Past Event: 2022 NCSBN Annual Meeting - What's on your mind about the future of nursing regulation? Discussion with the NCSBN Board of Directors and NCSBN Leadership Video Transcript

Event
Past Event: 2022 NCSBN Annual Meeting

More info: https://www.ncsbn.org/about/events/past-events/annual-meeting.page

Presenter
2022 NCSBN Board of Directors

- [President Douglas] So, we're here this afternoon, the Board of Directors joining you to consider some of the questions that were submitted to us ahead of time. This year what we did was go about this to give you an opportunity to submit some questions. We ended up with a lot of questions.

So, many of them have been combined. We've had to defer some, but we are happy to try and answer them. I think board members... I will be asking the questions and then turning to the board member who is assigned to the question. And I think they have some notes and some prepared thoughts that they'll share with you. And looking at the range of topics, we've certainly covered a lot of the key issues that have been raised during this meeting and I know are key issues for you all as regulators.

So, without further ado, let's get started. And the first question came to us from Joe Baker from Florida and really has to do with board governance. And the question is, can you discuss alternative models to appoint, select nurse regulatory board members since many experienced numerous vacancies and delays with gubernatorial appointments?

And Susan VanBeuge is going to take this question. Susan, I'll turn it over to you.

- [Susan] Thank you very much, Board President. So, I have some prepared notes to answer this question. It was a great question from Joe Baker. So, this question has both pragmatic and political dimension. First, members are there both to provide strategic direction and contribute to the necessary operation of the Board, particularly in relation to the timely and fair consideration of complaints.

The absence of a full slate of members can compromise the efficiency and effectiveness of this important and necessary function, drawing media attention and increasing stress for both the complainant and the licensee, who, when delays occur, can experience considerable stress.

I think we can all identify with that. Some boards have managed to get their legislatures to accept additional pro-tem appointees who can serve on discipline panels and contribute to the work of the

Board in different ways. For example, this is a model used by Washington State and also the Nurse and Midwifery Council in the United Kingdom.

With the absence of board members, the composition of the Board can be compromised when expertise is missing. This, depending on the vacancies, may result in the likelihood of biased decision making, increased vulnerabilities such as those highlighted by the Supreme Court case of the FTC v.

The North Carolina Dental Board. So, by highlighting the consequence, along with building a coalition of advocates both from the public, interested entities like AARP, and professional organizations such as the associations and local education providers leveraged with the governor to make appointments can be increased. So, we can put some pressure on their utilizing those groups.

In addition, there's a wider issue that needs to be considered. In 2017, the NCSBN published a report entitled "Regulation 2030." And as part of the analysis, the changing nature of board membership was highlighted. In short, various aspects of the governance of the Board can be compromised when appointments have been delayed.

But let's focus on the appointment of board members now. First, we need to do all we can to ensure potential candidates have a good understanding of the role and make sure that they are aware of the vacancies. By highlighting the competencies needed, we are better able to articulate what is missing and how it will impact the functioning of the Board, its accountability, and the capacity to act in the public interest.

Second, as was in the case in the United Kingdom, the nursing regulator worked with other regulators to propose a completely new approach where vacancies were filled through competency assessment process. There's an excellent and recent document that was just published by the Professional Standards Authority that describes this, and it's available to download.

Additionally, there is an older document that highlights why getting this right is so important. This older document can provide you with some useful insight as you're thinking about what that board composition looks like. I hope that's helpful.

- Thank you very much. Appreciate that. So, moving on to the next one, which really has to do with clinical placement, and this question came from Melissa Temple and Donna Hanley. "There's been a significant increase in nursing content being offered online because of the COVID pandemic. Therefore, colleges and universities are recruiting more students from out-of-state and pursuing approval for students to participate in clinicals in their home state. I receive emails weekly from proprietary and public institutions offering nursing programs asking what our state regulations are for approval of student clinical. We are currently revising that process due to the high volume of requests. Nursing programs in the state have also asked for more regulation of out-of-state programs offering clinical in the state to the extensive process they must follow. In reviewing the process of other states, every state requires something different. Has there been any thought in minimum clinical guidelines states could adopt such as with the Nurse Licensure Compact allowing for mobility of clinical placement for students?"

Karen Lyon is going to take the response to this question. Karen?

- [Karen L.] Thank you, President Douglas. This is really a great question and it was actually investigated by a committee back in 2014. At that time, the recommendation was that the home state,

and, of course, that's the state where the nursing program would be located should approve the nursing program using NCSBN's model rules as a guide. The host state where the student takes the didactic or the clinical education, therefore, would not need to further approve the clinical or didactic portion of the program, and this could prevent all of this confusion that happens that we see across states.

The focus is on trust among the Boards of Nursing as well as using the model education rules to promote consistency. Currently, the model education rules that provide the Boards of Nursing with legally defensible and evidence-based guidelines for promulgating the rules, and we encourage the Boards of Nursing to use these.

Related to distance education, the model rule states, "The distance education methods are consistent with the curriculum plan." That is, distance education should not be held to a different standard from traditional education programs. The three nursing specialty accreditors state the same concept as well.

In regards to the second part of the question that had to do with minimum clinical guidelines that states should adopt, well, that should be the goal. NCSBN has developed a web page on distance education, and you can find that at www.ncsbn.org/671.htm. And that has specific requirements that Boards of Nursing may have.

To develop this web page, the NCSBN staff reviewed all the Boards of Nursing's rules and regulations looking for their distance education requirements for both pre-licensure and APRN programs. They then contacted all the Boards of Nursing to be sure that they had correctly interpreted their rules and regulations.

This is posted on the NCSBN website with a drop-down box for each jurisdiction. There is a separate area for pre-licensure programs and APRN programs.

- Thank you, Karen. Appreciate it. So, moving on to the next one, which was really a topic for some discussions submitted by the International Physicians Network from Anna Lee Yang and Angelia Yang.

NLC. More states joining the Nurse Licensure Compact, especially big states like California and New York. And Mark Majek will address this topic.

- [Mark] Thank you, President Douglas. The pandemic has put the NLC on the radar in most single licensure states. The temporary measure put in place over the past two years through governor's emergency declaration and orders led to the confusion for many nurses and employers. The temporary nature of these orders and lack of knowing whether such orders would be extended beyond the expiration dates caused significant staffing issues.

Many hospitals and single licensure states have pressured their state hospital association to take steps to seek NLC membership. The remaining single licensed states have some level of union opposition, although in some states the union may not be large enough and influential enough to keep the NLC legislation from passing successfully.

Despite union opposition to the NLC, we are seeing more democratic governors support the NLC. For example, in New York, the governor included the NLC as part of her budget bill. The Nevada governor very recently announced his support for the NLC.

In follow-up, looking at the larger states, California had NLC legislation in 2021 and New York had NLC legislation in 2022. So, we're seeing NLC legislation being introduced in states that have never had a bill before. The Alaska Hospital Association recently shared their goal of seeing the NLC gets enacted in 2023 in Alaska.

The Hawaii Hospital Association has also recently advised us that they will have an NLC bill introduced in 2023. In 2023, we anticipate seeing NLC legislation introduced in almost all the remaining single licensing states.

The NCSBN has contracted with lobbyists and strategic states where needed, and we believe that we will see additional states successfully pass the NLC legislation in 2023.

- Thank you, Mark. The next question was submitted by Lori Glenn, Sarah Chacko, Pam Sickafoose, and Karen [inaudible]. Revisiting the APRN consensus model to allow for a standard entry-level prior to specialization, removing barriers to APRN or CRNA scope of practice, allowing CRNAs to work to the fullest extent of their education and clinical experience, telehealth, and APRN Compact, education requirements, regulatory requirements, and regulation of APRNs.

That's a combination of items that were submitted by several people. And Susan VanBeuge is going to take that question as well. Thank you.

- Thank you, President Douglas. So, there's a lot to unpack here. So, these questions address the regulation of APRNs, the elements of the APRN consensus model, and removing barriers to APRN full practice authority. The consensus model establishes the educational requirement for APRNs as completion of a graduate education in a nationally accredited program.

National APRN organizations have called for a doctoral degree to serve as the standard for entry into APRN practice. Most have established goal dates for this to be achieved. To date, only the CRNA educational programs and certifying bodies, the NBCRNA, have agreed to require a doctoral degree for CRNA program graduates in 2025.

Regulation of APRNs remains a patchwork of consensus model alignment across the U.S. jurisdictions. We continue to support removal of barriers to full practice authority for all APRNs, including those for CRNAs at the state and veteran's affair level.

Since 2008, there have been discussions about the benefits and challenges of the consensus model. Recently, the LACE Network has been surveying its members about not only the impact of the model on their member organizations but the potential need for a review and possible modernization of this 14-year-old regulatory framework.

The authors of the model provided for the possibility of revision as healthcare needs evolve. We have observed patient care become increasingly more complex, and the technologies utilized to provide care continue to advance. The question of whether the APRN consensus model will be modernized still remains to be seen.

As the pandemic has revealed, an agile and accessible nursing workforce is more important than ever. Removing barriers and expanding access to telehealth services is one of the many benefits of the APRN Compact.

Under the APRN Compact, a CNS or clinical nurse specialist could provide remote monitoring of a stroke patient who returned home to recover in another state. A certified registered nurse anesthetist of CRNA could remotely access pain management for a patient. A certified nurse midwife or CNM could evaluate a mother and baby in a rural area, and the nurse practitioner, or NP, could remotely monitor a diabetic patient, all made easier by removing the barrier of requiring multiple single-state licenses through the APRN Compact.

A report released in December by the U.S. Department of Health and Human Services found that massive increases in the use of telehealth helped maintain access to healthcare services during the first year of the pandemic. The report found that Medicare visits conducted via telehealth increased 63-fold from about 840,000 in 2019 to over 52 million in 2020.

That's a lot to sink in right there, I think. CMS released its Medicare telemedicine data snapshot which looked at claims for Medicare fee-for-service, Medicare Advantage, encounter data, and Medicare enrollment information. They identified over 28 million unique telemedicine users from March 2020 through February 2021.

The expansion of remote and virtual technologies while increasing access to patients, especially in the underserved and rural areas may create challenges for Boards of Nursing, but it's also a great opportunity.

Thank you.

- Thank you. The next questions have to do with workforce, something that we've already talked quite a bit about and so we know it's on everybody's mind. This came from Sue Smith, Robert Muster, Joyce Jeter, Juliana Resic [SP], Lori Glenn, Kalika Bible [SP], Donna Hanley, Kendra Lindloff [SP], Carolyn McCormick, Linda Stone, Crystal Tillman, and Anne Rich.

So, just to summarize those various questions, it focused on how to increase adaptability, flexibility, and response time, supply of nurses, impact on COVID, how will we move forward to regulate the nursing profession in light of this? The cost of healthcare and the risk of patient care in light of staffing shortages, overworked RNs, and a decrease in LPN licensure, staffing ratio issues.

What are some of the strategies to improve the shortage? How the workforce is being impacted, acute care and faculty shortages, increasing hydration clinics, nurse substitution. Nebraska Hospital Association initiated task force to revise nursing regulations for scope of practice and nursing education.

So, Karen Evans, if you would take a stab at unpacking all those questions. We don't have Karen with us. We're going to skip over that until Karen comes back, okay? I'm sorry that I didn't... So, we're going to move to question number six, which has to do with... So, Karen Lyon and Cathy Borris-Hale, you'll be up a little early, so just want to give you a heads up on that.

Questions related to education and diversity. I have a question from Brittany Dawson and Sherri Sutton Johnson. Expanding access to education, improving diversity, improving health equity, and improving racism. My focus on the future of nursing regulation is centered on the actualization of sustainable efforts to ensure inclusion and equity in nursing education and regulations.

The detrimental impact of systemic racism and subsequent inequities and inequalities have been highlighted during the pandemic response. We need to move from identifying the problem to consistent

and measurable solutions. And I think Karen Lyons, you're going to take the first part of this, is that right?

- Yes. Yes, I am, President Douglas. I'm going to take the first part. My partner in crime over here, Cathy, is going to take the second part. In its State of the World Nursing 2020 Report, the World Health Organization called on countries and regulators to consider mechanisms to increase the demographic and geographical diversity of students in nursing schools.

NCSBN is committed to the principles of diversity, equity, and inclusion. In our current strategic plan, Objective 8 specifically addresses the need to promote and encourage diversity while increasing member participation. The International Center for Regulatory Scholarship or ICRS, which you've heard so much about this week has created several resources for our membership and other regulatory bodies, including the diversity, equity, and inclusion and regulatory practice course.

This course provides an overview of concepts and practices in diversity, equity, and inclusion that is relevant to nurse leaders and gives participants the opportunity to analyze a workplace policy or practice that could produce inequities in how certain individuals can progress, succeed, and advance in their nursing career.

- [Cathy] So, in addition to the certificate program course, NCSBN staff are also developing a tool for diversity recruitment and retention planning that can be used by nursing regulatory bodies. This tool will walk regulatory bodies through the steps of designing a diversity recruitment plan for your jurisdiction and provide creative solution for implementation.

This could be shared with nursing programs and other institutions to help increase diversity at a broader level. NCSBN's 2020 National Nursing Workforce Study reports that 19.2% of the U.S. registered nurse workforce self-identifies as belonging to a minority group.

The voices of the various cultural group that make up your jurisdiction have the potential to enrich your nursing regulatory body by highlighting issues and identifying solutions that might otherwise be overlooked. Our communities are diverse, and nursing regulatory bodies will be better positioned to protect the public if our boards and staff are compromised of professionals who are representative of the population they are charged with protecting.

And since I'm going off the Board this year, I'll feel free to go off script a little bit.

- Are we surprised?

- And I wanted just to put a little personal feeling into this. And that said, from our workplace to our home, we have to be comfortable having discussions about racism, diversity, and inclusion. These are necessary for us to be aware of our own personal biases and promote action and change. We have to look at how our regulations, and when we look at discipline, how different groups of people may be charged or looked at different and have a different experience.

And you can't do that when you only see the world through your eyes. There is a great HR specialist, Chief People Officer for UKG, Pat Wadors, who said, "When we listen and celebrate what is both common and different, we become wiser, more inclusive, and better as an organization."

And NCSBN is doing that.

- Thank you, Cathy. And actually, I think you have the next one as well.

- Yeah, I'm going to stay on script because this one is long.

- So, this is discipline-related. We have a topic from Christie Perman and Juliana Resic. COVID disinformation, misinformation, vaccination requirements, nursing liability and malpractice, and the increasing crisis of diversion in the workplace.

So, there's a lot in all of that, but that's what we receive. So, Cathy, if you will take that.

- Okay, thanks. We'll tackle this one bite at a time. So, we're going to start with the COVID disinformation and misinformation. So, in July 2021, the Federation of State Medical Board, FSMB, issued a news release about the spread of COVID-19 vaccine misinformation or disinformation, and the risk of disciplinary action by state medical boards.

December 2021, NCSBN, along with 15 additional nursing organizations, urged nurses to recognize the dissemination of misinformation, not only jeopardizes the health and wellbeing of the public but may place their license and career in jeopardy as well. So, in recent legislative sessions across the country, many states have filed legislation to protect healthcare professionals who spread misinformation.

For example, in Indiana, a bill was filed which permits a prescriber to create a standing order that allows a pharmacist to dispense Ivermectin, and that's a bill name with that, and the bill also states a pharmacist is not allowed to provide information to the patient that discourages using the medication to treat COVID-19.

While in Wisconsin, a bill forbids healthcare entities, as well as regulatory boards from taking adverse actions, including discipline a license against a healthcare professional for expressing professional healthcare opinions, including any statements, policies, studies, publications, or orders. In contrast to the bills filed in Indiana, Wisconsin, and many other states, a California bill would make it easier to discipline a physician for spreading misinformation.

This bill specifies that dissemination of COVID-19 misinformation constitutes unprofessional conduct and list factors that the medical board must consider before issuing such discipline. And if you want to hear some more information about that, contact Cathy Russell.

She's got some good stuff on it. So, let's go on to the next one about vaccination requirements. So, the Center for Medicare and Medicaid Services, CMS, is committed to ensuring that America's healthcare facilities respond effectively in evidence-based way to the coronavirus disease of 2019, public health emergency.

So, on November the 5th of 2021, CMS published an interim final rule. This rule established requirements regarding COVID-19 vaccine immunization of staff among Medicare and Medicaid-certified providers and suppliers. The U.S.

Supreme Court in January allowed the vaccine mandate rule to take effect nationwide, and a federal judge later dismissed a Texas challenge to the mandate. I think our third part had to do about nursing liability and malpractice. So, the number of boards' adverse reactions, and we're talking about RNs, PNs, and APRNs reported to NPDB remains stable 2017, 2018, 2019, being around 23,900 a year.

There was a 20% drop off in reported adverse actions in 2020 and '21. And this makes sense that it's probably related to the pandemic. The number of medical malpractice payments reported to NPDB remains stable at an average of about 710 a year over the 5 years.

So, there does not appear to be a drop during this time period. And now onto the increasing crisis of diversion in the workplace, very astute observation. NCSBN is participating in a multidisciplinary team, the Opioid Regulatory Consortium, to address the issue of the high rate of overdose death and opioid use.

The first summit of the group was held in Washington, D.C. in March of 2022. A small group meeting will be held in September to discuss further steps, and you'll hear more about that very exciting stuff going on around the country. Thank you.

- Thank you very much. That was a lot of different topics in one. And we're going to move back now to the workforce question. I'm not going to repeat that question for you, but there was many people that wrote in about workforce, and I'm going to ask Karen Evans if she will respond to those questions. Karen.

- [Karen E.] Thank you, President Douglas. Yes. So, the first response I want to speak about is, how do we increase adaptability, flexibility, and response time, the supply of nurses? So, the most logical way to increase adaptability, flexibility, and response time, as well as the supply of nurses to specific areas is by having jurisdictions adopt the mutual recognition model as 39 states have done in the U.S.

The Nurse Licensure Compact and the APRN compact modernized licensure systems that are over 100 years old and allow nurses fluidity work across borders physically and virtually, and do so safely. In order to truly have agile system, every jurisdiction has to be part of the compact.

Also, the way to increase supply is to license more nurses more quickly and get them into the workforce. NCSBN will be undertaking a study this fall that will analyze how much faster nurses could be licensed and enter the workforce when the jurisdiction belongs to the compact.

The second part of this question is, how do we resolve the provider shortage for nursing assistant to MP? How will we move forward to regulate the nursing profession in light of the impact COVID has had on its workforce?

Right now, we need more data. NCSBN is in the midst of completing a number of studies that examine the impact of COVID on the nursing profession. These studies range from the impact of COVID on students in their education all the way up to advanced practice nurses. One of the most significant of these studies is the National Nursing Workforce Study.

This will be the first study to describe the state of nursing workforce since COVID began and the impact of COVID has had on the RN and LPN workforce. These data, which will be released in the spring of 2023, will give us the insight we need to identify needs and develop targeted solutions for the future.

Okay, the next question is the cost of health care and risk of patient care in light of staffing shortages, overworked RNs, a decrease in LPN licensure, and staffing ratios, pay rates, and SNF settings. Risk to patient care related to staffing shortages is exactly the reason regulators need to be involved in workforce issues.

Take a look at your practice acts and regulations. Are they in line with current practice? Are all the roles in your state able to work to their highest potential in accordance with their education? Education of the RN is constantly advancing and as for the LPN as well. We need to recognize their potential and allow them to practice at their highest level while still under supervision.

We also need clinical models that have advanced support workers from the nursing assistant up to the RN role and beyond. This is being addressed in NCSBN's new strategic plan 2023 to 2025. The next question is... I have one more related question.

The Nebraska Hospital Association initiated a task force to revise nursing regulations for the scope of practice in nursing education the anesthesiologists have applied to credential anesthesiology assistance. The issue of nurse substitution, especially for APRNs is the very reason we need the APRN Compact.

If we do not allow APRNs to be mobile and care for the patients across the borders, there would be roles that can take and will take their jobs.

- Thank you, Karen. The next question is really generally about regulatory modernization, and there was a lot of different elements to this. And this came from Missy Poortenga, Gia Ramos, Karen [inaudible], Kimberly Hopkins, and Ruby Jason.

The question touched on having a centralized data bank to access nurse information, any disciplinary information, and the status of license. How to demonstrate the value of a board of nursing in a state focused on substantial deregulation. Will we consider issues that impact nurses globally? How can we see more similarities and less differences as it relates to the State Boards of Nursing regulations and the impact of changing models of care on regulatory duties and functions?

And Phyllis Johnson and Adrian Guerrero are going to take this one together, so I'll leave it up to you two to figure out who's going first.

- [Adrian] Thank you, Madam President. I'll take the first one. These questions collectively address both issues of accountability and strategic direction as it relates to regulatory modernization. I'll address the issues of accountability and my colleague will pick up the strategic direction part. Daniel Burrus, a disruption innovation expert, and futurist, said, "Information is power only if you can take action with it, then and only then does it represent knowledge and consequently power."

For me, information is about accountability and performance and is at the heart of many of the developments NCSBN has supported over the years. Our nurses' system gathers information on licensure status and makes it available to both the public and in more detail to our members. It is a tool to protect the public and reduce the burdens for the members and to facilitate cooperation across the membership and standardize our approaches.

Such information can and should be augmented with other information, and the work that we will do in the coming triennium on the licensure reform will also look at this. Additionally, the work we've done together in the past decade on the CORE, which is the commitment to ongoing regulatory excellence is a good starting point for demonstrating this value of nurse regulators. Several boards, such as Arizona, Georgia, Washington State and my home state of Kansas have all successfully used their data to either increase resources, attain autonomy, or in our case, resist attempts at a medical board takeover.

The work that is currently being done on Objective 1 takes foundational material to a new level. Products such as the critical review of the CORE system and the thematic analysis of the Sunrise reviews, and the soon-to-be-published "Sunset Report" all provide building blocks for a new regulatory board accreditation system.

And additionally, a publication titled "Acting in the Public Interest" also provides evidence-based arguments to counter many of the criticisms that we face when deregulation is on the legislative agenda.

- [Phyllis] So, in terms of strategy and modernization, we are entering a particularly exciting time. Not only will we be dealing with the consequences of what we have learned as a result of COVID, but also with the publication of new global guidelines for the regulation of health professions by the World Health Organization.

In the coming year, there will be many drivers for change. Working together, grounded in our collective experience, we can generate solutions fit for the future. The coordinated action of bringing legislation to our respective states makes development and implementation of standardized approaches possible.

Just look at what we have achieved together over the past seven years relating to the compact. Model acts and rules is yet another tool. And importantly, the generation, curation, and implementation of evidence-based practices are part and parcel of what will bring about normative change.

New models of practice are a reality, as is the increasing use of technology. Spotting these trends ahead of the curve is critical if we are to have regulatory systems fit for the future. Our annual environmental scan is a treasure trove of what is and what could be coming to a legislature near you, Madam President.

- Thank you. And last but not least, the question of something that impacts us all, legislative impact. We received submissions from several people, Colleen Casper, Vicky Byrd, Sue Painter, Kathleen Cohen, Lori Scheidt, and Donna Hanley, compact licensing and the impact of Dobbs v.

Jackson SCOTUS decision on licensees and what steps NCSBN is prepared to take to protect licensees' ability to provide essential services. Now, the part of that, no national licensure or keeping state Boards of Nursing, regulating nurses in their state, compliance with individual nurses and obtaining home state licensure is failing.

The rapidly changing regulatory environment. The challenges of licensure with changing state laws and regulations related to the Supreme Court decision and RaDonda Vaught case, generally, how regulations will work in what seems to be a post-regulatory environment, and then mechanisms to safeguard the public by carefully evaluating applicants being challenged by pursuits of legislation that weaken public protection.

So, various things that legislation certainly impacts. And together, Mark Majek and Lori Scheidt are going to tackle this last question.

- [Lori] Thank you, President Douglas. I will address the current and controversial issues that have impacts on regulatory boards, and my colleague, Mark, will pick up on the regulatory board control over licensure and licensure processes in this ever-changing environment. The Supreme Court decision on Dobbs v.

Jackson resulted in the immediate implementation of so-called trigger laws and a flurry of legislative activity as lawmakers across the country sought to either protect abortion rights or restrict access to abortion services. We know that this issue has and will continue to impact the nursing profession and regulation in various ways. We anticipate, and some of you may have already seen that there's a dramatic increase in the need for interstate licensure as patients likely will travel across state lines to seek these essential services from qualified providers when they're not able to get those in their own state.

The functionality of both the NLC and APRN Compact will allow nurses to continue to provide essential services across state lines, and some of those examples are pre- and post-abortion assessment via telehealth, mental health services associated with seeking or receiving care, prescription for abortion medications when not barred by state laws where the patient is located.

Clear communication and transparency by Boards of Nursing to stakeholders will be key in these uncertain and controversial times. For example, boards need to communicate to licensees in the public that they don't determine your ability to provide those healthcare services. We are indeed charged with enforcing the Nurse Practice Act as they're written, and I say that a lot in my job. The law is what the law is, and our job is to enforce it.

To the extent that Boards of Nursing can be a resource for lawmakers who seek their expertise, it's possible for boards to have an impact on resulting policy change at the legislative level. The analysis can be applied when looking at the RaDonda Vaught case in Tennessee. While any disciplinary matters fell under the jurisdiction of the Board of Nursing, the criminal charges and resulting legal proceedings, you know, did not.

NCSBN, of course, will continue to monitor the legislative environment, and I think you've seen from this organization that they monitor and then, when needed, task force or special work can be done to address that. Thank you.

- And I'm going to address the issues surrounding regulatory board control over licensure and licensure processes and the ever-changing environment. National licensure, occupational licensure reform, and removing or reducing licensure requirements and processes are all challenges faced by all regulatory boards. First and foremost, maintaining the regulation of nurses, LVN, LPN, RN, and APRN at the state board level is paramount.

Federal law discussions of national licensure or national regulation of aspects of care such as the interstate practice continue and reach to new heights during the COVID-19 pandemic. To ensure patient safety, licensure and enforcement activities should remain at the state level with experts at the Board of Nursing regulating the licensure and disciplinary processes to protect the public within their jurisdiction.

For interstate practice, which is increasingly more prevalent with the exponential growth of telehealth and nurse licensure compact and the APRN Compact remain the safest and most streamlined mechanism for regulated cross-border practice. The NLC and APRN Compact maintain licensure and enforcement at the state level, which is the key for patient safety and deterring efforts by the federal government to regulate nurses.

All licensure activity, including issuing, renewing, and discipline are maintained at the primary state of residence level. For disciplinary issues where practice occurs in a party state to the compact that states may take action against the licensee's privilege to practice in that jurisdiction only.

As it is modeled over the last 20 years a safe and successful operation of the NLC, it is expected that the APRN Compact will be successful in quiet calls for the national licensure for those in advanced practice. Second, boards are faced with the legislative efforts and pressures to do more with less, less resources, and/or less regulation.

Both scenarios threaten to impact the ability for Boards of Nursing to protect the public. In response to lengthy licensure processing times at various boards, we have seen lawmakers inquire into the regulatory processes and introduce legislation that would eliminate or amend those requirements. In attempts to bolster the nursing workforce, legislators have enacted legislation lowering qualifications for applicants.

Both scenarios result in disruption of regulatory processes and threaten public protection. It is imperative that the Boards of Nursing maintain a strong awareness of legislation introduced within their state that would significantly impact licensure standards and be prepared with evidence to support these standards.

Both Boards of Nursing should be prepared to speak to legislators about the role of the Board in maintaining these standards to ensure that the mandate to protect the public is upheld. Developing and maintaining relationships with lawmakers builds credibility and strengthens chances the Board will be called upon during these key discussions.

And President Douglas, may I have more time?

- Certainly.

- Thank you.

- You noticed the two rogue down the end. They're board members that are going off the Board. I'm not sure where he's going, but I'll take a risk here and say, "Certainly, Mr. Majek."

- Thank you, President Douglas. I might be singing to the choir, but not everybody belongs to the choir. So, in my day job as a government relations specialist, this is my key area of discussion with legislators. I'm reminded of a story just this last couple of years is that when students were on a Zoom call with their instructor going over information if they didn't...

Somebody on the Zoom call, one of the students told the other students saying, "If you don't get what you want, call a legislature to contact the Board." So, this is on a Zoom call with 100 people, and sure enough, within the next 2 days, calls were coming in from all these legislators across the state. So, that's okay.

But during COVID, we received a lot more calls from legislators, but I think the difference that I'm hearing now is they're asking, what can we do to help you? That's a huge difference. They're opening the door for us to come through, and you have to go through. So, when I'm looking at that, we always have this dilemma of we can't lobby. I hear that.

We can aggressively educate. We can stand by and let the nursing associations take... We can partner with the associations. The bottom line is we either have to go through the door or knock on the door. And I think we have to get more aggressive because we're losing those resources we need. If you want

somebody licensed in 10 working days, I need the resources, and it's my job as staff and our boards to get that across to our legislators and invite ourselves to the table or walk through the door.

Thank you.

- Thank you. And I want to thank Phil Dickinson and the team of staff who helped pull together these questions so we can have some general areas to discuss with you. I know it was a lot of information. And through that process, we identified a lot of NCSBN resources that you may or may not know exist.

I know I learned about some new ones. And this information will be made available to you all, so you can go back and look at the resources, whether it's on the website or obtaining it through a staff person as a follow-up to this session. I want to really thank the Board of Directors for answering these questions and being here for this resource-rich discussion.