a team. That is very important. And I think that that was also one of the components that I saw was very strong in Sweden.

Then another example that -- that I want to share with you is that based on all the conversation that we had today, the important [sic] of nurses really focusing on population health, really thinking about health equity, and -- and sosh- -- social determinants of -- of health. We in the state of Washington really thought we need to do something, we need to change our education in order to be able to address that issue, because we cannot continue, you know, focusing on acute care in our education and then preparing the students and they go out and in the, you know, community and clinical settings, they are already thinking about, you know, different nurses that they need.

So what we did for almost two years ago, all the 18 schools of nursing in the state came together and we published a white paper that is . . . a kind of, you know, commitment for all the schools of -- of this state, to really shift their perspective from acute care to population health.

So all of us have been changing and revising and re-envisioning our curriculum, and I know from the

University of Washington School of Nursing now, almost all of our programs are revised, you know, and we really -- you know, the main part of -- of our education will be focus on population health.

And these are the areas, you know, that we -- rather than having only one course here and one course there, we threading it throughout our pr- -- all of our courses, because we believe that it is very important that our students, you know, all the time, you know, get foster in a mindset that really is about population health. It's about addressing health equity. And so by the time they are graduated, we hope that this mindset is embodied in the -- the way of thinking.

So I'm very proud of -- of that -- that w- -- white paper, because it also brought all of us together.

The last one is a collaboration that we have initiated with the Seattle King County Public Health. So Patty Hayes, who is the director of Seattle King County Public Health, and the -- we met and we talked about all these issues. "Why is that? Why can't we, you know, really align, you know, preparing nurses to be really, you know, the nurses that you want in the community? So what can we do?"

We decided to pilot, to really come together, and work with each other in a program that they have

that is called Best Start for Kids. It's a six-year program, and it's . . . $400 million funding for six years, to really focus on kids, to really help the families and the kids to really grow up and become, you know, healthy, wonderful, accomplished, you know, citizens of -- of -- of this country.

And we thought if we connect our -- our students to this program so that instead of, you know -- and they -- they need to do the final projects, whether it is a capstones projects or doctoral dissertation or whatever, they need to do it on some topic, and we thought if we can pair them with that program, so that they actually work together with the m- -- members of the Best Start for Kids and really, you know, do studies that are related to that program, not only that they do something that is very useful and could be directly, you know, implemented in the real life of what's going on right now in -- in the Best Start for Kids, but also that we can really enthuse them to eventually pursue a career in -- in public health; in -- in population health; in, you know, policy. So that is a kind of really wonderful leveraging our resources in the best way by really talking to each other and finding, you know, those shared visions and sh- -- and shared goals and priorities that we have, how we can work together.

Because I'm sure that if you talk with, you know, all your counterparts, you find out that we do a lot of things repeatedly and in redundancy, all of us, but how can we really leverage our work so that we can synergize each other and really, you know, make sure that we cross-fertilizing the outcome of what we are doing.

So these are three examples. Again, you know, I can stay -- stand here and talk about all the good works that are done in the -- our state, but -- but these are just the things that I think that really can move us forward and really help us to make sure -- ensure a better healthcare delivery for -- for all our -- our -- our citizens in this -- this state.

So thank you very much for your attention. I know that you are very tired now. So the wine is just f- -- a few steps around the corner. Thank you.

PATRICIA POLANSKY: Thank you. Yeah, it is just around the corner. Ana is asking them if they can start early. So you -- you have kind of two choices: To start early, or you can run up to your room, because on the east coast it's almost 8:00 o'clock, to say goodnight or whatever you need to do or call the kids, and come down. But we're going to have it for about an hour. And we know everybody's exhausted.

So just a couple of quick highlights. We had big things. We talked about APIN. Remember APIN. We had ten states, two rounds of funding, and of everything that the Campaign for Action has done, almost 43 states were -- are working, worked, still working, moving that needle, pushing those rocks up the hill, on academic progression. And now, of course, we have NEPN doing that work, so that's huge.

Cross-sector collaboration. Did you hear that? That's the second box in the framework. The actual framework. The Culture of Health framework. Cross-sector collaboration. Remember, making health a shared value is the first one, and cross-sector collaboration. And that permeates everything we heard that.

We heard about $50,000 grant. $80 million worth of funding. Interprofessional collaboration. You know. Starting this education. We heard it earlier in the town-hall meeting. So I think that's great.

So you're gonna go out there, you're gonna lean in. You're gonna get yourself a meme. You're gonna find more Callie Annes. You're gonna look for people that look and sound like her and you're going to see that. The mustard seed dropping. Right? Because we must, must get young people and young nurses up and

involved in this work so we have someone to hand this off to. And then -- and I don't mean handing it off. We need that kind of thinking.

I was so refreshed by what you said.

Weren't you? I was watching all the heads nod in the room. Everybody's like, "Really? How cool was that?" Very cool. So good.

And last but not least, you're gonna leverage. Leverage things. Leverage what you've heard. Just this afternoon there's prob'ly 25 things just since we came in this room at 3:00 o'clock that you haven't heard before. Think about how to leverage one of those. Any of those. Some of those toward it.

And then the inevitable, beautiful thing that we just heard. We're all saying -- you know, we all grew up, you had to do three -- my day they told you you had to do three years of med/surg before you could do anything else, God forbid; right? And I'm not saying you shouldn't do some of that still. But from acute care . . . so from 2-North to the Pacific Northwest, which is where you're sitting, what they're doing, how they're thinking, how the dean's framing this, how you think about this . . . Kristi, all those beautiful, wonderful, really, on the outside of our minds thinking. So leverage that work. We're all good.

We're letting you out five minutes early. Well, actually, a half-hour. So serious if you wanna run upstairs. I don't know if some of you haven't checked in; they didn't have the rooms. But we'll have the setup out for about an hour or so. Free drinks. Go for it. And, you know, talk to each other.

We -- now, tomorrow morning, breakfast is gonna be served where you're having your drinks. It's part of the hotel here, if you're in this hotel. We're gonna start exactly at 9:00.

Right, Dr. Gorski? That's what's on the thing there? You're lookin' at it. 'Cause I didn't want bring it up.

Yep. 9:00 o'clock. So you have from 8:00 or 9:00 to get breakfast. We're not providing breakfast. The hotel provides breakfast. So you get it there, eat, and come down. Bell's gonna ring [bell rung], 9:00 o'clock, start. We'll see 'ya then.

Oh, yeah, please leave those.

Oh, and one thing I didn't forget, because here I got on my list again. But many of you got calls from Maureen in the back there. Maureen is somebody like Mary Sue and I that was out in an AC before we even had more than ten ACs, and she and Liz -- Liz, you should wave, too, over here -- were part of the original

group of what we then called regional nurse experts. And Mary Sue and I were on the phone, talkin' about doin' this and interviewed them over the phone, and Susan and Sue thought that was a great idea, and them and many others have been with us all along.

So I thank you very much, both of you. And in particular Maureen, for all the work you did on this meeting and getting us all lined up.

And Maureen's in the room, and she'll be here all day tomorrow, so we're good.

Anybody have questions? Concerns? Anything clarify? Otherwise . . . time to wine.

ANA HERVADA: Yeah, I think -- I think we're good.

PATRICIA POLANSKY: Yeah, we're good. Thank you for your attention.

(Meeting concluded at 4:59 p.m.)

C E R T I F I C A T E

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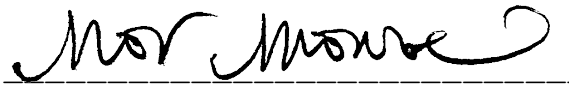
I, Nor Monroe, Certified Court Reporter in and for the state of Washington, do hereby certify to the following:

That my stenographic notes were reduced to typewriting under my direction;

And that the foregoing transcript, pages 1 through 95, inclusive, constitutes a full, true, and accurate record of all the proceedings had, and of the whole thereof.

Witness my hand this 21st day of August, 2019.



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FUTURE OF NURSING: CAMPAIGN FOR ACTION

INNOVATION IN HEALTH CARE 2020-2030

THURSDAY, AUGUST 8, 2019

Residence Inn by Marriott -- Seattle University District

4501 12th Avenue NE

Seattle, Washington 98105

I N D E X

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(SEATTLE, WASHINGTON; THURSDAY, AUGUST 8, 2019)

(9:02 a.m.)

MARY SUE GORSKI: Good morning. Good morning.

AUDIENCE IN UNISON: Good morning.

PATRICIA POLANSKY: Morning.

MARY SUE GORSKI: The level of energy for this time of the morning.

KIMBERLY HARPER: Well tuned for some of us.

MARY SUE GORSKI: And a reminder -- good reminder, Kim. It's noon for some of you.

So welcome. Welcome to Campaign for Action, Innovations in Health Care 2020-2030. I want you to get an official welcome this morning from Susan Reinhard, who is the chief strategist at AARP Public Policy Institute and the. . . . Sorry.

SUSAN REINHARD: We're good. We're good.

MARY SUE GORSKI: Center to Champion Nursing in America. And -- and it's been great to work with Susan over these years.

SUSAN REINHARD: So first I'm gonna tell you I'm gonna cede most of my time, almost all of my time, to the rest of the day, 'cause there's so much more we hear from you talking to Sue about how you want to talk to each other.

So I just want to welcome you again to this

amazing event and to thank Pat Polansky and the team who has been doing so much work. There are a lot of new faces today. So we wish that you can catch up with us, because there's a lot we've been doing. I gave some testimony yesterday to the -- the National Academy of Medicine. I guess we call it a town hall. Whatever that's called.

And -- and basically just wanna leave with you that AARP and -- and the Center to Champion Nursing in America, but the big AARP, 38 million members across the country, are committed to the future of nursing, and will continue for decades to follow, because we think nurses are so critical to the care of older people and their families, which means people of all ages. So thank you so much for being here. And I'm gonna turn it right back.

MARY SUE GORSKI: Thank you, Susan.

So one reflection that -- that we have made, and I -- we had some great conversations, and I -- I heard many of your conversation last night, too. But one reflection we wanted to -- to highlight is the tremendous amount of work that's gone on across the country. And we are very proud as Washington state to be able to tell you a little more detail about what we've been doing as a host state, we get that

opportunity and that privilege, but we also wanted to highlight those individuals that are here that have been working on this . . . since we have. Since the very beginning. Since before that. And this is what you have heard us talk about: The action coalitions. And there were action coalitions in each of the states. Most, if not -- not all, have evolved significantly over these ten years, and some into totally different ways of getting the work done.

But I -- there are some individuals here that have been through that whole ev- -- evolution. Kim Harper from Indiana is one. Mary Dickow from California is another. Randy Hudspeth from Idaho is another. Victoria Vinton from Nebraska is another. And Casey, Casey Blumenthal, from Montana. Those are the ones that I think about right -- right off the top of my head.

Many of you have been involved in this for a long time, and we -- as we are seeing, we have a lot more work to do. So it's just beginning. It's not even the middle. It's just the beginning. We do need some younger faces, though, to take over the work, too. And I think we have lots of new faces in this room that are gonna help with that. So that was just the reflection.

And -- and also to answer: Individuals wanted a little more time to talk with each other and to really

do some networking. We had an hour to do that, but we made some changes in the agenda to kind of accommodate that. So we still wanna give you these great panels that we have -- give time for the panel, some questions. We'll prob'ly start before 9:15 here, but we'll have a plenary panel. Notice that we took out the official break. That doesn't mean that people can't get up and around. But yesterday I f- -- saw that people felt free -- free to get up and move around as they needed to. The snacks will be right outside here, so that you'll be able to get drinks and snacks there. We'll do a couple more state exemplars, and then there will be a short presentation by Sue Hassmiller. She shortened hers -- her time, too. So thanks so much for helpin' with this.

And then we ended up with a little over an hour of networking. And we'll have specific tables set up with the exemplars and with the individuals that have done some presentations so that you can connect with each other. We would like to come back and wrap up at 1:30, so we'd like to -- you to stay close and -- and plan on just a very quick wrap-up.

So there we are.

Thanks for the feedback and the discussions, and now onto our first plenary.

UNIDENTIFIED WOMAN: So are there any breaks or people should just take breaks when they --

(Simultaneous talking.)

MARY SUE GORSKI: People should just take breaks when they went. So. And so there has been a lot of back-and-forth and -- and that's great. Okay?

Great. Well, we'll have you outta here by 1:30 so you can get on the freeway.

PATRICIA POLANSKY: We see the suitcases out there, so we're gonna get you out in time.

Okay. Would the plenary-panel speakers come up and have a seat here.

(Panel members talking amongst each other.)

PATRICIA POLANSKY: We're gonna be -- I don't know which one to talk into. Does this work? Yeah. Here you go. So. In case for questions.

Well, you are in for a real treat, as Mary Sue was saying. And again, we were reflecting on the enormity of everything people have done in this room; the anchor action coalitions that are here. Also wanted to add that Kim Harper volunteered, which -- which she did and whatever. So later, during the networking time, Kim has just anchor person -- lead, lead person -- for the NOBC effort, and she does have with her all of your state rankings. So if any of you wanna check in with

her on NOBC and see where that is.

MARY SUE GORSKI: Can you say what that is?

PATRICIA POLANSKY: Oh. Nurses On Board Coalition. Rah-rah. 10,000 nurses by 2020 on boards and leading across America. So Kim being really a lead person with that entire effort. She has that, if any of you are interested in that during that networking time, you can come also talk to her at a table. We'll get that all set up for 'ya.

Okay. Without further ado. We are really fortunate and very excited, actually, to have this panel of really so much experience in this panel. So if you don't just glance as they're presenting at their bios, I would just say recommended reading and a required reading, as your professors used to say. Because what they have done is everything imaginable and from rural to urban and every kind of sector, from long-term care and home care and visiting nurse. So you are going to get a full panoply coming from them.

And we're gonna start with Mike Ackerman, who's the director and Master in Healthcare Innovation. This is the theme of this meeting. So we're really looking forward to looking at that. And anybody who elevated from a candy-striper to the front of the room, you go, Mike. Go Mike. Go Mike.

MICHAEL ACKERMAN: That's gonna be my final job, also.

PATRICIA POLANSKY: There you go, yeah. I was thinking of going back and I'll be one of those people at the front desk, you know, you go back and volunteer.

And second would be Sue Birch. And Sue Birch is the director of the Washington State Health Care Authority. And you'll see in her bio she's just mildly responsible for covering two million lives. So she's gonna talk to you a lot about that end of -- of -- of the street and the avenue.

And then we're going to talk to Karen Giuliano, who is the associate professor of nursing at -- for Healthcare Innovation. And I love this: EntrepreNURSEship. How cool is that? How cool is that? Here from -- to share all of this with you.

And last but not least, and then MaryAnne Lindeblad, who is also -- home state here to Washington, but the Medicaid director. And again, been acute care, long-term care, behavioral health, elder care, and people with disabilities.

So we think we've got it covered, and you covered, and as I told them all, from their lips to NAM's ears, and for all of you to benefit.

So Mike, how 'bout you kick it off for us?

MICHAEL ACKERMAN: Thank you so much. Very thrilled, honored, humbled, all those words you use, to -- to be here with this esteemed group.

I wanna start with a story. About 15 years ago, somebody that I think you met yesterday, Bern Melnyk, was my research team, and she came to me, said, "Mike, I -- I -- I think we should start a center for clinical trials in medical-device evaluation [indiscernible] in the School Nursing in Rochester."

And I said, "Bern, it's not gonna go."

And I think yesterday you realize Bern has no limits. And so she said, "No, I think it'll go."

[Indiscernible] I said, "Industry doesn't wanna partner with a School Nursing."

Now, beauty of working in Rochester was, you know, it's the land with the -- that Ford built, so we always had a foot in practice education; research education. So I -- I practice as a nurse practitioner, so I had access to patients. And we grew that business.

And when you look at different products, like the CORTRAK feeding-tube device, Philips IntelliVue monitoring systems, that all came out of that center. And I'm really proud to say that we built that into a -- an enterprise where our nurses provided so much input into how the product was developed, and it became, "What

toy is Mike gonna bring us next?" Because -- and -- and they were so excited about being able to influence and innovate at the bedside. And that was 15 years ago.

And ever since that time I've been doin' this work. And Bern has tried to set the hook several times, and she finally did, and I ended up at Ohio State. So. Very happy about that.

I've got just a few --

(Audience member's phone talking.)

UNIDENTIFIED WOMAN: Sorry.

MICHAEL ACKERMAN: That's okay.

What if I said, "Hey, Siri," how many phones would light up? Hey, Siri. Anyways.

So I just wanna say, "Why not nurses?"

But I also wanna say we gotta start talkin' to other people. Okay? You know we're kinda preachin' to the choir here. Aren't we? Yesterday I had the opportunity to speak on sepsis to a group of people that do disinfection, water quality, air-quality work, at a hospital-acquired-infection meeting. These people had no healthcare background, but they're innovating in this -- in this infection-prevention wir- -- space. It was so cool. And -- and there's, like, self-sanitizing sinks and robots that clean things. And I'm like, "This is really cool."

And I'm like . . . this is where we need to be. We need to be out talking to others outside of nursing about what we do as nurses to innovate.

So with that. We need to create cultures and -- and this is what we teach our students, and this is really what we're trying to promote. We need to be disruptive. 'Kay? And I was trying to think, like, what could I do up here that would be really disruptive, just to get you engaged in the disruption? So I thought do I turn my chair around the other way? Do I get up and stomp my feet? What -- what do I do?

But we need disruption. But when you hear the word "disruption," what does that -- how do you feel about that? It kinda gives you this, "Ooh, disruption. Do I wanna be disruptive? Do I wanna work with people that are disruptive?"

But we'll never move innovation forward if we're not disruptive. However, healthcare doesn't like that word. Right? In fact, we even have a job title called "orderly." Right? Because we want things orderly. Right? So healthcare doesn't like disruption.

The other thing we need to cr- -- so we need to create a culture that promotes disruption and allows failure. Now, I didn't say error. I said failure. And those two words are not the same. The error comes when

we fail, we don't learn from it, and we make the same mistake again.

But I'll ask you and I'll challenge you: Does our healthcare system right now, does the culture in our healthcare system, promote disruption and allow failure? 'Cause if it doesn't, we'll never get past first base with innovation. And in order for innovation -- this comes from all the innovation-science work -- we -- we cannot -- we will not promote innovation unless we do that, and we gotta allow our nurses to do that.

When I left Rochester, S- -- Strong Memorial Hospital, we -- my -- my CNO there, Pat Witzel, was a wonderful woman. Our last magnet [indiscernible] visit, we had 25 exemplars. 25. You're lucky to get one or two. We had 25. And that's because we engaged our nurses in everything. And it -- I felt like proud papa, you know, when our nurses were walking the surveyors around. And, you know, we didn't tell people to hide in the bathrooms when they come. We -- we put 'em out there.

And our nurses were allowed to -- to . . . to -- to take things forward. And, you know, our favorite word was "Let's just do a pilot. Just do a pilot." Right? "If it doesn't stick, so what? Let's try somethin' else." That's innovation. That's

innovation work. And we have to promote those cultures. It's all about the culture.

And it's also about the leadership that -- that sets the culture. And we know from the data that most healthcare leaders and most leaders in academia aren't comfortable with what to do with innovation. They're not -- they're not familiar with the competencies of innovation. And this is academia and on the -- on the service side. And this data comes from a big study that was done through the American Academy of Nursing. 300 people, they looked at the -- I think there's 26 competencies for innovation. And they asked 300 people to evaluate themselves. Now, th- -- these are academy people; right? And it was really kinda staggering how inept that group felt around innovation. 'Kay? So we also need to develop our leaders.

I want you to -- to ponder this. Think about innovation both as a noun and a verb. 'Kay? Because it's both. Think of it as a noun and a verb. We have to -- we have to innovate. We gotta create things. And Karen's been wonderful at creating a lot of cool things and technology, and -- but we also have to help nurses understand: How do we move innovation forward? What's the innovation process? Who are the stakeholders? How do we move it? That's the verb. 'Kay?

So yes, we need nurses to invent. And you -- just -- just spend a day with a nurse and they'll give 'ya, you know, dozens of things that need to be fixed. Okay?

There was just a paper that came out from a physician in Hawai‘i, and [indiscernible] the title of the paper was, "Get rid of the stupid stuff." Right? That's title of the paper. And what they did is they got all the providers and nurses together and they put things into three buckets: Things that have to stick --

And it was mostly around EHR; okay? Things that have to stick for regulations, whatever we need to do.

-- things that if we tweaked would make life easier and better, and things that we just gotta get rid of.

So this leads me into this concept of the novation continuum that we're trying to develop. The novation continuum goes from innovation, which new/novel. Sometimes it's disruptive, sometimes it's incremental. Okay. But nurses need to be at that table. Nurses need to innovate. Ask 'em.

My plea to that group yesterday of all these -- these people doing all this infection-prevention work is that, "Please talk to

nurses before you invent the next best thing, because nurses will tell 'ya, and they wanna tell 'ya. They wanna be at the table. You gotta give 'em a chance."

So that's innovation.

On the other side of innovation is something called exnovation. Exnovation is getting s- -- rid of stuff that doesn't work. And we know from the science that the skill set for innovation is very similar to the skill set for exnovation. Okay? But how often do we do that? And it's a lot harder to get rid of stuff than it is to bring new stuff in.

How many of you are cr- -- anybody here critical care? Intensive care?

So back in the day we -- we had these red, rubber catheters to suction airways. Right? Right? Remember that? And then I brought in this thing called an inline suction catheter. And the nurse is, like, "Ah, this isn't gonna work. There's no [indiscernible] nah, it doesn't work. You can't hear it suck," you know, all this kinda stuff.

And I'm like, "No, it'll work. Try it."

And you woulda thought I was -- I was a heretic, to bring this -- to bring this in. And now if you were to take that away -- but there's my point. At the end of innovation is usually exnovation that we

forget about. And that's where the burnout comes. 'Cause we ask nurses to do this, and then we add this, and then we add this, and we never stop to say, "What can we get rid of?"

Here's an example from that paper, in the EHR in this -- in this one hospital. Nurses had to document incontinence, and they had to document fecal incontinence as well as urinary incontinence, and then they had to document the characteristics of the incontinence, and then they had to document what they did for the incontinence. So there was several clicks. Right? So they applied that across the whole health system.

Now, they had a neonatal intensive-care unit. Those poor nurses, when they changed a diaper, had to click six times to change a diaper. That's stupid. And there's an example of if you would have just asked the nurses about how could we do this better, they would tell you. But we missed that step.

So in the middle of the ter- -- the novation continuum is renovation. So we got innovation, renovation, exnovation. Renovation's process improvement. 'Cause we struggle. Where does quality improvement fit in this whole innovation game? And -- and Dr. Weberg writes about this all the time. We spar

about it a little bit. But . . . that's -- that's where process improvement fits.

And do we need innovation for process improvement? Absolutely. But -- but when you renovate your kitchen, it's still your kitchen. Right? When you innovate your kitchen, it's -- it's brand-new. It's something that didn't exist before. And that's how we differentiate. So this is this whole novation continuum, from innovation to renovation to exnovation. But don't forget the exnovation piece, 'cause that's what's drivin' people crazy.

One more thing. One more thing. And -- but it's very -- it's very difficult and very challenging.

So I think my time is up. Thank you.

PATRICIA POLANSKY: [Indiscernible] so we're -- we're going to go from that -- if you pass the -- there you go. Sue Birch up in the queue. So.

(Simultaneous talking.)

SUE BIRCH: I'm Sue Birch. I'm the director of the Health Care Authority here in Washington. My sidekick is MaryAnne Lindeblad. So together we oversee care for 2.6 million Washingtonians, and we cycle through a billion dollars per month. Billion, B, per month. About a budget of 12 billion per year. And we are a force-mover in the state here in Washington

because we really have seized the opportunity around the ACA and Obamacare and all the innovations.

So I wanna spend a few minutes just talking about this. And I'm sorry. I'm, like, kinda highly caffeinated, and I coulda been a night nurse last night, 'cause I think I was up all night. So -- so stick with me and let those phones roll.

So a few things. I wanna make sure that you all understand why Washington is really on the cutting edge of movement into the health-transformation space. It is because we have nurses lined up up top. If we do not continue to partner public part- -- private partnerships with business and seed nurses there in business, like we heard from our Amazon friend, if we do not seed more people in government to bust down the regulations and to change up government -- and nurses need to be right up top there. And I'll talk more about this in a minute. And education. And I say education very broadly, because it's really workforce and it's workforce realignment.

So I wanna talk about these spheres. I'm savin' a lot of MaryAnne's extraordinary work for her. She's gonna talk here in a little bit.

'Cause you do wanna hear how we were first in the country about transgender benefits. And we're

first, led by a nurse legislature, and supported by nurses on this stage, to be bringing up a public option in this country. A first into the Obamacare space. A first into an apprenticeship path. I could go on and on. We're first in the country to bring up a hepatitis C elimination strategy. Louisiana wants to fight with us. We'll take that fight.

I would -- could go on and on about the firsts that are going on, but I don't wanna do that. You need to hear about how we're getting this work done, and it's in these three domains. Okay? Remember that. Education workforce, policy-regulatory environment, and public-private alignment.

So a few things -- in case you're not going, "Wow. How'd they do that stuff?" And it might be the gray skies and all the coffee. And the light. 'Cause we s- -- work, like, all the time, I think. But -- no.

(Simultaneous talking.)

SUE BIRCH: It's been fun. I moved up from Colorado, and talk about we -- I left one disruptive state to come to an even more disruptive state. And truly, the Canadians love to meet with us because they call us the rebel alliance.

And so I also will tell you that we are very proud that we have the most number of successful

lawsuits against the current administration, and we're holding the front for all of you on reproductive health and all sorts of other things.

UNIDENTIFIED WOMAN: Thank you.

SUE BIRCH: You're welcome.

And we need more of those thanks, 'cause every day we say, "It's crazy. It's really crazy."

So back to kind of the learnings here.

It is really, really important that you all stop thinking about hospital nursing and traditional educational paths. And I know there are people in this room, and Azita presented yesterday, how the deans all aligned around a population-health framework. I know Mary Dickow, out in California, you're doing some amazing stuff with no nurses having acute clinicals.

People need to realize that the complexity of healthcare is changing so fast. You just go down these streets here in Seattle or any of the major big sistee- -- systems, and you will see ICU-level patients homeless, on the sidewalks, and they are out there, and we gotta care for 'em in different spaces and places.

We also know from all the great work that's been going on that all the technologies are meaning everything's gonna be done in the home, in the community, and our ICUs and our facilities are gonna be

so much more intense. But that shift is just extraordinary. We have to be ready for the emerging social issues. And if we didn't just experience another crazy event this weekend with gun violence, the social issues that are coming at us require us to rethink how we are retooling our nurses and our educators and our faculty. We gotta get them to understand this massive shift.

I loved yesterday, also, hearing about how -- shift about consumers. We haven't even done our work as nurses to really get our clients to no longer have that power differential in the healthcare space. We will be imploring nurses, with all the apps and whatnot, s- -- supporting clients, to really bring on a whole new level of new consumerism. And I already see it with the students and the millenials that are trailing us, because they don't want -- they will not sit in this room --

And Callie, thank you for sittin' in this room with us.

But yeah, you're going, "I'm not a millenial." But my point is is that we have to learn how to do chat rooms. We have to learn to do our work completely different. We have to learn to educate students on the run with us. They gotta be in the location. 'Cause

they aren't necessarily gonna wanna get trained in the same old, same old way.

Social determinants. MaryAnne's -- I'm stealin' all her thunder. But she's gonna talk about how she created a $1.5 billion, last-Obamacare-approved waiver, to shift to supportive employment and supportive housing. So we gotta get our -- our clients -- and I would tell you it's -- when I sit with Boeing and The Gap and Costco executives around healthcare and when we sit there, they are starting to run social-determinant data on their employees. And guess what? A hundred percent of 'em have behavioral-health issues. A hundred percent of 'em have financial strain. Everybody -- if you don't have anxiety going on in this country right now, something's wrong.

But they've tested their employees, and they are like, "We're with Sue on social determinants." They're finding they've got people living out of vehicles. They've got their own challenges. It's not the density that we have in Medicaid, but it is real across all socioeconomic groups.

And I mean that in the sense of think about how complex family households are now. Think about the strains people have about, "Will my engineers be building jets that somethin' goes wrong and then what do

we do when 300 people die?"

I mean, again, as we sit with private industry, they share with us all the time their challenges, and they are furious about healthcare delivery. Furious.

Do you know Pacific Business Group on Health is running one of the biggest campaigns in the country called hashtag-unnecesarean? Oh, yes. And they can tell you which hospitals have the worse C-section rates. And they are telling -- they are coaching their employees to find nurse midwives and doulas and use birthing centers. I'm so proud that California -- the left coast -- we have the highest density of . . . birthing centers. And guess what? Dominated by nurses.

So, you know, these are the kinds of things, guys, we gotta -- we gotta just -- we gotta sprint in this changing paradigm.

I know my time's running short.

MaryAnne has done an amazing job creating things like bundled payments; greater capitation. If you don't know about hybrid payment and if you don't know the basics of insurance stuff, you need to come spend a day with us or have us teach or speak at your classes. You have to have these basic principles as executives. And I know you guys, you are so far

advanced in this room, and I see heads shaking. But I will tell you: If you feel like "I don't have that or I can't articulate it," you need to --

Just wanna make sure that's not some governor --

(Simultaneous talking.)

SUE BIRCH: You need to make sure that you understand some of these basic principles. Because we -- this country is moving towards value-based purchasing and payment, and nurses have to cede their kind of power into understanding what portion of the pie, that value-based-paradigm pie, you get and you earn and you can demonstrate. So that's a whole different t- -- conversation.

Just real quickly, also. Labor. I think in a country that is having widening shifts in our socioeconomic stuff, where we are seeing more extreme haves and have-nots, when we are looking at whole swatches of this country going into minimum-wage movements, household wages and -- are critically important. And us understanding our influence, our challenges with labor -- and I mean the unions. And I am new to a union state. But something that you really gotta get tooled in and understand because it is a huge, huge opportunity for 'ya.

I wish Diane Sosne was here. She would represent how they lead the biggest union in the country, and that they used it as a way to do on-site educational tracks to take food custodians or environmental custodians and food workers and kind of they springboard them up to the kind of universities, just get them working and educated at work, and then to the doors of Azita and her colleagues.

And 60 percent of those in healthcare s- -- sphere are picking nursing as the final destination, and they're having to do it slowly and incrementally.

So my time is up. I just want you all to just know you, you, you have a duty. You need to bust in the doors with we policymakers. You need to make yourselves known into the business circles. You need to get yourselves appointed to more boards. And I mean all kinds of boards. And you absolutely need to do everything in mind with "We're gonna fail, but we gotta fail fast, and then get up and try it again." And there is no time to waste. Nursing has to be in this space.

And really I can't tell you how important it is to partner with your educators. I mean, Azita is a very creative force back there. We saw this at university [indiscernible] others where they wanted to help us with nurse-practitioner residencies.

We are all needing to align, 'cause the workforce that we need right now is not what is necessarily getting cranked out. All the places we visit always have retraining programs, and we gotta get better about letting that all happen in realtime instead of this, "Okay. Well, they get their four years or they --" yeah.

So anyways. Those are some of my thoughts. And good morning.

(Simultaneous talking.)

KAREN GIULIANO: Well, thank you so much for inviting me. It's -- I'm so passionate about innovation and having nurses be a real key part of it. And I know that the Future of Nursing: Campaign for Action can do a lot to support that.

So because nurses are the largest group of healthcare professionals and have access to patients 24 hours a day, nurses really have a uniquely practical and care-sensitive perspective in healthcare delivery, products, and services. Nurses touch more products and are part of more services than any other healthcare professional.

Nurses are the best clinicians to address everyday problems with healthcare, because most other healthcare professional groups do not understand the

full scope of these everyday problems and their impact on workflow and patient care.

Nevertheless, nurses are part of a team where every discipline and every job is important. That is why the best and most cost-effective outcomes for patients will only be achieved when all members of the healthcare team partner collaboratively and where expertise and role of the nurse can be truly recognized and highlighted.

The rapid change in healthcare requires all front-line providers to have entrepreneurial skills to support collaborative and meaningful healthcare innovation.

I could not agree more with Dr. Ackerman's comments on the need for change in -- changes in healthcare leadership in order to support innovation at the point of care. We need to create a culture that rewards new ideas and is willing to encourage the sai- -- the development and testing of new ways of working. With patient safety in mind, 'cause clearly that's super important, we need to create a culture that rewards those who are willing to innovate even when their ideas fail. Learning from failure is a fundamental requirement for innovation and one that we need to embrace.

We need to recognize that in our desire for patient safety, we continue to tolerate many practices today that are inherently unsafe and sometimes even dangerous because we are too hesitant and too afraid to support nurses and their colleagues in new ways of working.

Do you know that during an average 12-hour shift in a busy critical-care unit, a critical-care nurse will walk five miles per day, will spend only about one-third of their time in direct patient care, will complete over 70 tasks per hour, will get interrupted 12 times per hour, most of that during critical tasks of medication safety and -- medication administration, will spend twice as much time interacting with technology than with their patients, and will engage in over 15 workarounds because the system doesn't work. Nurses use workarounds to address inefficient work flows, bypass workflow blocks, compensate for inadequate technology, or deal with a range of everyday problems, such as staffing, equipment, and supplies.

At the clinical-practice level, one of the benefits of workarounds is that many represent very creative problem-solving, with solutions that could be replicated, become more widespread, and lead to

systematic improvements in healthcare. Workarounds are also the raw material for nurse-driven innovation.

The routine use of workarounds is an open secret. However, since our current culture at the bedside does not officially support workarounds, most continue to be used under the radar. This can cause the well-intended nurse to be exposed to the consequences of workarounds that may inadvertently turn out to be harmful, leaving both patients and nurses vulnerable. Workarounds can also create new opportunities for error, which will go unrecognized.

We need to create an environment in our clinical settings where workarounds can be developed using design-thinking principles, safely tested, and then used to improve practice in a manner that benefits patients and rewards nurses for their work.

Dr. Tiffany Kelley, a nurse, founder and CEO of Nightingale Apps, and visiting profesher [sic/ph] for innovation at University of Connecticut, describes the development of workarounds to existing problems as a first step in the innovation process.

Dr. Kelley recognized nurses were working around system-level limitations preventing access and use of important patient information. As a result, Dr. Kelley developed the idea for Know My Patient, a

patent-pending mobile solution to address this need. Know My Patient is designed to support nurses with the information they need from the start of their shift report throughout their workday. Tiffany envisioned a way to make the information accessible and efficient while integrating within a health -- within the electronic health record to drive safer, more efficient, and more timely patient-centered care. This innovative product is developing a pervasive workaround affecting the nursing profession today.

The creation of a culture to support nursing innovation, such as Know My Patient, will require changes in the way we do business in our professional organizations, our clinical environments, and our academic settings. We need to change from a culture of no to a culture of yes.

The American Nurses Association is currently recruiting for a vice president of innovation. Which is great. The ANA could become one of the key places for nurses to learn about opportunities to engage in innovation and contribute to improvements in healthcare without having to leave their clinical-practice settings.

We need to transform our clinical environment to include opportunities for front-line healthcare

professionals at all levels, to engage in medical-product development, new workflows, and system improvements in healthcare. Most nurses, especially those practice in direct-care settings, do not see themselves as having either the ability, the support, or the power to innovate. Leadership at the practice level has to work with direct-care providers on the development of new ideas to dispel the fear of getting in trouble because there's no policy for their idea.

Our new graduates come into our clinical settings with ideas, and we should listen, not discourage them. While experienced nurses can help our new graduates develop their clinical expertise, our new graduates can help the experienced nurses . . . with out-of-the-box thinking. They come to our settings with enthusiasm, a fresh set of eyes, and a contemporary set of new skills. We should develop ways to incent all nurses to stay at the b- -- in direct care and innovate without having to leave the bedside or go start their own company. And we must also provide support to measure the impact of these changes through clinical-outcomes research and then actively and purposefully disseminate those findings.

In the academic settings, we should continue to develop more graduate nursing education to provide

the skills needed for interdisciplinary innovation. Dr. Ackerman's program is a great example of that. At the undergraduate level -- and this is crazy, but you gotta do it -- we should integrate content on innovation and entrepreneurship, support interdisciplinary coursework with engineering and business colleagues or students, and make it a mandatory component of undergraduate nursing education.

More generally, we should support the development of basic business skills for nurses at every level of education and practice, establish interdisciplinary collaborations with our business and engineering colleagues, provide interdisciplinary education and opportunities for healthcare providers at all levels of professional development, establish ongoing collaborations which support a variety of academic, clinical, and, yes, healthcare-business partnerships.

My own business experience in medical-product development, and working with my business and engineering colleagues over the years, has served to highlight the vital importance of having a nursing perspective built into the product-development process, from idea to commercial release. I would like to see that same opportunity be available for all nurses.

We need to empower our nurses to empower themselves.

Thank you very much.

PATRICIA POLANSKY: We coordinated on our clothes.

MaryAnne have the mike?

MARYANNE LINDEBLAD: Yes.

So thank you for the opportunity to be here with you today. I'm MaryAnne Lindeblad. I'm the Medicaid director for the state of Washington. Medicaid directors -- the average life of a Medicaid director is about 19 months, and I've been in my position now for seven years. So I'm a little unique in -- and I'm a nurse, which I think is two things that -- that . . . make the position of Medicaid director in the state of Washington, at least today, a bit unique.

I'm very excited to be here today to talk a little bit about some of the innovations that we have done in the state of Washington. Sue touched on them a bit. But really about how they've been so nurse-directed and nurse-led.

We have used nurses I think . . . as -- as a Medicaid program in a much more robust way than you see in many states. We've brought our nurses on to really support . . . policy development; implementation; our

quality oversight; many leading, major program initiatives that I will be talking about briefly. And we've really created multiple opportunities for nurses to come into our agency, to improve how healthcare services -- services are delivered across not only the low-income population that I serve, but also our public employees, and soon to be school employees. So I just again wanna touch on a number of those successes.

First of all, back in 2014, we re- -- we received in the state -- State Innovation Grant from CMS, which really helped kickstart the work of an 1115, which is a kind of a waiver, that we got again from CMS that allows us to operate our Medicaid program differently than other states might. And this transformation waiver, we were the last one in the previous administration to get a waiver like this, and they're really not giving out these kind of waivers anymore, so we're kind of at the end of a line. But our waiver really focuses on a culture of health and the importance of that and how we deliver services.

I'm gonna again touch on a few initiatives that came about because of that waiver, but I also wanna emphasize that nurse involvement was significant in each one of these, and the implementation of these programs, really many are nurse-led.

So first -- and again, this is very brief descriptions. But developed across the state nine different Accountable Communities of Health. And these -- these are organizations at the local level that really focus on healthcare and healthcare solutions that are unique to those communities. And again, cross-sector, so multiple different people coming to the table to help resolve issues that are local, and through the waiver will help -- we were able to fund much of this activity.

The second piece of a waiver -- of our waiver really innovative services to provide family-caregiver supports to individuals who -- families who are caring for an elderly or disabled loved one, they wanna keep that person in the home, but there's not always ability to do that. It's challenging. You don't have kind of supports. So this program offers supports. It offers training. It offers, you know, perhaps if they need supplies; if they need a wheelchair ramp. I mean, some really simple things, but also things that keep families able to take care of loved ones and either not having to go onto Medicaid, which because of a state recovery, a lot of folks don't wanna do that, or keep them -- postpone Medicaid.

So we have two different programs: One for

individuals on Medicaid that can -- kind of a different set of benefits, and also a program for individuals that are not yet eligible for Medicaid, but the family doesn't have to spend that money down to ultimately get them on there. So again, some really innovative programs. Again, much nurse involvement in making those things happen.

The third piece of our waiver, which Sue mentioned, is to provide supported housing and supported employment. So looking at the social determinants of health. Looking at . . . if you really t- -- wanna try to get someone out of poverty, and they have some significant health issues, getting 'em a job and helping them keep that job, getting a roof over their head and helping them keep that roof over their head, is really such a critical piece.

So that's another program that we were able to implement through the waiver . . . in order to really provide that kind of -- those kind of supports. It's not to pay for housing. It's not to pay for p- -- you know, pay your salary. But really those supports that wrap around you so you can say employed; stay housed.

Through this waiver, those are sort of the three key pieces, but there's many other pieces tied to it. One major innovation that is helped supported by

the waiver is our integration of behavioral health and physical health. So in most states, if you looked at their Medicaid program, behavioral health sits in a differently agency, it's delivered differently, you have to qualify differently, and physical health sits over here. Well, in Washington, we've brought those two things together. We're a big managed-care state. We contract with five managed-care plans. And now those plans are fully responsible for the whole continuum of behavioral-health needs. So you don't have to meet different criteria to get into services. You can actually get services in a way that is much more holistic and approaches you through a whole-person care approach.

Again, nurse-led process. My key n- -- the -- the -- this program was -- there was k- -- key there was one nurse that was so key to making this happen. And we are -- very few states are going down this kind of direction. They talk about integration, but they still keep the lines of service separate.

And we're just already starting to see the benefits of this program. We've -- actually are phasing it in over the state. We have about 70 percent of our enrollees in a fully integrated program.

I was at a meeting a couple of weeks ago, and

a provider stood up and just said she could not believe how much difference this program made in the lives of the people that she served. And advocates, same thing. It's just really been beneficial in how we provide services to a very vulnerable population.

In addition, we are -- we have a lot of innovative programs going on with substance abuse and how deliver to services for individuals with substance-abuse disorders, and started what we call a hub-and-spoke model, which what does is it provides nurses who can support other practices, physician practices, so they can actually provide medication-assisted therapies and other things in their practice because they have a nurse-care coordinator that can help unload some of that work that the physician previously was doing. So he maybe only could take two or three people; now a physician can take many, many more individuals under their practice that need substance-abuse-disorder treatment because they have a nurse-care manager assigned to them and is part of that. And we have really been a leader in -- nationally in how we provide those services.

In addition, you know, we are a big home- and community-based delivery system in Washington, so folks -- seniors/elders -- besides the program I talked

about earlier. Our system is very focused on home and community based. We have very few people that -- that end up going into nursing homes. In fact, we're often rated number one nationally because of that delivery system.

Another program that I wanna talk about -- again, very high level -- but a nurse-led program is our Health Home Program. And that was a program that was -- the opportunity to do that was offered up as part of the Affordable Care Act. We took -- took that opportunity. And it was a program in partnership with Medicare. And basically if we could design programs that help bring the costs down for Medicare. So, you know, there are services that Medicaid provides, services that Medicare provides, but they're -- a lotta the services that Medicaid does provide, they may be -- they may benefit an individual, but the money -- the savings wouldn't accrue to the state; they would accrue to Medicare.

So we entered into a program with Medicare, and through that program, in the last three years, we've saved so much money that Medicare has s- -- has shared in savings. We've gotten over a hundred million dollars back over a three-year period. Again, totally nurse-led. Very, very exciting.

I'm just about -- I'm getting my time up. But

I do also wanna mention very quickly that in our last legislative session there was the creation of a long-term-services-and-supports trust. And what that means is through a payroll deduction, people will be paying into a trust fund that once that fund gets seeded and we'll start enrolling folks in, means individuals that are residents in the state of Washington can get up to $36,000 in-home and community-based services once that program is up and running.

So again, I think, you know, there's -- there's been so much activity about professionalizing our long-term-care-delivery system; bringing more nurses to that program. I could talk on and on about what we do for kids. I wish I had more time. But I just wanna point out that through all of this innovation how much of it was nurse-led; nurse-directed; nurse-led. Nurses came up with the ideas. Nurses created the environment to make this all work.

And so if you ever wanna come to -- come and visit our Medicaid program, we would be happy to have you come.

And the state of Virginia coming in September to spend a couple days with us.

PATRICIA POLANSKY: Brad. Clean up now.

I told him he's the cleanup.

BRAD STUART: Okay. Thank you.

I brought some slides, but --

Ana, we -- we don't -- well . . . that's -- that's . . . that's the first one.

I just wanted to -- I just wanted to put up the title -- 'cause it's kinda ponderous and long -- of this article that just got published in "Health Affairs" last month. "Health Affairs" is policy journal. And it describes a program that we started, with the help of the Robert Wood Johnson Foundation -- thank you very much -- back in really 1998. At the time it was a -- kind of an original program. That's a polite word for it. We -- we wanted to work with people who were really ill. I'm an internist, and I have worked in the hospital a lot. I no longer do.

That leads me to a question. How many of you have practiced or do work in the hospital?

Have or do.

(Simultaneous talking.)

BRAD STUART: Okay. How many of you have or do work primarily in home and community? Have.

Okay. Good. That's great.

'Cause the point I would like to make is that as we suspected, back when RJW helped us in the late '90s to get a -- this program going, as we suspected,

things have really swung around to the point where our most seriously ill patients really are not going to be coming into the hospital at the rate that they have been before or still are now. CMS, the f- -- and Medicare are pushing very hard to get the sickest patients to be treated at home and in the community.

And if I had to tell you the one movement that I think is gonna change nursing the most radically, it's that. That all of the new payment structures, some of which are just coming out as we speak, the new Primary Care First initiative, for instance, is all about reducing hospital admission and using interdisciplinary teams of care, which in our model it -- are -- they're all nurse-led. That is the way of the future. Okay? And I -- I would have felt shy about saying that, what was that, a quarter century ago. I no longer do.

Next slide.

These -- these people are the sickest of the sick. But they're -- if you work in the hospital, and particularly if you're in the ICU, these are the people you're seeing. If you see the Medicare population in the hospital, many of them are in this category. It's only a -- I'd estimate about less than 5 percent of the entire Medicare population is this sick. But a quarter of all the costs are accrued by services that these

people receive, and most of them are in the hospital. The big money goes to hospital care. That's what Medicare wants to change.

Their care is not driven by what they want; it's driven by what the system is used to doing. And that's a critical point. Because we talk a lot about advanced-care planning and blah, blah, blah. My opinion, a lot of that is lip service. We haven't developed new services to go to people where they live and find out what they want. That's what we do. And when you do that, it works pretty well.

We have existing services. Hospice/palliative care. I'm a -- I'm a 20-year hospice/palliative-care vet myself. They're underused, and I think they will remain that way. The palliative care's mostly in the hospital. Needs to be much more out in the community.

So our next slide. This is what RWJ helped us start back in the late '90s. Sutter Health. I'm a northern-California person. Northern California, in case nobody's told you, is where the k- -- really crazy people live. We started back in '98 or '99 a program that evolved into what we call advanced illness management. I -- like I said, I worked in the hospital a long time and done a lotta things to a lotta patients and got very tired of the way we provided care to our

sickest patients. Then I got involved in hospice at home, and I -- I really woke up. I mean, I had a h- -- huge moral and career awakening when I realized what we can do with nurses, social workers, and others for people at home, no matter how sick they are. In fact, the sicker they are, the better we can do. Why? Because we can bring support to them so that they get that they don't have to go back to the hospital. We're not deciding for them. When they get the right support, they decide. I mean, who would wanna go back to what I used to do to people? Nobody would.

So we -- the program -- the phrase was used yesterday: "Pushing the rock uphill." That went on for 10/12 years, until CMMI, the Center for Medicare and Medicaid Innovation, came out with a billion dollars appropriated by Congress to be given in grants to help promising programs. Ours got a $13 million grant to spread the program across Sutter Health, 24 hospitals, 5,000 affiliated docs, and a lot more that -- who don't care whether Sutter exists but still wanted to work with our program.

I put some of the numbers up here. We were able to keep a lotta people outta the hospital and generate a lot of savings. And for those of you who are in statistics, it was really significant. This was a

big, big evaluation study done of the University of Chicago. It was one of three evaluations that are described pretty fully in this paper. So if -- if you wanna read how we did this and how we studied it so that we could really prove that it worked, I recommend you pick this paper up. It's -- it's -- it's all about innovation, particularly at the nursing level.

It was mentioned that nurse-led teams in Medicaid, but, you know, in -- in standard medicine, will more and more allow physicians -- primary care, palliative care, and -- and others -- to expand their patient panels by a factor of five or ten.

We have three medical directors. 3.0 FTEs of palliative-care doctors seeing over 2,000 patients a day. They're not seeing them. The teams are seeing them. The docs are working through the teams. Everybody's up in arms about, "We don't have enough palliative-care doctors."

Well, we aren't going to any time soon, as the population of these patients just explodes. It's not gonna happen. Who's going to do the real work?

Next slide.

You know, CMS now is going to pay primary-care practices and teams of -- other teams of providers that have yet to be invented. We only invented one model,

it -- it works extremely well, but there are lots of others out there to be developed that will be able to get these new serious-illness payments. And if I were in your shoes, I'd be going out to primary-care practices that choose to participate in Primary Care First, and I'd be sitting down with them and saying, "Look. We have an organization here who knows how to take care of these patients. You guys . . . you -- you folks and primary care are gonna get tremendous bonuses based on how many people you can get outta the hospital. We can help you do that. And if you -- if you contract with us, we will work together to help you see a lot of people that you're not seeing now, increase your business, and really, really improve your outcomes." The -- the ones that really, really matter. And I don't just mean cost and hospitalization. That's what CMS is gonna measure. I mean doing the right thing . . . for people and providing what they really want and what they really need, which are people who know what they're doing to go out to where they live, visit them, support them, and listen. I mean, as a primary-care doc myself, we don't get paid for that, but that's what it's all about. And that -- that's where the results really come from.

So last slide.

Nurses can do a lotta things that they f- -- don't frequently do or think of doing. There's a lot of evaluation and management tasks that can be done in the home that doctors are only too happy to delegate to nurses. This delegated model, I believe, is one of the ways of the future. Not just for nursing, but also for social work; spiritual care; many of the therapies. Physical therapy. Some of our best care managers were physical therapists who are out there trying to help these people stay functional, which is what they want. What do Americans want? Independence.

I've got a set of in-law parents right now who refuse to leave their home, and boy, they should not be there. But my wife is on the phone 23 hours a day with her sisters, across the country, trying to figure out how to prop them up. That's what it's gonna be like. They need this, but it's not available in Connecticut. Okay? It will be. And you can help it and other programs like it to develop.

So it's all about leadership. I urge you to look into this. And my contact info is on the head slide. There's a lotta work to do, and we are really poised for some serious progress, finally. After 50 years of trying, we are on the threshold, and actually crossing it.

So. Thanks very much.

PATRICIA POLANSKY: Okay. Well, the good news is we have better than 45 minutes. We've allowed a lot of time for you to talk to the panel here and for us to really talk about how to do this and what you're experiencing and what some of the threats are.

So lemme just for a second, you know, just dial back some of what you heard and again . . . soup to nuts. Talk to others. And that's a goal we need. Meaning people other than nurses. Disruption. Right? How do we disrupt. Disruption's not a bad word. It's not a bad word as long as you allow failure. But failure, as -- as we heard, is not mistakes or errors, but failure. So on the innovative side.

These great new words. Exnovation. Right? What do we get rid of. That's a big complaint. All nurses here, the -- you know, the fatigue part. Renovation and quality improvement. So yesterday heard this theme; right? The whole thing is you can try to go low cost and whatever, but the whole idea is the scale's gotta go up on the quality-improvement side. You heard from someone from Press Ganey testify yesterday; right? That's all about measuring.

I love this concept, which I think we could all take home: Innovation is a noun and a verb.

Innovation is a noun and a verb. Thank you for teaching us that.

Then the one, two, threes of education, public-private alignment -- alliances, and how to get to these, you know, troublesome emerging social issues. And these aren't things anymore that just happen, as we all know. They used to happen very infrequently. Now twice in 13 hours; right? This past weekend.

It's a very strenuous, difficult world, and nurses are gonna be there to step up. So we have to think about all of that.

The social determinants of health for employees. Hashtag unnecessaries [sic]. Right? And to deal with this. Failing fast. Heard [indiscernible] talk about failing fast. Fail. Move on. Identify, "Okay. This is not working. Next."

I'm gonna own part of that . . . in a -- in a little bit of my life thinking, just again in -- in bringing these people here. I think that's one of the best concepts. Sometimes you get accused of being pushy or too fast or, you know, you're not listening, but failing fast is something you have to get comfortable with when you lead. It's a leadership quality. And again, we really th- -- we thank them for bringing this up. But I think it's a real themed -- you know, for all

of us to think about.

Then the entrepreneurial skills. Innovation at the point of care.

My first husband worked for JCPenney, and he was an innovative-technology person. He was a computer person. And he worked on the project to put the first point-of-sale system in, believe it or not. JCPenney did that. Those are all the things now that you just go and scan, you don't think anything of it. But they used to have to bring it in and put it down, "One blouse, number 62," skew number. Right?

So it's probably a legacy that I always had because it revolutionized that -- that connection.

So I love the fact that you said this, you know, innovation at the point of care. Because that's where it happens. And for any of you've been patients or your families or with your -- as -- as Brad was saying, parents now, boy, do you see that.

But again, I think we need to take that nursing lens. So we -- you know, let's talk more about that.

Then the workarounds. Nurses are the -- really the innovators of all workarounds; right? We know how to do that better. So the point was workarounds are raw material for nurse innovation.

Thank you, Karen, for that.

Know My Patient. A culture of no to a culture of yes. That's very culture. Culture of no to a culture of yes. I'm just sharing what you just heard. These are gems gems.

And then moving into our graduate programs and down to the baccalaureate program with innovation, basic business skills, all these things. It's a new world. It is a new world. It is never going to dial back, looking around the room, except for a couple of people, to where we learned how to become nurses when we were -- I had a board president always used to say, "When I was a baby nurse." The president of the board at the time used to talk about that.

That's decades ago. Decades and decades. Not five years/ten years. We're talking 10 years; 20 years; 30 years; 40 years. So we need to dial forward; right? So let's talk about that. The hub-and-spoke model. How the social determinants can be used to lift people out of poverty. Nurses as care coordinators. Home and community-based care.

Susan and I were smiling, smiling, smiling, and smiling. Because when I first got my job over in the department of health in New Jersey, Susan dragged me out here.

Right? Susan, we came out to see these home-based models.

Blew my mind. Blew my mind. People being cared in homes, in their homes, with, as you said, a much better solution than that ICU picture you show.

Then long-term-care services. All the stuff that Washington state has done. And just remember, it's no accident NAM came here. You're hearing why NAM came here. Because nurses are front and center here. You just heard about 15 or more, 20, examples between Sue and MaryAnne. Nurse-led. Nurse was in this. Nurse-directed. Nurse. Nurse. Nurse. Nurse. I'm looking at you. Nurse. Nurse. Nurse. Nurse. Nurse. Nurse.

Be that nurse. We have to be those nurses.

It was a great day the day I left the office and went over to hear Brad and others from h- -- the "Health Affairs" journal. And that was in June.

Do I have that right? Cam? And Brad?

And it's the June issue, this June, of "Health Affairs," which is a policy journal. And Brad's sending you there because it's about nurses inside there. And Brad talked about a lot of things that day, but he pointed up how important it is to have nurse-led models. So please make sure you do that, because it's

outstanding work, and he shared part of you with --

And then . . . the problem that we all have: What the systems is used to doing. That's what . . . they said, actually. We're so used to doing what the system's used to doing. Right? It's like the way you brush your teeth. Every day you get up, man shaves exactly the same way, you comb your hair the same way, and you brush your teeth the same way. You don't do up/down/this/that. Whatever you do, however you comb it, you do it the same. We're creatures of habit.

So. For thinking about this lens and why we're here. Let's pull that up, a little bit of that. What is -- what's the system used to doing and what can we break of that?

And then, again, we brought up yesterday, and part of NAM, too, the one -- one of the greatest things that Washington State did was take that CMMI money from the Affordable Care Act, that money that 37 states get. But they acted on it. And nursing needs to act on these kinds of grants and -- and go to where the money is, if you will, and join up and this new effort.

And then, you know, all the nurse-led teams.

And Susan will remember the d- -- the day this Primary Care First came out, I was on the email to our leadership, and I'm like, "Look at this." Because

nurses are in there. All APRNs are in there. Into this Primary Care First. So this serious business, as Brad just said, and -- and a realtime for all of us.

So we have the mike there. We have mikes here. And we have almost the rest of the hour. So be brave and come on up here and let's get a conversation going with all these people here and ask 'em things. So while you're thinking --

Or -- or Sue --

(Simultaneous talking.)

SUE BIRCH: -- so while you guys are waiting to come up or -- or -- j- -- you don't need to come to the mikes. You can just yell out questions.

(Simultaneous talking.)

PATRICIA POLANSKY: Well, it's easier on the mike, Sue, for the recorder.

SUE BIRCH: Can you -- it's not on. Maybe.

(Simultaneous talking.)

PATRICIA POLANSKY: There you go.

SUE BIRCH: One thing, while you guys are comin' up, or w- -- whatever hand shoots up, and I'll just fill in time, but I would kinda argue with my innovator friends. I'm not purchasing more stuff. I'm demedicalizing with our policy work, everything that's been talked about between the three of us. And so I

don't want more gadgets at a hospital, nurses, and I don't want -- I'm not -- because my money is going away from hospitals. And that is not meant to be threatening. But you guys, that is the reality.

In this state, MaryAnne and I gotta deliver about a 5 percent reduction in our spend. I see heads shaking. And so what I wanna tell you is: Yeah, I wanna hear about innovations, but I wanna hear about the ones that are gonna go deep into ROI or deep into three areas. You either drive my costs down in the right direction -- 'cause spoiler alert: The more we waste in the U.S. healthcare system in healthcare, the more we take from the other sectors: Education, environment, all the other more important things than our overmedicalized, overcomplicated U.S. healthcare system.

So first area: Show me a reduction in cost. Show me a improvement in quality. Massive improvement. Or show me a better member experience. And unless you can show me an app or stuff, gadgets, that are gonna deliver there, I'm not investing government money. So just little spoiler alert. And I -- I do know there's all sorts of good innovations. But anyways.

I see Susan --

(Simultaneous talking.)

UNIDENTIFIED WOMAN: So lemme just ask the

question, 'cause you can answer it, too, 'cause we had this great conversation ahead of time. I would like people to address family caregivers. As we shift people to the homes and communities, I've had very little over the last two/three days on that, except for, of course, Washington that does that. But you and I just talked about the technological innovations and the implications for family, so --

KAREN GIULIANO: All right. So I want to respond. So first of all, I appreciate your comment. However, it's somewhat based on the false pretense that innovation costs money. Actually, it's not innovation if it's not gonna do something that's either gonna d- -- improve the patient experience, improve patient safety, which down the road should have cost improvements. It's gotta improve nursing workflow, which, again, down the road has cost improvements. And has an ROI attached to it. Every single thing I ever do is usually based on either improving patient care, improving the nursing workflow, 'cause I like to work on stuff just that nurses use. And my -- my experience is in acute care. And it has to have an ROI. If I can't figure out an ROI, I'm not even going to step two. Number one.

Number two, that brings the point that nurses have to be able to complete ROIs. So every nurse should

be a- -- you don't have to go to business school.

(Simultaneous talking.)

UNIDENTIFIED WOMAN: -- ROIs?

KAREN GIULIANO: Return on investment.

But you do have to -- I -- I don't wanna see another generation of nurses graduating from undergraduate or graduate education without knowing how to at least do some simple calculations on Excel. Because you can't talk to anybody anywhere, especially someone who's giving -- g- -- trying to give you money without being able to have a disciplined, informed conversation where you can answer those kindsa questions.

PATRICIA POLANSKY: Mike had his hand up. There you go.

(Simultaneous talking.)

MICHAEL ACKERMAN: What Karen said and . . . so . . . Apple has made it very clear, Tim Cook has made it very clear, they're beek- -- they're going to become a healthcare company. And we met with Apple Health -- the senior leadership at Ohio State met with Apple Health about four weeks ago. And for those of you that don't know, Ohio State is the only Apple flagship com- -- university in the world. So every one of our freshmen come in, get a iPad Pro, an Apple pencil, and

keyboard.

But a- -- and when we met with Apple Health, they said th- -- they -- they're interested in health, and they want this device to become a personal health assistant. They wanna drive all the patient's data to this device. They're not an enterprise organization. They -- they wanna partner with other companies that drive health and to the caregiver and the caregiver comment.

We just had my father-in-law move in with us. 84 years old. Bad stroke. Now I know exactly what we need. And I'm like, "Why hasn't this been addressed?" And -- and I -- I have a certificate in design thinking. And we redid our bathroom. And I sat in his wheelchair for about two hours in his old house, trying to figure out what he needs. That's what we need. That's how we innovate.

So it's not just gadgets. And I -- I -- I echo what Karen said. When you think innovation, you think new stuff; new gadgets. It's -- all you heard here was system. System innovation. You know. And that's -- now, it's cool to design stuff. But you're right, we don't wanna add cost. Innovation is defined by bringing f- -- value, not necessarily just increasing cost. So.

But thank you. I -- and -- and we need to make it clear, and maybe we didn't make it clear enough, about -- about that -- that comment. So thank you.

PATRICIA POLANSKY: Please identify yourself, your name, and where you're from.

RANDALL HUDSPETH: My name's Randy Hudspeth. I am from Idaho. I actually didn't work in Idaho a lot of my career, though. And I'm -- I wanna ask a question primarily to Dr. Stuart, but to any of you.

So my background and my career has been a lot in nursing administration, and my last -- the last job I had was as a systems CNO for the Cleveland Clinic. So that's pretty well-known organization. And then I retired and came -- moved to Idaho and got this great job that I have now of [indiscernible] but. . . .

So, you know, I -- it seems to me that dealing with the financial side of this, outside of a lot of the other innovative concepts, I know we focus on cost savings for acute care. I -- I believe we don't take into consideration always that there's a lot of cost shift there. There's cost saving in acute care, but a lotta that funds -- those go shifted into home health or acute care or some other mechanism. So it's not all savings for us.

I wonder if at the national level and the

conversations you're at are there -- is there talk about how we can incentivize people in one box on Medicare and the other box on Medicaid, two different paradigms of thought on their healthcare. But I know that as the Medicare group grows -- and having my own family experience with this, where the Medicare deductible is $186. So that's not a big deal. You pay your $186. If you have a decent co-insurance or supplemental insurance, after $186, everything is paid. And people, then, like my mother, it's a social event to go to the doctor and request one test after another after another. Which in my opinion has been needless, but being a son of no value, you know, of . . . so [indiscernible] listen saying, "You don't need this," you know. So she goes.

S- -- how can we or is there conversation about how can we incentivize people not -- you know, I mean, [indiscernible] how can they not come and seek care needlessly? And is there a role for nurses to be that safeguard so that people -- we can't -- you know, it's not gonna be acceptable to say we incentivize people not to use your health insurance and then you stay home and just get sick because you get a reward for not going.

But can nurses be incentivize [sic] to be that

insurance policy, and can that incentive go beyond up there where MDs and NPs may delegate to RNs, but that RNs themselves could be directly rewarded for being that insurance policy; not having the payment go through a provider level.

Is that a conversation? That's my fundamental question.

PATRICIA POLANSKY: Plenty. Somebody start, 'cause --

(Simultaneous talking.)

BRAD STUART: Yeah, yeah, that's -- that's absolutely a conversation. But, you know, you -- I'm a -- like you, you know, I've -- I've been at this for a while. For me it's about 50 years. That's a half a century of wondering why we're doing things the way we're doing them, and getting no -- at the beginning, anyway, getting no understanding from colleagues about why I was so concerned about it. I didn't ee- -- I thought I was really weird. And that still may be the case.

But more and more I think we -- we -- and when I say "we," I mean up to and including CMS, and even the -- you know, the highest levels of our government. And I'm gonna leave the administration out, not -- not because I wanna bring politics into this, but because I

just don't think they have much to say about it.

I think what's happening is inside Medicare and the Centers for Medicare and Medicaid Services, I've spent the last probably quarter-century working with CMS, which used to be -- you prob'ly remember the Health Care Financing Administration, HCFA. Those of you with hair this color remember HCFA. Turned into CMS.

I went back to HCFA in Baltimore in I believe nineteen-ninety-something, four/five, and sat down with Tom Hoyer, who at that time was HCFA's head of all their home-base services -- hospice, home health, everything else -- and brought him the idea that I had just gotten funded by Robert Wood Johnson. And Tom is a great guy. Still -- still is. Heading up a division of -- of the Health Care Financing Administration.

He said -- he said, "That's a very interesting idea. I want you to come back in two weeks and meet with the heads of all my departments."

And so I flew back to California. Spent my own money to fly back again two weeks later. Sat down with Tom and about 15 other division heads at -- at HCFA. The reason Tom called that meeting was to tell me why the ideas that I had were completely impossible . . . to operationalize and implement. That was 1995. Or whatever it was.

Now, you know, not that many years later, we have CMS completely reorganized and coming out with ideas that -- yes, they're still limited. I don't like that you've gotta go through primary-care physicians to get this done.

But I'm -- I'm now used to decades of negotiating to get things to move forward. And as I tried to say as clearly as we could in this paper, you/we have to start new things. You've got to get them started.

And our -- our motto, speaking of all this, at -- at the very beginning of our project, when it was only two of us doing it, was: Fail early and fail often. You have to try. You have to get out there and try. I believe -- and this is clearly a personal prejudice -- it really helps to have a physician champion who's willing to stick his or her neck out and lobby for things.

But it's so critical to have nursing right there at the table with you, because the nurses are the ones who really know what's going on. You know.

I walked into the ICU as a physician, and it was the nurses I would go to to find out what was happening. Then I would stay when the rest of the docs had made their rounds and left to talk with the nurses,

many of whom would say to me I was the only physician on the f- -- on the physician-nurse communications committee, you know. "I -- how can I carry out this order? This isn't right."

But they couldn't say anything, and they -- they had to.

Things are changing now. And I -- I believe that as CMS moves forward, they -- there will be more and more direct . . . applications of nursing leadership and nursing practice into care of patients because there has to be. We -- we have got to pull nurses together to lead teams of community health workers. Many of us are not just using nurses; we're using everybody we can find. There's all kinds of new paramedic programs that don't go out and just pull people into the hospital anymore. They evaluate, treat, and keep people home if they can. You know, we -- we've got innovation happening all over the place.

And I believe we're headed toward exactly what you said. And I also believe, as I will continue to believe as long as I'm around, is we're not there yet.

SUE BIRCH: So Brad, I'm gonna jump in. MaryAnne's [indiscernible] --

But before that. LARCs. Long-acting, reversible contraception. Guess what profession is

placing more of them than anybody else in the nation? Nurse practitioners. And thank you to the . . . Buffett Foundation, and now thanks to the Upstream movement. That is creating a massive shift.

And if you don't know about LARCs, that's a concurrent policy mechanism, just like we're seeing the Health Homes play out right now, that is showing the extraordinary savings. When you can reduce a teen pregnancy or an unwanted pregnancy and -- by use of the new, long-acting, reversible contraception, it saves us across all sorts of domains. But we need nurse researchers that can do that work right alongside of us right now, that that work is going on here in this state and in Delaware. It started in Colorado and at Washington University. And again, that's just one example.

Nurse-Family Partnership is another one that we know -- we can't even get Nurse-Family Partnership to scale, but we really need to heed the brilliance of David Olds, that researcher that was able to show the cross-sector savings. 'Cause to your point --

Where'd he go? Randy?

(Simultaneous talking.)

SUE BIRCH: Randy stepped out.

But cost avoidance, cost savings, and we have

another term that we use, all these things have to be sharpened, and nurses have to be at these negotiating tables, they have to be at these meetings with foundations, those private investors, and they have to be reshaping the policies right alongside to make these things lift. And that has to happen concurrently.

MARYANNE LINDEBLAD: And I just wanna mention our Health Homes Program, because that is all nurse-led. It doesn't require physician order. We data mine. We [indiscernible] through our data mining we identify the highest-needs folks.

The organizations that we've identified, they go out and find these individuals. Nurses are going out; visiting; engaging them. Not -- not everybody wants to be engaged, and sometimes it takes multiple visits to get someone engaged. But bringing them into these Health Home Programs, which is a care-coordination program, but it is not something that you have to go through -- you know, that you have to go through a physician and get an order to do it. I mean, it is -- it's directly reach -- reaching out to individuals through nurses; nurses being reimbursed directly.

So I think there are some really innovative things happening, it's just that it's kind of hit and miss. And I would tell you that of the number of Health

Home Programs that started through the ACA, Washington, again, has one of the most successful programs because we made it relatively simple and we used a nurse-focused approach to do it.

PATRICIA POLANSKY: Please, your question.

(Simultaneous talking.)

BRAD STUART: One more quick, quick --

(Simultaneous talking.)

BRAD STUART: -- point.

We had a choice among the many design decisions we had to make when we were starting this thing: Were we gonna create an opt-out or an opt-in model for physicians. In other words, were we going to have to have the nurse call the physician and ask if we can see their patient or not. And I made a unilateral, executive decision to make it an opt-out model, meaning I was gonna trust that the doctors weren't gonna say, "Hey, wait a second. What are you doing to my patient?"

They were going to say, "Okay. I mean, we --" they have 24 hours to opt out if they don't want their patient to participate. None of the doctors opted out. They were happy to have the nurses come in and manage the situation.

I only say that just to help assuage all the doubts we all have about medical culture is never gonna

change. Well, it's already changing. And so the opt-out model is just one example of how we can design new structures and processes that will -- that will help that culture change.

PATRICIA POLANSKY: There you go.

Please, your name and where you're from.

MARGO LALICH: Yeah, good morning. My name is Margo Lalich, and I'm coming to you today from Hawai'i, but I've spent much of my career next door, in Oregon. And I've worked at the intersection of what I consider the three health systems, and one is public health, one is private, both as a -- in practice and in nursing-leadership positions, and the third health system I continue to argue is in school-based health services. Every student is a pediatric patient, and every educator and adult working in the school system is an adult seeking care in public health or private healthcare. And school-based health services, whether it's school-based health centers or school nursing, is nurse-led, at leadership positions as well as in practice.

And so my question is really around policy. Because there are pools of limited resources at the federal level that are available to school -- the delivery of school-based health services, but it's not

being included in this conversation that you're hosting today and across the country in terms of alternative payment methodologies. Reimbursing nurses. Even in loan-forgiveness programs.

So I'd like to hear your feedback on that. Because school-based health services and our school system and the relationship between educational outcomes and healthcare are indisputable, so we need to start including this in the conversation.

Thank you.

SUE BIRCH: Thank you for that question. The only reason it's come up -- we only have ten minutes, so it's really hard to talk about all those critical life --

(Simultaneous talking.)

SUE BIRCH: -- but I would argue that it is being discussed. MaryAnne has quite the pediatric-bundle development. We're looking at how we might pay in life-stage bundles. And I know our pediatricians are, you know -- pediatricians do amazing work, but they don't see any shared savings 'cause guess what? Their savings don't occur till the 54-year-old, you know, doesn't have the heart attack because the pedia- -- a- -- pediatrician and the pediatric nurse practitioners and those school nurses have done their

job.

You are right, though. Education, and certainly under the current regime, is not a place where we can innovate very broadly. Our best hope is with school nurses and school-based health center. And we are very fortunate that there are very . . . key significant efforts in this state, through King County and some of our other very population-dense zones, that are leading with the SBHCs and the school nurses.

Our superintendent, Chris Reykdal, and I have met several times, talking about how do we get a nurse and a behavioral-health worker in every school in Washington. There are mill levies. If you look at "The Spokane Times" --

MaryAnne, is that name of that paper?

(Simultaneous talking.)

SUE BIRCH: They are running -- they are running a mill levy.

But I would back up to tell you we're doing something right now. In 23 days we bring on 400,000 school employees under more uniform health insurance. And when a schoolteacher starts saying, "Wow, my health-insurance coverage that I'm getting now is real and substantive and a preventative benefit," or, "I can see a dentist," guess what? They're going to lead down

to all their classmates [sic].

So that's the first thing Washington is doing, is we had to bring on uniform school coverage. I liken it to a mini ACA for the school teachers. Those teachers will come under our -- MaryAnne's and mine -- coverage models. And we're look- -- through benefit design and through kinda re-education. That's the first thing we're doing. But we are working on some other creative bundle payment thoughts.

The LARC movement I just talked about, we're trying to build a reproductive-health bundle so that we don't just keep paying the same old fee-for-service, dysfunctional, or even capitated way.

And through our Accountable Communities of Health, there's a lot going on with our schools. I wish Sid [sp] was here, who's one of the school-based nurse practitioners in Tacoma, 'cause I think you would be wowed at the energy that MultiCare, which is a massive system, is putting into school-based services.

MARYANNE LINDEBLAD: I think we're -- also do a number of things to try to support the schools in terms of administrative function. So even if teaches are making referrals into care or to help -- trying to help families find care, whatever, being able to do administrative match, so there's more dollars coming

into schools so they can per- -- so they can support health-related activities.

And also, as Sue mentioned, a real push on the mental side, so that there's a mental-health practitioner in every school, 'cause I think that is really critical in pairing up with a nurse.

So there are a number of activities. But I would say if you look of all the different, you know, aspects of the healthcare-delivery system, we clearly haven't taken as much advantage of how we use schools as innovatively as I know there's opportunity to do so.

SUE BIRCH: So the takeaway for you guys in this room on this one is if you're doing stuff that is Medicaid dense, or you're in a Medicaid-dense school, or if you know there's all this activity happening to kids under Medicaid that you're not gettin' reimbursed, bust down the door and find people like MaryAnne and I.

The nurse practitioners in this state came forward when I first got here, and same with the home-care industry, they sat down with MaryAnne and I and said, "Wait a minute. The differential between payment on nurse practitioners is different for the commercial industry than the Medicaid industry. What can we do to solve that?"

We have some solutions in play, and have

solved that in certain segments. We're not done. It's not totally fixed. But we are on a path to fix that and equalize that.

(Simultaneous talking.)

UNIDENTIFIED WOMAN: -- [indiscernible] in 2015, a lotta states are doing innovation with amendments to their state Medicaid --

UNIDENTIFIED WOMAN: Yes.

UNIDENTIFIED WOMAN: -- plans --

(Simultaneous talking.)

SUE BIRCH: But you are right. This room should take charge of this very basic issue. And this is a great example, and this is why I love -- these guys will get us some great app for school nurses or something.

But more simplistically, this group should be finding the leadership and connecting it and being part of the conversation to let's level that out. That is the easiest thing in America for us to fix. And it's as -- equally as important -- we waste all the money at the end of life, on pr- --

I'm looking at Brad, 'cause I'm actually remembering now that we crossed paths through Sutter years ago.

We waste all the money in end of life, and we

need all of that money redistributed down -- or upstream, to the first part of life, so that -- you know. That's culture health, that rebalancing. Taking it outta the hospital sick system and rebalancing to home and community-based systems.

And you're right, we don't do enough. But given everything we're doing, it's remarkable that we are even advancing on that front. So great question.

PATRICIA POLANSKY: Yeah, please. Go ahead.

TERESA GARRETT: Hi. I'm Teresa Garrett. I'm from Utah. I've spent my entire life and career in Utah, multiple different venues, and never in a hospital. How's that?

(Simultaneous talking.)

TERESA GARRETT: That's my claim of fame.

I am really intrigued by the inherent conflict that happens in the d- -- in this whole idea of disruptive innovation in one hand and culture of safety in the other and how do we bring those two things together so that as we're trying to push people to use a checklist and please don't make something up or do -- please don't do a workaround -- I mean, that's, like, evil word, you know. So how do we -- how do we bring that creativity in different language? Because when -- when you opened up and you said, "Who likes the word

'disruptive'?", it's kinda like, "Who likes the word 'creative'?" Nobody likes -- you know --

(Simultaneous talking.)

TERESA GARRETT: -- people don't like to say they're creative, and they are. So help me put those two things together. Thank you.

MICHAEL ACKERMAN: That's a great question. And we actually talk to our students about this all the time. And it starts with the culture. At -- you know, we throw that out there all the time: The culture, culture, culture. But it really starts with the culture and setting up an ecosystem where . . . that side or people at the point of service have an influence in what decisions get made.

The current system is broke. There's -- we've -- we have -- we have epic failure at the senior leadership level to drive innovation and create this culture of safety. I think it's -- it starts there.

And . . . when the -- when the people at the point of care are involved, and they have the -- the structure to -- to make decisions and be disruptive within this -- this -- the confines of, "Well, if -- if we do that, make sure you think about this, 'cause it could harm this."

So nursing has historically worked in a

vacuum, in the silo, and we have to get used to talking to business people, we got -- have to get used to talking to quality-and-safety people, we have to get used to talking to tech people, to create this ecosystem. And I've seen it work beautifully, when that culture's there.

So I use -- one of the -- well, KP is -- is one [indiscernible] Kaiser does it very well. Geisinger in Danville, Pennsylvania. They're innovating every single day, and it's done right at the -- right at the point of service, and it's one of the safest hospitals in the country [indiscernible] systems in the country, but it's also one of the most wired. There's innovation happening every day. So it can request, but it gets back to that culture. And -- and that's where the leadership has to understand what does it take to create that ecosystem.

And I just can't overemphasize that enough, that the leadership has to understand what innovation is, first of all; how do you do it. They have to be comfortable. We gotta remove the . . . vertical alignment of leadership and decision-making and create more of a horizontal approach. And I think when that happens, then you start to see this whole -- everything start to come together. And that's -- that's how I

would approach it.

(Simultaneous talking.)

KAREN GIULIANO: Yeah, I just wanna say a couple comments about that. First of all, culture of safety and disruption are not mutually exclusive groups. So I wanna make that really clear.

And in fact, if we had a culture of safety, we wouldn't need critical-care nurses to do 50 workarounds a day. So thinking we have a culture of safety is just plain wrong. We're trying to get there. But to think that innovation is an important part of that I think is a mistake.

I'll give you one example of something I'm working on right now. I'm working with a start-up, and we're creating -- all you -- if you either been in the hospital, worked in the hospital, or had surgery, have prob'ly worn those s- -- sequential compression devices. And you -- when are they used? After surgery, mostly, or at a time -- somet- -- which is one of the big places, 'cause that's when patients are at risk for DVT.

Well, guess what else happens after surgery? You're at risk for more falls.

Those current devices, the most common ones, have this big battery pack, required to be plugged in, are also connected to your leg, so they actually create

a fall risk. There is nothing safe about that.

So guess what happens? They don't get used. Compliance rates are about 25 percent. The nurses don't put 'em back on. The patients hate 'em. They're uncomfortable. So now guess what happens? You have to be put on anticoagulation to be s- -- prevent -- that's not safe 'cause now you're giving them a bleeding risk that they don't need to have just because they had surgery.

So we're actually working on -- actually worked with the start-up, and we were awarded a $1.8 million small-business, incentive, research grant, innovation research grant, and we're developing a small, mobile, battery-operated device that is cheaper and can be used in the home. And I am totally -- so now not only do they -- it can go right to the home. It's not two devices. And guess what? It can reduce that prophylactic anticoagulant use in the home.

I think a lot about -- somebody mentioned that we push costs off to the outside of the hospital. I think about that all the time. So every time I do an ROI, it's gotta include what's happening to the patient after they leave my acute-care setting. And by the way, I don't want anybody there that doesn't need to be there, especially someone after joint replacement,

'cause they're gonna get an SSI if they stick around too long. I wanna get them out to the home and on this mobile device.

So stay tuned. We'll know if it works in about two years.

(Simultaneous talking.)

SUE BIRCH: I do wanna just say we can even leapfrog your innovation, because we have a total-joint-replacement program in this state, and so if you choose to go into our evidence-based TJR program -- first off, it's almost like -- I think it's 40 percent of the surgeries aren't even necessary. We make you do physical therapy. Our physicians, our contracts, all the team that's involved in the TJR program --

First off, we're just, like, stopping the unnecessary, overmedicalization of joint replacement, number one.

And there are huge incentives. There's no copays. They have travel. It's all the upstream. It's the actually intervention. And then it's all the postvention.

And talk about nurses, you know, having a role in rethinking that whole process.

So again, we love that the right device is gonna be available at the right time, but we gotta first

and foremost -- again, I would say nurses, we have a role to help in the design. And it was a nurse politician -- she was here, Representative Cody -- who invented the Bree Collaborative and the Health Technology Commission here in Washington that first and foremost sets the paradigm for kind of legitimacy. Kind of that good seal -- the algorithm that we write into our contracts to say, "Here's the standard of care you're gonna participate in if you want to get our payments for total-joint-replacement program."

(Simultaneous talking.)

MICHAEL ACKERMAN: You guys come to New York. Please? Please come to New York.

PATRICIA POLANSKY: Exactly.

BRAD STUART: Just a -- I hope this'll be short. We're gettin' toward the end of our discussion time here. So I wanna pull back and look at the whole system for a second. That -- that question that you just brought up is -- is an incredibly important one. Why are we hurting so many patients through errors and how can we disrupt and get past the checklists?

I think -- again, this comes from being around a long time, but it wasn't that many years ago when paper charts were everywhere in the hospital. You'd see a patient that would come in from somewhere else, you

have to go through a stack of charts that -- literally two feet thick to get through -- to get their real history. Now we have EHR, and we're in the f- -- early phases of it, where, honestly, it's a pain in many places to implement EHR.

But just wait a coupla years until we get to where we're already seeing a integr- -- big integrating systems where EHR -- it's not just a data repository. It's a -- it's a realtime communication device. And if you take nurses and you put some of them in the home, a couple of them in the hospital, a couple of them embedded in big physician practices, and integrate them all through EHR, what you find is that you have way fewer errors because the care is automatically coordinated.

And that -- the big-picture topic that we're discussing here is fragmentation of the medical system. Which if you think about it has gone like this in the last 20/30 years. It's -- it's so -- things are so complex. There's so many new things every day. That's gone from a place where we didn't have to worry about it before, because it was pretty straightforward to treat patients 40 years ago. Now it's not. But it will be. Because we are on the way to a time when we're gonna be tied together much more closely and the checklists will

be embedded automatically in the work plan that comes through the EHR.

So . . . you know, I don't wanna be overly optimistic about this, and I also don't wanna downplay the problem of medical errors, but I think we have to continue, like we're saying, innovating on the structural level to continue to change things so that they're more and more tied together.

And once again, at least in -- in our model, nurses play a central role in being the care managers and coordinators. But you can't just think about one care setting. It's not just about the home or just about the hospital. It's about all of them.

And, you know, virtual integration I think is gonna be another big future topic. You don't have to have Sutter Health or Kaiser owning everything to -- in order to integrate. We are going to have to virtually integrate places where we're a- -- we're aggregating all our information in -- through interoperable systems horizontally so there's no one vertical owner but we are talking to each other. And we're gettin' there, but it's a -- it's a -- in a way it's a nice problem to have. Because the errors are horrible, but we have so many more options than we used to, and it's a -- it's a -- it's a two-edge sword.

MICHAEL ACKERMAN: It's -- and I think the big paradigm shift is patients own their data. The system doesn't own their data. Patients own their data.

And Dan, what's the app that -- you said the third-party app that the patient actually owns their data and it'll integrate any system --

(Simultaneous talking.)

MICHAEL ACKERMAN: -- that they're in?

DAN WEBERG: So there's a new start-up that's out there called Seqster, S-E-Q-S-T-E-R, and it's basically the Mint.com for health data. So it goes in -- the patient logs in through their patient portal, and it pulls all their medical records into one spot. They don't have to have business agreements. They don't have to have Apple approve it. It's all patient driven. And so it's really interesting. And they've got a lot of disruptive things going on with a lot of the people in this area.

And so I think that's gonna change the paradigm, 'cause now you can port your data wherever you want, to any health system you want, to any provider you want, and it's -- it's a game changer. It's -- and it just jumps the interoperability piece completely. And we don't have to play nice between servers and Epics and all that. So anyway. It's really cool, it's really

disruptive, and ch- -- check it out.

MICHAEL ACKERMAN: Yeah. And -- and -- and I -- there's prob'ly more innovation out there on -- in this space. But again, it used to be you'd have to ask permission to give the patient their x-ray. Remember that?

(Simultaneous talking.)

MICHAEL ACKERMAN: "Well, we gotta in- -- we gotta get permission."

It's like, "This is crazy. It's their data. It's their x-ray." So.

And -- and -- and I will s- -- say that the EHRs, like -- and I know . . . Epic is really working hard with us, to -- to make sure that it's a much safer system. And then CMS, what was it, two years ago came out with a -- the head of CMS came out with a "Dear Doctor" letter --

(Simultaneous talking.)

MICHAEL ACKERMAN: -- that basically apologized for what they did to us with the EHR and the requirements for the EHR, and said, "We want you, providers, to help us fix it." So -- and -- and that was mind- -- mindboggling, when you get this letter that says, "We're sorry that we've caused this -- this harm," basically.

PATRICIA POLANSKY: Sue.

SUE BIRCH: Right. So this has been an amazing panel. It's been like drinking from a fire hose. It's amazing. It's like what -- what do we take out of here? And I know Pat tried to sort of encapsulate some of the -- the gems here.

So I wanna -- and -- and you talked about what we asked you to talk about: Innovation. Right? So that has been amazing.

I'm gonna put everyone on the spot here. So Robert Wood Johnson Foundation is investing in a huge report now, the National Academy of Medicine, Future of Nursing 2030, and it's really to -- for nurses to address the social determinants and health equity in this country. Innovation is part of that.

People in this country paid a lot of attention to those first recommendations, which were very specific; very practical; very intentional; very directional. And that's what you have to do to have people follow up and take action. Right?

So I'm gonna ask each and every one of you just, you know, to think about now what you're --

And -- and when you make a recommendation at the Academy of Medicine, there has to be an audience to. So you have to direct it to an audience. Could be to

nurses; to nursing associations; to corporate America; to CMS. It has to have an audience first. And then you have to say what you want that entity to do. And then you have to say by when. Okay? And those are the kind of very specific and practical recommendation [sic] that drive these reports that then drive people to action and to take [sic] policy changes.

So I'm gonna ask you, giving [sic] that formula, what would be your highest recommendation that you would offer?

UNIDENTIFIED WOMAN: Start there [indiscernible].

KAREN GIULIANO: I guess I'll start, because I actually -- knowing how -- the purpose of the report and how it works, that's why I actually ended my comments with those bullet points.

So I guess if I -- if I'm gonna focus on innovation, I would say we need to get -- we need to change our undergraduate nursing education so that as -- if I had to pick one priority in -- so that we create a mandatory coursework as part of the way schools get accredited. That requires -- a lotta times they have capstones, anyway, so let's make those capstones interdisciplinary, so that they leave with a different set of skills than they have today and that can set them

up for success in negotiating the --

SUE BIRCH: Requires them to do what? Change the curriculum to --

(Simultaneous talking.)

KAREN GIULIANO: To require them to have content in biz- -- some business content and some knowledge of engineering. So to wir- -- or at least a very [indiscernible] on a collaborative team with an engineer, a business person, and a front-line provider. Doesn't just have to be a nurse. Can be PTs can do this, too. But -- or whatever. And t- -- and to collaboratively look at and s- -- solve a problem. [Indiscernible] or at least write a paper about how they'd solve a problem, so they can go through the motions, much like they write a paper on how they treat a patient with diabetes or anything like that. So that they've at least gone through the steps once, it's not brand-new knowledge to them, and it has to have an ROI with it.

UNIDENTIFIED WOMAN: [Indiscernible.]

KAREN GIULIANO: Yeah.

SUE BIRCH: I would say to the committee, and I already have . . . invest in programs that support an -- key nursing leadership at the intersections of workforce and education, being one; two, policy and

government; and three, kind of public partnership. And unless states and our national bench of leaders is comprised of significant nurses with the talent to be in those conversations and to be shaping things, we are missing the opportunity to continue to create a culture of health.

PATRICIA POLANSKY: Wanna pass?

MICHAEL ACKERMAN: Go ahead.

PATRICIA POLANSKY: He's writing.

MICHAEL ACKERMAN: I'm still -- I'm still trying to formulate --

(Simultaneous talking.)

UNIDENTIFIED WOMAN: -- this part, isn't it?

BRAD STUART: I just -- I just put this together in -- literally on the spot, so . . . and so it's . . . there -- take that -- take it for what it's worth.

But I would -- I would . . . petition CMS to come up with a test of a new model that -- we don't really call them Medicare demonstrations anymore. But this -- this would have been a good Medicare demonstration, would be a nurse-led initiative to go beyond what we now -- what CMS now has shown that it means by "care coordination." Care coordination's ver- -- k- -- they're paying for care coordination and

Primary Care First. Right?

But the -- CMS still has too narrow a view of what care coordination means. They're thinking about, "Okay. Let's see if we can coordinate the primary-care docs and the specialists." That's their thought about care coordination. No way is that gonna make as big a dent as a nurse-led initiative to place care managers in major care settings and -- and communicate in realtime. And you'd have to define the population. I pick the sickest of the sick, because that's where the money is. And also the need is -- the human need is. And -- and test a model where nurse-led teams are coordinating care among all those settings.

And I know you'll find, because I think we have data to back it up, that you'll come up with what some people call wrap-around care management.

There's a big focus right now on postacute care. In other words, what happens when you discharge a patient into the community. Basically nothing. They fall into a vacuum. What ha- -- what would happen if you coordinated those services so that nurse-led teams in the community would be able to catch those folks and manage their postacute care? You -- you'd have much better outcomes, very much . . . heavy-duty ROI, from a -- an initiative like that.

And wrap-around care management means once you manage their postacute care, that -- and get that -- those teams mature, you know, it's been shown that that wraps around to pre-acute care and controls re-admissions.

So I -- I think there'd be a lotta bang for the buck if CMS were to test that. And that's coming from my concern that the Primary Care First initiative, as -- as has been pointed out, isn't adequate to really do serious illness care.

PATRICIA POLANSKY: Okay. That's great.

Who's ready next? MaryAnne?

MARYANNE LINDEBLAD: Oh, gosh.

(Simultaneous talking.)

MARYANNE LINDEBLAD: My brain just keeps going here in terms of --

(Simultaneous talking.)

PATRICIA POLANSKY: -- one recommendation --

(Simultaneous talking.)

MARYANNE LINDEBLAD: Ha- -- hard to make one recommendation, so I've written down four different ones. So. But -- but I think I'll just really focus on -- I -- I really w- -- from a nursing perspective and I think about my own education. But creating more opportunities and more residency sort of outside the --

the typical nursing milieu, but really outside, more into the community; more into other sorts of organizations, for example. You know, sitting in a Medicaid program. Sitting in a behavior -- you know, more in a behavioral-health environment. More out into the community. More into schools. I just think there's lots of different places where nurses could be exposed much -- much more broadly to the community and much more of a public-health focus than we see today.

(Simultaneous talking.)

MICHAEL ACKERMAN: That's a lotta stuff.

PATRICIA POLANSKY: Closin' up.

MICHAEL ACKERMAN: So how many people here teach undergrads? Or are involved in undergrad?

You know, and this isn't my recommendation, but . . . you know, when you teach undergrads, you -- you -- you teach to the test; right? I mean -- and until NCLEX -- until NCLEX changes its format -- 'cause we're measured by how many people pass their boards; right? And if you got a 50 percent board pass rate, nobody's gonna go to your school.

Now, I know you disagree with me, some of you disagree with me, but until NCLEX puts more of an emphasis on community health and on -- a- -- but it's all med/surg. Right? I mean . . . we can -- we can

agree to disagree.

My recommendation's gonna be around leadership. And I think we need new leadership-development models and programs that emphasize the role and the process of innovation. Because I think the -- the data says that 50 percent of the current CEOs in this country in healthcare -- not just hospitals, but healthcare in general -- don't know what to do with innovation. They know they need it, but they don't know how to drive it. They don't know how to fund it. They don't know how to create an ROI for --

So I -- i- -- i- -- it's all around leadership, because without the leadership to drive these initiatives, it's very difficult. So I think that -- that would be my recommendation.

To who -- it's not necessarily American Hospital Association, 'cause that's just hospitals. I think defining l- -- healthcare broadly, whether it's home health or community health or hospital health. So that -- that would be my recommendation.

PATRICIA POLANSKY: There you go.

Yes, Azita, please. Can you come to the microphone?

AZITA EMAMI: And also and -- have my recommendation. Thank you.

(Indiscernible talking.)

AZITA EMAMI: Oh, okay. Great.

So my recommendation is that for the academic nursing, have mandatory content on prevention. That is very important. I think that we need to really shift our focus and -- and really emphasize that pr- -- the prevention. That will help to have much better health outcomes.

And also, for the, you know, practice, you know, part, the clinical and then the hospital settings, incentivie [sic] prevention and incentivie patient education. Because if we -- I mean, right now nurses, they -- they know that this is very important, but it doesn't pay anything if you -- they -- they cannot include it in their content of their pr- -- daily practice, and that is what we need to -- to change in the mindset of -- of -- of the healthcare system in this country.

PATRICIA POLANSKY: There you go.

Well, on this note, on this note, fabulous. Was this fabulous or not? [Indiscernible.]

How 'bout we just take a five -- five-minute stretch break, whatever. Get some ice tea. Run wherever. And we'll start at about . . . how 'bout we start at five after, ten after, right in there. We'll

get you back in here.

(A recess was taken from 11:00 to 11:10 a.m.)

MARY SUE GORSKI: Okay. Shall we get started again? It is so tough to break up these conversations. Get some coffee. Yeah. Give a couple more minutes for people to finish up.

(Brief pause.)

MARY SUE GORSKI: Okay. Let's get started. We have another group to share with us. Ring the bell. You're a teacher.

UNIDENTIFIED WOMAN: Yes, I am. I love my bell.

(Bell ringing.)

MARY SUE GORSKI: See? My problem is is I -- I love these conversations, too.

UNIDENTIFIED WOMAN: I know.

MARY SUE GORSKI: And they're really important. So. But I also -- the time of -- of this esteemed panel is valuable, too. And we have -- we have people just getting a few snacks, but I think that we can get started.

So. Wow. That was an amazing panel that we just had.

And I think people will filter in. There's a whole bunch getting snacks right now.

And now we have another panel. And this -- I think the timing here is great, because I think David said it, is this -- that now this is how each of these initiatives kinda gets done: The grassroots. These are examples of projects that are meeting those objectives that we just went through in the last panel. So.

Sofia Aragon is, as you've met, the executive director for the Washington Center for Nursing, and she's gonna moderate this panel.

And I'll let you get started.

SOFIA ARAGON: Thank you, Mary Sue.

So I'm just gonna go ahead and have the panel present this great information. Yesterday I barely scratched the surface of what we're doing here in Washington state, so I'm really thankful for my colleagues to take the time and let you know a little bit more about what they're doing on the ground and their leadership role.

So first we'll have Sara Bear, who's the nursing program administrator and director of the Palliative Care Institute at Western Washington University.

SARAH BEAR: Well, good morning. I get to share with you a success story from Washington.

First, little background on the three

organizations that participated in this. We have the Washington Center for Nursing, which is our state-wide nursing resource center; the Nursing Quer- -- Care Quality Assurance Commission, which is our State Board of Nursing; and something we call the Council on Nursing Education in Washington State, or CNEWS, which is a gathering of all deans and directors of approved nursing programs in Washington state. And we meet twice a year.

Since 2008, the Washington Center for Nursing has worked with CNEWS to create and fund a master plan for nursing education, outlining several important recommendations for nursing-education improvement. The Washington Center coordinated efforts for implementating -- implementing these recommendations and published progress updates.

By 2016, it was clear that certain key complex issues facing nursing were getting in the way of our ability to produce a nursing workforce that was needed by our growing communities, and the master plan needed revision. At the same time, the Nursing Commission was noticing complex issues facing programs that were putting the stability of these programs in jeopardy. The Nursing Commission passed a motion to hold a nurse-educator-solution summit to address these issues and provided data to illustrate the complexity.

Also in 2016, the Washington Center for Nursing worked with CNEWS to developed a nurse-educator survey, which was published in 2017, and helped to raise awareness about the complexity of nursing education. Keynoted factors were that 70 percent of programs were claiming vacant faculty positions. Low salaries were contributing to many faculty contemplating leaving their position. And it also called out the high number of expected retirements over the next ten years: 38 percent in the community- and technical-college system, and 40 percent in the university system.

As a result of this data and the growing concern over the nursing landscape in -- for nursing education in Washington, these three groups launched the Action Now initiative, with the vision of securing the future of a healthier Washington. Four priority issues were identified as critical needs for nursing-education: The opportunity for nurses to advance their education, nursing education funding that was failing to keep pace with need, a lack of quality clinical-practice experiences for all students, and a nursing-faculty shortage.

A work group for each of these four issues was formed and shared by members of the steering committee. Key was the deep understanding of the steering committee

that finding solutions meant including stakeholders beyond nursing. Work groups spent months developing solutions that were vetted by the steering committee and identification of student -- of solutions to move forward was completed with one issue selected as priority.

Faculty salaries was identified as the most critical and immediate need. Multiple nursing programs in our state were unable to fully admit students due to a lack of faculty. Master's prepared nursing teaching [sic] in our community- and technical-college systems were earning an average of $60,000 per year, and associate-degree RNs newly entering the workforce were earning an average of 70,000 per year.

The Washington Center for Nursing survey showed 67 percent of nursing faculty considered leaving their position in the past two years. The number-one reason was compensation that was far below industry rage -- wage, and the number-two reason was workload.

Even with full faculty staffing in our state, nursing programs turn away 34 percent of qualified applicants, or eight hundred and thir- -- 814 students per year. Capable students were being turned away when the demand for nursing care was increasing and Washington's projected growth rate for RN employment

through 2024 is estimated to be 19.6 percent, which is higher than the national average.

The solution that we settled on was a salary increase to nurses in higher public education to replicate the 2017 increase for RNs in state institutional and governmental programs of 26.5 percent. We hope with the increase in part-time and full-time nurse-educator salaries to have improved retention and recruitment, complete enrollment for all nursing programs, and stabilization of our nursing programs.

The steering committee . . . the steering m- -- committee was formed from members of each of the three key groups and key stakeholder from industry and union leaders. The Washington Center provided staffing and support to create a joint strategic plan, a timeline for action, identification of key stakeholders to partner with nursing, and supported fundraising. The leadership team was comprised of the leads for Nursing -- the Nursing Commission, the Washington Center for Nursing, and CNEWS. A consultant was hired and a charter was developed addressing goals, SMART goals, roles for leaders in r- -- work groups, meeting guidelines, conflict resolution, and so on.

In the fall of 2016, a kickoff event was held with the purpose to present the significance and the

work of Action Now and seek guidance and suggestions for solutions, including policy changes. There were a broad scope of invited guests who participated in discussion and shared stories.

In the fall of 2018, we had the Solution Summit, with the purpose to bring together nurse educators, healthcare partners, consumers of nursing services, government, and policy leaders all came together to review the proposed solutions for all four of our key issues. To note, we raised $25,000 as a steering committee to support this issue.

The success: House Bill 2158. $40,800,000 has been appropriated from the Workforce Education Investment account solely to increase nurse-educator salaries in the community- and technical-college system.

Other successes included the engagement of industry leaders, nonnurses, and nursing leaders. Another success was the education of our legislators using data and stories. We had clips from variety of nurse educators across the state talking about their situation, which we shared.

We had over two years of work. We had continued momentum with consistent and collaborative communication between the leadership team and between and within the steering committee. We noted there was a

clear bonding between the three groups when we were focused on one common goal.

Some of the challenges? Data collection was not as easy as we thought. We found that some of the nursing leaders did not understand how to calculate their FTEs, their vacancy and turnover rates, and they did not always have a clear understanding of their budget. Our communication plan was not well developed, and we did not send out consistent information to our stakeholders on a regular basis. And the time commitment. The leadership team met with weekly phone calls for two years, and the steering committee met for two years, once a month, for four-hour meetings, face to face.

Some of the . . . lessons learned. That we are stronger together with a shared vision. We used our voices, our resiliency, our energy, and our passion to achieve this legislative success, collaborating with nursing and nonnursing leaders as key members of our team. We had engagement from our union coalition for lobbying support, and that was essential. Communication and more communication was a lesson learned.

Some positive, unexpected outcomes that we've seen: Some schools have been able to fund their salary increases and been able to fill nursing-faculty

simulation positions, which in turn supports the issue of clinical-practice constraints. Others have been able to fund nurse-educator salaries and add additional faculty, which has led to a decrease in workload, identified as the second reason faculty were leaving their positions in our state.

Some of the challenges that we've learned is that C- -- the CNEWS president rotates on an annual basis, so that was difficult for consistency in the Action Now leadership team. We are also seeing some university faculty now move to the community- and technical-college system.

And in the community- and technical-college system, faculty salaries are part of the collective-bargaining process and are negotiated at each institution. The institutional response to increased nurse-educator salaries has varied, and there have been many implementation questions. Some schools have experienced a positive response from other disciplines and from their bargaining teams, leading to quick and successful implementation of nurse-educator salaries. Other schools are still working through the process.

Some of the strategies for these implementation challenges. We have monthly collaborative calls for deans and directors, focused on

implementation questions and sharing of strategies. The Washington State Nurses Association has taken the lead being the point of contact for deans and directors to answer questions, and then they share those concerns up with the union coalition.

The Washington State Nursing Association has also developed talking points for deans and directors on the intent of the legislation, as well as a "frequently asked questions" document. They have shared these documents with the community- and technical-college presidents, union leadership, and the state board for community- and technical-college system, providing excellent support for our nursing-education programs.

Our next steps. We need improved data collection, education for our nursing-program leaders, funding for university faculty, and consideration of how to support the private schools and an improved communication plan.

Thank you.

(Indiscernible talking.)

PAULA MEYER: Thank you, Sarah.

SARAH BEAR: You're welcome.

PAULA MEYER: I'm Paula Meyer, and I'm the executive director for the Nursing Care Quality Assurance Commission, otherwise known as the State Board

of Nursing for Washington state. So when I say "commission," think state board.

I'm here to talk about our collection of demographic data. So IOM report said by 2020 we need 80 percent of our baccalaureate -- or our nurses prepared at the baccalaureate level. Well, we had no idea how many were. We knew how many graduated from baccalaureate programs, we knew how many graduated from an ADN program, but we didn't know how many had continued their data [sic]. That was the spur and actually the point that got us to move forward on this collection of demographic data.

So the Center for Nursing, in the law that says these are the things that they must do, they must talk about the supply and demand for nurses. Well, they don't have the data. The state board has the data. But we only have some of the data. So we said, "We've gotta do something different."

So in 2017, the nursing board said, "In order to apply for your license and renew your license, you have to submit demographic data." We worked with the National Council of State Boards of Nursing on their E-notify system so that that data can be entered, because they're working with the National Forum of Workforce Centers on the minimum dataset.

And we said, "In order to have a consistent state [sic] of data across states, let's use a consistent dataset. Let's use the MDS. That's what the E-notify is doing." And if that dataset is revised at all, then the questions on the National Council E-notify are changed, as well.

So again, January 1, 2018, the board, or commission, adopted rules that said, "If you are going to apply for licensure or renew your license, you need to submit your data through this."

Well, that made some people a little nervous, to the point of where --

Thank you, Sarah.

-- about the security of the system. Because whenever you put sensitive data into a national database, people get twitchy. So we had to talk about what sort of security measures do we have in place to secure this data.

And really boils down to three elements: First of all, we know who has submitted their data. We don't know what their data is. So we've made a clear distinction between, "Did you register? Thank you very much. We can proceed with your licensure." But that aggregate data is then going to be transferred to the Center for Nursing for analysis and for development and

that. So that's the first one.

The second one is -- it's called SecureAccess Washington State [sic]. And we all just love this SAWS [sic] system. And I say that with bitter satire, because it is a difficult system to try to get through. And that's how we do our online licensing system, as well, is we have to go through this SAWS step, and it's a very, very dense firewall to get through to enter your information. So that's the second level of security.

The third level of security is through the National Council of State Boards of Nursing. All of that database that they have with all the licensing has to meet NIST three, National Information Security Tests. So it is at the highest level that you can get until you go to Department of Defense data.

So we've got those three levels of security. So we've tried to ensure people, "Yes, we've got very secure databases." In God we trust. Everybody else bring evidence. Okay? So we're trusting that these security systems are going to assure safe access, but also no one that shouldn't access that data has access to it.

So three organizations: Washington Center for Nursing, Nursing Commission, State Nurses Association. We said, "We gotta communicate this."

And just as you said, that communication is absolutely key to the success of anything we do. So we took on a heavy communication strategy. We developed one newsletter article that we all agreed to. So we had the same newsletter article for WSNA, Center for Nursing, and Nursing Commission. We repeated this over and over throughout our newsletters. We posted this on our Web page. We sent this to every nurse on our LISTSRV. And right now we have about 90,000 email addresses for our licensees. So that same letter went out to all of them. Every presentation we did, whether it be to a School of Nursing, whether it be to a local WSNA chapter, whether it be to a hospital, we communicated this, we communicated this, we communicated this.

So. We put it in place. And what happened? 60 percent of the licensees completed their data. We said, "That's pretty darn good for research purposes, but I'm a regulator. It's a rule. We need 100 percent." So 60 percent entered that.

We next sent email notices to those people who hadn't registered. Of those, we increased to 70 percent.

So the next year, we sent a much more formal letter, with my signature on it, to people who had not

registered. Well, that got us up to 80 percent.

But we also found that 2,000 of our addresses were incorrect. 2,000 of those letters were sent back to us.

So we now said we have a data-collection and a data-integrity project. So not only are we collecting this data, but we cleaned up our licensing database as a result of this.

Okay. So we get now to this year, and we have 80 percent of our licensees that have contributed data to this. So upon licensure, upon application, they're contributing their data, and every year with their renewal, they need to go into the E-notify and they need to update that. "Have I changed my address? Have I changed where I work? Have I changed what I'm working? And have I changed my education? So that I've gone from an LPN to an ADN to a baccalaureate to a master's to a DNP." So that -- all of that data's coming.

Center for Nursing is contracting with the University of Washington Workforce Center, and they will be doing the data analysis for us.

And we said, "Oh, my gosh. Now we've got this, what do we do with it?"

I'm happy to say the secretary of health, John Wiesman, sent out a directive to the department. This

is the first-ever directive that a secretary of health has sent out. The title of it is: "Equity, Social Justice, Inclusivity, and Diversity." So we -- we will use that directive to start to look at this data.

How are we going to use this for equity in nursing? How are we going to help nursing assistants step up and become LPNs? How are we gonna help LPNs go to be BSNs? How are we going to look at this as a diversity issue and a social-justice issue and a inclusivity issue?

So I'm gonna finish with that and just say: More to come.

REBECCA PIZZITOLA: This -- yes. [indiscernible] so [indiscernible] my Fitbit says my heart rate's pretty high right now, so I'm gonna speak prob'ly pretty fast as considering I'm a New Yorker.

But I do have some slides that I'm -- they might not be in order of what I say, but you can just go to the first slide, if you'd like.

So this is gonna be a little repetitive. I don't know exactly what you heard yesterday after the NAM part of the day. But I'm actually not a nurse. I'm a public-health professional. So for me, I was trained on things like the socio-ecological model that looks at everything from what do you do at the individual level,

what do you do at the community level, what do you do at the policy level, to really ch- -- influence health.

Actually, are there any public-health people in the room? Just public health and not nurses?

UNIDENTIFIED WOMAN: Well, I was public health first and then a nurse.

REBECCA PIZZITOLA: Well, that counts.

But I'll bore you a little. But this is something you see more now that -- social determinants of health has been talked about for over half a century, but we're fine- -- it's finally getting the attention it deserves. So we know that about 80 percent of health outcomes come from everything aside from what happens in the hospital or the clinic or wherever the patients are where they're getting the medical care.

But we have a healthcare system. We have social workers. We have what people do at home. That's the entire system of healthcare, not just medical care.

So this is how I -- why I was brought into the Washington Center for Nursing, to kinda lend that viewpoint a little bit more.

And I do wanna also say, just given my time in the public-health sector, I applaud nurses and just everybody for making this finally happen, 'cause public health for a long time has looked like, "Hey, Rebecca,

do you want a job that's working on tuberculosis?"

"Okay. But this person is homeless, so what else are we going to do?"

"No, no, no. We just work on tuberculosis. This is what the grant says. This is what we have to do. We can't do anything else."

So just wanna applaud nurses for taking a lead on this, because you guys are doing the job I always wanted to do.

KIMBERLY HARPER: Not too late.

REBECCA PIZZITOLA: So social determinants of health are about 80 percent of the problem. And when I did my research, it actually said that 50 percent alone is related to ZIP Code. So one of the important things, when I get more into the project I've been currently working on, what I wanna do is mention is that social determinants of health are often linked to just poverty, but they are so far beyond that. I mean, you have anything from someone who speaks in a different language so doesn't understand what a doctor or nurse says. You have someone who maybe is transgendered and gets mistreated. You have someone who's just a different race and gets discriminated against. So we just have to remember that it's everything.

And we heard in the previous panel about

social isolation, not only for the elderly, but even if you look at the fact that millenials and everyone beyond, we're becoming increasingly socially isolated, even if we have 5,000 friends on Facebook. I mean, whether it be because we're more comfortable with going to therapists or not, therapists are being more commonly used, behavioral health is an increasing issue, and so we have to look at social determinants of health well beyond poverty. It's not just the most complex patients that need help. It's everybody.

But on that other note, one of the number-one predictors of health outcomes is education, employment, and income, so poverty is critically important.

The big thing that I think has to be reiterated over and over again is that social determinants of health is really looking at not just what we think patients need and telling them what they should do to be healthy, but what are they not only able to do but also willing to do. You have to factor in patient values. You have to factor in can they afford to do this. I mean, again, that's social determinants of health. These are all synonyms to me.

But we see this ch- -- change in thinking from wherever we were before, just treating people in clinics, in hospitals, to a culture of health where we

look at everything through the health lens. If we do X in the community, if we build sidewalks, if we improve safety, if we have more parks, how is that gonna influence health for the better or the worse?

There -- everything is a double-edge sword or a two-sided coin, so you're always gonna -- you're always gonna have a downside. The question is: Do you have more of an upside. So don't be afraid to innovate, cause there's always gonna be something wrong with it; there's always going to be a barrier.

So this actually brings me a bit into some of the wir- --

Totally forgot I had slides. So. Anyway. Just ignore those for now.

So the big project I was hired to do was working on what the action coalition has been doing for years, they've been building leadership in this state among nurses, and I was brought in to help build upon that by looking at how can nurses increasingly take the lead in screening for the social determinants of health at the point of care and then run with that and try to fill those gaps for those patients.

So we conducted about 37 focus groups around the state, about 375 participants, including mostly nurses, but also home-health aides, plenty of soesh- --

social workers, some physicians, just to get a better idea of what they're already doing, what barriers they see, and to sorta shift their mindset out of the barrier mentality to if we had a magic wand of what would we do to improve the system and just get the patients what they need.

And a lot -- we're still digging into the data, because that's a lotta data when you have focus groups, and they're recorded for an hour and a half each. But some of the key lessons really are that, I mean, people do get stuck on the barriers. Do they have time, particularly with the nursing shortage. You're already strapped for time. And if you're in acute-care setting, that's even harder because your patient is f- -- or you might wanna focus on the most critical thing at that moment.

But over time and with people who come in time and time again, there are opportunities to figure out what else is going on in their life and to really harness the power of nurses' ability to build that trusting relationship with patients, to figure out how they can solve these problems, or at the very least just listen to a patient and empower them to think about what solutions they're able to do.

And building upon that, we are currently

looking at a pilot in the fall. We're looking for partners for this. But we want to pilot a screening tool. There actually are plenty of screening tools out there. Epic has plenty of questions within their system. But we wanna do something -- we want to move towards more of a validated tool. What questions do we wanna ask? How do we wanna ask them? What do we do once we get the answers? Can we have intero- -- interoperable sharing of that data? Who's going to act on that data? Who's gonna actually follow up and see if the patient acted on that data and figure out why or why not?

And just develop -- just build that sort of infrastructure and that system, 'cause it doesn't seem to be in place. And even when people are able to ask the right questions and get to the meat of the problem or the heart of the problem, they don't really know what to do when you give a patient a list of 30 homeless shelters and 29 are full and there's limited -- cell phone minutes are out and they can't call that last one. So this is a whole big problem.

But I think as we move forward, as we develop the tools, we have the policies that support nurses and doing this work, and giving them the time to do this work, and also preventing secondary trauma from doing

this work, then we can move in that positive direction.

And as people have already said, you know: Fail fast. Don't get tied to a project just because you spent so much time on it. If it's not working, move on to the next one and just keep going. There's always gonna be a downside.

And just continue to also work not only across silos, but definitely across sector. I mean, some of my past, I was working at UCLA, trying to bring together the nursing school, the medical school, as well as the oral-health programs, and just getting people really working together, working the community, seeing how do you change the knowledge, attitudes, and behaviors of healthcare workers not just in education, but just by linking them all together and getting them to the table to agree on things.

So are -- so -- so you really wanna have that multisectoral approach to everything that you do. And I don't know how the payment systems are going to follow that. But you have to -- I think if you motivate people, change the culture, especially sar- -- starting with education, you can move people in that direction. And then as they move into this hard work, working with harder populations, just help them build resilience as they move forward.

I think that covers everything on my scribbling. So. I'll finish there. Thank you.

DAVID REYES: Hi. I'm David Reyes, with the University of Washington in Tacoma. So just wanna make that distinction, 'cause the Seattle campus, the mothership, is its own entity. We have our own faculty, self-governance, and our own program.

So I teach in our RN-to-BSN program. We don't have an entry-level program. And then we have a Master's in Nursing program with two tracks: One in education and one in leadership.

And so we've heard a lot about social determinants of health, and we were fortunate to be one of the site-visit locations for the PHIN, the public -- Population Health in Nursing, work that's been going on. So I can share with you sort of an exemplar, and we're most grateful and -- and -- and honored to have been selected to have our work showcased.

So I'm gonna talk about how we are approaching population health in nursing and understanding the context for that.

I have to say that my hair is gray, and I haven't been an academic very long. I'm actually just starting my sixth year. So I was actually in practice -- I've been a nurse for 30-something years,

the first third in acute care, and then I was a home-care nurse. So I remember the old HCFA forms that I had to go back to the office and fill out to justify what I was providing in the home. And it was after that experience that I actually sort of launched myself into k- -- my career in community public health. Actually, I was -- I got laid off from a -- my old job at the -- at the hospital, but that was a good thing.

So, you know, I -- I approach my now teaching practice in a very different way. I think also, you know, we heard about the context of our -- our students. So one of the things that we are really paying attention to is how are we actually framing our program. And we look at it somewhat from an ecological framework. Also in the t- -- in the sense of what is partnership in terms of accomplishing this goal of our students graduating with their experience of going on to get their BSN prog- -- degree. As well as what is perhaps the shift in mind that they are now leaving this education with.

And one of the things that we know actually about college students, about a third of students across the country experience food insecurity. So when we start talking about social determinants of health in our education, one of the things that we started thinking

about is what is happening with our own student population.

And I have colleagues who are doing research around college students and are finding that our students are also some of the populations of communities that we are trying to reach out with and work. So how do we actually provide an educational system that also is meeting the needs of students who are experiencing or have experienced ACEs. Right? And how do we navigate that need to learn and to thrive and succeed at the same time they have the pressures of the educational environment, but because they are nurses, most of them are already working already, they have already transitioned and are transfer students, and almost all of them are working full-time and they are going to school full-time.

So here we have an environment where we are trying to teach them or have them to think about what is it like to actually work in a community setting, learn about population health, when they might be experiencing some of the same challenges in their own lives. Right?

So one of the things that we've been conscious about in the last couple years is around resiliency in our students who are beginning to do work around understanding and having them think about ACEs both from

a personal level and not necessarily [indiscernible] to talk about what is going on, but have them think about what's that impact and where is the resiliency. What's the assets and the assets they have in their own lives to succeed in their career and certainly in their education.

So that's been a real focal point for our -- our -- our program. And this is with the RN-to-BSN students.

So when we are approaching in education, we actually have courses that are threaded through the program, the curriculum, around social justice and diversity. They have to take a course. And what I first started teaching that -- this course --

It's Diversity, Health, and Inequity. I don't teach it now because I've been taking it other directions, but it's still threaded through our courses.

-- is that we actually started having students take the implicit-bias test --

How many of you are familiar with the Harvard implicit bias? Right? Some of you are.

-- as a way in which they can begin to think about their implicit bias, unconscious bias, in a way that's very different than us talking about and understanding what structural racism is. Because when

we think about those words, we think, "Well, I'm not one of those people. Right?

And so part of what we're trying to do in our curriculum is begin students think critically and reflectively about what it is to be a nurse and what are their own biases in terms of how that's gonna affect their patient care or their clinical practice or their practice in the community or wherever they're going to be.

So that's our thread that we have begun -- we -- we started and then is transferable into other courses.

Now I teach a course in community public health. And in that experience, we also have a real foundation in cross-sector partnership. And so because we are an RN-to-BSN program, we have a hundred clinical hours, which I know the commission knows, which right now is our responsibility as that program, 'cause we don't have clinicals in others. And that's another . . . issue that I won't go into.

But the question is: How do we then provide a learning experience for students that maybe is meaningful and attainable.

So, you know, of course when students come in, they think, "What's a clinical?" [Indiscernible] the

clinical term, "Oh, it's at a hospital. It's in a clinic. I'm gonna see patients," etc.

And so part of their framework for this ecological model is thinking about, well, what is care? Where is that? Is it in the home? Is it in the community? And what is the differential between the hospital and in the community?

And so they've already had a course on social determinants. They're very well versed in that and they hear it over and over . . . again in different contexts. So when they come into this course, they have to choose -- they get a choice of a clinical -- what we call a clinical practicum and our cross-sector partnerships are based in the community, depending on the clinical faculties' interest and relationships.

And we've heard a lot about relationships, and that's really where it starts. It might be [indiscernible] the healthcare system delivery system. But 99 percent of the time they're actually in the community.

So my practice is actually a lot with the local health department. Some of our faculty have relationships with the school districts. Some of them have 'em with homeless agencies. And so these clinical experiences are then -- clinical, are actually with

those agencies who ha- -- actually come to us and said, "We have a population and a project that we want to assess," so we ground it in assessment.

And so this is some of the challenge, is how do we then really think about what is assessment in a population level, and how do nurses transfer knowledge in what they've learned in the clinical setting into now the home-based or -- or in a community setting.

So for example, some of the practicum experience that we've had with the students are, for example, taking them out to do a community assessment around food security. So a couple of projects that I'd worked with students are, one, we had them actually involved in what we call the Community Health [indiscernible] Assessment; Community Health Improvement Plan process, the CHA or CHNA.

So we know that one of the requirements for nonprofit hospitals now is that community-health needs assessment. So we actually had students learn about conducting a focus group with community leaders around what was going on in their particular community around these issues of access to healthcare, about chronic disease, things that they're familiar with, but also what are the other issues around homelessness: Drug abuse, housing, et cetera.

So we use the social-determinants framework for them to actually have this learning experience. So it wasn't just an exercise. It was also applying learning in a situation that also was contributing to another purpose, which is how we actually planning for health at a population level.

Now, that comes with challenges, because students who are coming into this aren't used to the fact that they have an unknown project. So some of our learnings about this is -- is -- and I like the term we heard about -- about leaning in. We use the term "living with immig- -- with ambiguity," but I'm now gonna use the term "leaning into ambiguity." And that students are learning about population health, there's an ambiguity about learning about what is the unknown and asking them think differently about what their clinical algorithm might be to treat or diagnose a patient, but how do they actually live and learn differently and actually be more reflective about the information they're gathering from a community setting.

The other part of this is that how do they actually think about leading this. How do they become leaders and how do they begin to think about policy change, 'cause that's another focus of our program.

And so one of the products in which they have

to actually produce at the end of this experience is actually a executive summary of their project, and they also then have to actually present that in a poster presentation to the community partners in a forum. So they get the experience of them reflecting back what they have learned, but also what are they recommending for change. What are they recommending for change that might actually influence that community that they're working with.

So for example, we had students -- not my students that worked actually with a school district in -- in Pierce County, very underserved, where they started working with students around social-emotional learning. Now, for students who are clinically oriented to talk with kids about what's going on in their lives on a social-emotional-learning level was very scary for them. So part of our goal here is, as well as this [indiscernible], is how are they actually thinking about the skills that they've learned and actually applying them in situations that may be different, but they're also innovative. Right? So we're also trying to get them to think about their clinical learning practice and how to apply that in a different setting.

Finally, just to think about, then, how are they actually learning and leading with each other. So

a central part of our curriculum is actually them being a part of a team in focal groups and actually taking opportunities to lead the group. And it's one of the challenges I think about our learning system now. I think about when I was an undergrad many, many years ago, about this sense of what agency is in terms of leadership, and that perhaps what we may have forgotten to do or have maybe sort of put off to the side is how are we actually getting our students now to think about being change leaders and change-agency leaders.

And we've heard a lot about the need for leadership, but we've gotta think -- I -- in my s- -- views, really bring that much more upstream. We talk about upstream determinants of health. But how are we thinking about upstream learning? How are we actually getting students to think about what does it mean to be a leader, wherever I am in my environment, whether that's in a home setting, home health, it's clinical, wherever that might be. What is the progression that they then take in terms of their own professional leadership and role.

It's interesting to me that, you know, our goal -- well, I would love every student to be a public-health nurse at the end of their career. I know that's not possible. But I also say to them that they

are population-health nurses because population health is a continuum. We talk about the life course. They're working with clinical populations who then go into their home communities, and then, you know, for those that serve population health, we're at this high level. So if we can make that shift and difference in their -- in their thinking, then we've succeeded.

So I'm gonna stop there 'cause my time is up. Thank you.

SOFIA ARAGON: Thank you very -- oops. Thank you very much, panelists.

Victoria Fletcher is one of our panelists who was unable to make it at the very last minute, but I'm wondering if we can pull up her slides, and I will just touch on the remaining time we have; also leave time for questions.

Some of the key points. So she wanted to dive a little bit into the Leadership Nursing Action coalition and their work.

Next slide.

And one of the things they did, and this is in conjunction with the Health Care Authority, Healthier Washington Project. They actually asked nurses around the state, through the Center for Nursing Board, which includes all of our major nurses associations as well as

the nurse educators, nurse executives, ARNPs, public-health nurses, and we found that only 29 percent in 2016 actually knew about the impact of social determinants or the culture of health or the Healthier Washington initiative.

And I'll touch on some activities that actually brought their knowledge of -- on the pers- -- postsurvey to 48 percent. So I'm feeling like this effort really prepared well for more statewide conversation on these issues.

Next slide.

So how nurses currently address SDOH was the big message. So in the survey, nurses actually told us how did they want to learn about these things. So in response to that, we published some articles that were also in the Nursing Commission News, so every nurse received that, as well as major nursing-organization newsletters. We co-produced a video with Healthier -- with the Health Care Authority, because they have professional communications staff, and really leveraged a $5,000 grant that we were awarded by Robert Wood Johnson Foundation to produce a great ten-minute video that is on the WCN website, if you'd like to take a chance to look at that.

And Dorene Hersh herself was at the table with

Medicare and Medicaid leaders, with Sue Birch, to discuss our progress here. So I'll say that while I feel a bit that nursing leaders often bring up the question of "How can we get to the table?", many times is, "We're at the table. So what next?" Here's what -- how we need to challenge ourselves.

Next slide. Next slide.

Okay. And this is a lot of what we talked about yesterday. I will add that I was hoping that Victoria would share that she serves on the Health Benefit Exchange Advisory Committee, and that is the agency created in the Obama administration to provide those health benefits, and right now that committee is looking at how do they implement the public option that just passed for the state last year.

And Victoria, on being a nurse who has served on many boards, she and I talked about through her experience knowing when is that right timing to bring up how are we going to make sure that the value of nursing services in this [indiscernible] health plan to be introduced in these conversations. So I'm sorry you missed out on that. But very glad that she's engaged in that group.

'Kay. Next slide.

M'kay. So some recommendations she wanted to

state in terms of, you know, what should the NAM consider in the report is to state the explicit goal of diversity in the workforce. Data desegregation in agrit- -- in academic progression and graduate dee- -- degree attainment is something that we're working here in Washington state.

And something Paula really touched on is that we actually look at demographics in terms of the unique makeup of Washington. And I'll say that we have over almost 300 Asian Pacific Islander groups here; almost 50 Native American tribes. We have new African immigrants here in the state of Washington. And that might look very different in Florida or Maine. So that data desegregation is really key to seeing how your population is progressing.

The other piece is the question about how can national organizations like the National Academy of Medicine, the Robert Wood Johnson Foundation, and the AARP Center to Champion Nursing in America help advance these activities. And number one, convening states to share challenges and successes is really important. Rebecca talked about our tool on social determinants. And actually, it began with a tool that the Ohio Action Coalition created, and we folded that into our focus groups, asking nurses, "If we were to put this to work

as an example, what are some barriers and challenges for you?"

Providing grant funding for research and increased capacity for implementation is really key. I mentioned that Dorene Hersh leveraged a $5,000 grant to do all the great work she did. And another public-health-nurse-leader grant that was offered after that actually gave us Rebecca. So that although we were doing great progress on the volunteer basis, really key to be able to hire the staff with expertise to do the research and actually disseminate the information to advance the work.

And then finally, publishing state exemplar experiences so that that information is easily accessible to everyone around the country is what we would recommend.

So in our short amount of time, I wanted to give the panelists an opportunity to say: What do you think these national organizations. . . . Oops. How would these national organizations help advance your work?

SARAH BEAR: Well, very practically, I think that the faculty shortage is a nationwide issue. So continuing to convene states that are working on increasing the diversity and specific strategies to

improve the -- the position of nursing faculty will be very important. Documenting the changes that are being made now and sharing those strategies out I think would be really important.

And when I think about what we've heard -- technology, innovation, and nursing education -- there's been a lot of comments about how do we change nursing education to be what it needs to be today and in the future. So those have not quite settled in my head yet, but I think that's what we really need to continue the conversation.

PAULA MEYER: And as far as the demographic data, I think we're gonna have a better picture of where we are compared to our state's population. And then what are those disparities? Where are the gaps? And then what do we need to do as policymakers -- and I know it makes people a little bit nervous to say that we need X amount of nurses in this area, X amount of nurses in this area, and is the State going to actually drive nurses to that area. I -- I don't see us doing that.

But what NAM can help us with is to get the data out and to get the disparities out and to actually communicate that. We said that's one of the things that we need, and one of the things that we saw as our downfall, is this communication. So the more

communication we can have about some of these initiatives, I think the better we'll be.

REBECCA PIZZITOLA: I got it.

Well, I think a lot of what they're already doing is really great, so just expand upon that. So like Sofia said, I'm funded by Robert Wood Johnson right now, and I think what's great about this thing -- unfortunately, my grant will be ending. But what's great [indiscernible] is that it's a small-enough grant that has allowed such flexibility in the work that we can do. 'Cause obviously if you have a $10 million grant or whatever -- I was working [indiscernible] at UCLA, we were -- we had to very strictly meet our deliverables and defend every reason that we deviated, and also kinda spend down at the end of the year and buy a buncha iPads that we didn't even need just to put in a closet. So there are these things like that.

And I think Robert Wood Johnson and other places can look at ways to fund more innovative produ- -- projects like that.

But along those lines, also, I think it's important to look at doing this in the longer run. So maybe smaller grants, but smaller grants that are committed for a longer time period so people can have the longer vision in mind when they do this work and act

on the lessons that they learn.

'Cause, I mean, once my grant ends, I have no idea what's gonna happen with the data, and maybe they won't be able to get another grant to use what they learned. So I think those things have to be considered.

And then as -- as Sarah was saying, just learning how to share the data more openly, not only within the state and between different organizations, but just nationwide. I mean, we -- we have to not only share best practices, but then move towards validation. What tool can we use?

Very few people have heard of the Core 5 screening tool that we're currently use -- using as an example. Very few people are gonna use the 14-question tool that I believe Medicare uses. So it's just to find a way to get a tool that is -- that can be used across all different settings and that is validated: You're asking the questions in the right way depending on the population that you're serving; you're getting the answer that you need to do the work. And I think that's something that really has to happen at the federal level.

Let's see. What else. And just bringing my soap box again of public health into all of this. I think we just always need to consider, whether it be in

grant-making or anything else, what are the interventions that we can . . . move forward at all different levels of the socio-ecological model.

So when I first started this job, I mean, I understood things about the social determinants of health, and I understood nursing was the largest healthcare workforce, and eventually learned they're the most trusted profession, but I still was like, "But still, why nurses? Why not someone at the food bank asking these questions? Why not public-health professionals?"

And I know that while I'm now changed in my thinking, there's still people I talk to within the context of even just this project who aren't nurses and they're kinda -- they're still confused. They're saying, "I don't understand. Why are they doing this? This is public-health work," or, "This is social work."

So I think at a national level, we have to figure out how to convince people that nurses are a good place to start or are the center of this work. And then, again, the money has to follow all of that.

And I wanna say something else, but I lost it. So. Your turn.

DAVID REYES: So a couple things that come to mind, sort of alluded to earlier, which is . . . how are

we actually valuing the population-based education? And frankly, I think that unless it's on the NCLEX, it's not gonna happen that we are actually putting another value that we want our nurses to actually finish their education and have that as a framework.

One of the things is having U-Dub as a system is that our . . . president actually created a initiative for the whole university: W- -- every student will be exposed in some way to population health. That doesn't mean that they go into population health. But if they're in a policy-making position and they're a finance person, they understand that the decisions that they make are gonna affect people. So . . . how do we expect that of ourselves as a discipline if we aren't asking our students who are graduating to actually have that level of knowledge. That's where -- that's upstream, I think.

I think then it's like how are we looking at nursing education? And as we look at how we're reconceptualizing curricula is that we have to retrofit, because some of those are hard-wired. So what's the support and the resources to actually develop new curricula that allow us to look at these social-ecological frameworks in nursing education that emphasize population health. And then where is the

resourcing ability to actually then look for outcomes.

And so we think about these cross-sector partnerships between population-health entities and the healthcare-delivery system, intersectionality of that. What is that gonna look like? We're expecting nurses to cross. Some of them are beginning to think how about -- do they do home visits who haven't done home visits? Or how are we utilizing nurses in community settings to now actually go into these acute-care entities and say, "This is what social determinants actually look like," versus sort of again [indiscernible] individualize it at a level where it becomes only the value-add in terms of the ROI and the money.

So here's a good role for nurses as those care coordinators, if you will, is actually those navigationals between community and the health system; delivery system. So how do we create models that we can then actually test and evaluate to see how does that actually affect upstream, and then what's the impact as we think about individual behavior, although, you know, we s- -- it isn't all about individual. But we do wanna see how does that impact the fact that if I have diabetes and my A1C is down or that I'm able to actually get outside and walk, because I know if I can get out and walk or eat fresh fruits and vegetables, that

actually [indiscernible] help my -- my lifestyle. Right? But it also impacts the community.

So I think those are three things that we could start -- begin to look at.

REBECCA PIZZITOLA: Actually, I remembered my other point. So I think just when I think of federal government or federal whatever, standardization usually happens at that level at least in a way that's a little more helpful sometimes.

And I think something I've also come across just in this project alone is even sitting down with the nurses who completely understand what the social determinants of health are, but in the question number one they're stumped because they forgot that they're called "social determinants of health." Of course they know housing, transportation, domestic violence, whatever it might be. But, I mean, we have all these terms floating around. Cultural of health. Social determinants of health. Health equity. Equality. Inclusion. Diversity. And it just -- I think we have to take a minute and stop and understand what each of them mean.

And actually, it's one of the slides that I definitely didn't touch upon at all. But I think there are simple ways to see this and there are simpler ways

to communicate it. And we don't all have to coin a term, but I think at the federal level we can maybe not only educate, but just . . . show how these things all relate together.

And even as Sofia said with the survey, like, part of the reason that people didn't know what these things were called was simply because they weren't introduced to the term. But it's not a new term. The World Health Organization talked about social determinants 50 years ago. But still it's new to people and people don't get it.

So I think just kind of finding a common ground with the terminology is critical to move this discussion forward.

SARAH BEAR: I have one more -- one more quick. . . .

(Indiscernible talking.)

SARAH BEAR: One more quick -- oop -- comment. Our state has an innovation WAC that was approved in 2016, and to my knowledge, not a single nursing program has submitted an application to be innovative.

At our Nursing Education Summit, we had a speaker, Pablos Holman, who leads the Innovation Lab. He's a world-renowned hacker, and he takes things apart and puts them back together again in a different way and

designs these absolutely amazing things. He challenged us to think about how we're doing nursing education and how we are not embracing technology. We're not using holograms and virtual this and virtual that, whatever else he was talking about.

So I think pilot projects to help us engage with industry partners who can --

He also spoke about how hard it is to innovate and redesign when you're immersed in the system and were raised up in that system.

So really the need to include industry partners that think differently, to help us take apart nursing education and redesign it, incorporating technology from the beginning. So I think pilot-project money to support nursing education to do that would be extremely helpful. Thank you.

SOFIA ARAGON: So I'm looking at our organizers. Are we at time? Okay.

Well, that's s it. Well, thank you very much. And we're around to answer questions.

MARY SUE GORSKI: Wow. That was great. That was great. How to implement some of those -- those projects and the -- the successes and the challenges that come with it. So that was another great panel.

We have two additional, real brief,

five-minute presentations, to kind of give your -- just a little bit more --

Er- -- why doesn't everybody just stand up for just a minute, though. Stand up and move around just a little bit. Great. [Indiscernible.]

(Simultaneous talking.)

MARY SUE GORSKI: Okay. We're just about to the time that we're gonna have some time over lunch for the last hour and 20 minutes to kind of gather in groups and share some of this information. So we're -- we're almost at that -- that point. I hope you've been taking notes, I know I have, to -- to remember the people that I wanna talk to and -- and explore ideas with.

We do have another couple of states that are gonna share some innovative projects that they have.

Casey Blumenthal from. . . .

(Simultaneous talking.)

MARY SUE GORSKI: Montana. And I've only known you for, what, ten years? Casey.

And Victoria Vinton from Nebraska.

CASEY BLUMENTHAL: Well, now I don't have to introduce myself. However, I have been given five minutes, no more, or I get the hook. So.

PATRICIA POLANSKY: The bell.

CASEY BLUMENTHAL: Sit down. Pay attention,

please. I get the bell.

UNIDENTIFIED WOMAN: There you go.

CASEY BLUMENTHAL: I am from Montana. I'm here with Kris Juliar, our director of our Montana Area Health Education center. And we've been partners in the action coalition since 2011, when we started. At that same time I also started the Montana Center for Nursing.

And . . . in the last year, the Center's leadership council has done some exhaustive work on trying to figure out what would be the best way to deliver leadership education to our rural and frontier counties. We have a lotta, lotta geography. We have 48 critical-access hospitals across the state out of 60 total. Some of them are very, very tiny, from three beds to five beds; ten beds. Not many of them meet the 25-bed maximum.

And so as one of our former senators, who shall not be named, used to say, "There is a lot of dirt between light bulbs," and this makes it really difficult for our nurses to get education in person.

And so one of a -- a -- previous surveys that we did identified a gap between what nurses perceived they had in terms of leadership skills and what their colleagues had and whether they had access to this. And they -- they mostly believed that they had decent

leadership skills, but their colleagues didn't. So . . . there's a disconnect there.

And we anecdotally heard all the time from these nurses, particularly the DONs in the small facilities, that they needed leadership training. Oftentimes they were thrown into the position with no skills; no additional training. And their turnover was very high because of this, about 30 percent a year. And they're very hard to recruit to some of these communities. And they just -- they're overwhelmed. It's -- they have 15 different hats, which is not unusual in nursing anywhere, but it just seemed to be too much for many of 'em, and they had to run screaming, never to return.

So what we did was we looked at this and we then decided that would be a good theme for our annual summit, where we bring practice and education together. And we brought in some different perspectives this time. We included public-health professionals and leaders in those fields, in the state, and we brought in policymakers, and talked about leadership and policy and how do we effect change at the individual and organizational and community level. And people really loved that diversity in the educational content, I think.

And then we also applied -- the action coalition applied for a grant, 2019, from Robert Wood Johnson Foundation, and received the grant. So now we're working on a Reaching Rural Project, which will offer online trainings focused on a variety of diversity components, including leadership roles and healthcare delivery in tribal and frontier communities, with a specific focus on chronic diseases. And the learning modules will cover trauma, informed care, adverse childhood experiences, mental health and substance abuse, integrated behavioral-health management and practice, and other culture-of-health components.

So the goal is to host diverse cohorts through the project. The learning communities will be open to any nurse working in rural frontier or tribal communities in the state. And this provides a new, innovative, high-tech method for the nurses to relate to each other and feel some connection, because they don't get to see each other very often, and to learn and share and collaborate, and then provide improved, high-touch care and support to their co-workers and their patients.

This sounds fairly straightforward for those of you who have all this AI and VR stuff, but I will tell you that our nurses have a fairly low degree of computer literacy, and they also have a lack of

bandwidth in their facilities or their homes. They may not be able to even do this at home. They might have to come into the facility to connect online. So it's not as easy as just flipping on the computer for them. And then if something goes wrong, they don't know how to troubleshoot.

So this is something that -- that we hope will be successful. Our cohorts are -- it's in the process of being implemented. And it will be just a new way to approach leadership education to these folks who can't get away or can't afford to get away.

(Simultaneous talking.)

VICTORIA FLETCHER: So. Great to follow Casey. I've known Casey actually from the beginning of this work with the Future of Nursing: Campaign for Action.

So Nebraska has had the joy of learning that -- that collaboration is really the way that you get things done. And so our collaborative, innovative, healthcare project came about, and it's called Health Plus Housing. The idea started percolating at the 2017 campaign meeting in Albuquerque. Anybody else there here besides me?

We all heard someone by the name of Stacy Lindau. She's a physician from the University of

Chicago and a Robert Wood Johnson Foundation fellow. Where she presented her story of MAPSCorps, which is . . . building a referral base using students to learn better about their ZIP Codes and what services are actually available. And NowPow, which is -- at the time is the only social-determinant-of-health shared-resource-referral system. So you build your resources through MAPSCorps, you plunk 'em into NowPow, and then . . . teams use the resources to make close-loop referrals. And . . . what it does is it helps you know that actually a referral is made, something was done, and it completes the loop.

So. At that meeting I brought Live Well Omaha's Sarah Sjolie, who is their CEO, as a collaborator to listen to what was going on and how could we collaborate with this very -- this organization that is a catalyst for health in Omaha.

And so we -- following an Accountable Health Community meeting came together on this health-and-housing piece, and we joined Live Well Omaha, the Omaha Housing Authority, and Omaha Healthy Kids Alliance, and developed a pr- -- pilot project which basically flips healthcare on its head. The project is designed to start where health begins, in the home, not waiting until a person becomes sick and seeks care.

So in our pilot project, which goes live August 12th -- that's Monday -- we are actually making the home the patient in a way and working with Omaha Housing Authority's inspectors. They've been taught to use a tool that . . . grades the house as far as its health. So they'll go in; grade the house; make the referrals through NowPow; make sure that they're done. The pay- -- the home's residents get nudged with reminders that, you know, "This so-and-so is coming to your home to take care of this problem." The house is regraded. And then in -- within this time frame, we educate the tenants on the maintenance of a healthy home and evaluate at the end. Very similar to the nursing process. So assessment, planning, and evaluation.

As nurse innovators, Naxpar [ph] is that we are part of the evidence-based education in planning a tool that serves as a checklist on how you maintain a healthy home and what the reasoning is behind that. We've been part of the planning, the grant-writing, the problem-solving, and we'll be part of the evaluation process.

The expected outcomes of this project include improving health of the property. And when you improve the health of the property, you improve the health of its residents. There should be increased tenant

retention, which would decrease the turnover within the house and increase in a h- -- property's value. And so that's a big win for Omaha Housing Authority. That turnover costs money, when you have people not staying in the home.

Nursing's participation allows our expertise in evidence-base health perspectives to be an important part of these communery -- community projects and gets nursing noticed. It's very -- been very fun to be part of a collaborative group that looks at health and housing.

And, you know, it -- it -- "Oh, nursing's at the table. Well, great. That is a incredible idea."

And -- and we do bring -- our perspective does bring a lot to collaborative projects within cities and communities.

So. Yeah. So that -- that's our project. And it's . . . been in -- in the works for a coupla years. And it's go time. So. Thank you.

MARY SUE GORSKI: That's great. I -- I think we should just take one more clap for all of the great exemplars.

(Applause.)

MARY SUE GORSKI: Amazing work. Amazing work.

And we will have a -- an opportunity after

lunch to do some -- or during lunch to do some networking. But before that, Sue Hassmiller has a few things to say. We had planned a little bit more, but she -- she chose -- said no.

SUSAN HASSMILLER: Give it back.

MARY SUE GORSKI: Let's give it back.

SUSAN HASSMILLER: So first of all, this has been an amazing day. It's built on an amazing day built on another amazing day, because we were at site visits before we were at the town-hall meeting all over Seattle. So. My head is spinnin'. I don't know which way to go.

But lemme tell you two things: First of all, let me give you a little bit of information that we should be giving to all the action coalitions, really, and then I wanna talk about something that Robert Wood Johnson Foundation is going live with tomorrow. I was hoping it was today and, you know, it is tomorrow.

So first of all, the -- the process -- the National Academy of Medicine process, is such that we had our last town-hall meeting. There will be probably two other public, open meetings. They won't be big -- you know, big deals like the town-hall meetings and site visits and all of that stuff. But we'll probably have a couple of technical-assistance panels that will be open.

So -- and I would imagine that we will live-webcast that, as well. So stay tuned for that.

So we'll be plodding along all this time and the hard work begins. We had so much fun over the summer. I mean, it was, you know, challenging putting everything together, but that was really fun. Now we have to get down to the brass tacks.

So we will -- once the report -- all the recommendations are in, they go through a very, very grueling process, you know. A turn -- you know, we get blinded reviewers from the -- the community to look at everything. Those reviews come in, and every word has to be paid attention to. All the words that come in now have to be paid attention to, and all the words from the reviewers have to be paid attention to, as well. There's a lot of legal review. And then we are anticipating a press conference probably around the last week in November, something like that. And that will be a formal press conference that will -- I imagine we'll live-webcast that, as well.

If you remember from the last time we had a press conference, we had a live webcast. Because so many people joined, the whole thing crashed. I don't know if you remember that. I hated it at the time, but of course . . . it sounds great now, but I don't want it

to happen again. I really don't. I don't want that to happen again.

But we'll do that prob'ly the last week of November or so.

And then the first week of December we'll have an official launch, like a -- that's the big party. An official launch in December in Washington D.C. We'll have, you know, many, many, many, many hundreds of people there. And we will probably live-webcast part of that, as well.

But it'll be similar to last time, where we -- you know, we're gonna celebrate where we are in the campaign. And we have a dashboard. So we'll celebrate a number of these dashboard indicators and where we've come so far. And my boss will be there, Dr. Richard Besser. Victor Dzau, president of the National Academy of Medicine, will be there.

So the first part will be the campaign and celebrating everybody. You know, this has taken everybody to really accomplish these recommendations. And then we will launch the big report. And there will be a panel, probably by some -- with some of our committee members, maybe our co-chairs. And then we anticipate a -- an armchair conversation. See? We're already thinking -- I -- you know, you gotta think

there, then you just gotta work backwards. Right? That's how this Future of Nursing stuff goes. It -- it's how everything goes; right?

So we -- we're gonna put my boss on the spot and the CEO of the National Academy of Medicine in an armchair conversation and sort of --

Are we being recorded? I guess we are. Yes, we are.

We're gonna make them talk about all this and -- and see where all of this goes.

So we're very excited about all of this.

And the thing that I wanted to announce to you -- again, given that there's been so much information -- I really understand it. But Robert Wood Johnson Foundation has something they call the Culture of Health Prize.

How many of you have heard of that? Almost everybody.

So every year we have a big contest, and we -- we announce probably between three and four prize winners. The prize winners do get money, but more important than that, they get tons and tons of recom- -- recognition. Not only from their own community. We just -- you know, whatever city or community is the prize -- we just disseminate the heck out of everything,

as we normally do.

So I just -- it would be such a goal, you know, for me and for all of us, and it would -- it would make such a stand for nursing, if [indiscernible] one of our action coalitions really took the lead on one of these culture-of-health processes. It is a lot of work. And listening to all of you, you know, Casey said we -- we all wear so many hats, and -- and we do. But this is a -- bringing all the hats together, if you will.

There are a lot of people working in this space, social determinants, all over the place. And, you know -- and housing transportation. Victoria. All these -- these different areas. And I always say, "But nursing has to be in that mix." And I'm so desperate to keep nursing in that mix. And that's, you know, why we have this report.

So if any of you are interested. Some of you are -- you know, may be as -- not as far along in the social-determinant space, and working with so many different partners, and that's what it'll take. But the prize for 2020 is announced tomorrow, and it'll list all the criteria. And . . . and maybe -- maybe not for 2020, because it is a long process, you know. Maybe you can't jump in this year and say, "We're gonna do it," because. . . .

I don't know what the -- the application time -- timing is, you know. The announcement is tomorrow and -- I don't know.

(Simultaneous talking.)

UNIDENTIFIED WOMAN: -- usually November 1st.

SUSAN HASSMILLER: What is it?

UNIDENTIFIED WOMAN: Usually November 1st.

SUSAN HASSMILLER: First for -- November 1st. Okay. So that doesn't give a lot of time to bring an entire community together.

But this -- this is what I can tell you: If anybody comes up to me and says, "I -- I feel really strongly that, you know, one of the communities in my state -- I really believe we can do this," you know, we really wanna help you. Because to take a stand -- for nursing to take a stand, it would be really important to me at Robert Wood Johnson Foundation -- at AARP, as well -- to say that, "Nurses have done this." But we will help you. We will help you.

MARY [UNKNOWN LAST NAME]: I just wanna share something on that point. Do you mind?

(Simultaneous talking.)

SUSAN HASSMILLER: I'm done.

MARY [UNKNOWN LAST NAME]: So just this past

June I was invited with the Action Coalition to go to Mariposa County in California. I don't know if you know where that is, but it's at the mouth of Yosemite. And it's about a five-hour drive from my house. But I went. And the reason I went is I was asked by the public-health nurse leaders to attend, 'cause they had heard me speak on culture of health at their statewide meeting, and one nurse from that county reached out to me.

But the brilliant thing that happened at that meeting, Sue -- and you need to hear this, 'cause I haven't written to you about it -- is they also invited Iola, Kansas, which was a Culture of Health Prize winner. So the CEO from Iola Thrive, or whatever their tagline is -- I'm sorry; I'm blanking on it -- came out to Mariposa County to guide us in a thought process around how do you become a Culture of Health Prize winner.

So I want you to know that the Culture of Health Prize winners -- and we have a number of them in California, but not like this. Not in a very rural, underserved, opioid-crisis section of our state.

So Iola came out and showed how they built it and told us about how long it took and encouraged our Mariposa County team. And it was a brilliant set of

people that came to this meeting, from the police department to the press to the public-health department to whoever would be involved. And you can do that in small, rural communities, 'cause everyone knows each other and works together.

So I just want you to know the prize winners are willing to share with you.

SUSAN HASSMILLER: Yeah, and you know what? You don't -- it would be great for nursing to lead it, but -- but here's the other way to get in: The other way to get in is just to tell me -- tell us if you're interested. Right? And then we can keep track of those communities that are further along, they've been at this for a couple years, and maybe we can insert nursing into something that's going on.

You may not know -- you probably don't know what's going on in your state, because these thing kinda spring up and -- and they come together, and they don't generally include nursing. I will just tell you that. It's a lotta people comin' together around this space, and they do not include nursing.

So whether we lead it or whether we insert ourselves, both would be important.

So I'm just gonna leave you with a little two-minute video, if we can just play that a minute.

(Video played: Klamath County, winner of the 2018 Culture of Health Prize. 12:32 to 12:36 p.m. It was not taken down in this record.)

SUE BIRCH: That's the challenge.

PATRICIA POLANSKY: Okay. Well, we're all -- we're all exhausted. But you can't go yet. The meeting actually officially ends at 1:30.

So the lunches, the box lunches, are gonna be out where . . . they're gonna be out where you had your wine and your reception last night instead of here. This is a little too crowded for those.

We have stanchions in the room for the states -- for the five states that did exemplars; the two today and the four yesterday. I mean the two today, the two yesterday, and Washington. So that's five.

This is Kim Harper. NOBC. She's gonna stay right around here.

KIMBERLY HARPER: I'll stay right around here.

PATRICIA POLANSKY: So anybody wants to talk about the nursing leadership, NOBC, the national movement, everything that's happening there, or if you wanna check in so you can take back home where your state is, she pulled all this up yesterday and she has it for you. So even if you maybe just do a pit stop because you wanna talk to somebody else, that would be

worth the time.

There are a lot of suitcases out here. We, the staff, are prepared to stay here. We have the room till 2:00. But we had to end earlier 'cause takes an hour to get to SeaTac, we know, and many of you have flights out, give or take, at this time of day. I mean, it's the -- it's traffic. Right? So you have to allow 45 minutes to an hour to get to the airport from here. So that's why we had to kind of telescope the meeting so those of you could get across the country and home.

But what we're gonna do is staff's gonna put the stanchions out so you know what states are -- be sitting there. You can do speed dating. You can get in the corner with who you brought with you and sit and take this time now and talk about, "Whoa," or what you wanna think about or talk about or maybe what you're gonna do.

There are these five chairs up here, if three or four of you wanna sit up here and talk to each other, pull 'em around. There's plenty of room to do that.

Again, you can get your box lunch through the door and then come back in here.

The recorder is finished for the day, because this is your time.

We have staff here. We have Win and Scott

Tanaka on -- and you've heard "health equity" in everything all of yesterday and a good bit of today. So they are in the room.

Maureen is here. Mary Sue is here. In terms of education, academic progression, all of that. Ana and I are here. Population health. The PHIN program that you just heard David talking about that we did the site visit. Sue Hassmiller is here. Susan, you're still here. So we brought -- rarely get this many people from the office to be in one place at one time.

Liz Close is also here, and she has worked with this campaign as a nurse expert from the get-go, and I'm sure Liz is willing to sit in with you, to, you know, bounce things off of.

So this is work time. We don't want you all to go out the door, because, honestly, this is something you asked for, and we had built this into the program. So it is a lot. Sue said: Like drinking from the fire hose. That being said, you got, "Whoa. Whoa." And there's a lot to think about and talk about. So even if you just muse with yourselves, it's going to be good time.

So 1:30 will be when we're just going to come back in here and just close up for two/three minutes. Again, if you wanna still sit and talk, the staff's here

till 2:00. And we wish you safe travels, and we thank you for being here, and for our speakers who are still in the room.

(Applause.)

(Meeting concluded at 12:40 p.m.)

C E R T I F I C A T E

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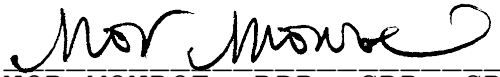
I, Nor Monroe, Certified Court Reporter in and for the state of Washington, do hereby certify to the following:

That my stenographic notes were reduced to typewriting under my direction;

And that the foregoing transcript, pages 1 through 161, inclusive, constitutes a full, true, and accurate record of all the proceedings had, and of the whole thereof.

Witness my hand this 21st day of August, 2019.



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