FINISHED TRANSCRIPT

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>> SANDRO GALEA: Good afternoon. My name is Sandro Galea, and I have the privilege of serving as Dean of the Boston University School of Public Health. On behalf of our school, welcome to today's Public Health Conversation.

These events are meant as spaces where we come together to discuss the ideas that shape a healthier world. Through a process of free speech, open debate, and the generative exchange of ideas, we aim to sharpen our approach to building such a world. Guided by expert speakers, we work towards a deeper understanding of what matters most to the creation of healthy populations.

Thank you for joining us for today's conversation. In particular, thank you to the Dean's Office and the SPH Communications team, without whose efforts these conversations would not take place.

It is, I think, fair to say that nurses are the backbone of

healthcare in the US. Each day, nurses are on the front lines of providing both treatment and preventative care. All of us likely have, or will have, depended on nurses at some point in our lives-whether for ourselves or our loved ones. Today, we will discuss the evolution of nursing in the US, and how we can best support those who do so much for our health, by addressing challenges such as staffing shortages and burnout. I look forward to learning from all our guests and from you, our audience, as we discuss this important topic.

I am now pleased to introduce today's moderator.

Jessica Bartlett is a medical reporter at the Boston Globe, covering hospitals, health insurance and health policy. She has covered health care for nearly a decade, and for most recently with the Globe since 2021.

Her work has focused on the business side of healthcare, with stories on a variety of topics including the evolution of the healthcare market, the pandemic's effects on health care, health care affordability, legislative reform, workforce challenges and the ongoing hospital capacity crisis. Her story "Voices from the Front Lines," which included voice testimony from nurses working in hospitals amid the pandemic, won a media excellence award for multimedia journalism from the journal Occupational & Environmental Medicine.

In addition to her frequent articles, she is a regular contributor on Boston Globe Today, and has made frequent appearances on Bloomberg radio and New England Cable News. Prior to her work at the Globe, Jessica reported on health care, cannabis and craft beer industries for the Boston Business Journal, and spent four years covering local news for the Globe. Her work has also appeared in South Shore Living Magazine.

Over to you, Jessica.

>> JESSICA BARTLETT: First, we will hear from Linda Flynn, who serves as dean and professor at Rutgers School of Nursing.

Dr. Flynn is widely recognized for her extensive research into the effects on patient outcomes of system factors such as nurse staffing levels and organizational culture and her collaborative research work frequently focuses on the seldom-examined effect of staffing levels on patient outcomes in outpatient dialysis -- a hot policy issue in several states. Next, we will turn to Ernest Grant, who serves as Vice Dean of the Office of Diversity, Equity, Inclusion, and Belonging at Duke University's School of Nursing. He is the immediate past-president of the American Nursing Association and is the first man to be elected to the role. Then we will hear from Sarah Szanton, who is the Dean and Patricia M. Davidson Health Equity and Social Justice Endowed Professor at the Johns Hopkins

School of Nursing. She holds a joint appointment in the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health and the Johns Hopkins School of Medicine. Her main research strands are improving health equity among older adults, aging in community, the effects of financial strain on health, and structural racial discrimination and resilience. Finally, we will hear from Shannon Zenk, Director of the National Institute of Nursing Research. With a background in nursing and public health, Dr. Zenk's research is centered on environmental injustice and health disparities. Since becoming Director of NINR, Dr. Zenk has led the development of the Institute's new strategic plan with a bold focus on social determinants of health and health equity and serves as the co-chair of several NIH-wide efforts, including the Social Determinants of Health Research Coordinating Committee, ComPASS, IMPROVE, and the Climate Change and Health Initiative.

>> LINDA FLYNN: Sorry for the technical play here. Are we good to go? All right.

So I'm going to start really quickly by answering a question about why should we care if the nursing workforce is in a state of crisis? What is the connection between nursing and the public's health?

And this little picture here is really taken in New York City around the time that the term "public health nursing" was first joined.

There are decades of research and, in fact, when I search the Rutgers library database, there are about 1,500 studies that have shown that there is definitely a quantitative impact of nurse staffing levels on patient outcome and patient adverse events.

So I'm going to share with you just a first meta-analysis that was done in 2007. Robert Kane found an association between increased levels of RN staffing and levels of hospital mortality.

The one in pink is a study in 2010. I was co-navigator of this study of four hospitals in three states. And what we found is that if the other two states, Pennsylvania and New Jersey, would adopt the California legislative staffing ratios, we could reduce post-surgical mortality in New Jersey by 7%.

And then, lastly, one that was just published in 2021, 52,000 patients admitted to the hospital for sepsis, a significant relationship between lower RN staffing levels and higher odds of patient mortality.

So what is going on with the nursing workforce today? It's a perfect storm. It's an impact of the pandemic, which I will

talk about in a minute, increased violence towards nurses, limited educational capacity, and our schools of nursing, all combined with an increased demand for nurses.

This is a picture I wish I could forget. Unfortunately, I just can't get it out of my mind. Our health care system at the institutional level and state level and federal level, unfortunately, was not prepared for what happened when the COVID pandemic hit. We did not even have enough PPE to protect our physicians, our nurses, our other health care workers in the hospital.

A high percentage of health care workers, be they physicians or nurses or techs, died of COVID. I read in an article recently that one nurse in a New Jersey hospital in Newark, New Jersey, in her ICU watched eleven of her nurse colleagues die.

So that, in combination with the tragedy of patients diagnose, their families saying goodbye, it's really impacted the mental wellness of our nursing workforce.

It's not surprising, with that background, that between 2020 and 2021, 100,000 nurses left the profession.

Health affairs study published that in 2022.

And just to make sure, the NCSBN conducted a national stratified sample of almost 300,000 RNs across the country. They also confirmed that 100,000 RNs, as a population estimate, left the workforce during the pandemic.

They also reported that 25% of current RN respondents plan to leave the workforce by 2027.

Population estimate, this equals to 900,000 additional RNs planning to leave the workforce by 2027.

62% of the sample reported increased workloads and unsafe staffing levels and about 50% reported symptoms of occupational burnout using items from the Burnout Inventory, which is the national standard.

In 2023, I supervised a study in a sample of 156 New Jersey nurses, RNs, who practiced during the pandemic and are practicing now.

64% scored positive for occupational burnout using the entire Maslok Burnout Inventory.

51% screened positive for PTSD.

There's a large and long-standing empirical literature that reports poor RN staffing levels, unsupportive work, and burnout with plans to leave the nursing workforce.

Again, in the Rutgers library database, there are about 300 empirical studies that have quantified these relationships.

Additional impact on the workforce today, it's the rising

violence that is being aimed at staff nurses, especially in hospitals. It's proposed that this is due to the low staffing levels that currently exist. When patients have to wait longer for their pain medications, when their call bell is not answered, the patients and the families become irritated.

Also, another factor is probably just the mental -- threats to mental wellness that's a threat to the workforce and the generate -- general population.

When I don't necessarily give credence to research conducted by those who work for unions, I think this is worth sharing. This survey was conducted in 2023. It was almost 1,000 respondents for 48 states, both aligned and not aligned with the union. 26.3% reported that violence has increased a lot over the past year. Almost 68% reported that over the last year, they were verbally threatened. 36% reported that over the last year, they were slapped, punched, or kicked. 35% almost had objects thrown at them over the last year. 38% were pinched or scratched. And 30% were spat on or deliberately exposed to body fluids.

So what does the future hold for us?

HRSA has been estimating a severe nursing shortage for the past 10 years. They are now adjusting those estimates, and they're saying that we will have a shortage of 350, 500,000 RNs in the year 2026. 350,500. They believe it will remain the same through 2031 and will not stabilize until 2035.

The Boston Globe reported in April 2024 that there were over 5,000 vacant nursing positions in Massachusetts. Now, we don't know how they define nursing, whether they're talking about register nurses or care techs included, but that's a lot of vacant positions.

And, last but not least, the American Association of College of Nursing reports that last year, over 55,000 qualified applicants to schools of nursing were turned away.

Over the last phi -- five years, they were reported up to 80,000 applicants being turned away.

I'm embarrassed to tell you how many qualified applicants we turn away from Rutgers school of nursing. Why? Lack of faculty, lack of clinical placements, lack of space.

From my perspective, and I'm speaking only for myself, as dean, who is expanding our admission cohorts, it's the lack of expansion investment funds.

We cannot wait until students are standing outside our classroom doors to start hiring faculty, renovating space, and finding clinical placement.

So what can we do?

First of all, as a researcher who has been involved in this line of inquiry for the last 20 years, I advocate for safe RN staffing legislation.

I think in our hospitals, we need embedded mental wellness counselors that are accessible to nurses during their work shift and near their units.

I think we need to create and sustain support of work environments where there is respect for nursing and respect for nurses.

I think we need improved violence protection in our nation's hospitals and beyond.

And I think we need state and federal aid for expansions.

So thank you very much for your attention, and thank you very much for inviting me to this important panel discussion.

>> JESSICA BARTLETT: Thank you so much for that presentation. Incredibly informative. I'm excited to ask you more about all of those slides.

Next, we will turn to Dr. Grant. Dr. Grant, whenever you're ready.

>> ERNEST GRANT: Thank you so very much to the Boston University school of Public Health for the opportunity to speak to you about some of the challenges facing the nursing profession and things we'll continue to face for the very near future.

I would like to spend just a few minutes speaking from my point of view of what I think are the biggest challenges facing the profession since nursing probably became accepted as a true profession.

I say true because American Association of College of Nursing has developed over the centuries. The first nurses were the monks that cared for those society has shunned until being taken upon by women and those blazing a trail, such as Florence Nightingale, Marion Mahoney, and Lillian (indiscernible).

They helped forge nursing into what it is today.

Some of the challenges I see the profession facing is racism, workforce shortage, burnout, and legacy, among more.

I will explain terms in a few moments.

When I entered the nursing profession in the '70s in North Carolina, I looked around and didn't see many nurses who looked like me. Our profession did not reflect the diversity of the patients that we cared for.

I wanted to be a change agent to help change that.

There's obviously no doubt, in the ensuing years, that considerable progress has been made with more opportunities for Black and Latinx and others to enter into the profession.

It's still one in five in the nursing workforce. This is not and still is not reflective of the minority population as a whole, which is growing proportionately and will represent more than half of the total population in this country by mid-century.

When I was elected president of the American Nursing Association, one of the efforts was to increase diversity in nursing.

I have long believed that the diversity of the patients we care for need to be better represented.

We need to help our society address the growing racial disparities in health care and health outcomes.

That means it would result in higher quality of care for our patients.

A little bug called COVID-19 came along and helped address the issues.

In 2021, the National Commission to address nursing was created.

In addition, there are 39 other nursing organizations representing a broad spectrum of nursing practice, racialality, and ethnicity, and other diverse groups and regions around the country that serves to affiliate with the commission.

Now, you may be saying: What does all of this have to do with workforce issues, et cetera, but I think it will come through as I continue with the presentation.

The goal is to address racism within the profession from four distinct areas, nursing education, clinical practice, nursing research, and policy.

It also examines the issues of nursing nationwide, focusing its impact on nurses, patients, communities, and health care systems to motivate all nurses to confront individual and systemic racism.

Now, a definition for racism, assault on the human spirit in the form of actions, biases, prejudices, and ideology of superiority.

Another challenge I see facing the profession is of nurse burnout and well-being.

Additional surveys that were conducted by the American Nurses Foundation during the COVID pandemic revealed that nurses were suffering from significant burnout as a result of having to work mandatory overtime, the retirement of older nurses, and younger nurses that wanted to leave the bedside for other positions or because they felt the work was too hard, or they wanted lucrative positions as a travel nurse.

Quiet quitting became the phrase of the day, and how to address it became the challenge.

We recognize that nurses must take care of themselves first before they can be expected to provide the care that their patients need.

Employers must realize that measures must be put in place to address physical and mental well-being of nurses and all members of the health care team.

We cannot expect to continue to be asked to do more and more of our providers and provide opportunities -- and not provide opportunities for downtime.

We know that the consequences of overworked, overstressed individuals -- and that does not include -- we have to take care of ourselves before we're expected to take care of others.

The workforce shortage itself is not new. It was predicted over 25 years ago. But we're in a crisis, not a shortage.

The reason I use the word crisis and not shortage is because there's a need of 3 million nurses by 2030, according to a report I just saw. That is just six years away.

When we only graduate 250,000 nurses a year, that is not enough.

We must look at new ways to recruit and retain nurses at the bedside. We must address the issues that are contributing to workforce shortages such as violence in the workplace. Also, that may be caused by patients, family members, or our own nurse colleagues. We must also address the long hours and the low pay that also contributes to this shortage.

Finally, nursing, as a profession that, is a profession that integrates many things to ensure good health for those we care for.

The image of nursing and what it takes to be a nurse is not fully recognized by the general public. Nursing has an image problem and that the average Joe on the street has no idea what it takes to be a nurse.

They know you may work at a local hospital, but when you ask: Do you know what a nurse does? There's a complex look on their face.

A couple of ways to address the issue may involve, one, developing a strong and diverse nursing workforce that is representative of the community served and be prepared to meet the growing health needs of the country.

Another is to ensure that workplace culture that values the physical and psychological safety and well-being of nurses.

And equip nurses and the public to be strong advocates for nursing and health care improvements.

Finally, as I made the comment earlier, that there's a challenge to nursing's legacy. Nursing is a profession with a

strong body of research, evidence-based practice and scholarship.

One of my favorite sayings is if you're not at the table, you're on the menu. Our problem is not being at the table or not being heard when decisions about the profession are made by those who are not members of the nursing profession.

Thank you for the opportunity to provide this opening comment, and I look forward to doing more about this topic with my fellow colleagues.

>> JESSICA BARTLETT: Thank you so much. That was illuminating. I'm really excited to ask you more about all of that.

Next, we'll hear from Dr. Stanton. If you could join us on screen, we look forward to your presentation.

>> SARAH SZANTON: Thank you. I will just share screen.

Thank you for having me. I can tell, listening to the first two, that I'm on this panel as the ridiculous optimist and the one -- you will find mine very different but complementary.

Where my head is: How can we change the future of health? Not just nursing but all of health. Try to imagine that and work backwards to what can we do now.

I think I represent the strain of thought that we may have enough nurses, but we have the wrong health system, the wrong medical system, really, and it's reactive. It's acute-care focused.

So, you know, some of you will listen to what I'm going to say and say that's crazy and ridiculous and we can't achieve what you're talking about.

I'm a big fan of high-hanging fruit. Low-hanging fruit, anyone can do. It's the high-hanging fruit that creates new ways of thinking, new collaborations, new dreams that other people can attach their methods to.

And so this is what I'm up to.

This may seem like a ridiculous thing to spend some of my eight minutes on, but, in 2010, some leaders in Baltimore said, We should make the Harbor swimmable not just kayak able.

We've gone from the picture on the left where it's trash everywhere in the harbor. Now you can swim in it.

It was a conscious effort. Many people came together. Some said, We need oysters? Now there's oysters.

There's a trash wheel that's self-propelled. They go around picking up trash. People love them. They have their own Instagram.

Wetlands have been moved into the harbor.

The point is if you just see the crisis in front of us, sometimes it's hard to make a big idea that can have a giant

impact. I'm really inspired by the harbor.

So we all know that the U.S. health care system is broken. It's not a health care system. It's a sick care reactive system.

Just as one example -- you can pull out so many statistics -- we spend a high percentage of our GPD on health care than any other OECD country, what people call developed countries. It's almost double. Germany is the closest, and they spend about 12% of their GDP. We spend 20.

That could make sense, but we actually have the worst health outcomes of any of those countries.

So the mismatch between what we're paying into it and the value we're getting is chronic. It's something we've talked about for 30 years. Oh, well, if everyone has insurance, then we'll have better outcomes, and that's really important.

But for a place like Baltimore, 94% of the people have insurance now because we're a Medicare expansion state. We have the same health inequities that we've had. So it's not just about insurance. It's about many things. We can go into that in another talk. But with my eight minutes, I'm just going to go into ideas.

So this slide, it says disability, but the point of this slide is that the green line on the top is the idea that we all started mostly at the same early life point, in terms of being born. If you told me you have a two-year-old, I would probably be able to guess that they say no a lot. They can walk and probably run. They're arguing with their siblings, if they have them.

And we all start off with a similar trajectory. Over time, that widens where some people have better health than others.

Those are for structural reasons. They have so much to do with social determinants of health and so much we can go into with questions and answers.

But the gap, that is our opportunity. That is our opportunity to make everyone's life better. There's nothing that says people need to have poor health outcomes.

I'm not seeing the chat anymore, but if people want to put into the chat what are some of the elements you would think a perfect health system would look like, I will wait for just a moment. I know we're busy people, and I only have eight minutes. So I won't stay for too long on this.

But just think one attribute of what a perfect health system would look like.

Thank you. I see the chat things moving up in their numbers. I won't read them right now, but I will look back on them when we're done. Thank you for putting something in.

I would say equity, right, that not just everyone has an equal chance but that we have equitable health care. Free from suffering and experience joy and able to participate and probably want it to cost less. I will really enjoy reading your comments. Probably you have other good suggestions.

So how do we get from here to there?

Well, if we begin with the end in mind, we want that kind of a health system. One thing that's already happening that we can go along the winds of change are there's a shift towards value-based care. It's not the be-all/end-all care. For those not following the shift, more and more providers and health systems and states are being reimbursed, not just for the care but you have a hospitalization or you see a physician or see a nurse practitioner or have a procedure, but paying for health instead of health care. Paying for outcome that we all want to see. So that's creating a difference from volume, trying to get as many patients in, to volume. Maybe your practice sees fewer people a day, but you see them for longer, and they walk away with what they need and moving from paying for process to paying for outcomes and moving from paying no attention to social drivers of health to, yeah, when many of us were trained 10, 15, 20 years ago, we were not trained to -- we were trained to perhaps ask if someone had food or could pay for their rent, but we were not trained to do something about it. That was the social worker's job or someone else's job. Now it's much more incorporated in the health system.

I just want to point you to the National Academy of Medicine. Primary care is the only form of health care that's associated on a population level with a population health impact.

This was co-chaired by a nurse.

So what we are working on at Johns Hopkins and doing it with the University of Maryland and all the nursing schools in Baltimore, to HBCUs and to historically white institutions. We have taken inspiration from Costa Rica and Brazil and, to some extent, Cuba, to have a geographic empanelment.

Each nurse will have 12 to 14 blocks who is their panel. That's an RN and a community health worker.

The hospitals of the future are only going to be operating around ERs and ICUs. Everything else is going to happen in the community. Hospital home, it's already happening. You all know people get sent home the day or two after a heart attack.

Our nursing education needs to change to focus on not just traditional community health and public health but acute health in the community.

We have a history of insurers working together on

hospitalizations, so on the next stage, we're standing up the system as fast as we can. The next stage on that will be on population health. We also think it can solve the primary care shortage as well as the nursing shortage. We also think it's a great thing for stable careers for community health workers, they won't be going from grant to grant.

So I will stop there. I look forward to questions.

I just want to say if anyone tells you you can't boil the ocean, I disagree. You have to start with small pots and get increasingly into bigger pots to test what you're doing.

>> JESSICA BARTLETT: There you go. You're getting health care tips and how to boil the ocean in one panel.

Thank you so much for the presentation.

Dr. Zenk, when you're ready, you can join me on the screen.

>> SHANNON ZENK: Hi. Good afternoon. Hold on. Just let me share my screen again.

Good afternoon to everyone. Thank you so much for inviting me to join you today and what a great panel. I've learned a lot and received motivation and inspiration from the panelists coming before me.

So it's a pleasure to virtually join you all to discuss the future of nursing. We are, undoubtedly, AT a tipping point. Everything from GFS to nurse violence is taking a toll on public health and it's putting stress on an already fragile health care system. Needless to say, the next 10 years of nursing could go a lot of different ways, really, as could the next 10 years of health and health care. Any of us interested in change need to be actively engaged in guiding that evolution.

So I believe that the future of nursing is to be found in transformative action to achieve health equity and that nurses are meant to lead these efforts that center health equity and address the major drivers of health and illness in our country.

I also believe that nursing is ready to take on this challenge. Much of the discussion in nursing right now, as Drs. Flynn and Ernest has discussed is focused on issues, especially for colleagues working in hospitals.

However, we also need to think about the context in which those issues reside.

So healthy and equity, I would argue, is both a crisis for nursing and health issues to be addressed.

We know that racism and unjust economic forces are two of the most important structural factors contributing to health inequity. Inequities are seen most critically, for example, in premature morbidity and mortality. Simply put, people are dying too soon because of racism and economic forces.

Now, this fact alone should stop us all in our tracks. We also see within the health care and the public health systems the ripple effects. This includes significant financial considerations as we grapple with where and how to allocate scarce resources.

Perhaps most importantly, the structural and social drivers are contributing to less effective care and worse outcomes.

It really is not hard to see how that can contribute to challenges for nurses directly in the work environment.

In order to create meaningful change for nurses and the individuals, families, and communities that nurses seek to serve, we need to widen the lens and prioritize health equity as our common goal.

Achieving health equity means ensuring all people have the opportunities and resources they need to achieve the highest level of health.

I think everyone here understands this.

While it may seem simple, it was absolutely essential for nursing and INR and nursing science to boldly declare that we are prioritizing health equity.

Relatedly, we need to ensure that our work encompasses all the drivers of health, including critically the social determinants of health, including those structural factors that shape the conditions of daily life.

Too often these ideas are viewed as outside the scope of nursing and biomedical research or are not prioritized on par with those other areas of science.

INR's position is distinctly different. We believe health equity is a realistic and achievable goal and an additional emphasis on the social determinants of health complements what was already so special and unique and nursing research.

Nurses and public health professionals know that the most important health-related activities often happen outside of hospital walls. The holistic perspective is unique, and it's important. Combined with our values and the emphasize on relationships with individuals, families, and communities, nursing can provide essential leadership.

Along with this, nurses can ensure that our whole picture of health is fully integrated into all biomedical health and research efforts.

So that's what we are emphasizing at NINR. How do we take the valuable work that nurse and nurse researchers have been doing for years and expand it even more?

We think the answer is focusing on health equity and prioritizing the social determinants of health.

So, as director of NINR and really an absolute, true believer in the power of nursing's perspective to bring about real change, I am especially focused on generating the evidence base that will make this future possible.

Nursing should be at the forefront of research in this area, which includes bridging social determinants of health, health care, and public health.

Taking on this leadership role is really consistent with where nursing has historically been and nursing strengths.

That's one of the reasons we made health equity part of our Mission Statement at NINR.

We've been working really hard to fund innovative research that addresses health equity. We're also committed to supporting emerging nurse scientists along their career path.

We want the science and the research we support to have a healthy impact on all.

I believe the next 10 years of nursing will include, as Dr. Sarah Szanton and others suggested, high-quality and rigorous research to guide the shift.

Community engagement has emerged as incredibly important to all research efforts. And we at NINR believe that nurses are ideally suited to do this work and use this approach.

In our strategic plan and the recent funding initiatives, we emphasize the multi-level approaches that demonstrate cross-disciplinary and cross-sector collaboration and meaningful community partnerships.

So, to be clear, I am very optimistic about the future of nursing and nursing research. But there are real challenges that have been discussed. I'm going to highlight one more.

We have to address these. If we're going to make the scientific advancements that I think nursing is capable of. We have, unfortunately, seen a dramatic decrease in the enrollment in Ph.D. programs over the past 20 years of nursing.

This means we will not have the cadre of nurse scientists we need to tackle the issues we see in health and health care.

In 2021, the national academies released the Future of Nursing 2020-2030 report and discussed the challenges for the nursing profession as well as recommendations for strengthening nursing capacity and expertise.

This report reiterated the report for more Ph.D.-prepared nurses.

And even more notably, they specifically say that those nurses are charged with systematically building the evidence base around concepts and issues that connect the social determinants of health, health equity, and health status, as

well as associated nursing interventions.

At NINR, we work with those recommendations, and we're committed to providing opportunities for both funding researchers and training new researchers to build that evidence base.

So, as I close, I want to emphasize this point. The future of nursing is bright. It is closely tied to the future health of our nation.

The persistence and magnitude of health inequities in the United States calls for an all-hands-on-deck approach that leverages the strengths of nursing and nursing research.

And I want to personally invite all of you here to join us in this pursuit of innovative, nurse-driven, equity-centered solutions.

It is really such an honor to be part of this conversation. Thanks, again, for inviting me.

>> JESSICA BARTLETT: Thank you so much, Dr. Zenk, and thank you to all of our speakers for their presentation.

I'm eager to jump in here. There's so much to follow up on.

Before we get started, if all of our presenters could turn on their cameras and microphones for our discussion. For the audience, get your questions ready. We'll have about 20 minutes at the end of our program to get to your questions, which you can submit using the Zoom Q-and-A function at the bottom of your screen. Notice that's different from the chat function. If you want me to see your questions, be sure to put them in the Q-and-A function.

Just a start, listening to all of these presentations, I'm struck by the scope of the challenge that is before us. I mean, burnout and staffing challenges are historic. COVID has escalated these issues, and they existed in the path nationally and especially in Massachusetts -- where I have a focus -- there's not much diversity in nursing.

While one might expect the solution is to increase the pipeline of trainees, hurdles exist there too.

So I wanted to start, Dr. Flynn, with you. Given the challenges, given the scope of these issues, where do we start? What is the thing we do first? Or maybe there are many things we can do simultaneously.

>> LINDA FLYNN: Yeah. Thank you, Jessica.

Again, at the root of the problem, unsafe staffing levels. Understandably, we're short of nurses who choose to practice. Unsafe staffing levels contribute to burnout, contribute to nurses' job dissatisfaction, and their intentions to leave their job and their actual leaving of their job.

I'm in favor of safe staffing legislation. I think nurses need to feel comfortable that when they are employed, whether it's in a hospital setting or a non-acute care setting, that they will be in an environment where they can provide the quality of care that they were taught to provide. So I think that has to be fundamental. We are all working on increasing the pipeline. We, at Rutgers, are doubling our admission cohorts over the next three years. About half of the big 14 or whatever is doubling the cohorts. We don't want to feel like we're leading the lambs to slaughter.

I always tell my colleagues in acute care settings and non-acute care settings, we educate them, and we educate them very well. In fact, 60% of our student body across degree programs, from undergraduate to Ph.D. are students of color. And they're well educated. But it's up to you guys. You're going to have to help us. You're going to have to help retain them.

So we're not going to achieve health equity if we have a severe nursing crisis.

>> JESSICA BARTLETT: Dr. Grant, we talked about burnout. You mentioned it in your remarks, but so much of the onus of that is placed on the workers. There's solutions that the administrators and the executives have to make. How can we incentivize the larger part of the organization to prioritize these problems in a way that can be challenging financially, in particular, in this economic climate?

>> ERNEST GRANT: That's a really great question. I think it boils down to health care administrators actually actively listening to what it is that the nurses at the bedside are saying that they need or that they want or what is going to keep them there.

When I was president of ANA, one of the things I encouraged not only chief nursing officers but the chief financial officers to do was shadow a nurse for a week, not a day but a week. They needed to do that to experience what it was like to work 12 hours without the possibility of going to the bathroom or getting a good drink of water, and they would understand.

And when asking for help, there's a pattern that happens when they suck it up and begin to distribute the patients out more, and then when the next shift comes on, and they say, We still need more nursing, then you get challenged. The first shift did it. Why can't you?

It becomes a game of acceptance or expectation that we're going to do that. We need to change those expectations and say, No.

Listening to what Dr. Flynn has said, no, we need to have those numbers in place so we can ensure that correct care and proper care is being done.

So there's a way to begin to address that, but I think those in administrative positions need to be able to understand and actively listen to what it is that is going on in the culture, in the environment, and work with nurses to begin to change that.

>> JESSICA BARTLETT: Dr. Zenk, how do we ensure that diversity is a cornerstone of a longer-term solution, given that the challenge is systemic and larger than individual programs? How is that a core component of solving this challenge over the long term?

>> SHANNON ZENK: Diversity in nursing, you know, as Dr. Grant has really nicely laid out, is essential to address the needs of the population.

In all aspects of nursing and from my perspective, including the nursing research workforce, we have to ensure diversity. It's absolutely critical for nursing to be effective and for us to be effective in improving the nation's health. So it has to be a focus for all of us. It is in nursing research, and it is, I think, I'm really proud to say, increasing across the discipline.

>> JESSICA BARTLETT: What are the ramifications for not finding solutions to many of these problems rapidly? The shortages are already having an effect? What do you expect to see, Dr. Sarah Szanton?

>> SARAH SZANTON: Many have talked about the vicious cycle. If we're not well staffed in all of our areas of health, then it costs more. So the earlier someone can get seen for something, the cheaper it is. Of course, the better it is for their life.

I would say that if you talk to nurses who are doing hospital-at-home work, they're nursing doing hospital-at-home of people, and they're very happy. They love it. In some statistics, they would have been called "left the bedside." I want to put another point of view up here. We never say a lawyer is not a lawyer. We're always nurses, but some people are doing their same work out in the community, and they're not being counted in these kind of hospital views. So I think it's really important to be thinking holistically, from public health to individual community health to individual acute all the way to hospitals. Partly because the hospitals are dramatic places where people have their worst days, and it's where the emergencies happen. It gets a lot more coverage. But I think

we need a broader, more holistic view of what do nurses do and where do they do it. The future needs to entail a list across the whole spectrum, including research."

>> JESSICA BARTLETT: Dr. Flynn, you mentioned, in your remarks, the staggering number of nurses leaving the workforce in the coming years. I'm curious, from your perspective, what the runway is that we have to come up with some solutions to bring more people into the workforce to start to fundamentally address these problems. We talked about this cycle. What will it mean if we don't make that kind of progress in the time that you think we have?

>> LINDA FLYNN: Yeah. That's a really good question, Jessica. HRSA does project that the shortage will continue until I think it was 2036. Even in the best-case scenario, it's going to be with us for a while. I do believe we have to look at both sides of the pipeline. Schools of nursing need to increase their admission capacity. We're able to do that because we have some investment funding. So that is something that states as well as the federal level needs to consider.

But the other side of that is the retention issue. You know, we can produce them, but they need to retain them; right? And so I think there is, again, a whole body of research that quantifies what a supportive nursing practice environment is. What are the characteristics of it?

That is definitely a key to retention.

As an old public health community nurse myself, I totally understand the need to have nurses in dialysis centers and Medicare-certified home-health agencies and skilled nursing facilities, but all of the quantitative research I talked about has been replicated in those settings, some of it by myself, by me. And those core values, what nurses look for in the workplace transcends setting. So this is manager that employers, regardless of whether it's hospitals or community-based agencies need to take seriously.

(Overlapping speakers)

(No discernible speaker)

>> SARAH SZANTON: In the chat somebody asked -- and I think it's relevant to all of us about -- the licensing exam --

(Audio interference)

>> SARAH SZANTON: Everyone wants their students to pass this very important licensing exam. There's a focus on the skills you need in the first year of nursing. When they do surveys, they find that most people go into these medical or surgical floors in the first year of nursing, and many people will have gotten that advice. But the more we have people that go straight into community jobs, and the more we honor that has

part of our education, the more the influx will change to reflect community health, and then all the nursing schools can teach toward that test instead of teaching (indiscernible) so it's kind of a problem that we're all in.

As we start to change it, the influx should change as well.

>> JESSICA BARTLETT: It sounds like a chicken-and-egg problem.

With the shortage of nurses, we can try to solve these problems down the line -- forgive me if the newsroom is a little loud here in the background -- in order to deal with this present problem, there's nurses that are not allowed to take time off. In many ways, that exacerbates some of the burnout problems.

How do health systems deal with the present challenge on the ground? Patients will keep arriving. There are not enough nurses right now. How do we keep from exacerbating this problem over the long term while recognizing the needs of the present moment in

>> ERNEST GRANT: That's a really great question. I think what a lot of health care systems have done -- obviously, up until about a month ago that the national emergency surrounding COVID was finally lifted, so that did away with the mandatory overtime that hospitals were able to apply to nurses.

But, again, I think still comes down to the fact of recognizing that you can't have staff who are suffering both mentally and physically from just exhaustion of having worked over time. That results, as we all know, in a lot of patient care issues, you know, looking at medication errors and all other types of errors and things as well. So it creates an unsafe environment in which to work.

So health care institutions, what they need to do is figure out some way to be able to allow for that time off that nurses need.

Some system of checks and balances as well to ensure the staffing needs are covered. It's going to result in the need to higher more nurses and to make the job more attractive.

One of the things they maybe need to look at is look at the units where there is high retention of staff. What sit about that unit that make -- what is it about that unit that makes people want to work there and makes nursing staff want to stay with that particular nurse manager or nursing supervisor and perhaps implement that throughout the rest of the institution?

You know, there's ways to look at it and address these issues, but it's a matter of really taking that concerted effort to sit down and really draw things out and get a good, clear

picture from that perspective.

>> JESSICA BARTLETT: Dr. Zenk was wondering if you see the solution as needing to be broader than just health systems, both individually but also collectively in order to particularly dealing with social determinants of health, it's such a foundational challenge.

Do public entities and governments have to be a partner to resolve these things in order to move the ball forward? While we don't typically think of these things as the onus of health care systems, they are increasingly -- they cannot do it by themselves. How do you view that partnership?

>> SHANNON ZENK: Health care is certainly important, but it's only one of the drivers of health, the determinants of health are much broader than that. We know that social and structural factors are foundational and major drivers of population health and the health inequities we see.

So nursing has an important voice as well as role to play in the health care system but as well as much broader than that and addressing the social determinants of health, and that involves working across sectors, and that involves research and practice that engages with policy and policymakers.

And so nursing, I think, one of our strengths is the breadth that we have, in terms of our knowledge, and thus the roles we can play.

And the many places that we can engage to improve the health of public. Health care is part of that, but it's much broader than that. It's the community and beyond.

>> JESSICA BARTLETT: Dr. Sarah Szanton, you mentioned the exam and the potential shift of training down the line, how else do we need to shift training as hospital care shifts and changes?

>> SARAH SZANTON: That's a great question. Well, I think many of us at nursing schools are used to checking in with our clinical partners. Sometimes they're on our board. Sometimes they're on our faculty. But when we say that we often are checking in with the hospitals that are near us, which is critically important. We always need to be there and educating students who want to work in hospitals. But I think we don't as routinely check in with the school system and what is going on with the nurses and with the jails and the health care for the homeless where we are and all the other places that our students may end up practicing. And so I think we coordinate and think through our education, in general. And perhaps this is a big overstatement that the clinical partners that maybe we started off with when we worked with, and I think one of the questions

in the chat was, you know, how can people go into community because it pays so little?

We, as a school, along with Morgan State and (indiscernible), two HBCUs in Baltimore, stepped up when school nurses were needed. We said, yes, if you can pay them enough.

They were paying a market rate that they were getting in acute setting, and they hired them like that. It was instant.

Usually people in the community earn less than people in the hospitals, which doesn't make sense because you're more independent, you're more on your own. These jobs can be hard. School nurses are seeing 40 patients a day. But they love it. It's a great partnership with the school system.

So it's a long answer to your important question, to look at the future of education, we've got to be thinking more broadly about the health of our nation and who are we educating for.

>> JESSICA BARTLETT: First of all, compliments to the audience. You're a lively bunch. Maybe I'm not attending enough webinars. There are a lot. But we're going to try.

Starting with this first.

So, Dr. Flynn, someone asked if these studies you mentioned mostly focus on nursing working in the hospital setting, or do they include home health agency and case management nurses who directly work in the community?

>> LINDA FLYNN: You mean the shortage or the drivers of the shortage?

>> JESSICA BARTLETT: Whichever one you want. It just said "these studies."

>> LINDA FLYNN: Exactly. I was one that extended this question into other areas. Yes, I also extended it to study these drivers among international nurses. Things like a supportive work environment, which means -- and there are several pillars to that, that you have a nurse manager who is supportive and works with you, that you have the respect of the physicians, as your colleagues, that you have the respect of the organizations administration, and they listen to your concerns, and that there's opportunity for advancement. These are the pillars of a supportive environment and that the staffing, whether it's home health or whether it's acute or whether it's dialysis or whether it's skilled nursing facility, is a state staffing level where nurses can deliver the care that they've been taught to deliver. So, yes, these factors extend across settings, and that is evidence-based.

>> JESSICA BARTLETT: Thank you so much.

Someone asked: As a nurse, what can I do to advocate for

improvement in nursing conditions?

I don't know if this question stands out to any of you in particular. Or I can choose someone to answer.

Dr. Sarah Szanton, what do you think of this?

>> SARAH SZANTON: So I never once worked in a hospital. I worked with migrant farm workers, and I'm assuming this is improvements in working conditions -- I would turf that to Dr. Flynn and Dr. Grant. I do think banning together and having a collective voice is person.

>> JESSICA BARTLETT: Dr. Grant, your thoughts or Dr. Flynn?

>> ERNEST GRANT: Go ahead, Dr. Flynn. I will follow up with you.

>> LINDA FLYNN: While I'm not necessarily a fan of collective bargaining, I'm not against it either. It's a fine line, sometimes, that we must adhere to.

But letting your voice be known. Right now, nurses are voting with their feet, and that's not necessarily good for the public. It doesn't necessarily enhance health equity, obviously, and it's not good with respect to patient health outcomes.

So rather than, perhaps, voting with your feet, let's talk about letting your voice be heard and in multiple ways. Particularly, engage the public, as someone has already mentioned.

You know, four years ago, five years ago, nurses were heroes. Now they're becoming victims of violence. That's a pretty quick turnaround. Let's help engage the public and help them understand what we contribute.

>> ERNEST GRANT: To contribute to what Dr. Flynn has said, there's a Nursing Governance Council which helps to set policies regarding staffing, but the other thing too, I agree very much with getting the public involved to be on your side to advocate for better staffing.

Also, you, as a nurse, should become more politically savvy and realize that it is the policymakers, the politicians both at the state level and the national level, who make decisions that will affect your ability to practice as a nurse. I think meeting with them or explaining to them or even joining their team and volunteering to be their health liaison, a lot of times, a lot of politicians, the information that they get is information that is fed to them by a lobbyist who also has their own special interest at play.

I think they need to understand the consequences of that vote, be it a good or bad consequence. You, as the nurse,

speaking up.

So going to them and telling them you're a constituent of theirs or you are in the community where a piece of legislation they may be considering is going to be affected.

And, also, letting them know that you're a registered nurse and that you vote. That's one way to get nursing's voice out there.

Of course, joining your professional nursing associations as well and whatever legislative activities they may have going is another way to become involved and help change working conditions from that perspective.

>> JESSICA BARTLETT: I know we have so many audience questions to get to. I can't help myself, as a journalist, to ask one of my own, to follow up with this.

We didn't talk about workplace violence. A lot of hospitals have instituted policies to combat workplace violence.

How do you view that particular solution?

>> ERNEST GRANT: I will speak first to that. As I mentioned, a lot of times, institutions will have the policies, but sometimes when the incident happens, and the person with whom the incident has occurred begins to follow the policy, sometimes they're discouraged from doing that. Sometimes you're sending a mixed message. There's no follow-through. If this policy is violated, obviously, steps will be taken to either -- whatever needs to be done for the perpetrator. Having it on the books and not implemented is not a good thing because you're really sending out the mixed messages, and that's something we really want to get addressed. That's my opinion for that.

I don't know if my colleagues have something different, but I would love to hear what they may have to say as well.

>> JESSICA BARTLETT: Thank you so much.

Moving on to some other audience questions here.

Dr. Zenk, the person asked: Given there's the an emphasis on physical nursing, what about mental health --what are your thoughts on nursing curriculum shifting to also highlight mental health, and education and strategies to care for those with developmental, cognitive, and physical disabilities?

>> SHANNON ZENK: Nursing needs to include all individuals in all populations. So I think that's absolutely critical that we're preparing nurses to help with all of those populations. So the curriculum needs to reflect that.

I think I would be interested in Sarah's perspective on this. I think nursing has always recognized the importance of mental health in a broad perspective, what it means to be healthy. I think our curriculum has been successful in that,

but I would be curious about her perspective too.

>> SARAH SZANTON: I will just jump in and say that I agree with everything Dr. Zenk said, but it's been in the last 20 years or so that the textbooks and the teaching has gone from here is your predominant person -- and they're always white and able-bodied and other ways in which someone might think of them as sort of the general person. Then there's this little text box of, oh, if you're Black, you have hypertension and this type of thing and this thing. It's been a big shift to change the textbooks and the lectures regarding all the intersections and there's not a standard person and every deviation off is a different kind of person. It's important to have really diverse nursing faculty and nurses and to be thinking about all our learners as whole people as well.

So that includes people's mental health and all of their strength.

Part of the shift we really need to make is not to just be thinking about people's needs and deficits but what their strengths and resources are, and that includes communities and families and people.

That's part of what it's important to get people out in the community because you see their whole self and you see the pictures and the neighborhood. I think they're talk act this holistic view.

>> JESSICA BARTLETT: Another audience member mentioned that making the financial case for nurse value is critical because prevention saves money, but when it doesn't happen, that's hard to count.

Any thoughts on how the develop the framework and financial literacy and business acumen for nurses to drive campaigns?

Some of this seems to speak to nurse research.

Dr. Zenk, I don't know if you wanted to take this question.

>> SHANNON ZENK: Could you reiterate the last part of it?

>> JESSICA BARTLETT: Sure. This person asks: Are there any thoughts on developing the framework and financial literacy and business acumen for nurses to drive well-evidenced campaigns?

>> SHANNON ZENK: Yeah. That's a tough one. For me, what comes to mind is the breath of interventions that are needed. I think there's much more that nursing can do in terms of developing different programs, systems, models of care to address those range of factors. And I think we do need evidence in those areas.

I don't know if other colleagues have thoughts about that as well.

>> SARAH SZANTON: Linda talked about it a little bit, in terms of nurse value and when you have states with lower -- I don't know -- I don't mean to speak for you --

>> JESSICA BARTLETT: Do we need to quantify nurses as an employee? Should that be part of their education?

>> LINDA FLYNN: Value-based care, there's quite a bit of literature. I know we do it at the -- we're just starting to do it at the undergrad level. Basic economy-value determination. There's so much in a curriculum, sometimes it's hard to find a slot for that. I think it's very important, and we are starting to take that very seriously.

>> JESSICA BARTLETT: Dr. Grant, another person here mentions -- and this has been spoken about in this conversation -- that nurses are voting with their feet. They're going to travel agencies. They're leaving the bedside. Though those jobs are critical and necessary, as pointed out.

How can hospitals and administrators gain that trust back from their workforce? And can they?

There's been this huge cultural shift because of the proliferation of traveling agencies and the need for them during the pandemic. What can be done to ensure the workforce -- and for people coming into the workforce, too, that the jobs there are fulfilling and will not leave them as husks of themselves?

>> ERNEST GRANT: That's a good question. We're seeing the shift. What systems did was create their own internal travel agency so they were not paying out as much money to the travel agency as they were. That helped to retain some nurses. You know, one of the things that I think is important is that, yeah, the health care facilities do need to look at what are some attractive packages, if you will, that they can put together that would help to keep and retain nurses, such as if you're there for six months or a year or something like this, you get sort of a bonus.

A bonus could be different things to different people. For someone my age, a bonus could be, you know, like an extra two or three weeks of vacation. For someone who may be burdened with student debt, it could be, okay, we'll pay you an extra five or 10,000 there are to help reduce your student debt.

You know, there's a lot of ways that institutions can look at creating a retention package, if you will, that would make the workplace environment a much more enjoyable place. You want to also have the nurses feel as if they belong there. That's one of the most important things as well, that they enjoy coming to work, that they are part of the family and not just a number or a robot but that they have a say in policies and how things

are done.

So, you know, those are just a couple of quick examples off the top of my head that, perhaps, institutions are looking at or maybe would like to consider as part of a retention package.

>> JESSICA BARTLETT: We probably have time for one more question. I'm going to choose this one because I thought it was really interesting.

Dr. Sarah Szanton, this person mentions that many nurses might not be educated in public health potentially because of some kind of stigma associated with that work, that it is perceived less than a nurse, as perceived by some organizations. Do you perceive that to be there? If so, how do we combat that?

>> SARAH SZANTON: That's a great question. It exists on the medical side, too, where there's different classifications. As someone who works in -- when I was describing what I was doing, it was like, why would someone want to do that? I guess they couldn't hack it.

There's the bias. Right there.

It starts with paying equally, and then just getting people to shift to different roles that require different skills, et cetera. I think that's part of addressing that bias.

>> JESSICA BARTLETT: I think we maybe have more time. I'm going to ask as many questions as I can.

Another person, Dr. Zenk, mentioned where you get your strong optimism from. I'm going to shift that question, as we look to wrap up this conversation, if you could manifest for us -- I think it was Dr. Zenk, in your presentation, you mentioned the end goal, kind of the vision. Within the next five years, if you could manifest what achievable strides in some of these crisis, what would that look like to you? What is achievable in the next five years, as we think about the crux of this conversation and the scope of the challenges before us?

>> SHANNON ZENK: Yeah. I am optimistic. There are challenges, to be sure. I believe in the power and potential of nursing. I think we have a unique perspective. I think we have a very distinct positioning ranging from acute care settings all the way through so many community settings. We have incredible potential and opportunity to make a tremendous difference in improving the public's health and reducing health inequities.

I don't think it's out of the question for nursing to step up, to contribute to solutions, and make meaningful improvements in the health of patients, families, and communities.

So I'm optimistic. I think it's achievable. I think nursing is well positioned to lead those efforts.

>> JESSICA BARTLETT: Thank you so much.

Well, thank you, all, for taking the time to chat. I mean, we certainly have a scope of solutions in front of us, after this conversation. If people are paying attention, I think we can achieve those milestones you've set out for us in the next five years.

Before turning it back over to the Dean, I just want to thank you for your time today. Thank you for letting me be part of the conversation as well.

>> DEAN GALEA: Let me echo the gratitude to the panel.

You made reference to such an engaged audience. I thought it was truly an engaged audience with interesting comments and really interesting questions.

I want to thank the panelists for really interesting thoughts. You know, we host this within our public health conversation series, seeing nursing as an essential part of the work in communities that public health tries to forge forward, and having these leaders guide us today is a privilege.

Thank you for the work you do. Thank you for being part of the conversation.

For everyone in the audience, thank you for engaging. Have a good day.

>> Happy Nurse's Week.