2021 NCSBN Annual Meeting - Model Act and Rules Committee Forum Video Transcript

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2021 NCSBN Annual Meeting

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Presenter
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- [Ruby] Hi. I'm Ruby Jason, and it's my privilege this morning to present the work of the Model Act and Rule Committee. The committee's charge was to perform an ongoing review, revision, and development of Model Acts and Rules that now reflect the current regulatory environment and to make sure that our Model Act and Rules remove any language that is not appropriate to public safety such as, you know, disciplining a license for lack of child support payments.

While that is important, it is not public safety. The committee met for approximately two years and we looked at an awful lot of literature. We looked at studies, we looked at the FARB model, and we also consulted with LPN experts in assuring that we captured the work of the LPN accurately.

We also looked at the NCSBN Outcomes and Metrics Study and we also presented this program previously at both the director meeting in February of 2021 and at the membership at the midyear committee in March of 2021. So for many of you this is a repeat, for some of you this will be the first time you've heard this information.

First of all, I'd like to talk a little bit about what exactly is a Model Act and Rules. There are new members to NCSBN and to regulation. So I want to go over what a Model Act and Rule really is all about and we've all worked with environments where it's best practice, where it's evidence-based practice, etc., and that's what model rules really are.

Model Act and Rules are number one, they're adopted by the NCSBN membership as representation of best practices and processes for nursing regulation. We, the committee have done all the research for you, all the leg work for you, and come up with what we believe to be a best practice, literature-based, model act and model rules. Now, this is a tool, it is a non-binding set of documents that will allow you to reference these documents when you are advocating for legislative or regulatory change.

So the methods for addressing existing Model Rule and Acts, what we did was we reviewed, although it's not an exclusive list, we reviewed public safety standards, we reviewed of course, the North Carolina

Dental decision by the Supreme Court, we looked at best practices, evidence, modernization, streamlining, and of course, in the middle of all of this work, COVID-19 hit and we have also adopted the Model Act and Rules for what happens when there is a declared emergency in your area or in your jurisdiction so that your board can remain nimble and respond to these emergencies.

Presentations today, we're going to talk about what is currently in Model Act and Rules, the recommended change, and most importantly, why the committee decided that given all the information we had, this was an important change to make.

I'm only going to talk today about significant changes, the nonsignificant changes you will find in your business book. The first thing we tackled was the structure of Boards of Nursing. We look at what the current Model Act and Rules said about member terms and it had a very specific number of terms that a member should serve.

However, in looking at all of the information we had, there is no evidence to support that a specific number of terms is in or not in the best interest of public safety. In fact what you really need according to what the committee members read and what we discussed was individuals who have both institutional knowledge and who also have new perspectives.

So the committee recommends that we take out the term limitations and just allow boards to determine based on their jurisdiction and their statutory authority what it is that the current number of terms that are allowed in that specific jurisdiction.

The board powers and duties. Currently, there's a lengthy laundry list of items that boards are able to do and that the Model Act gives them the power and authorities, but it should be streamlined and outline basic authorization for each Board of Nursing activity. So what we've had is now we've slimmed down the list of the current board powers and duties, and focused on authorization to conduct the activities because that's really what a Model Act does.

It give statutory authorization for a Board of Nursing to conduct activities. Frequency of meetings. The current language is quarterly. There's no evidence to support that any minimum number of meetings is more efficient than another. So the board...

The recommended language is the board shall meet at least whatever it is you decide in your jurisdiction. Education program approval. Currently, the language talks about standards for nursing education. However, there is no statutory authority currently in the act for allowing a board the processes that they use to approve nursing education programs.

So the language that the committee has recommended is that we provide the authorization in statute for the board to actually do the processes that it uses in order to approve nursing education programs. Data sharing.

Currently, the Model Act recommends that you do data share. However, we do recognize that in some jurisdictions, there may be statutory limitation to that and so we have added information that we should share data where permissible in order to align with specific jurisdictional statutes.

Licensee public announcement. The current language talks about how the board has the authority to regulate the manner in which the nurse announces their practice to the public and we recommend that be

removed. That's more of an employer activity and the Model Act does include nurse identification, entitles, abbreviations, etc.

So there's really no need to spell that out in the Model Act. Membership in private organizations. The current language clearly refers to NCSBN, particularly in the part where it says they develop national licensure examinations and the committee felt that it is not appropriate to include membership in NCSBN within the description of Board of Nursing powers and duties, also occupational licensing reform played a part in that recommendation.

And then so the recommendation is that that language has changed to participate or hold membership in national organizations that promote the provisions of this act. Public members. Currently it says that public members shall have no financial interest in nursing services and based on literature, we could have a potential conflict with that in direct interest in any healthcare services not just nursing services.

As healthcare services expand and new businesses are developed, quite frequently what we want to make sure of is that our public members have no material financial interest in the provisions of any service that provides healthcare. Lawsuits. Currently, the language is that board members are immune from individual civil liability while acting in the scope of duties of the board of directors' members and the committee felt that the provision should tie back to the jurisdictional law governing the subject.

So that's not for the Model Act and Rules to advocate for special treatment of Board of Nursing members and you can see the recommendations here. And actually some of us who are not attorneys on the committee talked about what does it mean for Board of Nursing members to enjoy immunity and the lawyers on our committee which we had wonderful participation from set us straight and said "Enjoying immunity is a legal term."

So there you have it. Okay. And then we wanted to remove the requirement under the act to allow the state to represent individual board members and leave that up to the jurisdictional authority. Executive officer.

Currently the rules read that you will appoint and employ a qualified RN. And within this audience we have plenty of examples of individual executive officers who are not RNs who are doing a spectacular job. And so we want to remove that limitation and appoint and employ a qualified individual. That individual maybe a nurse by the board's tradition and practice, but it does not tie in a Model Act and Rule that it has to be an RN because there really is no evidence that states that an RN is the best qualified individual in every case.

Executive officer effectiveness and there is a current language that talks about the Board of Nursing evaluating the executive officer. And we recommend that that be removed because that's really an employment activity and that is really a state specific process and really has no need to be in a Model Act. All right.

Now we talk about scope of practice and here's where probably much of our discussions occurred and much of our healthy discord occurred. And a lot of these recommendations were extremely well thought out although some of these recommendations may not be in keeping with what you believe the recommendation should be. So this is your opportunity and this is the meaning before you vote on these Model Act and Rules to really, let's discuss this if there is issue with the board, the committee's recommendations.

Okay. Delegation. Currently there is no language about delegation in the act and we make the recommendation that really defines the term delegation, and we make sure that the nurses understand the accountability for ensuring delegation authority.

Establishing nursing diagnosis which is currently in Model Act. The proposal is we participate in and establishes patient diagnosis. Now, is that a billable diagnosis? Is that, you know, nursing has historically been about the symptomatology associated with illness or injury, and the treatment thereof.

And if we go to this patient diagnosis, as the literature really recommends, it's recommended by the National Academy of Medicine Committee on Improving Patient Diagnosis that there is no evidence that nursing diagnosis contributes to the overall care of patients and there's a pushdown for participation in developing a interdisciplinary patient diagnosis.

Again, this does have a significant impact and change in the Model Act and Rules, and probably is something that we would like to hear from the audience about how they feel about this. Assessment. Again, we did speak with a group of LPN practice experts and currently the language is focused assessment for the LPN and comprehensive assessment for the RN.

And we looked at the definitions for focused and comprehensive and both of those definitions require collection analysis and synthesis of data. So we have recommended that it's LPN assessment and RN assessment. Nurse Licensure Compact conformity.

Throughout the act, we have determined that it is in the best interest of the Model Act and Rules that the wording reflect the conformity in the National Licensure Compact or the Nurse Licensing Compact. And you can see here what we had, license in good standing, the recommendation is active and unencumbered.

Discipline. There's currently no language in Model Act about discipline in another jurisdiction. We wanted to make sure that that was covered that if you are aware that a nurse practicing in your jurisdiction has discipline in another jurisdiction that that be addressed, be able to be addressed by the board.

Retain jurisdiction. There is currently no language in the Model Act and Rules regarding retain jurisdiction. The board should retain jurisdiction over an individual for investigatory purposes regardless of the status of their license and of course, public safety concerns. So you can see our recommendation there. Employment of unauthorized individual.

The current language talks about the failure to verify that the nurse's authority to practice in that jurisdiction is valid and we have removed the verification to the actual employment of the nurse. So it shifts violation activity from a lack of verification to actually employing the nurse. Automatic suspension.

The current language reads, unless the Board of Nursing orders otherwise a license to practice nursing is automatically suspended if. We are recommending that this language be deleted. Automatic suspensions could have an issue about due process concerning licenses, summary suspensions, and other emergency actions are still maintained in the Model Act.

But this particular sentence, it has been recommended for deletion. Student loans and child support. We have recommended that this entire section be removed although in your jurisdiction, the board may have authority to go ahead and discipline a license for the lack of payment of child support or student loans.

However, in terms of Model Act and Rules for public safety there really is no nexus to nursing and no nexus to public safety. Alternative to Discipline Programs. The current rules have many, many extensive requirements for ATD programs. However, now the ATD programs have been studied a little more broadly, much of what is in rules is located in the actual ATD program policies and contracts.

So we removed the actual requirements for an ATD program, but committee recommends that we go ahead and leave in the authority for a board to have an Alternative to Discipline Program. Disciplinary hearings. This language is just updated currently.

There isn't any in the current Model Act, but we want to get updated to understand, to accompany the fact that we are now doing things electronically, we're doing things virtually, and to include in Model Act the ability to continue to do so in the future even in the post-COVID world. Licensure.

The current language states that an applicant for licensure by examination who successfully meets the requirements of this section shall be entitled of licensure as an RN or an LPN, or VN. And the language we felt did not allow for much Board of Nursing flexibility. So we recommend that the language be changed that the requirements of this section as determined by the Board of Nursing by rule.

So it gives the Boards of Nursing the authority to write the rule to determine what the standards for licensure really are. Temporary licensure/ permit. There is currently a provision in Model Act and Rule about a temporary permit. We are recommending that that language be removed. There are employers who continue to allow individuals to work even after their temporary permit expires or even after their permanent license has been issued.

And of course, analysis before there is any kind of criminal background check. So we are recommending this be removed. Administration of the exam. There were specific language about time, location, etc., and we are recommending that be removed because the Board of Nursing do not administer the examination and therefore, that language is antiquated and does not need to be there.

Application and licensee background. Criminal conviction matrix, currently there is no language about a criminal conviction decision making matrix. Occupational licensing reform trends and as such have removed a lot of barriers to licensing particularly when it comes to previous criminal convictions and criminal activity. So we have recommended that the language be changed to list the factors that boards could consider and it provides the boards with a mechanism for making an assessment, and then based upon your jurisdictional laws using that assessment to make your decision.

Criminal conviction, sexual offense. Current, there is language in the Model Act about sexual offenders and I'm sorry, it's currently in rule. This is one of the things that we took from rule and felt that it needed to go to act because bars to licensure need to be legislatively authorized.

Boards do not have the jurisdictional authority to bar anyone from licensing. Initial inclusion in the model rules and we wanted to make sure that the language was clear in statute. So it was moved to act and it was also expanded to include individuals who were unable to give consent. COVID-19.

Vaccination administration. This has been widely used already. Currently there is no language in the Model Act to discuss any type of emergency rollout if there's a declared emergency and this grants the boards the ability to waive specific requirements in order to meet the needs of the emergency declaration.

Licensure exemptions and renewal delays. This language, there is currently no language in the Model Act about that. However, these particular paragraphs are for both retired licensees and those licensees that are inactive, how they can go ahead and reactivate their license based upon jurisdictional rules and requirements.

But in the Model Act it does give the authority for boards to go ahead and issue those temporary or reactivate the retired and inactive licenses. Academic programs. Again this is from COVID and this is something that a lot of boards have already enacted. There was no current language in the Model Act now.

It talks about the boards being able to waive certain criteria of their educational programs in order to meet the needs of the emergency declaration. Other, telehealth. Of course, telehealth, currently there isn't anything in Model Act and Rules. And I could probably say that in a lot of your acts and rules now, there's not a lot about telehealth. And what the committee recommends is an emphasis on the fact that we regulate the practice of nursing which occurs where the patient is located at the time telemedicine technologies are used.

You can call a telehealth, telemedicine, whatever, but it's not relevant where the practitioner is. It's relevant to jurisdictional authority where the patient is located and it is consistent with language in the nurse licensing compact, and it is consistent with public safety.

Unlicensed assistive personnel. We recommend that that be removed because nursing assistive personnel has grown far beyond just the CNA and the medication assistant. Duty to report in a timely manner. Frequently, individuals would report only at the time of renewal of their license which could be years in the future and we have recommended that language be put into Model Act that says that they have to report any conviction, finding of guilt, or entrance into an agreed disposition of a felony offense when it occurs, not just at renewal time.

Board ordered examinations and this language, there is no language currently, but we are recommending this language to extend protections for those performing the ordered examinations. And there's some liability language in here to protect those individuals who do examinations for the board. The title of doctor and currently, the Model Act says, "An APRN with an earned doctorate may use the term doctor or abbreviation 'Dr.'" And we recommend that this be deleted because it does not address those individuals that have a PhD or other doctoral degrees, and they are RNs and LPNs.

And it's really not appropriate for regulatory model legislation. I want to thank you for paying attention to my slides and I hope that our slides and our recommendation will result in some really great discussions about these Model Act and Rules.

Remember, this is a template for best practice, evidence-based regulation that you can invoke if you ever need to lobby for legislation or rule change. So thank you.

- [Rebecca] Thank you, Ruby, for your presentation.

- Hi, everyone.

- Ruby and Nicole Livanos are joining us for a live Q&A.

Hi, Ruby. Hi, Nicole. Please type your questions into the Q&A box and Nicole will be reading those questions off.

- [Nicole] Great. Hi, everybody. It looks like we have a few questions which is great. So the first question comes from Evidia McKenna [SP]. What is the basis of the wording? And this is pulled from the definition of practical vocational nursing.

Other healthcare provider which acts do not require the substantial specialized skill, judgement, and knowledge required in professional nursing. So this just so everybody knows is on page 46 of the business book in the definition section.

- Okay. Ruby, would you like to address that first or would you like us to address that?

- Why don't you guys start addressing it and then I can add some clinical context to it?

- Okay. I believe that aspect was included... The committee decided to include that aspect as a means for the LPN to delegate to unlicensed assisted personnel. As far as if there's any special kind of critical questions about that, you can feel free to follow up with that.

Nicole, do you have anything to add?

- I think in this, they were referring to delegation to the LPN from the professions that are listed there, registered professional nurse, APRN, physician, licensed dentist, or... And we included other healthcare providers there to include anyone and for this document to be forward-thinking, and what other professions may come about that could delegate to the LPN.

- Yes. So you know, the LPN role has changed quite a bit in recent years. There are areas where the LPN is the continuous care provider or the RN developing the plan of care, but not exactly doing the actual interventions.

So depending on what your jurisdictional definition is of delegation versus assignment, I know in Oregon it's a very different mantra, but the whole thing is is that we want to have the LPN be integrated into the patient healthcare team a little bit more than they have been in the past and recognize their contribution.

And that they are a key player to ensuring public safety. And so should have the same type of relationship with other healthcare professionals as the RN has.

- Great. Thank you, Ruby. We can move on to our next question. I believe this is located on pages 4 and 5 of the business book. The question come from Carol Moody. Under scope of practice for both LPN or for LPN and VN, in Article 3 Section 1, C1, it reads collecting data and conducting nursing assessment.

I understand focus was removed, but how are you differentiating LPN assessment from an RN assessment as I do not think assessment is taught in LPN programs? This has been a stumbling block for nursing practice over the years.

- Yes, it has. So when we started looking at this, we really started seeing that what the LPN does and what the RN does is based on individual jurisdictions and individual...and their education. The RN has a broader in-depth education, the LPN has more of a basic education in the same topics, yet many of the same things are touched on.

So what we wanted to do was we wanted to get away from the term focused and comprehensive because they're not used in all jurisdictions, and really rely on the educational preparation of each, and within the jurisdiction of the rules of the jurisdiction about the differences between RN and LPN practice.

So for example, I'll use the State of Oregon. LPNs can do just about any task that an RN can do because their tasks. The Oregon rules say that the RN has to do the comprehensive assessment which is the gathering of all data and developing a plan of care with that data.

The LPN can do an assessment based on how they view that patient at that shift at that time and combine that with the RN assessment to develop the plan for that particular day. So there are other states that say that LPNs can't start IVs, that LPNs can't or can't access central lines or those types of things, and each state should decide within itself what it means for an LPN assessment and define what is an RN assessment.

And it really shouldn't be articulated in rule or a Model Act that the LPN and the RN have a specific type of assessment, i.e., focused for comprehensive. So it really we just removed the wording from the Model Act and Rule in order to give the jurisdictions the ability to establish in their own areas what LPNs and RNs are capable of doing.

- Thanks, Ruby, for that explanation. We'll move on to the next question from Sheila Bonnie. There's two questions. The first is on page 80 of the clean copy in your business book. We're looking at the board powers, I believe.

Would there be consideration of adding "a privilege to practice" to discipline for Boards of Nursing disciplining a licensee from another state who holds a multistate license? So if I am correct, we're looking at Section 5L which is under board powers and duties. It says that the board powers and duties are to discipline a licensee or certification issued under this act for violation of any provision of this act.

- Was it privilege to practice? Was that in the question?

- Yes. It would so be adding disciplining a license activity.

- The privilege to practice. Right, right. Okay. So the thing is is that that really belongs in the NLC, you know, that language should be in those rules rather than in a Model Act that is a model for all jurisdictions regardless of whether they're in the compact or not.

So what we try to do is while we mimicked some of the NLC language, it's still allowed a general adaptation adaptation of a Model Act and Rule for all jurisdictions regardless of whether they're in the compact model or not because privilege to practice is language only that is only found in the compact. Most other jurisdictions have the ability to directly discipline a license versus a privilege to practice.

So we felt that that really does belong in NLC.

- All right. Thank you, Ruby. And another question, the second part of the question there. We're looking at page 87. Sorry, pardon. Article 6, Section 20, page 87 of the Model Act and Chapter 6.4, okay, of the Model Rule.

A clarifier for simulation. Would we consider adding a clarifier for simulation such as, med/high definition might be helpful to avoid excessive use of low definition simulation as part of the 50% recommendations of clinical hours?

- I believe that the simulation language is based upon the research that was being done. You know, the issue that we have found with COVID and that the committee talked about was the fact that when you have a situation such as COVID when the clinical placements are cut off for a lot of programs, not every school has the ability to do high fidelity simulation and we wanted to make sure that it is up to the educators to determine whether or not the modalities that they use to educate their students will allow those students to meet the goals and objectives of their clinical program.

To say that it only use high fidelity particularly in a time of national disaster like we have now or national emergency like we have now, you really are handcuffing a lot of programs by saying that, "Oh, well, you guys can't use simulation because it's not high fidelity and you should only use certain percentage when those students just can't get into any kind of clinical placements."

So I think that staying away from some of that very specific language, I would expect educators would use the best education literature that's out there versus something being really reciped in statute that might not apply to all cases.

- Great. Thank you, Ruby. I believe we are heading to Sallie Beth Todd's question and from my review of it, we may have hit our first typo. I consider that a success for her before we get into Q&A without reaching one. But we're looking at business book page 45.

And the definition of focus nursing assessment which of course, focus was crossed out. So it is now the definition of nursing assessment. We said that or the existing language for every definition reads, "Nursing assessment means," and we had, "Nursing assessment may mean." And so I believe we want to cross out the may and make a definition that would be consistent through the act.

So we will make that change. Thank you so much, Sallie, for cutting that.

- Thank you.

- So we'll move on to the next question and that comes from Diane Martins in Rhode Island. Would you please discuss the transition from nursing diagnosis with recent diagnosis? Where did the recommendation originate?

- Yes. Again, lots and lots of conversation. And the nursing diagnosis has been with us and really it did define the profession of nursing as really dealing with the human responses to specific illness or injury, and what those human responses could be, and lift the diagnosis of the disease itself and the injury itself to our advanced practice and medical colleagues.

This recommendation actually came from various sources of literature in that nursing diagnoses is really not recognized by anyone, but nursing. And that for nursing to really be a true partner and really come

out of the previous model of, you know, providers' diagnosis and nurses respond to it symptoms only, all the literature does point to the fact that interdisciplinary teams are the best resource for our patients.

And they should be working off of one diagnosis. And that does not mean that the nurse is going to change what the science and art of nursing is and that is dealing with the human response. But it talks about the fact that nursing should be at that table to say, "This is part of this patient's diagnosis, this is what I know, this is what my assessment says."

And either support or possibly add to the original diagnosed or the diagnosis of the advanced practice nurse or our medical colleagues. Is it a reimbursable diagnosis? The jury is still out on that, but we wanted to stop thinking that we are only doing nursing diagnosis, that we have always had and always will have the ability to define the patient's risks and the patient's responses to whatever is going on with them in their illness or their injury journey, but we also wanted nursing to be part of that bigger medical picture or that bigger patient picture of really dealing with the actual issue that the patient is having.

So that's why I believe that one of the conversations we had in the committee was this is going to require a little bit more research before we can truly define it, but it was recommended in the literature as being part of the current rules in the integrative team model for patient care rather than nursing does this thing and medicine does that thing, and, you know, social work does that thing, that we are all in the table together and that would be the best way to do that.

How to implement that? That's future research.

- Thank you, Ruby. And I just, if I...

- And I would just... Oh.

- Go ahead, Rebecca.

- If I just... To quickly add, also that change was to keep the diagnosis centered on that patient instead of the profession as Ruby did say and that came out of a report entitled, "Improving Diagnosis in Healthcare," that was by the committee and diagnosis, excuse me, diagnostic error in healthcare. It was an IOM 2015 report.

So when Ruby was referencing literature, that was what she was referencing.

- Yeah. I don't have a lawyer's brain. So I can't remember all that literature source.

- I have notes.

- I just know we read it and we could talk about it, you know.

- All right, wonderful. So our next question comes from Carolyn McCormick. I have a question in regard to LPN pre-licensure nursing education standards. The requirement is for nursing administrators of LPN programs who have graduate degrees and RN programs have doctoral degrees.

We know there's a nursing faculty shortage. This would increase that problem. It seems this could read, it should be preferred. Same could be said for qualifications of all nursing faculty to have graduate degrees. The simulation center be accredited and 35% of total faculty are employed full-time. So everybody knows that these standards, the education standards on page 154.

- Again, a Model Act and Rule is about best practice. It is non-binding. There are certain jurisdictions that can meet those standards and there are some that cannot. So I think the key here is to remember that the Model Act and Rules is based upon the evidence that shows this would be the best practice, not the practice that you implement in your jurisdiction.

But let's just say that you really did want the nursing program director to have a doctoral degree, this will allow you to argue that fact. The argument for not having that particular degree would be jurisdiction specific based upon what's going on in your programs and also, you know, your state rules and what you are developing as a regulator that best fits the picture of your current situation because again, these Model Act and Rules are what the literature recommends.

And 35% of your faculty, etc., having your simulation person be certified, all of that is found in literature. And again, my memory is not what it used to be. So I can't remember the exact articles that we've read, but I'm sure that if you wanted to ask Nicole or Rebecca, they can probably send you the reference later on after this meeting.

But we did again, everything that we proposed here, we really looked at it and really said, "Okay. What would be the best practice thing that we're going to do?" Again, it's a hard time. Yes, faculty is short. If you set your bar this high, you may end up with no faculty at all. So again, it's about what's going on in your jurisdiction and what can your jurisdiction support without compromising the fact that what is in the best interest of the education of future nurses.

- Thank you, Ruby. And I will add to that that the committee was fortunate to be able to look at the outcomes and metrics study guidelines that came out as we were actually meeting as a committee. So kudos to Nancy Spector and her team for putting that together.

That was really informative for this specific section. So thank you. All right. We'll move on to the next question from Shannon Dobbin. Research also shows that the real learning and simulation occurs during debriefing. It's not about the mannequins.

You can achieve the same outcomes through online virtual simulation with effective debriefing. So I believe that may have been a comment.

- Yeah. And that is correct. The real what we're learning and simulation and the critical thinking, stimulation of critical thinking really happens in the debriefing and sometimes prebriefing, but mostly in the debriefing to really pull out what those students have learned during that particular scenario. And it really is not a lot about, you know, high fidelity.

And again, we have evidence during this COVID that some of the individual programs who have had really good debriefers have had the same kind of outcomes as a very high end simulation or a very high fidelity simulation. What's really important is that the faculty and the people who run the sim lab understand where the learning really occurs and that's in the debrief.

- Great. Thank you, Ruby. We will move on to our next question. It comes from Valerie Fuller. Why remove the doctor language? It should be a protected title for nurses with doctorates and the model language has been helpful when the AMA put forth proof an advertising argument.

- The reason that it is removed from the Model Act is because it really referenced APRNs previously and it, you know, I know lots of RNs with PhDs, it doesn't really talk about the fact that a PhD is also a doctorate, and it really doesn't belong in a regulatory rule.

I believe that that is more of a cultural thing with physicians. I mean, nobody is licensed as a doctor. They're licensed as a physician and it really should be armed within each regulatory board to really communicate the difference between what someone's academic title is, what their earned degree is versus what their licensure is because you're not licensed as a doctor.

You're licensed as a nurse practitioner or a certified nurse midwife, or a physician, but you are not licensed as a doctor. So when it comes to regulation and the fact that licensing is what really regulatory body should be dealing with, they shouldn't be dealing with academic titling, just license titling.

So it really was felt and we did discuss the fact that, you know, having it in this act allows us to have some, you know, legitimacy about our academic titles, but again an academic title doesn't have any place in regulation.

And that's what it is. It's not a licensure title. It's academic. Just because, you know, culturally we refer to physicians as doctors, that's not what we're talking about here. We're talking about the academic preparation and really that's what the whole language used to be in the Model Act.

It was about degree you earned not license that you have.

- Great. Thank you, Ruby. So we are now onto our last question and that is from Amber Marts. When referencing nursing diagnosis and changing the language to patient diagnosis, is the recommendation from the medical community and NCSBN that nurses now collaboratively develop medical diagnosis with the physician and midlevel provider?

Is there a recommendation about how that be facilitated?

- I believe that how that be facilitated is outside of the jurisdiction Model Act and Rules. Yes, of course, the whole idea of this was to foster collaboration and making sure when you look at the article... Thank you, Rebecca, for reminding me what that article was.

The fog is lifting out of my head. When the article really was reviewed, it was about the fact that we are all working off of a different song sheet for a specific patient and it's the patient's diagnosis that should drive our interventions, interventions by our medical colleagues and advanced practice nurses that it really does talk about sitting down at the table and looking at that patient, and from a perspective of nursing and the science of nursing, and the education of nursing, how is nursing going to intervene with that.

Again saying, you know, nurses has their own diagnoses really still separates us from our other colleagues and that time needs to change. How that is implemented in your jurisdiction, really it's about how your facilities really do that and about what kind of education between you and the facilities you can give to the medical community and the nursing community about the concept that it is really the patient that should actually be the center focus not your diagnosis and my diagnosis, and my deal with symptomatology.

I mean, I can remember a time when we couldn't dare say the patient had, you know, diverticulitis. We just had to say that they have abdominal discomfort because diverticulitis was a diagnosis and that those times need to end because pretty clearly, our healthcare system is incredibly fragmented and nursing could be at a very strong leadership position to start changing that and being the ones to drive the change towards integrated care rather than siloed care.

- Great. Thank you, Ruby. And with that, we conclude the live Q&A for the Model Act and Rules. Rebecca and I want to extend a thank you to Ruby as well as Amy Fitzhugh for leading us and charing the committee over these last couple of years, as well as everybody who participated in the committee's work.

Thank you so much.

- Well. I want to thank you and...

- It's been a long time.

- Yeah. It's been a long time and we could not have done it without the support of the incredible staff that NCSBN gave the committee to work with. So thank you to everyone that worked on this committee.