Bringing Nursing Regulation & Education Together

LEADER TO LEADER

FALL 2022

NCSBN's Annual Report Program:

Essential Data for Regulators and Educators

In the fall of 2020, NCSBN launched the **Annual Report Program** (ARP) for nursing regulatory bodies (NRBs) in the U.S. For this program, NCSBN collects the nursing education annual report data that most NRBs require. The goals of this new program are twofold. First, NCSBN is assisting the NRBs with this time-consuming data collection. Secondly, NCSBN is then creating the *first-ever nursing education database* for the nursing community. The ARP team has developed evidence-based core questions that are asked among all the participating NRBs, thereby collecting consistent data that can be compared nationally.

Besides demographic data, all the questions are based on the quality indicators and warning signs reported in NCSBN Regulatory Guidelines for Pre-licensure Nursing Education (Spector et al., 2020). Each NRB also has the opportunity to submit their own additional questions (AQs). NCSBN then cleans, verifies and analyzes the data for each NRB. The NRBs receive a final report of their state's data, with asterisks by those programs that don't fully meet certain evidence-based quality indicators. Armed with the annual report data, the NRBs and programs can work together to identify needed program improvements *before* NCLEX pass rates and other outcomes fall below standards. NCLEX pass rates are lagging indicators, meaning that they don't begin to fall until other key quality indicators have not been met.

Map of Participating NRBs

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... and more

This is a win-win situation for NRBs and nursing programs.

Annually, NCSBN will disseminate a report of the aggregate data from participating NRBs, which the NRBs can compare to their programs' data. Additionally, since the participating programs receive a report of their data before they submit their survey, the participants can compare their results to the de-identified aggregate findings. This is a win-win situation for NRBs and nursing programs.

NRB participation in this program has increased each year. In the inaugural year of the program, even though we were in the depths of the COVID-19 pandemic, we had 20 NRBs participating. Currently we have 30 BONs participating. Our goal is for all NRBs to eventually participate. See the map for those participating NRBs. ◆

REFERENCE:

Spector, N., Silvestre, J., Alexander, M., Martin, B., Hooper, J.I., Squires, A., & Ojemeni, M. (2020). NCSBN regulatory guidelines and evidence-based quality indicators for nursing education programs. *Journal of Nursing Regulation,* 11(2), S1-S64. https://www.ncsbn.org/research-item/ncsbn-regulatory-guidelines-and-evidence-based-quality-indicators-for-nursing-education-programs

Annual Reports Participants Weigh In

We interviewed some of the participants of the Annual Report Program, and here are their perspectives:

Gerianne Babbo, EdD, MN, RN
Director for Nursing Education, Washington State Nursing Care Quality Assurance Commission

We have used the data to present a report to our Commission every year, and to identify programs at risk and programs out of compliance with the education rules. The way the data is provided to us streamlines the process of assimilating and analyzing the data for meaningful use.

The nursing programs have been very supportive of the new format. The support from Nancy Spector's team is amazing. They respond to nursing program questions in an expedited way, and the communication with our staff is remarkable. Truly collaborative!

Our process was to streamline our questions so we do not repeat what NCSBN is asking. It has simplified the process, and has also given us evidence-based data that we can use to support nursing education programs in our state. We are so grateful for the collaboration with NCSBN and the fact that our state is adding to the database for nursing education! ◆

Sherry Richardson, MSN, RN
Executive Director, Tennessee Board of Nursing

We use this information to track information related to nursing program enrollment, completion, faculty numbers and much more. Additionally, we can update the questions as needed each year to remain current.

It has been well received by Tennessee schools of nursing. Most questions are similar to previous reports requested, and the NCSBN team is helpful in answering questions and assisting.

Many staff hours have been saved since NCSBN began assisting us. This has been very helpful as we have experienced increased staff turnover in the last two years. We have been able to obtain the same information as the report we previously worked with, and additional information as needed. The NCSBN team compiles the data and sends us the complete report for distribution. We look forward to the continued partnership for this helpful reporting tool! ◆

NCSBN's Annual Report Program:
Report of the 2020-2021 Aggregate Data

here were 20 nursing regulatory bodies (NRBs) participating in the 2020-21 Annual Report Program, and this is an overview of some of those data. Access the entire report here.

Many NRBs and their nursing programs were overwhelmed in 2020 because of the pandemic, and some wanted to delay their participation. Data were collected on diploma, licensed practical/vocational nurse (LPN/VN), associate degree (ADN), baccalaureate degree, accelerated bachelor of science in nursing (BSN) and masters-entry programs. Of the 20 NRBs participating, there were:

- 843 nursing programs;
- 112,147 students enrolled in their programs;
- 8,263 full-time faculty;
- 3,104 part-time faculty;
- and 7,768 clinical adjunct faculty.

NRBs and nursing programs can use these key indicators when evaluating programs so that changes can be made before the programs fall below standards.

Based on NCSBN's 2020 study of nursing education quality indicators (Spector et al., 2020), we have identified eight key quality indicators for nursing programs. NRBs and nursing programs can use these key indicators when evaluating programs so that changes can be made before the programs fall below standards. See **Table 4** (page 4) for a comparison of the quality indicators for each type of program. Below is a summary of the key quality indicators that were reported in the 2020-21 Annual Report Surveys:

1. The majority of ADN, BSN, accelerated BSN and master's entry programs are nationally nursing accredited. LPN/VN and diploma programs need further work in this area.
2. The vast majority of the programs have full approval status at their NRB.
3. Many of the programs experienced major organizational changes during the year being surveyed. Some of these changes would include new director or assistant/associate director, staff or faculty layoff, change in university/college leadership, collapsing programs, or economic efficiencies. Our research suggests that this lack of upper administrative support has led to poorer outcomes.
4. Programs with three or more directors in five years have been linked to poorer outcomes.
5. All of the programs had at least 50% direct care clinical experiences, which are linked to better outcomes.
6. 35% full-time faculty in a nursing program is linked to better outcomes. 26.3% of the programs in the database had less than 35% full-time faculty, which could lead to poorer outcomes.
7. While our study did not find graduation rates to be a quality indicator, the national nursing accreditors, the U.S. Department of Education (USDE) and many NRBs use it as an outcome. The accreditors and USDE cite 70% graduation rate or above as meeting their requirements. As can be seen, many in this database did not reach this level.
8. Lastly, programs that are younger than seven years old have been linked to poorer outcomes and might need more frequent oversight. While the vast majority of programs in this sample are longstanding, there were some categories with more than 10% of the programs being new.

Table 4. Key Quality Indicators

	LPN/VN	Diploma	Associates	Bachelors	Accelerated BSN	Master's Entry	Grand Total
N	275	7	326	208	23	4	843
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Accreditation Status							
Yes	47 (17.1%)	3 (42.9%)	236 (72.4%)	201 (96.6%)	23 (100.0%)	4 (100.0%)	514 (61.0%)
No	228 (82.9%)	4 (57.1%)	90 (27.6%)	7 (3.4%)	0 (0.0%)	0 (0.0%)	329 (39.0%)
Programs' Approval Status							
Fully Approved	261 (94.9%)	6 (85.7%)	291 (89.3%)	191 (91.8%)	22 (95.7%)	4 (100.0%)	775 (91.9%)
Not approved/ Conditional/ Probationary or Warning Status	14 (5.1%)	1 (14.3%)	35 (10.7%)	17 (8.2%)	1 (4.3%)	0 (0.0%)	68 (8.1%)
Experienced Major Organizational Changes							
Yes	140 (50.9%)	4 (57.1%)	155 (47.5%)	113 (54.3%)	18 (78.3%)	4 (100.0%)	434 (51.5%)
No	135 (49.1%)	3 (42.9%)	171 (52.5%)	95 (45.7%)	5 (21.7%)	0 (0.0%)	409 (48.5%)
Director Turnover							
Least Than or Equal to Three Directors Over the Past Year	257 (93.5%)	6 (85.7%)	293 (89.9%)	193 (92.8%)	18 (78.3%)	4 (100.0%)	771 (91.5%)
More than Three Directors Over the Past Year	18 (6.5%)	1 (14.3%)	33 (10.1%)	15 (7.2%)	4 (21.7%)	0 (0.0%)	72 (8.5%)
Less Than 50% Direct Care Clinical Experience							
Greater Than 50% Direct Care Clinical Experience	247 (89.9%)	7 (100.0%)	304 (93.3%)	204 (98.1%)	21 (91.3%)	4 (100.0%)	787 (93.4%)
Less Than 50% Direct Care Clinical Experience	28 (10.2%)	0 (0.0%)	22 (6.7%)	4 (1.9%)	2 (8.7%)	0 (0.0%)	56 (6.6%)
Less Than 35% Full-Time Faculty							
Greater Than 35% Full-Time Faculty	218 (79.3%)	4 (57.1%)	239 (73.3%)	146 (70.2%)	12 (52.2%)	2 (50.0%)	621 (73.7%)
Less Than 35% Full-Time Faculty	57 (20.7%)	3 (42.9%)	87 (26.7%)	62 (29.8%)	11 (47.8%)	2 (50.0%)	222 (26.3%)
Less Than 70% Graduation Rate							
Greater Than 70% Graduation Rate	134 (48.7%)	1 (14.3%)	200 (61.3%)	137 (65.9%)	15 (65.2%)	3 (75.0%)	490 (58.1%)
Less Than 70% Graduation Rate	141 (51.3%)	6 (85.7%)	126 (38.7%)	71 (34.1%)	8 (34.8%)	1 (25.0%)	353 (41.9%)
Programs Established Before 2016/After 2015							
Before 2016	260 (94.5%)	7 (100.0%)	296 (90.8%)	182 (87.5%)	19 (82.6%)	3 (75.0%)	767(91.0%)
After 2015	15 (5.5%)	0 (0.0%)	30 (9.2%)	26 (12.5%)	4 (17.4%)	1 (25.0%)	76 (9.0%)

Another interesting finding from these data were the number of clinical hours in nursing education programs. The number of clinical hours has been discussed in the literature, though at this time there is no evidence supporting a minimum number of clinical hours. Currently, in the U.S. only 13 NRBs require specific numbers of clinical hours (NCSBN, 2021). Please see **Table 2** below for the distribution of hours among the program types.

Table 2. Breakdown of Program Hours by Program Type

	LPN/VN	Diploma	Associates	Bachelors	Accelerated BSN	Master's Entry
N	275	7	326	208	23	4
Direct Patient Care Hours						
Mean	386.3	530.21	437.61	625.64	578.85	665
SD	±169.14	±303.9	±173.05	±202.57	±192.3	±200.32
Simulation Hours						
Mean	54.63	35	69.9	85.66	113.91	50
SD	±63.74	±37.92	±85.45	±69.52	±109.5	±28.19
Skills Lab Hours						
Mean	124.27	113.64	110.12	112.13	119.46	153.75
SD	±126.24	±68.34	±78.04	±63.76	±67.61	±123.37

The survey question asked for typical (or pre-pandemic) hours, as the pandemic adversely affected direct patient care clinical hours because practice facilities closed their doors to student nurses (NCSBN, 2022). Additionally, it also impacted simulation and skills lab hours because of social distancing requirements in many states.

Table 3. Clinical Hours from 2010 – 2021

	2010 (median hours)	2017 (median hours)	2020-21 (mean hours)
Master's entry	770	780	665
Bachelors	765	712	625.64
Associates	628	573	437.61
Diploma	720	683	530.21
LPN/VN	(data not collected)	565	386.3

The evidence supports replacing at up to 50% of clinical experiences with simulation if nationally adopted simulation guidelines are followed

(Hayden et al., 2014; NCSBN, 2016)

Direct care clinical hours have been decreasing over the years. See **Table 3** for 2010 and 2017 data from an NCSBN national sample (Smiley, 2019), as compared to 2020–21 data from the Annual Report database. One answer could be that programs are using more simulation to replace direct care clinical hours. The evidence supports replacing at up to 50% of clinical experiences with simulation if nationally adopted simulation guidelines are followed (Hayden et al., 2014; NCSBN, 2016). However, looking at the mean number of simulation hours, both among all programs and for individual program types, the simulation hours are also relatively low. Indeed, Hungerford et al. (2019) found that, when comparing nursing education program clinical hours among the U.S., Australia, New Zealand and the U.K., the U.S. has the lowest number of clinical hours in RN prelicensure programs[1]. This trend of clinical hours (skills labs, simulation and direct care hours) bears watching in the future.

[1]Australia mandates 800 hours; New Zealand mandates 1,100 hours; the United Kingdom mandates 2,300 hours.

This trend of clinical hours (skills labs, simulation and direct care hours) bears watching in the future.

There were other findings in this aggregate analysis — including demographics — such as geographic location, availability of resources, and institutional ownership. Additionally, other quality indicators, such as services provided to students and certification of simulation faculty, were examined.

See the full report of the Annual Report Aggregate Data for 2020–2021. Analysis of the 2021–2022 report will soon begin. Be on the lookout for a Spring 2023 special COVID-19 *Journal of Nursing Regulation* issue for a report of the COVID-19 data that was collected during 2020–2021.

If your NRB would like to participate, please submit an inquiry to request more information. ◆

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Questions from APRN Students and Faculty

By Jolene Zych, PhD, APRN, WHNP-BC, Nurse Consultant–Advanced Practice, Texas Board of Nursing

Board staff frequently receive questions from students and faculty in advanced practice registered nurse (APRN) education programs. Sometimes, the questions are very similar to those received from prelicensure programs at the professional or vocational level. More often, however, the questions are unique.

Some of the more interesting questions from both APRN students and faculty are related to scope of practice. Students who may be seeking to push beyond the boundaries of the role and population focus of the program may appeal to board staff to grant permission for such experiences. Often, these students are part way through a program and realize that they would really like to practice in a different role and/or population focus and are looking for a way to make a change without starting over. While those students may not have to repeat the graduate core courses in advanced assessment, advanced pathophysiology or advanced pharmacotherapeutics, they must be able to demonstrate that they have been educated for the full scope of the role and population for which they will ultimately seek licensure and national certification. Similarly, program faculty sometimes look to board staff for support of appropriate scope of practice boundaries when students seek to complete clinical learning experiences that are beyond the scope of the role and population focus. Although sometimes the answer to the question is clear, more often these types of scope of practice questions are unique to the specific situation or practice setting.

> Although sometimes the answer to the question is clear, more often these types of scope of practice questions are unique to the specific situation or practice setting.

Credit for prior academic courses and practicum experiences completed in other graduate degree programs are also a subject for frequent inquiry. Gap analyses, syllabi and communication with both programs is often helpful to staff when rendering a determination. Often, the program at which the course was completed can offer helpful insight into whether the course was appropriate for APRN education and for the role and population focus. One recent experience by Texas board staff serves as an illustration. The post-graduate program gave academic credit for an advanced assessment that was on the student's transcript for the student's Master of Science in Nursing with an emphasis in nursing education. The program provided the syllabus for the student's advanced assessment course. Accompanying the syllabus was a letter to board staff confirming that, although the advanced assessment course was a graduate level course, it was not an appropriate course for students intending to practice in an APRN role. The letter was not solicited by board staff; however, the program director felt compelled to clarify this information for the purpose of rendering an appropriate determination. Communication with faculty representatives of both programs was necessary to determine the appropriate course of action.

Board staff across the U. S. are aware of the challenges APRNs have when trying to identify appropriate clinical sites and preceptors for their clinical learning experiences. When challenges arise, students and faculty may be tempted to authorize the student to practice with an APRN who is licensed in or practices with a different population focus that is beyond the scope for which the student is completing education. Although such practices may be acceptable in some states, Texas law requires completion of didactic and clinical education specific to the role and population focus with appropriate preceptors.

Interesting questions also arise when an APRN student commits a basic nursing error while participating in an APRN clinical learning experience. While these types of questions do not arise often, board staff must be prepared to address such situations when and if they do because these students are already licensed nurses. Concerns can range from

minor incidents that are easily remediated by program faculty to significant violations of the nursing practice act and/or board rules that rise to the level of conduct subject to reporting. Texas law also provides an option for the student to be reported to the Nursing Peer Review Committee within the nursing program. The Texas Occupations Code clarifies that the nursing peer review process includes the evaluation of nursing services, the qualifications of a nurse, the quality of patient care rendered by a nurse, the merits of a complaint concerning a nurse or nursing care, and a determination or recommendation regarding a complaint. The peer review process should be a discussion that is focused on fact-finding, analysis, and a study of the events that occurred or concerns that were raised in a climate of collegial problem solving when reviewing nursing care or practice-related concerns. The committee focuses on obtaining all relevant information about an event to determine if licensure violations have occurred and, if so, if the violations require reporting to the board. Just as Texas law separates peer review determinations from employment determinations, peer review determinations related to an APRN student are separate from determinations regarding student eligibility for reenrollment.

Board staff must be able to have discussions with other regulatory colleagues and tap into their varied knowledge and expertise.

When answering questions related to APRN education, it is necessary to remember that there are multiple factors underlying each question. As is often the case in regulation, it is rarely possible to give a simple yes or no answer; rather, it takes a great deal of communication to understand the question and relevant background information. Board staff must be able to have discussions with other regulatory colleagues and tap into their varied knowledge and expertise. It is also helpful to have collegial conversations with students, program faculty, subject matter experts, and other entities that can and should weigh in on the question at hand. ◆

REFERENCE:
Texas Occupations Code, §303.001(5)

The APRN Compact: Two Years in Legislative Action

In August 2020, NCSBN delegates adopted model language for the APRN Compact. Since this adoption, the APRN Compact has been introduced in the 2021 and 2022 legislative sessions and has been enacted in three states, Delaware, North Dakota and Utah.

Once seven states adopt the model language, the APRN Compact will become operational. After two years of legislative action, the APRN Compact has found a strong source of support in state-level nursing organizations and many lessons have been learned regarding the policy.

The APRN Compact was introduced in Maryland in the 2022 legislative session and was heard by the Senate Education, Health and Environment Committee. While this bill ultimately did not advance, we anticipate a reintroduction of the APRN Compact in Maryland in the 2023 legislative session.

On March 10, 2021, North Dakota became the first state to enact the APRN Compact with nearly unanimous legislative support. This bill was supported by the North Dakota Nurse Practitioner Association, the North Dakota Association of Nurse Anesthetists, and the North Dakota Nurses Association, among other stakeholders. North Dakota is a state with full independent practice and does not have a transition to practice (TTP) period, a requisite period of temporary supervision, collaboration, or mentorship with a physician or other health care provider prior to independent practice. Because of this, there was concern expressed by national stakeholder groups that the physician lobby in the state would equate the APRN Compact's inclusion of a 2,080-hour practice uniform licensure requirement to a restrictive TTP and lobby for the state to adopt a TTP. This fear was not realized, as neither lawmakers nor physician groups argued before the legislature that APRNs should be restricted by a TTP period.

A Policy Solution: 2,080-Hour Practice Requirement for Obtaining a Multistate License

The APRN Compact allows multistate licensees to practice without a supervisory, collaborative, or mentorship relationship with a physician or any other health care provider and the prevalence of TTPs created a barrier to the legislative feasibility of the compact. A 2,080-hour practice requirement was included as a uniform licensure requirement to obtain a multistate license, a practical solution to achieve licensure mobility for APRNs, without imposing the restrictions of a TTP on licensees. After analyzing TTPs across the country in 2018, the most common length was 2,080 hours, so, the number was chosen to enable a majority of states with the TTP roadblock to have a better chance of successfully enacting the APRN Compact.

It is crucial to note that about **90% of APRN licensees** would meet this requirement on day one.

Delaware Gov. John Carey signed the APRN Compact into law on Aug. 4, 2021, making Delaware the second state to enact the APRN Compact. Delaware was the first state to successfully remove their TTP from statute in a companion bill to the APRN Compact legislation. The APRN Compact not only spurred the removal of a 24-month TTP, but also eliminated the joint regulation of APRNs by the Delaware Board of Medical Licensure & Discipline. The Delaware Nurses Association, the Delaware Association of Nurse Anesthetists, and the Delaware Organization of Nurse Leaders were among key supporters of the APRN Compact.

The third and most recent state to enact the APRN Compact was Utah, which enacted legislation during the 2022 legislative session. The Utah Nurse Practitioners Association took the helm on APRN Compact efforts by having the bill introduced and leading a coalition that included the Utah Nurses Association, the Utah Association of Nurse Anesthetists and the University of Utah School of Nursing, among others. While this bill ultimately passed with unanimous support, there was opposition from two organizations-the Utah Medical Association, who opposed the full practice authority provisions in the compact, and the American Association of Nurse Practitioners, who continue to have concerns over the 2,080-hour experience requirement. Despite opposition, Utah nursing

stakeholders united behind the compact and propelled the bill forward to passage.

These surveys demonstrate both the need and wide support for the APRN Compact among APRN licensees.

In addition to support seen at state legislatures from nursing organizations, the APRN Compact has also seen strong support from individual APRNs, which has been demonstrated through surveys conducted by boards of nursing. A 2021 survey conducted in Wyoming found that 45% of APRNs held active licenses in more than one state and 72% of APRNs supported the adoption of the APRN Compact. In a 2022 Maryland Board of Nursing survey, 92.57% of participants stated they would be supportive of a 2022 introduction of APRN Compact legislation. Finally, Arizona conducted a survey in 2022 which revealed that 65% of APRNs felt there was a need to provide APRN care or educational services to individuals living or traveling outside of the state, and 92.5% of APRNs stated that they are in favor of Arizona adopting the APRN Compact. These surveys demonstrate both the need and wide support for the APRN Compact among APRN licensees.

Over the past two legislative sessions, the APRN Compact has continued to grow in membership and in state-level organizational support. Surveys have demonstrated increased interest from individual APRNs as they continue to learn how the APRN Compact will benefit their practice and the potential multistate licensure has for modernizing the APRN profession.

The APRN Compact allows an advanced practice registered nurse to hold one multistate license with a privilege to practice in other compact states. The APRN Compact will be implemented when seven states have enacted legislation. Take action to bring the APRN Compact to your state. Visit www.aprncompact.com or contact aprncompact@ncsbn.org. ◆

Q & A

Q: How can I apply for an NCSBN Center for Regulatory Excellence (CRE) grant?

By Nancy Spector, PhD, RN, FAAN, Director of Nursing Education, NCSBN

A: That is a great question! I was recently at the NLN Education Summit in Las Vegas, where Janet Monagle, PhD, RN, CNE, associate professor, Massachusetts General Hospital Institute of Health Professions; Kathie Lasater, EdD, RN, ANEF, FAAN, professor emerita Oregon Health & Science University, visiting professor, Edinburgh Napier University; and I gave a presentation to nurse faculty about accessing research databases to conduct nursing education studies. The audience had considerable interest in applying for NCSBN's CRE grants.

From left: Nancy Spector, Janet Monagle and Kathie Lasater.

The program awards up to $300,000 to seasoned researchers for two years of research that builds the science of nursing regulation. The next submission due date is March 31, 2023. Research priorities are:

- The impact of legalized marijuana
- Substance use disorders in nursing
- National and international regulatory issues
- Economic analyses, e.g., Nurse Licensure Compact, APRN practice, etc.
- Remediation
- Innovations in nursing education

Grant application, FAQs, project expectations and contact information are all available on the NCSBN website. Additionally, there is a section highlighting the grants that have been awarded since its inception in 2007, to give you an idea of what has been funded. You can also read about three grantees' experiences with the CRE Grant Program in the latest issue of NCSBN's *In Focus* magazine. ***We look forward to your grant applications!***

NCSBN's CRE Grant Program and *Journal of Nursing Regulation* Advance Nursing Regulation Research

By Sherri L. Ter Molen, PhD, MA, Associate, Nursing Regulation, NCSBN

Sherri L. Ter Molen, PhD, MA

Just as nurses rely on a combination of objective and subjective information to make sound clinical judgments (NCSBN, n.d.), nursing regulators turn to scientific inquiry, a mix of observations and inferences (Babbie, 2007), to make decisions and to shape policy. Since nursing is the largest health care profession in the U.S. (AACN, n.d.), it is not surprising that there are multiple nursing journals that publish clinical research. Yet, there is only one journal that exclusively publishes papers on research and other data and information that impact nursing policy and regulation, NCSBN's *Journal of Nursing Regulation (JNR).*

Nursing regulators and health policy leaders around the world trust *JNR* to deliver the latest research on topics ranging from nursing education, licensure and practice to health care policy, legislation and, of course, evidence-based regulation. To support rigorous exploration, NCSBN's Center for Regulatory Excellence (CRE) Grant Program provides up to $300,000 to researchers from any discipline who propose original quantitative or qualitative projects "that advance the science of nursing policy and regulation and build regulatory expertise worldwide" (NCSBNa, n.d.). At the completion of their projects, grant recipients submit manuscripts containing their primary data and research findings to the *JNR*, and, after peer review, many of these papers are published, making this information available to NCSBN members as well as academics and others who have individual *JNR* subscriptions or institutional access to ScienceDirect, Elsevier's platform of peer-reviewed literature.

Nursing regulators and health policy leaders around the world trust *JNR* to deliver the latest research on topics ranging from nursing education, licensure and practice to health care policy, legislation and, of course, evidence-based regulation.

This cyclical relationship between the CRE and *JNR* led to the publication of Spetz et al. (2021) "Barriers and Facilitators of Advanced Practice Registered Nurse Participation in Medication Treatment for Opioid Use," for example. Through this mixed methods study, the authors explored the factors that affect advanced practice registered nurses' (APRNs') abilities to offer buprenorphine treatment to patients with opioid use disorder. They concluded that the states that require physician oversight of APRNs have stunted the growth of the much-needed addiction treatment workforce since there is a lack of buprenorphine-prescribing physicians who could provide the required APRN supervision, especially in rural counties. The following year, *JNR* published Brooks Carthon et al. (2022) "Supportive Practice Environments Are Associated with Higher Quality Ratings among Nurse Practitioners Working in Underserved Areas." This group of authors merged original survey data with U.S. Area Health Resource Files to explore the relationships between nurse practitioner (NP) scope of practice regulations, practice environments and the NPs' self-reported ratings of the quality of care delivered in primary care facilities. They found that NPs' evaluations of quality of care suffered when these nurses did not feel supported in their workplaces. Therefore, they concluded that primary care shortage areas, which tend to be rural communities, might be able to attract more NPs if working conditions were improved. Together, Spetz et al. (2021) and Brooks Carthon et al. (2022) suggest that, if health care facilities in underserved areas improve their work environments, and if APRNs have the autonomy to prescribe buprenorphine without physician supervision, health care disparities between urban and rural settings may be reduced.

NCSBN is proud to offer the CRE and JNR, which are in place to cultivate the regulatory knowledge that nursing regulatory bodies need to support their work ...

Another interesting and related pairing of CRE Grant-funded articles are Li and Cimiotti (2021) "Nurse Staffing and Patient Outcomes during a Natural Disaster" and Weaver et al. (2022) "Nursing Activities and Job Satisfaction of the Licensed Practical Nurse Workforce in New Jersey." Li and Cimiotti conducted a cross-sectional analysis of New Jersey state and association data to study nurse staffing during Hurricane Sandy, and they concluded that nurse mobility was so essential to providing care during this disaster that they recommended the nationwide implementation of the Nurse Licensure Compact. Weaver et al., on the other hand, compared licensed practical nurses' (LPNs') scope of practice, the work they perform and job satisfaction in long-term care facilities versus other settings. Their survey data indicated that some LPNs are practicing beyond their scope, particularly in long-term care facilities, and the expanded duties are leading to decreased job satisfaction. These researchers also recommended that nursing leaders, educators and regulators should listen to LPNs to learn more about the work they are performing and that they may need to redefine the LPN scope of practice. These two studies suggest that, if nurses were officially granted the authority to supervise unlicensed assistive personnel, for instance, their job satisfaction may increase. Further, if the LPN scope of practice were expanded, registered nurses (RN) might be freed up to perform other duties, which might lessen the strain on the RN workforce during surges as well as normal times.

Comparing and contrasting two scholarly articles can highlight issues and point to solutions, but conducting a full review of literature, comprised of many articles on a given topic, can provide a more holistic view for informing decisions and developing regulations. Additional scientific inquiry is always needed, and so NCSBN is proud to offer the CRE and *JNR*, which are in place to cultivate the regulatory knowledge that nursing regulatory bodies need to support their work in protecting their publics from harm. ◆

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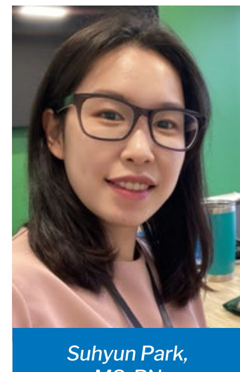
– **Dena Hinkle, RN**
2019 graduate intern

For applications and more information, visit our webpage or contact us at regulatoryscholars@ncsbn.org.

Expanding my Perspective on Nursing Regulation through NCSBN's Regulatory Scholars Program

By Suhyun Park, MS, RN, 2022 NCSBN Scholar in Residence



Suhyun Park, MS, RN

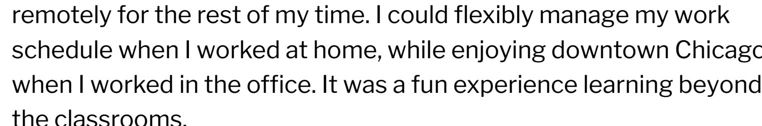
This past summer, I had the opportunity to work with NCSBN as a Scholar in Residence in their Regulatory Scholars Program. I worked under the close guidance of NCSBN Director of Nursing Education Nancy Spector, PhD, RN, FAAN. As a PhD student at the University of Minnesota, my dissertation work is focused on electronic health records (EHR) usability. I am currently working with in-hospital nurses to co-develop an efficient EHR dashboard.

Two years ago, when I first arrived in Minnesota from South Korea to start my PhD program, it was far from what I expected from college life. As COVID-19 was widely spreading, my PhD program converted all their welcoming events, classes and even conferences to virtual formats. It was a radical change for students and faculty, but we soon found ways to adapt to the new situation. Even though it was once considered that nursing education should ideally be delivered in classrooms and hospitals face-to-face, it does not always work this way now. Aligned with the changing needs of nursing education, I found that NCSBN has been collecting nationwide data from nursing schools on this very topic. As a student and a future educator, I wanted to ascertain how nursing schools have changed to adapt their ways after the pandemic, and how they could be directed to improve learning effects in the future.

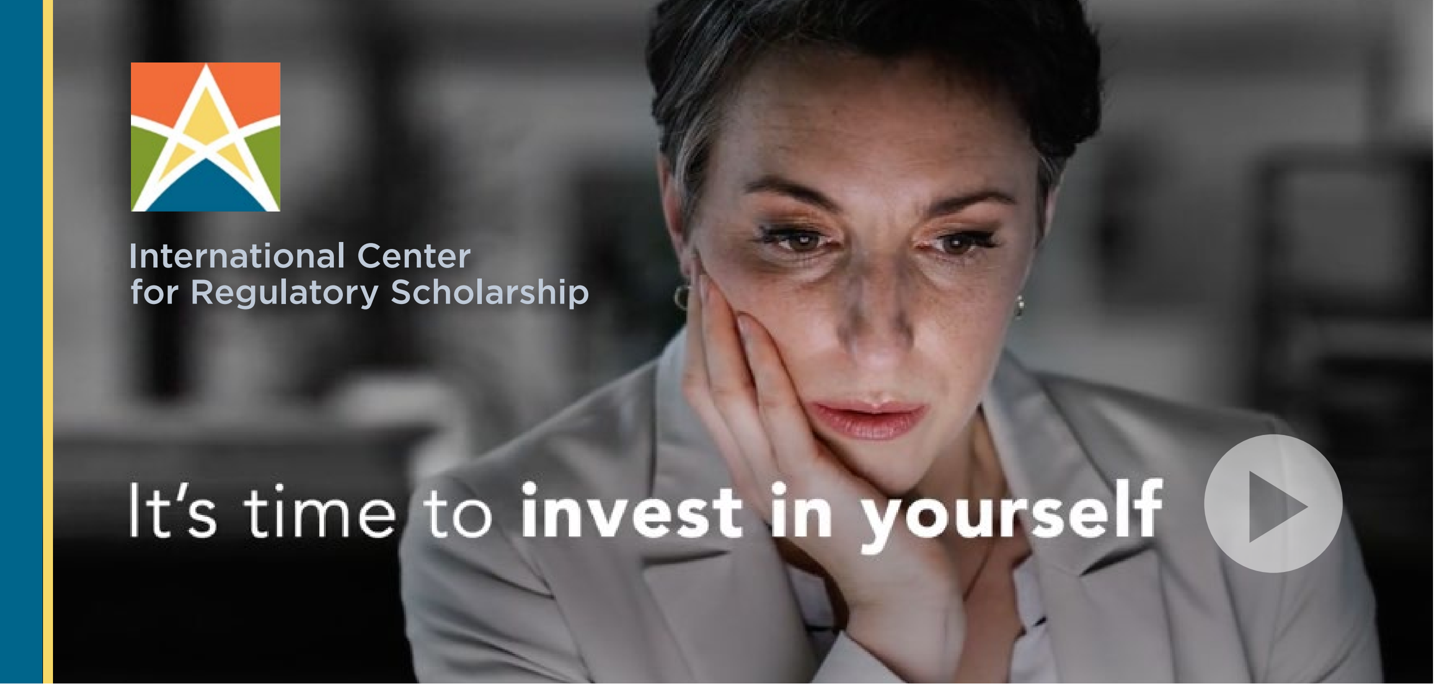
> "I had regular meetings with experts, including but not limited to nursing researchers, nursing regulators, lawyers and lobbyists."
>
> *Suhyun Park, MS, RN*

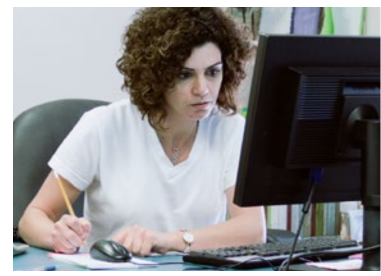
During my time as the Scholar in Residence, my work started with understanding the role of nursing regulation across states. I had regular meetings with experts, including but not limited to nursing researchers, nursing regulators, lawyers and lobbyists. It was surprising that all experts in the domain fields were convened together in NCSBN to better inform nursing regulation. For my project, I worked in the department of Nursing Education to analyze and interpret nationwide data about the effect of COVID-19 on nursing education. Through weekly meetings with Nancy Spector, I learned how to approach the dataset to identify problems and suggest possible solutions. My experience was very interactive among regulators, educators and researchers from across the country. It was interesting to be a part of the team generating evidence to guide nursing regulation.

I also appreciated the hybrid format, visiting the office the first and last week and working remotely for the rest of my time. I could flexibly manage my work schedule when I worked at home, while enjoying downtown Chicago when I worked in the office. It was a fun experience learning beyond the classrooms.



Overall, I feel grateful that I could expand my perspective on nursing regulation through the Regulatory Scholars Program, being able to view how NCSBN works with the boards of nursing and witnessing the policymaking process. From the lessons learned, I will keep discussing nursing regulation in my research and teaching going forward. As one way of improving the effective use of EHR going forward (which is my core research focus), I would like to discover the impact of the unique nurse identifier integrated into EHR on nursing-related outcomes using data analytics in the future. ◆





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