Past Event: 2022 NCSBN Annual Meeting - Education Session: Workforce Issues Video Transcript

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Presenters
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Joan Stanley, PhD, CRNP, FAAN, Chief Academic Officer, AACN
Loressa Cole, DNP, MBA, RN, NEA-BC, FAAN, ANA Enterprise Chief Executive Officer
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David Benton, RGN, PhD, FFNF, FRCN, FAAN, CEO, NCSBN

- [Maryann] I'd like to introduce to you my illustrious panel of speakers today. First of all, virtually is Robyn Begley. She is the Chief Officer of AONL. To my left is Joan Stanley, the Chief Academic Officer of AACN.

Also virtual is Loressa Cole. She is the ANA Enterprise Chief Executive Officer. And finally, two people down from me is Linda Christensen, the Chief Legal Officer from the National League of Nursing.

And I cannot forget the person to my right, David Benton, the CEO for NCSBN. I'm Maryann Alexander, and I will be moderating this session. Well, thank you all for joining me today. I'd like to begin with a pretty perfunctory question, and I'm going to first direct it to Robyn and Loressa, but then, of course, the rest of the panelists can join in.

Let me ask you, Robyn, Loressa, is there currently a nursing shortage, or is the shortage regional or institutional? Robyn, would you like to begin?

- [Robyn] I'd love to start off. Thank you, Maryann, and it's great to be here with you all today. I wish I could be in person, but virtual provides us the opportunity to be in two places at once. I would answer your three-part question with a three-part answer. Yes, yes, and yes. There is definitely a nursing

shortage in the U.S. This is one of the primary issues that we are seeing in our workforce across the country.

However, we are observing that there's variation as we look at regions across the country and, of course, by organization or by healthcare institution. This is not just a hospital and health system issue. This really permeates all areas where nurses practice. I know my colleague, Loressa, probably, and ANA has some wonderful statistics.

You know, in preparing for today, you know, there is just such a wealth of information, and the statistics that we find are confusing. However, you know, in trying to find the most current information, 2022, I think it's important that we look at, you know, different aspects of the data.

Researchers of the McKinsey Institute estimate that the U.S. will have a 10% to 20% nursing gap by 2025 as the number of patients needing care exceeds the number of nurses. I can tell you that at AONL and AHA, we are working with a company called Prolucent who is actually on a daily basis scrubbing the hospitals and health systems postings.

And the number of healthcare organization vacancies for registered nurses is very significant in many organizations in the double digits. Loressa, I'm going to kick it to you to see if...

I know ANA also does a wonderful job at collecting stats.

- [Loressa] Thank you, Robyn. Certainly, I agree with Robyn, ANA agrees with Robyn. This staffing shortage has been referred to in communications that ANA has sent out, including to HHS, the surgeon general, and many others as a crisis. And we'd like to, I think, sometimes say, "Well, it's a crisis for hospitals."

Otherwise, people are doing okay. And I really disagree with that. And ANA does have some statistics that speak to the general population and numbers of nurses that suggest that we're losing ground. And we've encountered, historically, of course, we all know this, nursing shortages over the decades for a variety of reasons.

But I certainly think that with the statistics speaking for themselves, we're headed for a shortage, unlike perhaps something that we've never seen. There's a variety of reasons for that. Hospitals do account for a large portion of the shortage as they approach about a 20% vacancy nationwide. But when you take a look at just what's happened through the pandemic, in 2021, nursing supply dropped by about 100,000 nurses in this country.

And we certainly are not in a time with the aging of Americas, our baby boomer nurses dropping out of the workforce, we're not at a time where we can lose any ground such as that. And certainly, I know one of the questions coming will speak to the effect of the pandemic. But we have to consider that a large number of nurses under the age of 50 dropped out of the workforce last year.

And that number is actually larger than the number of retirees. So, I think we all have cause for significant concern. And I will just echo what Robyn said. There's a variety of reasons as there has been for all of the shortages that we've encountered over the decade, but the pandemic certainly has been a factor that has escalated this problem. It's significant.

- Anyone else have anything to...?

- [Joan] I would just add that...Loressa mentioned this, some of the reasons for the shortage, but also, I would add that this is something that is going to continue to grow as we look at the increased need for nursing care, which if you look at what's occurring in our healthcare system, the increasing focus on prevention and population health and the increased chronic disease and management, in addition to the aging of the population, but if you look at those two areas, those are areas which nursing needs to be able to focus on and will increase the numbers of nurses needed and worsen the shortage if we don't come together and do something about it.

- David, do you want to weigh in and also give us a global perspective?

- [David] Yeah, thank you very much. So, I actually think this is a bit like the blind group of people trying to figure out what an elephant is. They all get a little different perspective on this and, you know, some people think it's a wall, some people think it's a pipe when they're touching the trunk, etc.

And I think part of the problem is that we don't have the right data connected together. Now I know that some of the work that NCSBN has been doing in terms of the NCSBN ID number gives us the potential to do that.

And if it's embedded within the patient record, then we start to get real numbers in terms of who's actually providing service at a point in time. But I don't want to just focus on the numbers issue because certainly, at a global stage, they're starting to recognize is that you've got to look at the numbers. You've got to look at the quality and scope of the practice of the practitioner.

You've also got to look at the distribution, are they in the right place? And how often are they moving around? So, if you think about where countries like Brazil has been able to move from only 20 years ago, they really only had healthcare in their large urban centers.

And by going through a process of thinking about progression so that you could start as a support worker and you could move through the system, they have now been able to cover the entire nation with a model of care that has that focus on primary care.

So, I think part of what we need to do is really rethink how we pull all this data together to get a much better understanding. A recent report from the U.K. government identified some of the variations. And if I was to be in the treasury at the moment here in the U.S., I would be asking questions about, well, how come our health outcomes are in terms of the international space so poor compared to the amount of money that we spend?

So, have we got people doing the right thing in the right place? And are we educating them in a way that actually is fit for tomorrow, not for yesterday? Demographics are shifting. That point was made by Joan around aging population. The number of people coming into the programs over time is going to decrease because of the falling birth rate.

And these are global trends. These are not just about the U.S. or Canada. And working patterns are changing. The way that... When I went into nursing, I envisioned that I would be in nursing for the rest of my career. That's not the way that people think these days, and therefore, that mobility factor also needs to come in.

So, I think it's a big challenge, but I think there are solutions out there. We have actually got to put our pride aside and say, "What can we learn from everyone else?" And that might be learning from North

Dakota, or it might be from Saskatchewan, or it may be from Thailand. It doesn't matter. Let's look at it all and figure out what is going to provide the service for the future.

- Okay, David, I want to pick up on one of the things you said about applications to nursing programs. And that's a big question I'm asked quite frequently. Joan and Linda, do you want to weigh in on that? What does application numbers look like?

- Well, let me just clarify that, you know, when I was in...and Maryann said that I was with AACN, and I want to clarify that I'm with the American Association of Colleges of Nursing and are members of the baccalaureate and graduate schools of nursing. Sometimes we get confused with the other AACN, which is the critical care nurses on the West Coast. So, I just wanted to clarify that.

We've been called the AACN of the East versus the West. So, we do an annual institutional and data system survey which collects data on the enrollments and graduations of all baccalaureate and higher degree programs. So, what I want to share with you is some of the data, and these are primarily enrollments.

Now, we have been told that the applicant pools have decreased somewhat, but what we're looking at is the enrollments. And the good news is that enrollments in entry-level traditional baccalaureate programs continued to go up this past year.

It went up 3.3%, and the increase also enrollments in Doctor of Nursing Practice programs increased by 4%. And then the not-so-good news is that the enrollments in master's programs did go down approximately 4% this year, and we continue to attribute that probably to the increased enrollment in the DNP programs.

But also then applications or enrollments in Ph.D. programs continue to decrease this year but only by slightly less than 1%. But that trend has been going on for about the past 13 years, so then enrollments have dropped, and I can check the number, but I believe it is about 13% over the last 13 years.

Also, the one group of programs that experienced the highest decrease in enrollments this past year, and this is a trend that's been going on for the past five years, and that is RN to BSN or RN to MSN programs that are designed for already licensed nurses.

So, I think when we look at the solutions and what's happening, we don't want to go backwards in our enrollments and the numbers, but that population is a little disconcerting in those programs. And we hear anecdotally from our practice partners that this is probably due to burnout and for individuals not wanting to take on another expectation or requirement.

However, this trend did start prior to the pandemic.

- Linda.

- [Linda] Yes. I represent National League for Nursing, where we have programs from LPN, LVN, all the way through graduate. And our surveys are showing absolutely similar trends, similar data. We do know that it depends upon types of programs as you know, whether the enrollments are up and down. Some of the key pieces of data that we have pulled out, a lot of whether or not the nursing programs are getting filled has to do with the number of faculty.

Faculty are leaving and faculty are resigning as other nurses are resigning, and that is putting up a barrier in terms of the numbers of students that can come into nursing programs. The traditional issues have been with the number of clinical sites that are available, and things are easing up with COVID.

That did put an extra burden on clinical site availability for a while. That has eased up according to the reports and the information that we are receiving. There, of course, is still issues with numbers of faculty and prepared faculty in the educational arena to really educate the students that want to come in.

- Right, thank you. I think you've given us a very good look at the current environment, but now I want to project ahead a little bit. So, NCSBN data, the last time we collected it in 2020, although we have a new study going on right now of the workforce, but in 2020, it showed us, if we look at those data, that there were an equal number of nurses retiring as there were entering the workforce.

If we look at NCLEX data plus the retirement data from our study, will that be enough to sustain us for the future? Can you look ahead and tell me what does the future outlook look like? Anyone?

- So, Maryann, it's Robyn. You know, that number is from 2020, correct?

- Correct.

- And I'm just worried that the last two years are not going to reflect what we saw in 2020. We know from, you know, the hospital and health system side that the number of retirements has absolutely escalated. Anecdotally, you know, in the very beginning of the pandemic, we did see and we heard from some, you know, planning to retire baby boomer nurses that they would hang in there for a little while.

And they got through perhaps the first wave or the second wave of COVID. But particularly in '22, starting the end of 2021 but also into this current year, our hospitals and health systems have reported very dramatic rises in rate of nurses retiring but also of other clinical disciplines.

I mean, it was almost as if the team members hung in there, you know, for the beginning but now that it is very evident that the pandemic was not going to be a short-term one-and-done situation that people continued with their plans and are retiring.

The American Hospital Association is actually in their current survey that is going out for this year tracking that information, and so it will be very interesting to see what was anticipated versus what was actually realized and if people left prior to the traditional retirement age of 65, you know? Were we seeing early retirements at 62 or even earlier than that?

Remains to be seen, but that is what anecdotally we are hearing from the field.

- Loressa, do you have anything to add to that?

- Yes. I think I'll tag on to what we know, what we have anticipated for several years now, and that's the retirement of baby boomers. If you look at our friend, Peter Buerhaus' numbers, he will tell you that projected is about 650 RNs will exit the workforce between 2020 and 2030.

And that's, as he says, about 2 million years of RN experience exiting the workforce. Those are scary numbers. But I do think, as Robyn said, that's probably a low estimate because we are encountering nurses. We all can name someone I'm sure who had a later planned retirement date and is really reevaluating.

I think the other thing that we're not really anticipating are all the new jobs. When it comes to the availability of nurses, you know, there's just jobs that we never anticipated our nurses would have.

I don't know how many of you saw the article a week or so ago that ER nurses are leaving for Botox, to inject Botox, and these medi spas are cropping up all over the place with jobs available for registered nurses. I mentioned this to a young audience I was speaking to this past week and asked how many of them knew a nurse that had gone to a medi spa.

And I was astounded that more than a dozen hands in the audience went up. And we just heard from Amazon about a pipeline of nurses that they need for their healthcare coverage. So, we really don't have a handle on demand, I guess is my point, and where nurses might go in the future. But when we consider, as I said before, that last year, this past year, the number of nurses under 50 leaving the profession outpaced the number of retirees, then I think we have to consider that.

We really don't have our heads around these numbers yet. The projections are going to change, and they are likely to be much more dire than what we've anticipated.

- David.

- Yeah. Again, I think just numbers in and numbers out actually hides a lot in between. So, I think there's a number of things that we need to think about in terms of getting this right. Are those entering the workforce now going to make a 40-year commitment to the profession, or are they going to maybe do that for a few years, then do something different?

And what does that mean for our workforce model, and importantly, for us as regulators? How do we facilitate them coming back into the profession at a later stage having been absent from the profession for some time in terms of their continuing competence and fitness to practice? So, I think some of these shifts are important.

One of the things that we saw during COVID was because of providers having difficulty recruiting into, for example, emergency room areas, the use of emergency medical techs and practitioners as a substitute for nurses.

And as we have moved down the route...and Joan and colleagues at AACN have very much been at the vanguard of pushing forward the concept of competency-based education. The thing about competency education is that you can then actually move across different disciplines as part of that process.

So, do we know whether we've got a shortage or not? The answer is we probably have, but we can't actually pin it down. And until we get things like eNotify, which enables employers to sign up their practitioners into our database so we can start to track this at a much more granular level, we really don't have a workforce planning model that is fit for purpose.

I know from looking at the data, that those people that are going through the relicensure system, we're not seeing a drop-off at all in that. But the question is, are they actually...? Although they've got an active license, are they using that license to practice? And therefore, is there a hidden shortage that we don't know about?

These are some of the things we need to deal with. And, of course, the other big issue is scope of practice. Some of you know that recently, I was in hospital and, you know, I was really quite surprised

at how limited compared to some other countries the RN scope of practice was. And again, some of the questions that we need to ask is about, are we using nurses for the right thing and to their maximum ability?

Because it may not be about numbers. It may be actually about getting people to do the right thing. And, you know, that's where technology might come in as well to take some of the burden off.

- Okay. So, David, you've brought us right... Joan, do you want to add to it?

- Well, I can either add to it or I can wait until your next question and get to it. But David did address a number of things that I wanted to expound upon or say because, no, having more nurses leave the profession than are entering is not sustainable, but I do think there are things that David you alluded to that we do need to take notice of and do something about.

And the first thing is that we, as a profession, need to come up with a unified vision for what nursing is in the profession and what professional nursing role is. And that includes academia, practice, and regulation needs to come together. And I think you alluded to that yesterday when you made some comments, but it was already something that was heavily on my list of to-dos that we really need to do.

And not only do we need to come together with a vision, but then we need to say what is and define the professional role of a nurse. What is a professional nurse? And what do they need to know and do at the top to...? And you talked about scope of practice. We need to elevate that role, elevate that benchmark, and then define what it is we expect them to do to be able to address the healthcare needs not only of our country, but globally, and also then to fill in the gaps and address the healthcare needs and improve outcomes.

We can't forget the safety and the outcomes. So, David, you mentioned one thing about the transition to competency-based education and the ability for that to measure and look at progression over time. One thing that AACN has done, and you may or may not be familiar with it, but we revised and approved a new essentials document, our membership did, and that document really is transformative, not just change, but transformative as far as nursing education goes.

And we are moving to a competency-based education and assessment model for nursing education, and that does allow, hopefully, the goal is that we defined behaviors that everybody has agreed to. And it was developed by both practice and academia.

We didn't just sit down and write it, although it might have been faster, you know? It was a three or four-year process to get agreement with practice and academia on what are the behaviors that are needed to be demonstrated for an entry-level professional nurse, and what needs to be demonstrated at higher degrees, at a graduate level?

So, that is in place, and that is, we hope, will transform as we heard yesterday the definition of transformation, and will allow progression and measurement across time. But I do want to say that we are not at this point where we are saying that it should be time-variable education. We still believe that programs should have a certain limit, certain requirements, certain expectations until we get to the point where we all are in agreement that when we assess somebody, then we know what we're looking at.

So, we've got a lot of way to go, but we are saying that. So, that is the unified vision and one thing that I believe we certainly need to do, and that is to come together with a definition. Because if we can define

what professional nursing practice is, then we can figure out what the competencies are and what they need to be able to do, and how to demonstrate them.

- I want to continue on this for just a moment and talk more about strategies. So, Linda.

- Absolutely. When we think of where the nursing shortages are right now, and I think Loressa alluded to the past, the changing roles and the expanded roles, the expanded settings that nurses can be on, it makes me wonder and question, where are we going to be in 5 years or in 10 years? Where will additional expanded roles be?

We have nurse architects, we have nurse attorneys, we have nurses working in all sorts of areas. So, the numbers, David mentioned, what kind of numbers versus the hidden numbers? We may have a certain number of licensed nurses, but how many of those nurses are practicing in areas of need?

And what is it going to take to really have nurses practicing and attracted and maintained in those areas of need? And what are the competencies surely of the nurses that need to be in those areas? These are all parts of looking at futuristic, where are we going to go? What's going to be needed? Are we planning for it?

And how are we going to get to it?

- Robyn or Loressa, any thoughts in terms of strategy from the practice point of view?

- Well, I'll start. On behalf of ANA Enterprise, I can't leave the session and not talk about what ANA has learned through the pandemic about the work environments of nurses. Certainly, one strategy has to be a clear and profound focus on the obstacles that nurses are encountering in the work setting.

We know that violence is an issue. We absolutely know that nurses have a fatigue factor right now that is unprecedented. And through a series of surveys conducted by the American Nurses Foundation called "Pulse of the Nation Survey" done throughout the pandemic, we absolutely know that mental stress is a significant factor that is, of course, affecting nurses staying in the workforce and affecting nurses' ability to provide competent care if you will.

So, certainly, we have to be focused. There are national initiatives from the surgeon general to the National Academy of Medicine coming forward with a plan to address not just nursing distress and mental fatigue and illness but all caregivers right now.

We have to pay close attention.

- Yeah, I would totally agree with Loressa. And in addition, I think some of you may be aware that AONL has conducted a longitudinal study and, in fact, next week, we are going to do our 4.0. But our nurse leaders, in particular, our frontline nurse managers report that they are not emotionally healthy.

So, you know, this impacts our nursing leadership ranks as well at all levels, very distressing. We've spoken before. I mean, the work environment needs to... We have a lot of work to do there, needs to improve. And you may ask if COVID created these issues. And I think, in many cases, we're seeing that COVID exacerbated or perhaps accelerated some of the concerns that we see from nurses right now, but it didn't necessarily cause it.

So, just certainly heightened the awareness. Underscore the violence in the healthcare setting issue. When we look across the country, again, this is one of those challenges where we don't have great data. First of all, there's no consistent definition for incidents of workplace violence in healthcare.

So, we find as we query, you know, our healthcare organizations, that there's a very diverse array of definitions if you will. And we know that it's very underreported and, in fact, many of our nurses and other caregivers, unfortunately, have expressed that this is part of the job, that they've been exposed to physical as well as verbal violence/abuse, and it's part of it, you know.

This is just something that they've come to expect. Totally not acceptable. So, a lot of work needs to be happening in that area. We know when there's, unfortunately, you know, a mass shooting or a very violent, you know, incident that results in loss of life, but there's really a whole spectrum. So, we are working on that spectrum, but also to define what that is and what are some strategies that can help mitigate?

I think we can't expect our healthcare system, in general, to be different from our society, really. We are seeing an uptick in violence across our society in many areas and regions. Of course, we would then see that if you will, you know, bleed into our hospital's healthcare system, you know, outpatient settings, really wherever care is delivered.

And it's a societal issue. I was fortunate to attend the International Hospital Federation Congress last year. And this is an international issue. This is not just an issue that we are seeing and experiencing in the U.S. So, you know, the International Council of the Red Cross has this as one of their main topics of focus. And again, as David mentioned earlier, this is something that I think we need, you know, global heads around to address the problem.

And we need to start it. It is not okay that our nurses and other healthcare, you know, workers are subjected to this.

- You know, I just want to follow up on that. I know you're talking about violent acts towards nurses, but, you know, the issue of lateral violence and nurses bullying other nurses is certainly an issue that has driven some nurses out of the workforce.

Should there be a no-tolerance policy in hospitals, or how can that be handled?

- Well, I'm just going to start that off. I'm sure others have opinions. Absolutely, there should be zero tolerance. And, you know, you mentioned nurse on nurse, and unfortunately, we've heard that I think since I became a nurse many years ago that, you know, "nurses eat their young." I think it's part of a leadership issue.

There can be no tolerance for that. And, you know, I remember my CNO days and, you know, I spoke with my nurse leaders, you know, and we worked on this for a number of years and those nursing students and the new nurses are your colleagues or your future colleagues, and working together will only, you know... The hazing and, you know, the abuse or the subtle lateral violence is not acceptable, and people have to be held accountable for it.

It's part of the behavioral expectations of our nurses and of all of our, you know, caregivers. It needs to be addressed and we need to hold people accountable.

- Thank you.

- I would like to add to that point about incivility in the workplace. There's a large body of work that ANA is participating in now. We're co-leads. We're not leading with minority nursing organizations looking at the prevalence of racism in our own profession. And when we think that still 80% of registered nurses in the United States are Caucasian, then we know that our population is not representing the communities that we serve, and a solution to secure the pipeline is to have a more diverse workplace.

We're not going to have a more diverse workplace if we do not make sure that nurses of color are treated better in our organizations and work environments. So, I just want to highlight the work of the national commission to address racism in nursing. You can go to nursesworld.org and read about that.

But again, ANA is not leading. The minority nursing organizations in this country are at the table with ANA to help address this problem, and I hope that you'll engage with the work, be informed about the work, and accept the fact that racism in nursing is a critical issue.

- I would just like to add to what Loressa said, and she's brought up an extremely important point. But the somewhat good news is, and we are progressing and continue to work on it, but when I looked at the statistics, over 40% of our current baccalaureate enrollments are from underrepresented minority populations.

So, we are moving forward, when you look at strategies, one of the strategies that I was going to bring up about trying to increase the diversity and also increase the numbers of applicants. If you look at the holistic admissions process and implementing that and making sure that the individuals coming into our programs are a good fit for nursing, that they will be successful, and that the process really goes beyond just a GPA or test scores.

So, we are actively promoting that and working with schools and other organizations around the holistic admissions. But getting back to Maryann's question about what can we do about the attrition rates and the shortages? I have a couple of suggestions broken down into different categories, and I just wanted to share a couple of them with you.

I think there are some low-hanging fruit and some more short-term things that we can do and also long-term. And one of them is really we've talked about identifying and addressing the role of the nurse and defining it. The public and other health professionals need to understand what that role is and the impact that we make on care, but also then recognizing the importance of nursing, and that needs to be in the forefront so that people are interested and want to come into nursing and understand their career trajectories.

Also, we need to better prepare our nurses for addressing wellbeing, not only in themselves but to be able to lead and work with team members and to address wellbeing and resilience in their team members. I think those are fairly easy on the relativity scale of easy to difficult. One of the other things that I think we need to do is we need to...having defined the role of nursing, but we need to provide opportunities for nurses to advance their careers and their career trajectory without stepping away from the point of care.

And I use that term as opposed to at the bedside because we're really looking at nurses working across the continuum. So, we talk about at the point of care. But there should be an option, an education option,

certificates and/or an education option for individuals to advance their education, potentially a master's degree that somebody can go on and get a master's and stay at the point of care in their particular area, take on additional responsibilities around quality improvement and care coordination and overseeing interprofessional teams without becoming an APRN.

And some people say that's blasphemous. I am a nurse practitioner by education, but not everybody needs to be an advanced practice registered nurse. We need nurses who are educated at a higher level who are staying at the point of care and overseeing that care. So, that is one thing that I think we need to do both as educators and practice. And the other thing is getting back to the faculty shortage.

I think some of the things that we can do fairly immediately, and that is, you know, our record show, just as Linda has said, that we are currently at the highest vacancy rate for faculty, and it's at 8%, was the last year. And that's the highest it's been. And some of the things that come to mind are if we had more joint appointments between academia and practice, that would allow faculty to have higher salaries, it would enable them to stay current in their practice, and they would be engaged and familiar with a particular institution or health system.

And I think one of the things that we saw during COVID, some places, was faculty and teams of students actually were allowed to go in and were assigned a particular unit or a group of patients and provided care depending upon the level of the students. Now we hear that COVID's over, that's being withdrawn, and they're not allowed to go in and do that anymore in some of those health systems.

But if you had teams of faculty and students, that would help not only address the clinical shortage areas for students but also the numbers of individuals providing care to patients. It would also help with the faculty shortage and it would attract more individuals. And also sharing of resources, allowing faculty to teach across programs. Every program does not need an expert in every single area.

And with technology now, we heard about the transformation of technology. There's ways that you should hopefully be able to share courses and faculty and other resources. So, I think we need to think innovatively about how we use technology and also the role of the faculty and education models.

- I would absolutely agree. The role of the faculty has been defined, but how do we facilitate it? How do we support it? I look at the certified nurse educator data very frequently. Three, four, five years ago, if I would look at what competencies faculty really performed the best on, it was on the basic teaching, it was facilitating nursing. It was evaluating students.

And I'm talking about classroom testing and the clinical evaluation, etc. Faculty did not perform well when it was being part of a university or even the scholarship part of being a faculty member. That has changed. The last one to two years, what we have seen is the worst place, the worst competency that faculty are performing on a certification exam to be a certified nurse educator is in facilitating nursing.

And that, I find, very, very alarming. They are testing better on university program evaluation than they are evaluation in the classroom or with a student. So, providing support to the faculty, and faculty can teach across programs or across different places. Clinical educators.

There are so many excellent clinicians that with some guidance and some support can really foster and promote the clinical learning that students are doing. And the faculty in the classroom, again, the support of how do you maximize that time? If you only have a couple of hours a week with a student, how are

you going to maximize that time? And here's where we get into pedagogy and effectiveness of teaching and teaching strategies.

- Yeah. And I would just add to what Linda said. Of course, I would argue that maybe you need more than a couple hours a week for students and faculty to be able to practice, and that's why we're also talking about more extensive immersions and opportunities, but yes, what Linda said. But also the DEU, the dedicated education units, allow expert and nurses identified within the healthcare system to help oversee students, and those models work extremely well where they're implemented well.

- So, a couple of thoughts I think is important to consider as well is that we...and I fully agree with the point that Joan made around needing to better define the profession. But we do have some solutions that we know actually facilitate people getting into practice. The Nurse Licensure Compact has made a huge difference.

Some of the data that we've seen in responding to natural disasters where there has been a focus point has enabled rapid deployment and reorganization of resources as a result of that. And I, for one, think that we really do need to have a compact nation where that level of mobility is available to all so that we can respond much more quickly.

And I say that because if you listen to some of the experiences of some of our military families, in particular, where they know that they're going to be moving, but the process of tracking down their records and getting through that process, etc., can be very disheartening for them, and it's a loss to service in terms of capacity to deliver care.

So, I do think the NLC as a compact nation is really important. I think we could do more with technology as well. We at the moment have a tendency to always go back to the beginning. Well, with blockchain and other types of technologies, you can capture the data, know that it has been securely accessed, and therefore, signed off so that people can then actually follow it through their entire career rather than having to constantly go back.

I mean, when I got my registration in Spain, I had to go back to my original program, which had been quite some time ago, and getting those records was a nightmare. And for people moving around, I just think that there's a huge amount of efficiency that we could put in there that would actually facilitate them.

I think the other point that we need to...and this is kind of linking back a little bit to the previous discussion about violence, is that violence can manifest itself in all sorts of different ways. And we know the issues around mental health in the workforce just now and the way that nurses can often fall foul of substance use, etc., is something that we really need to be mindful of and deal with in a very humane way.

And I think some of the work that Maryann and our team have been doing about finding out what the key factors are in terms of the alternative to discipline processes. So, we're not putting people through something that's going to fail. We're putting them through programs that there's a very high chance of being successful. So, I think we've got to come at this from multiple angles as part of the process in terms of moving it forward.

Regulators have a role to play, the providers have a role to play, education has a role to play, but together, we are actually going to get a better solution.

- So, I want to talk now about another role integral to nursing, LPNs. Should we be expanding what they do? In some states, we're seeing a decrease in the number of LPNs and LPN programs. In some states, we see more of a restricted scope of practice.

I'd like to know your thoughts on the LPN. And should we be growing their role and using them more effectively outside just the skilled nursing facilities? And I open that up to anyone who wants to jump in.

- I'll take that first. You know, from a practice perspective, should we be expanding their roles? I think I would respond by saying as with all other licensed nursing roles, you know, our RN licensure, our APRN, you know, certification and practice and I guess we consider that a licensure.

I think we have to examine, are they working to their full scope? You know, as David mentioned earlier, when he encountered some RNs in his care, you know, he was very surprised about the scope with which they practiced. Sometimes it's a licensure issue, and quite frankly, sometimes it is an organizational issue because when you look at the delta between what an organization, a hospital, for example, allows their nurses to do versus what's the scope of practice, the Nurse Practice Act, there's variation there.

We see that, of course, you know, on the APRN side, but I think we see that as well in our LPNs and our RN licensures and folks that practice in those roles. And to your point, Maryann, I think that there's a wide variation as I cross the country and talk with my colleagues.

I mean, the scope of practice for an LPN, for example, in one state versus another, that there's discrepancies there. So, that's one issue. You know, you mentioned LPNs in post-acute care. I know there are many hospitals and health systems, and I know this to be very controversial but are looking at the role, what is the appropriate role for the LPN in acute care?

And there's several large systems that are in that process right now. And I would say that from, you know, the folks that I've been in touch with, they're doing a very thoughtful not only implementation but analysis. So, I think the jury is out there a little bit, but I think 20, 25 years ago when basically, you know, we told nurses, you know, the LPNs that there's no room for you in acute care, we're going to move you to our ambulatory settings, I see the trend reversing.

This is also though, of course, had a big impact, you know, on our nursing homes and our post-acute. So, you know, there's always I guess that chain reaction when we look to, you know, "bring nurses back." I don't think I can let this conversation end without the work that is being done around the country on care model redesign, and whether that is including, you know, as David mentioned, technology in the mix, but also, you know, what is the team of the future?

Is the "modified" primary nurse model that I learned back in the 1970s as the way to deliver nursing care, I mean, is that...? And it's been pretty much taught that way since that time, you know? Is there a better mouse trap here? And, you know, I don't know in the next few years given the challenges we are facing in our healthcare organizations, you know?

The only other solution would be because if we don't have enough nurses, we are going to have, you know, "nurse-patient ratios" that are not safe, that are way too high, that I'm afraid going to lead to more burnout and more exhaustion and more exodus from the hospital point of care or, you know, bedside, you know, as we refer to it.

So, that whole model of care analysis... I know, again, there's organizations that are evaluating not only in hospital models but hospital at home models. Around 200 organizations around the country have pilots that are delivering, you know, acute level care in a patient's home.

I mean, I forget who said it before, but, you know, just imagine in five years where nurses are going to be practicing, and I think that's all levels of nurses.

- So, Maryann, I think you cannot look at the licensed practical nurse in isolation from how you deliver nursing in its entire continuum. So, the comments that Joan made earlier about really starting to define what nursing is all about, I think you've got to actually look at the entire continuum as part of this.

Certainly, when I was working in medical and surgical wards, we did have licensed practical nurses there in Scotland. They had often many, many years of experience and it was often their own personal histories that had actually prevented them going further because they weren't able to access education.

So, part of what we've got to think about is how you articulate from support worker, licensed practical nurse, registered nurse, APRN in a continuum, and people can actually progress through that at a pace which suits their life circumstance. And I think the more that we come out of COVID, life circumstance is actually going to be one of the key factors in terms of retaining and recruiting nurses.

And I think as part of that, we need to have regulatory framework that actually embraces that entire continuum so that we can make sure that people with the right skills are safe to practice, whatever that practice is, across the cradle to grave community to tertiary service.

And we've got to work that out because that's the reality of where we are.

- And David, I'd like to build on what you and Robyn have said, and that is the importance of teams. And if we define what it is that the professional nursing role is and then we figure out what it is that is needed, what other support services are needed within that team, they may be non-professionals, they could be other health professionals from other disciplines, they might be nursing.

But I would add that currently, we have a very... and I'm being a little bit of a devil's advocate here. And those who know me know I love to debate and be analytical. But we have a system right now that has so many different types of pathways to get from here to there to nursing.

We have multiple different credentials, we have different kinds of education programs, and that is extremely confusing for students who are interested in coming in. It's confusing for the public. It's confusing for nurses themselves and other health professionals about that scope and how people are used and what that credential means.

So, I definitely agree that we need to be clear about what that scope is, particularly if we figure out what it is that we want for professional nursing. We know we don't have enough professional nurses or will not in the future to address all those needs or to provide all the care, but we need to figure out what it is that the professional nurse needs to do in leading the team, no matter where they are, and then what other support workers there are.

The other thing that I would point out, and we do need to figure out ways to allow individuals to progress across, whether it's through competency attainment but across their trajectory. But I would point out, and it's always concerned me, that if you enter and let's say you have somebody

who's...because I got in this discussion with somebody last week about they were trying to find monies to help support students to go to a certified nursing assistant program and then to move on to do an LPN program and then to move on to an ADN program and then to move on to a BSN program.

And if you figure out how many resources that individual, how much time, how much effort, and how much that costs that individual, is that the way we want to help them progress? I do understand that there are certain circumstances that may prevent somebody from moving directly into a certain type of education program, but I think that we can do better.

I think by defining what nursing is, we can attract individuals to the profession. We need to provide more scholarships, more loans, more loan repayments. Maybe they can work off. I went to school as I worked off a loan working in an underserved area. And also mentorship to help folks transition.

But I think when we're constantly trying to put people into programs and think they can progress out, I mean, if you think about it, that's going to take them 10 years and how expensive that is. Maybe there are some internship programs where you take a semester off and you work with a faculty or you do an internship somewhere and you can make money.

There are already several programs that are designed that way in other disciplines, specifically engineering, but also in nursing so they can make money, they can progress, they can attain certain competencies, and then they come back for a semester and they learn some more and then they work. But this needs to be done in conjunction with academia and practice. But I think there are strategies that we can put out there to help move these people through and provide the opportunities that they need.

- We have three minutes left. I'm going to give the final words to Loressa and Linda.

- Thank you. I would simply say that I think that priorities for nursing right now, and we've not talked a lot about it, but if you ask most nurses what's the priority, it's staffing. So, we've, you know, alluded to it by talking about the pipeline, the shortage, the impact of COVID.

But I really do think that there has to be attention given at a national level, from a regulatory perspective, a policy perspective of defining what is safe staffing, and how are we going to get there, and why is it so variable from one part of the country to the other, one organization to another? So, I just want to put that on the table, there's work that's underway in a variety of venues that we really don't have time to talk about today, but I think it is the elephant, using your terminology, David.

It's the elephant in the room, and it's what nurses want to hear us talking about, is how are we going to shore up safe staffing? And how do we define that? And how can we reduce the variability? And I just wanted to also mention about the LPNs. I think we have devalued LPNs in the past, and there is a place for them when we talk about the tasks that RNs are doing that they should not be doing that could be delegated elsewhere.

Certainly, the LPN can play a role as can other providers, but it really is part of the interprofessional team in understanding the roles of each. If we bring them back into the acute care settings, and I'm well aware that that's happening, then we have to do better than we did in the past. They have a value.

We should define what that value is, and we should make sure that they're not practicing beyond their scope. And we also need to consider that as the LPNs were disinvited from the hospitals in their training

because there weren't an adequate number of clinical sites, they've been trained in a different way. They've not been trained in the acute care setting.

So, we have to consider and shore up what those gaps might be as we bring them back in.

- Thank you. Linda, final word.

- In order to find workable solutions, I think you have to identify what are the issues, what are the questions? And I think forums such as this and gathering such as this brings additional issues to light and additional facts about the issues to light. With the focus of the nursing organizations, and by that I mean not just the organizations represented on this panel today, but I mean the multitude of nursing organizations working together, I think we can come up with solutions that are going to answer many of the issues that are going to be facing us.

Those issues are going to change and we're going to have to adapt and we're going to have to be flexible, but we have how many thousands of nurses and that amount of creativity and that amount of looking at the future and looking at what the needs are and being creative has to propel us to help meet the needs of where we're going to be in the next 5 years, 10 years, 20 years.

- Well, I'd like to thank my panelists for all your wisdom and insight into this.