Report of the American Academy of Nursing's Models of Care Task Force

Transforming Health and Healthcare: Core Factors and Aligned Attributes of Nurse-Led Models of Care

Executive Summary

In a rapidly changing health care environment, the American Academy of Nursing's (Academy) Board of Directors assembled a Task Force of key leaders within the profession and charged them with identifying how models of care are impacting meaningful change in care delivery. These leaders investigated current models of care that have integrated technology, explored broad interprofessional teams, and considered current workforce challenges. Professional nursing societies, health system leaders, community stakeholders, and policy experts shared their insights to further guide the Task Force's work.

This report outlines the findings of the Task Force. Throughout the process, the Task Force considered the state of primary care and public health, workforce demands, the impact of technology, population-based care needs, as well as long-standing models of care. The Task Force heard from experts advancing virtual nursing and artificial intelligence and conducted a comprehensive review of the Academy's designated Edge Runner models. Attributes of models of care such as value and incentive systems, digital health innovations, and culture were also evaluated. A key finding was the need to promote and advance Nurse-Led Models of Care (NL-MOC) in the context of how health and health care is evolving.

As result of the Task Force's findings, the Academy reaffirms its support in the development, testing, and implementation of NL-MOC. The Task Force concluded that NL-MOC serves as a care improvement model and demonstrates positive clinical and financial outcomes, while simultaneously improving quality and equitable care. Further, the Task Force identified four core factors (patient-centered, evidence in practice, outcome driven, team-based coordination) and four aligned attributes (affirming culture, digital health innovation, resource-minded, value and incentive systems) that are integral to the success of the NL-MOC. As the work of the Academy continues in this space, the Task Force outlined the policy barriers that must be addressed in order to fully realize the potential of NL-MOCs now and in the future. Ultimately, the Task Force recommended a consistent and consensus-driven definition of NL-MOC be developed.

Introduction and Context Setting

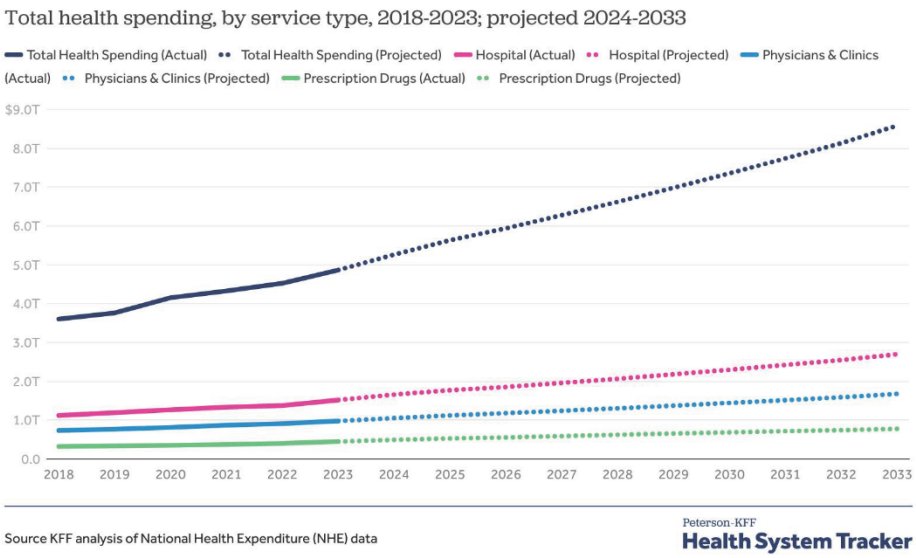
Health of the Nation and Its Cost

The current landscape of the health care delivery system is evolving rapidly due to a convergence of factors. To begin, when considering long-term health outcomes, in general, other similar nations perform better than the United States. Health outcomes such as life expectancy, maternal mortality, congestive heart failure hospital admissions, medication or treatment errors, premature deaths, and not seeking treatment due to the cost of care are only a few of the measures that demonstrate the United States poor performance compared to other countries.[1] The percentage of the population with multiple chronic conditions (MCC) and comorbidities continue to climb. A recent study found that

approximately 130 million US adults have MCC and approximately 194 million have at least one chronic condition (measuring 12 chronic conditions).[2] This translates to more than half the US adult population and more than three quarters of the US adult population have multiple or at least one chronic condition respectively. The complex patient care needed for individuals with MCC account for a disproportionate share of health care utilization impacting hospital and system-based resources (specifically related to the case mix index) reimbursement rates, and quality indicators. It is estimated that the share of individuals with MCC accounts for "64% of all clinician visits, 70% of all inpatient stays, 83% of all prescriptions, 71% of all healthcare spending, and 93% of Medicare spending."[3]

According to KFF, it is expected that health care spending in the United States will grow to $8.6 trillion by 2033 (not taking into account the regulatory changes and the implications of the One Big Beautiful Bill, Public Law No: 119-21), see Figure 1.[1] And yet, positive health care outcomes do not match the amount spent to achieve them. The U.S. spends nearly twice as much than other similar nations per capita on health care and have a lower life expectancy.[4]

Figure 1.



Source: McGough, M. Telesford, I., Winger, A., Cotter, L., and Cox, C. (2025, August 4). How much is health spending expected to grow? Pertson-KFF Health System Tracker.

Primary Care and Public Health

The rise of MCC and chronic conditions cannot be devoid of a discussion of public health and primary care. From a public health perspective, the infrastructure has historically been underfunded. To put this into context, in 2023, U.S. spending in health care reached $4.9 billion. This reflected a 7.6% increase compared to the 4.6% increase that occurred in 2022.[5] Of that funding, data from the National Health Expenditure Account by type of service, showed that more than $160 billion went to federal and state public health care services or approximately 3.3%.[6] This level of funding has impacted the public

health workforce, initiatives, and community engagement.

Considering the primary care lens, workforce shortages, maldistribution of clinicians, coverage, and access, as well as burnout, particularly post-pandemic have been cited as ongoing challenges.[7] While primary care reduces the overall burden of diseases and conditions on the health care system, unfortunately primary care is chronically underfunded in the United States. In 2022, five percent of health care expenditures were attributed to primary care for all types of insurance payers with that percentage dropping lower for public insurance such as Medicare and Medicaid.[8] The accessibility of public health and primary care will change again as a result of Public Law No: 119-21. In total, it is estimated that more than $900 billion will be cut from Medicaid signaling the most significant cut since the program began in 1965.[9] In total, the Congressional Budget Office (CBO), estimates that under the new law, 7.5 million people will lose Medicaid coverage and be uninsured in 2034. With the provision that establishes a new work requirement, 5.3 million people who do not meet it will lose Medicaid and become uninsured in 2034.[10] Further, in 2034, approximately 700,000 people will fall off Medicaid and become uninsured due to new requirements that expansion enrollees prove their eligibility every six months.[11]

Workforce Demands

The junction of care complexity and risk adjustments, rising health care costs, reduced Medicaid funding impacting hospital reimbursement, and pressures on an already stressed system are further impacted by the staffing needs, particularly nursing care. While the Bureau of Labor Statistics' *Employment Projections 2022-2032* note that the registered nurse (RN) workforce will grow to 3.3 million by 2032, it is also anticipated that 193,100 openings will be available as RNs retire and other nurses exit the field, each year through 2032.[12] Complicating the growth is the reality of the demand. There are 5.9 million licensed nurses in the United States of which only 5 million are RNs.[13] Between the years 2020 and 2021 the nursing workforce decreased by more than 100,000 individuals— marking the largest decrease in the RN supply over the last four decades.[14] Moreover, modeling demonstrated that this number was higher than previous projections and many of these RNs were under the age of 35.[12] Should the trend continue in the reduction of early-career nurses, the impact on the workforce, patient care, and quality writ large would be profound.

From a demand perspective, it was projected that there would be a shortage of 78,610 full-time RNs by 2025 and in 2035 the shortage would be 63,720.[15] Pairing an aging workforce[16], increased reporting of stress and burnout[17], and increased patient care complexity, leads to plunging quality indicators (such as readmission rates[18], infections, and surgical site infections[19], increased incidence of missed care, nurse dissatisfaction[7] and even changes in mortality rates[20]).

Impact of Technology

Over time, and to solve the complexity, the health care industry has relied on a multitude of strategies from technology, to staffing mix, to care delivery models, and to payment reform. At the federal level, policies have been put into place and recommend addressing increasing expenditures.[21] And no matter the context, or period in time, one strategy begins to take precedent based on political backing or larger

industry support. In the current environment, Artificial Intelligence (AI), and its explosive growth, appears to be a key driver. For example, hospitals have gravitated toward the use of AI and predictive modeling in such areas as health monitoring, identifying risks for inpatients, automating billing procedures, improving scheduling, identifying needs for high-risk outpatients and their follow-up care, among others.[22] In fact, "65 percent of US hospitals used predictive models, and 79 percent of those used models from their electronic health record developer."[20] Additionally, while AI can reduce the burdens of administrative and documentation tasks by allowing clinicians to focus on patient care, the critical thinking and clinical judgment of clinicians cannot be replaced by AI[23] nor can it replace the human connection that is central to the nurse patient relationship.

Models of Care

In the wake of increased pressure on the health care system, an increased focus on innovative models of care has emerged. Although models of care are extensively researched and discussed, there is not yet a common, comprehensive definition of a "model of care" as it is based on the context in which it is deployed. Broadly, a model of care encompasses an "approach that guides the delivery of health services, based on evidence and theoretical principles, with the aim of improving patient outcomes and optimizing healthcare delivery."[24] From the perspective of the World Health Organization, it is defined as, "a conceptualization and operationalization of how services are delivered, including the processes of care, organization of providers and management of services, supported by the identification of roles and responsibilities of different platforms and providers along the pathways of care."[25]

In application, this translates to a wide range of models implementing different principles and serving different populations with varying health and social needs across several settings, as no model is one-size-fits-all. Further, there is no standardized definition of a NL-MOC or the vital components of across them. In fact, in a recent conceptualization piece published in the International Nursing Review, from the perspective of authors in Australia noted, "Greater standardization in the conceptualization of nurse-led MoC (and MoC more broadly) will allow for a greater understanding of these MoCs, improved comparability between MoC, and development, research and evaluation of MoC and the roles that different health practitioners hold within them."[26]

Assessing Models of Care's Core Factors and Attributes

A simple solution to a complex problem does not exist. However, the question remains, is there a tool that pools solutions for maximum efficiency and effectiveness. In terms of marrying approaches, innovative models of care certainly can use technology, incorporate staffing mix, and address cost. Over time, models of care have been lauded as evidence-based, multi-dimensional strategies that improve quality and reduce cost. However, their ability to scale, spread, and be more widely adopted relate back to resources and the prevailing fee-for-service reimbursement model.[27] The aligned incentives are simply not there to motivate patients, providers, payers, and health systems to aim for the same goal.

Yet, this does not mean that no new models of care have penetrated the barriers outlined. At a time

when the long- standing drivers that lead to improved health and well-being— access, cost, personalized care, and quality— are more fragile, a re-examination of how models of care can be a more viable solution is warranted.

With this frame in mind, the Academy's Board of Directors convened a Task Force of key leaders in the profession to identify how models of care are impacting meaningful change in process, care, outcomes, and system improvement. These leaders convened over the course of a year to investigate current models of care that have integrated technology, explored broad interprofessional teams, and considered current workforce challenges that may inhibit progress. During this time, professional nursing societies, health system leaders, community stakeholders, and policy experts shared their insights to further guide the Task Force's deliberations.

As the work progressed, the Task Force made the distinction that the Academy's work is truly focused on NL-MOC and not the practice of nursing or the state of the workforce, that might include discussions on staffing, scope of practice, or shortages. Further it is noted that NL-MOC are not professional practice models (PPM) as defined by the American Nurses Credentialing Center Magnet Application Manual.[1] The primary distinction is that NL-MOC's framework focuses on the delivery of care while the PPM's framework focuses on the practice of nursing care.

It was clear that NL-MOC have been instrumental in health care reform or a result of it. Through a thorough review of the Academy's Edge Runner models and reflecting on the themes presented, the Task Force has identified a need to create a standardized definition of a NL-MOC in order to elevate their ability to be recognized, reimbursed, scaled, and spread.

With the context of the current health care system in mind, the Task Force reviewed emerging and long-standing models of care by assessing the Academy's Edge Runners and attributes that amplify their impact. Specifically, the Task Force presented considerations that would be a barrier, factor for success, or have an impact on care delivery should implementation of the model be widespread. This led to identifying overarching key findings and identifying four core factors and four aligned attributes of a NL-MOC. The Task Force reaffirmed the Academy's support of NL-MOC and offered policy implications as the organization continues to investigate its work in this space. The following report offers the thought journey of the Task Force.

Review of the Academy's Edge Runner Models

The Academy's Edge Runners initiative recognizes nurse-designed models of care that reduce costs, improve health care quality, advance health equity, and enhance consumer satisfaction.[28] These new and innovative ideas transform health and underscore the leadership, ingenuity, and determination of nurses. Edge Runner models demonstrate significant clinical, financial, community, and policy outcomes that are sustainable and replicable and address numerous areas of care across maternal health, primary care, acute care, aging, and beyond.

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[1] *The American Nurses Credentialing Center Magnet Application Manual defines a professional practice model as "the overarching conceptual framework for nurses, nursing care, and interprofessional patient care. It is a schematic description of a system, theory, or phenomenon that depicts how nurses practice, collaborate, communicate, and develop professionally to provide the highest-quality care for those served by the organization (e.g., patients, families, communities)."*

A key Edge Runner is *Transforming Care at the Bedside (TCAB)*, which was created in 2003 in partnership between the Institute for Healthcare Improvement (IHI) and The Robert Wood Johnson Foundation (RWJF). Though the TCAB initiative was initially aimed at improving care in medical/surgical units, it has since expanded to other care settings.[29] The TCAB framework centers around safety and reliability, care team vitality, patient-centeredness, and increased value.[30] Importantly, TCAB engages nurses and other frontline health care staff in idea formation and testing to lead to improved practices and processes.

For aging populations, Edge Runners such as the *Community Aging in Place: Advancing Better Living for Elders (CAPABLE)* program enable older adults to live healthier lives at home with autonomy by implementing client-directed changes in their environment that support well-being.[30] Additionally, *Nurses Improving Care for Healthsystems Elders (NICHE)* is an evidence-based model that supports nurse-led innovation in knowledge transfer among clinicians and has led to care improvements for older adults.[31] Across transitional care, the *THRIVE: Equity-Focused Transitional Care* model supports holistic, patient-centered, and equitable approaches to addressing gaps in post-hospitalization care, assisting patients with health and social needs.[32]

Overarching themes across these innovative care models include that the model places the specific needs of the population being served at its center; models optimize innovative uses of technology for patients and clinicians; and each member of the interdisciplinary care team maximizes their expertise and focuses on their role, practicing to the top of their professional scope and licensure. When models streamline operations by reducing waste and optimizing resources in these ways, they lead to increased patient and clinician satisfaction along with lower costs.

> ***Consideration:*** Further identify and recognize NL-MOC and identify opportunities. Describe how these NL-MOC offer efficiencies, improve interprofessional team-based engagement, and achieve high patient care outcomes.
>
> ***Consideration:*** Explore certification options that are required by the Centers for Medicare and Medicaid Services for reimbursement as well as industry best practices for the evaluation of such models.

Critical Success Factors	Interprofessional teams that function to the top of each team members scope of practice. Administrative design that can be developed within existing structures.
Barriers	Scalability, testing, and evaluation of NL-MOC for certification.
Impacts on Care Delivery	Amplifies patient outcomes by centering the model around populations, thus addressing patient acuity and volume of care in the design.

Reimbursement, Technology, and Environment

Value and Incentive Systems

Advancement in the valuation of care delivery, led by nurses, for payment and reimbursement is critically needed. From private insurance to Medicare and Medicaid, NL-MOC have been included as

reimbursable special plans of care. Considering the various opportunities for payment models of care (i.e. fee-for- service, bundled payments, capitation, and value-based care models), strong opportunities exist to support the identification of NL-MOC that meet the CMS criteria.

The Centers for Medicare & Medicaid Services Innovation Center (CMMI) plays a critical role in testing and implementing innovative models of care[33] and can advance nurse-led models that drive improved outcomes and promote the value of nursing care. For example, in 2025, CMMI launched the 10-year Transforming Maternal Health (TMaH) Model, which aims to develop a value-based alternative payment and care delivery model for maternity care services through increased access to clinicians such as midwives.[34] Additionally, initiatives such as CMS' Transforming Episode Accountability Model (TEAM)[35] that seek to improve continuity of care between providers will require NL-MOCs for the valuation of care delivery.

> ***Consideration:*** Funding for NL-MOC is critically needed to promote innovation in care that advances healthier work environments and better patient outcomes.
>
> ***Consideration:*** Payment must focus on the delivery model and additional barriers that contribute to payment restrictions must be met (i.e. provider billing, fee-for-service models, focus on preventative care).

Critical Success Factors	Funding mechanisms that leverage pre-existing payment/money channels.
Barriers	Current billing practices and overreliance on fee-for-service models.
Impacts on Care Delivery	Shifts framework to value-add rather than resource-depletion, which will bolster rather than impinge innovation efforts and workload management strategies.

Digital Health Innovations

Virtual Nursing and Artificial Intelligence

As technology in health care rapidly evolves, virtual models and models of care incorporating AI-driven technology present areas for nurse led innovation. To date, virtual nursing models have paired nurses at the bedside with nurses available remotely to the patient through technology 24/7, enabling patients to feel that care is more accessible to them when they need it while also helping nurses at the point-of-care/bedside focus their time on specialized tasks.[36] Virtual nursing can also be implemented for home monitoring and provision of fully virtual care, which represents a critical means to expand patient access across care sites and specialties. For rural-residing populations, this can greatly reduce the burden for patients otherwise needing to travel long distances to a physical site of care.

AI and other digital technology can similarly drive models of care so that a provider's time is focused on the specialized tasks that improve workflow and patient outcomes. AI is driven by data and information and its implementation must place the patient and privacy at the center - an inherent focus of the nursing profession. AI algorithms already support clinicians with critical work such as diagnosing

conditions, and AI is now being adopted to support nurses and ease the burden of time-consuming processes including documentation.[37,38]

Consideration: The concept of virtual models that involve interdisciplinary teams should be evaluated and further tested in amplifying NL-MOC. Outcomes analysis and patient satisfaction should be evaluated in multiple settings and population types.

Consideration: AI and other evolving digital and interoperable technology including large language models should be considered in strengthening NL-MOC.

Critical Success Factors	Regulation that enables virtual work. Clear models for implementation of supportive tools.
Barriers	Infrastructure to support onboarding virtual nursing or AI tools.
Impact on Care Delivery	Decreases volume of work by optimizing workload management tools.

Consideration: Virtual nurses may provide care from out-of-state locations. Regulatory structures including telehealth laws, and interstate practice laws should be reviewed by placing emphasis on the delivery of services that meet the aims of the NL-MOC.

Culture

Healthy Work Environments

Many organizations have recognized that nurse and clinician well-being is central to the success of any model of care, as nurses can provide better care when they have the necessary resources and support systems to do so. The report *Nurse Staffing Think Tank: Priority Topics and Recommendations* stated that in healthy work environments "nurses and other team members can provide their optimal contribution and derive fulfillment from their work and patients can achieve the best possible outcomes."[39] The ANCC recently created a program called Well-Being Excellence™[40] that evaluates evidence-based standards to assess and enhance an organization's workplace well-being efforts.

To that end, the American Association of Critical-Care Nurses (AACN) has established the *Standards for Establishing and Sustaining Healthy Work Environments (HWE)*. The six AACN standards for HWE are skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership.[41] Given the critical nature of a healthy work environment, it is important to measure the health of the work environment on a regular basis. Additionally, accreditation standards should reflect healthy work environment requirements.

These standards inform AACN's approach to critical care, with the AACN *Standards for Appropriate Staffing in Adult Critical Care* setting out seven standards that support healthy work environments.[42] The standards do not set a specific staffing ratio but rather highlight that staffing accounts for factors including volume, acuity, and workload.

Consideration: Creating a mechanism to foster adoption of the health work environment strategies, whether it be regulatory or accreditation criteria, will expedite adoption.

Consideration: Financial and education models must track back to supporting healthy work

environments in order for a true sea-change to occur.

Critical Success Factors	Using quantitative processes to measure the components of health work environments to track and trend progress over time. Addressing the whole team (administration, patient care delivery teams, etc.) in order to achieve the end goal of a healthy work environment.
Barriers	Financial resources and investment in wellness.
Impacts on Care Delivery	By addressing the factors that influence workplace wellness, it optimizes EACH of the characteristics it is influenced by, rather than adding constraints.

Overarching Findings

Based on the assessment of the Task Force, the Academy reaffirms the development, testing, and implementation of NL-MOC. NL-MOC are vital to improving the health of populations, communities, and individuals by demonstrating significant clinical and financial outcomes. NL-MOC should be based on a foundation of nurse and clinician well-being as well as healthy work environments, which are routinely measured. Further, NL-MOC should be incorporated, as appropriate, into health systems, obtain state and federal recognition, and reimbursement through private and public (Medicare, Medicaid, and/or Medicare Advantage (Medicare Managed Care)) health insurance plans.

A Nurse-Led Model of Care should be a nurse-designed, led, implemented, and evaluated care delivery framework that organizes, coordinates, and manages the health and well-being of individuals for a targeted population need. Through rigorous testing and evaluation, NL-MOC serve as a care delivery improvement model, are interdisciplinary, and demonstrate significant clinical, financial, quality, health equity, and consumer satisfaction outcomes overtime.

Through the Task Force's work and recognizing the variability in definitions for models of care and no centralized definition for NL-MOC, the Task Force recommends a consistent and consensus-driven definition of NL-MOC be developed. Based on the analysis conducted of the Academy's Edge Runner models, the current state of healthcare, and the need for value-based care, the Task Force has identified four core factors and four aligned attributes that are integral to the success of the NL-MOC and could be used to begin a consensus driven process.

Core Factors

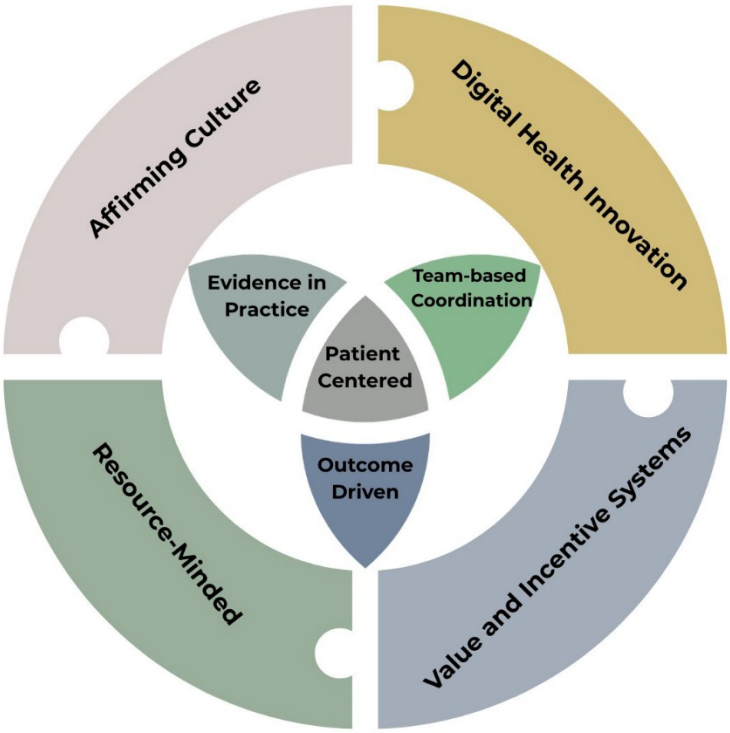
- Patient-Centered
- Evidence in Practice
- Team-based Care Coordination
- Outcomes Driven

Aligned Attributes

- Affirming Culture
- Digital Health Innovation
- Resource-Minded
- Value and Incentive Systems

Figure 2 represents a conceptualization and rationale for these key core factors and aligned attributes as well as subsequent policy considerations.

Figure 2. Core Factors and Aligned Attributes for Nurse Led-Models of Care



Core Factors

Patient-Centered

Every aspect of the care delivery should be centered on the patient. Patient-Centered care is a long-standing concept and basis for nursing practice and science. When the patient is the focal point, it leads to shared decision making between patients, families, and the clinician team. This in-turn creates more comprehensive care driven by transparency, value, and personalization. In designing NL-MOC, the patient population and the opportunity to affirm the patient's unique preferences, while considering their economic, social, and emotional well-being creates the optimal foundation.

Evidence In Practice

All NL-MOC must be driven by evidence. Consistently establishing and evaluating evidence is paramount. When adopting evidence in practice, it may be through an evidence-based strategy, which is a traditional, step-wise (i.e. identification of a clinical question, reviewing the literature, evaluating the evidence, integrating the evidence, evaluating the outcomes) approach to implementation or it may be done through an evidence- informed method that is more integrated and focused on a system-based approach of inputs and outputs. Whatever method is used to ensure evidence is in practice it must be done recurrently and consider the patient's preferences and values.

Team-Based Care Coordination

In the context of NL- MOC, team-based care coordination is essential. This creates ideal circumstances for patients and their families to thrive. The unique expertise of each health care clinician and professional only bolsters the lens from which care, progress, and outcomes can be evaluated and

improved. Within a NL-MOC, the compliment of clinicians work to identify shared goals for the team and the patient while establishing defined outcomes.

Outcomes Driven

Each of the NL-MOC reviewed in the Academy *Edge Runners* program utilized a variety of methodologies and evidence to establish the program. To determine the success of a NL-MOC, multiple data points must be considered to demonstrate improved outcomes including clinical, financial, quality, health equity, and consumer satisfaction. NL-MOC must be consistently informed by data, evaluated for replicability, scalability, and spread in other patient populations, care settings, or geography.

Aligned Attributes

Affirming Culture

In order for the patient, family, clinician, and entire health care system to thrive, the culture in which a NL-MOC operates has to affirm shared goals and outcomes built on trust, transparency, and engagement. Ensuring the well-being and safety of all parties involved as well as actively working toward accountability, equitability, and effectiveness is vital. This requires many of the standards in a *Health Work Environment* including: skilled communication, true collaboration, effective decision-making, meaningful recognition, and authentic leadership.

Digital Health Innovations

The pace of change in technology should be balanced with the human connection and clinician critical thinking. While AI and other technologies can improve the patient experience, data collection, support clinicians, and reduce burden, it can be increasingly difficult to distinguish between artificial and human output. Technology should be used as an opportunity to bring together organic and non-organic factors in health care, processes and procedures, and must be grounded in ethical and humanistic care.

Resource-Minded

NL-MOC should be cost-effective, and resource minded. This may mean streamlining care, considering how the clinicians on the team can be best utilized, evaluating practices that are not driving patient care improvements, or identifying how resources can be shared. The system, patient, family, and community should be considered to determine cost-effectiveness without sacrificing quality or impact.

Value and Incentive Systems

NL-MOC provide the opportunity to identify financial value and incentive systems that not only drive cost savings but also improve the health of the patients and communities. Value and incentive systems can consider the population served, create shared expectations for performance, with the aim of moving away from the current financial model of volume and fees for services. NL-MOC can align financial incentives with larger community health objectives to establish a health care system that is more affordable and efficient for all.

Policy Implications

Concurrent with the creation and spread of NL-MOC, policy barriers must be addressed to maximize their impact. Examples include:

- *Access to Care*: State legislation that restricts Advanced Practice Registered Nurses from providing care to the full extent of their education and training;
- *Digital Health Divide*: Increased access to broadband for reliable telehealth services, data transmission, and access to care, particularly in rural areas;
- *Cyber Security and Data Privacy*: Strengthened Security Standards for the Protection of Electronic Protected Health Information (Security Rule) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) to protect the confidentiality, integrity, and availability of electronic protected health information (ePHI) within electronic health records, ambient intelligence technologies, and wearable devices;
- *Value-Based Care:* Incentivize value-based payment systems focused on improving quality and enhancing efficiency;
- *Austerity Measure Removal:* Removal of current austerity measures in health care in order to forward movement, implementation, and utilization of care models that seek to improve care; and
- *Funding for Testing and Evaluation:* Increased support in the form of grants or demonstration projects at the state and federal level to determine effective models.

Conclusion

Health and health care delivery in the United States needs reform. The health and well-being of the nation teeter on a system that incentivizes sick care and service-based reimbursement, which has led to crippling costs for the patient, hospitals, and the federal government. Organizations and operations must change practices and develop a learning health system sees the value in and embraces NL-MOC. A learning health system, as defined by the National Academy of Medicine, is when the "science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience."[43] The Academy is committed to continued investigation of and raising awareness for how NL-MOC meet the demand of today and those well into the future.

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