Past Event: 2024 NCSBN Annual Meeting - Keynote: Global Leaders in RN: America's Health Responders Video Transcript

Event
2024 NCSBN Annual Meeting

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- [Jennifer] I am so excited to be here with you guys. One of the most important moments in my life has to do with you all and probably for most nurses. I remember 25 years ago, I was waiting to get my results for my NCLEX. And back then, it's fancy now, but back then you had to actually get it in the mail.

And I'm sure others remember that too. Had to wait for my results in the mail. And when it came, I was so nervous. I felt I did well in nursing school. I mean, I wasn't a straight A student, but I did well. But as most nurses, and I just was informed that everybody here is not a nurse, so I'm speaking to the nurses.

You all know what it's like. You study hard. You take the preparatory courses and all of that. But when you get in there and take the test, you just don't know. I think everybody has doubts. And I certainly did. And then that being a novice and all of that.

Anyway, long story short, got it. Opened it up and I passed it the first try. And I laid down prostrate on the floor and praised God. It was just the... I mean, it's right up there with marriage and births and everything, graduations. Everything.

It meant everything to me. So thank you,Maryann, for that great introduction. I need to actually steal that from you because that's not the one I use, but it's even better. So yes, you know who I am. I'm supposed to advance the slides myself. Okay, disclosures. No financial relationships to disclose.

And basically the disclaimer is that I'm not going to say anything that is going to get me in trouble. And if I do, please don't tell on me. So my objectives. I want to describe the commissioned corps. This is really great because when I came and spoke with the graduates back in April, I always like to give a little what I call commercial about the corp because in the elevator on the way down here, someone did refer to me and I'm not going to call her out, but she referred to me as Navy.

We're not the Navy. And so I always like to give a commercial whenever I'm speaking. But this time you guys invited me to talk about global nursing. And so now this is more like an infomercial on the corp. So I'll be talking about the role of the chief nurse officer. I'll be talking about the surgeon general's priorities and my priorities as chief nurse officer.

And then I will talk about the global nursing workforce initiatives. Okay. In Officio Salutis. That is our motto in the service of health. We were established in 1889. Most people don't realize that. Our history actually goes back to 1798, but officially in 1889.

So we just celebrated 135 years, I believe. So we're older than several of the other services. We are part of the U.S. Department of Health and Human Services. And we are over... I have to explain this because people say the U.S. Public Health Service.

And a lot of times we do that ourselves. We talk about the U.S. Public Health Service. We are the commissioned corps of the U.S. Public Health Service. So there is a difference. The Public Health Service actually refers to the, I'll just say, HHS instead of trying to say it all.

You guys know HHS. So HHS is made up of what? Twelve agencies. They call it operational division. So 12 agencies, 9 of those actually make up the Public Health Service. So you have... Well, CMS actually isn't one.

You have FDA. You have CDC. Those most known. Those that are actually involved in developing policy related to health and the health and safety basically of the country globally as well. So that's the Public Health Service. The commissioned corps is actually part of the Public Health Service.

So I'll refer to the commissioned corps when I'm talking about those of us in uniform. And the Assistant Secretary of Health, which we refer to as the ASH, is currently Doctor... Wow, talk about a brain fart. I am looking right in her face.

Oh, my goodness. Thank you, Dr. Levine. She'll kill me. Anyway, so Dr. Levine is our current ASH, Assistant Secretary of Health, and she has oversight. She is a senior advisor to the Secretary of Health of HHS on any matters related to health and in the science related to health.

Now the surgeon general heads up the commissioned corps in the Office of the Surgeon General. So he, who is currently Dr. Vivek Murthy, remember that, he reports to Dr. Levine directly to the ASH. And so that's the way the structure is set up. And he is the commander of the commissioned corps. So this is just a diagram that shows you how the government's set up, in case you didn't know.

I know you guys are very familiar with how we're set up. But this is really just to highlight the fact that we are not part of DoD. As you can see, the structure is you have the Department of Defense, you have our sister services. There are eight uniformed services. Not all of them are "armed." And you see that we fall under HHS, the Public Health Service. And in case you didn't know, there's the NOAA.

They're also a uniformed service. And then you have the Coast Guard, which actually doesn't fall under DoD. They fall under Homeland Security. So I mentioned a little bit about our history. And what I really want to highlight here is the fact that most people, you see like Ellis Island, you see pictures of Ellis Island and you see those gentlemen in uniforms.

Those are physicians. So when our service started, they were only physicians in the service. And so I highlight here when nurses came on board in 1944. So that was when they had the Cadet Nurse Corps. I don't know anyone familiar with the Cadet Nurse Corps, when there was a big push to recruit nurses. And so they set up the Cadet Nurse Corps. And that's when they made the smart decision to invite nurses to join the Commission Corps.

So what we do. We provide essential health services across all of the HHS agencies and beyond. So that's nationally and internationally. You will find public health service officers at, as I mentioned, FDA, CDC, Indian Health Service, Bureau of Prisons, the organization I work for, which falls under Homeland Security, which is Immigration Health Service Corps.

You will find us at SAMHSA. You will find us at HRSA. I imagine you're probably very familiar with HRSA. So essentially, pretty much all government agencies, you will even find us at the Department of Interior. We have nurses...well, not just nurses, but officers that work at the parks, at the national parks.

In fact, I get a chance to visit Yosemite in the spring. So I'm excited about that. We serve on the front lines of public health emergencies. So whenever a local infrastructure is decimated or overwhelmed, usually that happens when there are forest fires or hurricanes, we deploy. So personally, the last deployment I went on was in Puerto Rico.

When Hurricane Harvey hit and decimated the Virgin Islands, they had to transfer the patients from the hospitals on St. Thomas over to San Juan in Puerto Rico because the hospitals were destroyed.

And so we were there, boots on the ground, making sure that they were... Well, they were transferred to the hospitals in San Juan. We had to make sure that they were receiving proper care and services. And we also had to track them for the purposes of making sure where they were and then making arrangements for them to get back to St. Thomas when conditions allowed for that. So that meant that we were actually boots on the ground when Hurricane Maria hit San Juan.

So I remember crouching down in the hotel while the winds were blowing and windows were cracking. But they usually try not to put us in austere conditions like the military. They usually try to make sure things are safe, but it doesn't always happen. But the point is we respond to emergencies, not just nationally, but also internationally. I also had the opportunity, me and several other officers, not just nurses, all of the categories were represented, but we went to Liberia when Ebola was rampant and it was a pandemic.

We were there, boots on the ground, in Liberia. We set up what we called the Monrovia Medical Unit and we took care of... Who do you think we took care of? You won't be able to guess. You might. I heard somebody say something.

- [Man] Babies.

- Babies? Oh, that would have been nice but no. We took care of healthcare workers. We were the only force that was there, boots on the ground, taking care of healthcare workers. Why is that important? Exactly. Yep, so we were taking care of healthcare workers because that's what happened in Liberia.

The healthcare workers got Ebola and were dying off and then they weren't able to provide care for the citizens of the country. So, we also lead public health programs and policy development. As I

mentioned, you'll find us in pretty much all of the federal agencies and a lot of us are in leadership positions within those organizations.

This is definitely not the least important thing, but we advance innovation and science. And we were on the forefront of COVID, but we've been on the forefront of all pretty much small pox, you name it. The public health service has been engaged. So our mission and values, just like any other organization, just like our sister services, I'm sure you all have mission and values as well.

Our mission is to protect, promote, and advance the health and safety of the nation. And we take these values very seriously. Leadership. We expect our officers to take leadership roles not just in the service, but in their communities as well. We expect our officers to maintain the highest level of integrity. In fact, all of our officers have at a minimum a public trust security clearance.

And we serve. I've already given some examples of how we serve. We have, I'll stick to nurses, but we have nurses that work at the CDC. They're focusing on public health. So all that information that you find on CDC's website, nurses have had a hand in that. We have nurses that serve as consumer safety officers for the FDA.

So they're literally all over the world making sure that we have safe food imported into our country. We have nurses that provide direct care and services. I mentioned Indian Health Service. They're there. Indian Health Service has hospitals and clinics. We have nurses that are providing direct care there. Excuse me.

In Alaska. In very remote locations all over the country. Wherever there is an Indian reservation, you will find public health service officers there. And excellence. As a chief nurse officer, I personally require my nurses to maintain excellence at all times. And they do a great job.

It's not something that I have to even really demand. So chief nurse officer, the role of the chief nurse officer. Well, these are the main duties. This is not a complete list. But one of the things that I do is advise the Office of the Surgeon General in HHS on issues related to recruitment and assignment, deployment, attention, career development of nurse professionals.

This is a little bit more specific to public health service officers, but it does also apply to any federal civilian nurses that work in the federal government. And a big part of my job is to promote the Surgeon General's priorities, which I will be talking about a little bit later. As was mentioned, I am the designated U.S. government CNO, and that is under the authority of the ASH that I mentioned before.

Dr. Levine, I can't believe I forgot her name. And then, like I'm doing today, just engaging with stakeholders at the local, state, national, and international level. And all of this is a collateral duty. Because as Maryann mentioned, I have a day job as a Deputy Assistant Director for Healthcare Compliance at IHSC, which as I mentioned falls under Homeland Security. So I have oversight of risk management, quality improvement, accreditation, compliance, health plan management, which includes medical claims, provider network, and following up on any medical complaints.

So it's a pretty full plate, so I'm pretty busy. This slide, I just included this slide because I just wanted to share some information about our workforce. You all work with licensing, obviously, at the state level. We, just like any other nursing, any health organization, not just nursing organizations, any healthcare organization, we face the same issues as anyone else in terms of recruitment and retention.

We have at this time just over 1,100 active duty regular corp nurses and 23 ready-reserve. I didn't mention the ready-reserve. It's been in law for quite some time, but we actually were able to stand up the ready-reserve. So similar to other services that have a reserve, we also have a reserve corp that we can call on in emergencies when we're asked to deploy.

We can call on them, and like I said, it's just like anybody, a reservist, any reservist. Just like any other reserve corp, they have regular jobs and they leave that job to support our deployments. So just 23 right now, and hopefully we can increase those numbers. In this data, the second bullet here, I actually had some data going back several years just showing how our recruitment numbers are declining.

I just wanted to see if it's month by month, and so I looked in July and I looked a few months before that. And so in July, we have five retirements and two CADs. CADs means called to active duty. So this pace continues for us. Our retirements continue to outpace our called to active duties. So again, we're having the same challenges as everyone else, getting qualified nurses into our service.

So if you know anyone, I'm sharing this because I'm always recruiting. So family, friends, if you're not over the age of 44, maybe you could consider it. So our total numbers in the corp is 5,477. That's all categories.

According to law, we cannot exceed 6,500. So as you can see, there's some space. I'd like to fill all of those positions with nurses if I could. And just in comparison, the Army has half a million in there, half a million soldiers. And I think of those officers, there's probably about 60,000 officers.

We're officer-only, because I didn't make that clear. We don't have anyone other than the officers. We're instant all the way up to admiral. So compared to Army having 60,000, you can see our numbers are very small. But I like to say that we're a very elite organization. But we do need and welcome additional members.

So I don't know, is Dr. Dickison in here? He might not be in here. But he was able to... And he may have spoken on this. He was able to attend the Global Partners Meeting on Nursing and Midwifery back in May of this year. That was my first time.

By the way, I just got into this position in October, so I'm coming up on my anniversary. It's been busy. But I had the opportunity to attend the GPM-NM, just GPM they call it, back in May. And that is held overseas. And so I saw Dr. Dickison was actually there in person. And I was just happy that the U.S. was represented.

I, on the other hand, had to wake up at 2:00 in the morning to attend because of the time difference and because it was held at the WHO headquarters. So hopefully next year I'll be able to get funding to attend in person. But I was just really glad to see him there in person attending the meeting. And I'm sure it was a great experience. These are just some of my key takeaways from the meeting.

Every dollar invested in nursing averages about $3 to $5 in benefits. So that just shows how much nursing has an impact on patient outcomes for me. And that's very powerful. Nursing, of course, you all know, I don't have to tell you, we are the largest part of the healthcare workforce. This is just some data information.

There is a report, the state of nursing, that is put out by WHO, by the GPM. And so we're working together with other countries to make sure that our data is submitted. And that data, I believe, is

submitted through HRSA, directly to the NHWAs, which is part of the WHO. They're the ones that collect all the data internationally from all the different countries.

But one of the issues that was discussed quite a bit was this issue of migration. And I have a question for you guys later because I'm just not familiar with the licensing process for nurses that come from other countries. So that's my question to you when we get to the Q&A session. But this was discussed a lot about how countries that really need nurses are losing their nurses because they're coming here to the United States.

I also found out that, and it was a surprise to me, you all probably know this, but India actually is, like, the number one producer of nurses that come here to the United States. So we're grateful for them. But we are citizens of the world, of the globe, and so we should have some awareness and consciousness about the impact that that has on other countries and the care and services that are provided there.

So this slide keeps me up at night and makes me nauseous because this lists everything that the government-level chief nurse officer should be doing. And it's a lot.

But this was actually written. There's a white paper that was written by WHO detailing exactly what they expect a government-level chief nurse officer to do. And for those that aren't aware, because this was something I learned as well because, you know, in the United States, we do things a little differently, but in other countries, there is a separation between nursing and midwifery, which I understand it if you understand, especially third-world countries, midwives and the role that they play in their communities, they're actually kind of separate.

And that's why it's listed as chief nursing and midwifery. Although here in the United States, nursing is nursing and it includes midwifery. I don't know if we would go in that same direction or not. It's a little bit different for us here. But this first bullet here is very, very critical. Setting and evaluating shared and appropriate nursing and midwifery strategic direction, objectives and plans, and ensuring appreciation of the resources required to facilitate implementation with outcomes clearly focused on patient benefit.

To me, that is like the number one priority, but even just to do that, notwithstanding the other requirements, takes a lot of resources and commitment and collaboration with organizations like yourself. So a surgeon general's priorities.

That's how much time I have left, right? Let me speed it up because I want to have questions from you all. Social connection, youth mental health, workplace well-being, health misinformation, healthcare worker burnout, which to me translates into nursing burnout more than anybody else.

And then the latest one is the firearm violence. And that is Dr. Vivek Murthy, our surgeon general. So I won't spend a lot of time on these slides. I know they're pretty busy and there's a lot of information. Each one of these priorities, if you go on the surgeon general's website, the Office of Surgeon General has done a wonderful job of providing tool kits for communities to take any one of these priorities and fashion them to however you need to do so you can personalize them in any way you need to for your community, for your organization.

So I won't spend a lot of time, but there are tons of resources available if you visit the website. But the main point here... And this is something that the surgeon general has spent a lot of time on. In fact, he's gone all over the country. He's gone now all over the world talking about the importance of social connection and the phenomenon of social isolation as it exists now.

And so I will let him speak for himself.

- [Dr. Murthy] Loneliness is far more than just a bad feeling. Being socially disconnected, which can range from feeling alone to being isolated, is bad both for individual and societal health. Research shows that loneliness and isolation are associated with a greater risk of heart disease, dementia, stroke, depression, anxiety, and premature death.

In fact, lacking connection can increase the risk of premature death to levels comparable to smoking daily. Loneliness and social isolation are also far more common than we might realize. About one in two American adults report experiencing loneliness. Everyone can be impacted across all ages, socioeconomic conditions, and geographies.

This widespread disconnection presents profound threats to our health and wellbeing. Social connection is as fundamental to our mental and physical health as food, water, and sleep, and it affects our performance and productivity at work, school, and in our communities. Now is the time to invest in building social connection.

This first-ever Surgeon General's Advisory on our epidemic of loneliness and isolation shows us how. The keys to connection are simple. Answer a phone call from a friend. Invite someone over to share a meal. Listen and be present during conversation. Seek out opportunities to serve others.

These steps may seem small, but they're extraordinarily powerful. By strengthening our relationships, we can improve our heart and brain health, reduce our risk of diabetes and high blood pressure, boost our immune systems, and lower our risk of depression. We can build lives and communities that are healthier and happier, and we can ensure our country and the world are better poised than ever to take on the challenges that lie ahead.

Visit surgeongeneral.gov/connection to learn more.

- Thank you. Kudos to the AB team. So another priority of a surgeon general is youth mental health. I spoke back in June in San Diego at, what was it, the National Council of Nursing Workforce Centers, I believe.

And so I shared some personal stories, and I just got confirmation before I came in here that I'll go ahead and share those with you as well. It was therapeutic for me, so you'll listen. But anyway, mental health is essential. We don't always think about how it impacts our young people, and we take a lot of things for granted, but the young mind, as it's developing, it is influenced in a different way than it is for us when we're adults.

Loneliness impacts them differently, and I think that, well, I know, research supports that social media has had a negative impact in a lot of ways on our youth. So again, lots of information on the surgeon general's website about this, but I will share my story. And it's the story of Adam. Adam was a very, I wish I had a picture to show you, handsome, sweet boy, family friend.

I've known him since he was a little boy. And he's a wonderful big brother to his brother Aiden, who is on the spectrum, very protective of his brother, loves anime, very energetic, smart, wanted to be an engineer.

During COVID, as you know, our youth were very impacted because they had to not be in school, not be around their friends, so they suffered with isolation. And so one evening, Adam shot himself in the chest. And unfortunately, he did not survive that.

And so we don't have Adam with us anymore. And it's just for me, and I'm sure I tell the story, not to bring the room down, but just to share because I know that I'm not the only one. I'm sure others in the room have been impacted about in some way with the young people in your lives. And maybe they didn't take the steps that Adam took, but they're suffering.

And so it has to be a priority, something that we as adults have to pay attention to and address. So workplace mental health and well-being. We spend 30% of our lives at work. And so we have to be aware of the issues confronting us in terms of well-being at the workplace. I spoke to a group a while ago, and these were students.

And I was just amazed that over half of them, and they're young in their career, and I wasn't expecting the response, but over half of them had been victims of violence in the workplace. These are nurses. And so most of those in the room that are nurses, you know that something violence from patients is something that we do have to deal with. So we have the right to be protected from harm.

We need to feel safe in our workspace. We need the opportunity to grow. We need opportunities to learn, to train. If you want to pursue a different specialty within nursing, hopefully your organization gives you that opportunity to maybe shadow someone and get those extra skills. That can only benefit our profession even more. You need to know that you matter at work.

That you are recognized for the work that you do. There needs to be harmony at work. You need to have a seat at the table. Our profession, we need to make sure that we demand that seat at the table so that our voices are heard and our concerns are heard at the highest level of the organizations, of the healthcare organizations. We need to do a better job of connecting as a community within nursing.

You know the saying, nurses eat their young? I don't see that as much. Certainly in my career I've seen it, especially work in the emergency department as a new nurse. But hopefully we're getting away from that and we, instead of eating our young, we will get to the point where we're actually embracing our young. We're going to have to do that because we're aging out.

In the nursing, I know I'm talking to the choir here. You guys know the statistics. We are seeing more young people come into the profession, but still we're old. So we need to embrace our young and make sure that they feel supported. Health misinformation.

This is huge. And I'm so glad that the surgeon general included this as one of his priorities. This is something that we saw rampant with COVID. And we continue to see it. And again, this is something that... I mean, we live in a new world. We have social media and a lot of information is shared and it's not always the best information.

It's not always accurate information. And I have another story. This story is Sabrina. Sabrina, my sister-in-law, smart, an accountant working for the D.C. government for 20 years.

She gave me the best gift of my life, which is my niece, who I love and cherish very much. She gave our family the best gift. Well, I call her my sister-in-law, but technically she never married my brother, but

she's still my sister-in-law. I claimed her. I married her. And so smart, full of life, just beautiful smile, been part of our family for years. So I'm a nurse practitioner.

You know, the nurses in the room, you know, everybody comes to you with their problems. Christmas Eve of last year, my niece approaches me. She says, "Can you please talk to my mother?" I said, "Sure, what's going on?" Went back into a room in the house for privacy and just me and Sabrina. And she exposed her breasts to me.

And it was to the point of almost being necrotic. I just couldn't believe it. My breath was taken away. And as a nurse practitioner, I knew right away what this meant. And so immediately I took her to the emergency room, not because I knew they couldn't treat her there, but I knew that I could at least get her tied into a breast care center. Maybe we could get a CAT scan.

We could kind of see how extensive the cancer was. Definitely stage 4 without a doubt. So we got her into the breast cancer. She got radiation treatment. Cancer had advanced to her brain, to her lungs, to her liver, to her bones. And so the prognosis was not good.

Sabrina died in March of this year. We had to bury her. So I share that story because she found a quack online, I forget his name, that claimed that he was a physician. And she was buying supplements from this individual for the past year because he claimed he could cure her breast cancer.

So this is how dangerous this misinformation is. And I think that it's up to us. And I think that there's no other group than nurses that can really counter this misinformation on social media. Yes, we have to be. We have to be at the forefront of this because the impacts are obvious. And if I have the story, then I'm sure you guys have some stories as well.

So healthcare worker burnout. Again, this is something that has really impacted nursing. I wear a lot of hats, as you heard. But I also wear a hat as being an instructor, a clinical instructor at a local university. Anyone else teach?

Yes, we need teachers. So just because I care so much about the profession and I'm just dedicated to seeing that we have a qualified, committed new generation of nurses come into our profession. I do teach as a clinical... Well, I did. In all honesty, I had to give it up here recently, but I taught as a clinical instructor during COVID. And so I was able to bring students into the ICUs and see firsthand the impact of what this was doing to our nurses and being able to actually talk to them.

And these are new nurses like one to two years into their profession working. A lot of them were travel nurses and they told me nursing is not for them. They were they were getting out of it, which was horrible and devastating to hear. Not so much from the older nurses, because, you know, once you're a nurse, I would say over five years, you've seen a lot.

And maybe you have thicker skin, for lack of a better term. But these are new nurses and they were fed up. They didn't have the support. They didn't have the resources that they needed. They were struggling and patients were literally dying every day. So you can imagine the mental health impact of that as well. So, as it says here in the slide, 80% of the nurses say their units are inadequately staffed.

Only 12% happy in their role. Eighty-seven percent feel burnt out, underpaid, frustrated with the administration. But I'm sure you guys see this and you're aware. So this is the latest advisory from our

surgeon general and I'm so proud of him for doing this because, in my opinion, it took courage for him to be able to put this out.

But another story, unfortunately, Patricia. Patricia was my niece and young girl. Didn't have the best start in life. She made some mistakes. At the age of 18, she already had two children. I mean, it happens. But she got involved with some knucklehead and she was shot.

He killed her. Eighteen years old, two kids now without a mother and their fathers weren't really in their lives anyway. So now those kids are now being raised by my sister, who is their grandmother because of firearm violence.

So I just I think it's just amazing that he had the fortitude and I mentioned the courage to come out with this because it's very controversial, very political. But this is something along with the other issues and other priorities that he has that has to be addressed. It is a public health crisis. Fifty-four percent of adults report that either they or their family member have experienced firearm-related incidents.

So now I'll just talk about my priorities as chief nurse officer. I had to come up with something coming into this role. Obviously, retention and recruitment, deployment readiness and competencies. That's a little bit more specific to the corp because I just need to make sure that my nurses, when we have to deploy, that we are ready and that we have the skills necessary to provide the care and services that are needed by our citizens when we deploy.

The nursing "shortage" and the impact that it has on quality of care, access to care across the globe, barriers to practice specific to... I heard that you guys are close to getting the Compact for APRNs, the Compact States. Yay. Although I was just telling somebody, I think I'm still going to have to pay my fees to each state that I'm licensed in.

I'm not going to get out of that. Social determinants of health and education and how that impacts health overall and access to care and education. Health literacy is a big issue as well. Nursing leadership. As I mentioned, we have a lot of young people coming into...well, we hope to have even more young people coming into our profession.

And we really need to focus on developing leaders because those of us in this room and others are... We're aging out and someone's got to take our place. And emergency preparedness. Now, I really believe that had nurses been at the forefront of the COVID crisis, it would not have gone out of control the way that it did. And we would not have lost the high numbers of lives that we did if we had been upfront, if we had been educating the public about what to do in response to COVID transmission.

Yeah. And so it is a priority of mine to do what I can in this role to ensure that nurses are at the forefront of the next crisis. So one of the roles that I mentioned back is that I chair the HHS nurse council, which we just established back in May.

And this is made up of nurse leaders within those 12 members... I mentioned those 12 operational divisions within HHS. We have members from each of those 12 agencies that sit on this council. And what prompted the establishment of this council was that the previous chief nurse officer, when she attended that GPM meeting that I mentioned a few slides ago, when she attended that meeting back in 2023, she didn't have any visibility on what we're doing at the federal government level in terms of nursing, in terms of promoting nursing education, nursing workforce, nursing leadership and nursing practice.

And so this council has been formally stood up. And one of the goals is to make sure that the chief nurse officer, which happens to be me right now, is informed of what we're doing at a federal government level in terms of these pillars. And I forgot to mention research. Research, of course, is a foundation of everything that we do or should be. And I also established what I call the HOPE framework because as far as I'm concerned, nurses are the heart, but we're also the hope of the healthcare system here in the United States and the world.

This is just a diagram of what the HOPE framework looks like. It's internal to nursing and then it's also external to the community and to the public. So as was mentioned, internally within the nursing profession, we need to focus on honor, obligation, purpose and empowerment. As I mentioned before, we need to be acknowledged for the work that we do as nurses and the contributions that we make.

And we need to have data to support those contributions. Obligation. For over 20 years, we are the number one most respected profession in the country. And so with that respect comes an obligation that we have to have integrity. And it just highlights our commitment to service and just really strengthens what our commitment needs to be to ensuring positive patient outcomes across the country and access to care.

Purpose. Assignments within the organizations, deployments, missions that I've talked about already. And empowerment. Again, like I mentioned before, having that seat at the table, having that voice. And then facing the public more. Actually, I forgot to have these slides.

So anyway, forgot these slides. I already talked about that. Obligation, purpose, empowerment. So training and education is critical. Communication is critical. We should leverage social media. It's here, we may as well leverage it to our advantage.

Get messages out about health promotion and engagement. And outward facing towards the community. The focus is on health outcomes, health promotion and educating to fight against misinformation and health illiteracy. And that was it.

I did perfect. So questions. So back to the question that I had, which I forgot already. Yes. Who wants to answer that?

- [Woman] What's the question?

- I told you I forgot. Yes, yes, yes. Thank you. Yes. I'm curious about that. Does anyone have an answer for that?

Yes, the question was about the licensing process. Number 5. The question was about how nurses are licensed when they come into the United States from other countries.

- [Man] I was going to ask, are vets some of the best nurses to go after whilte they're in nursing school? Veterans from other services.

- I'm make sure I'm answering this correctly. Yes, we do target nursing school. I failed to mention this. We have what we call a junior and senior COSTEP program where students can be in their junior or senior... Well, nursing school, as you guys know, is a junior and senior year. They can come into the corp as instance, and they have an obligation to meet.

They get a stipend while they're in school. And during the summer break, if there is a summer break, they can come and work at one of the various organizations that I mentioned and when they graduate and pass the NCLEX, they will come into the corp.

- If they're already veterans of another service though, are they particularly advantageous to you for recruiting?

- Actually, that's a great question. It depends on how many years they have in service in one of our sister services. There's a limit to the number of years that can be transferred over when they do. And we do interservice transfers, so if they are currently in one of the services, they can convert over to the public health service, but there's a process for that. And as I mentioned, there is a limit to the number of years that can be carried over.

- Thank you.

- Mm-hmm. Yes, ma'am.

- [Roberta] Yes, this is Roberta Hills from Colorado. And to answer your question about licensing folks who come into the country from foreign nursing schools. Each state I'm sure has their own licensing rules, so all I know is what Colorado does. So the individual applies, they're required to have their education evaluated by a nursing credentialing company.

The one that really does a lot for us is CGFNS Commission on Graduates of Foreign Nursing Schools. Anyway they provide a report. We've told them what our rules require. We're looking for equivalency to our education and then we're part of the compact.

Even before we were part of the compact, we were requiring these applicants to demonstrate English competency. So if their education is taught in English, they're good to go. If not, they have to pass one of the approved English competency exams.

Then they take the NCLEX. They get a background check and they get licensed.

- Thank you so much. So those are the same companies that are going out to the countries and recruiting, right? No, it's a different company. Okay. Thank you for that. Thank you. Yes.

Do I have to wait for the light to go on? Is that light on?

- [Meedie] It is.

- Yes, ma'am.

- Good afternoon, Dr. Moon. Meedie Bardonille from the District of Columbia, affectionately known as the district.

- D.C.

- Absolutely. Dr. Moon, thank you for your presentation. My question specifically is regarding around the comment and the video that you shared from our surgeon general. And it's very difficult to understand and appreciate the misinformation that you spoke about. Can you share what your phenomenal organization is doing from the public health perspective regarding how the impact of

misinformation adversely impacts those communities of color, those that are underserved, underinsured as it relates to health inequities and disparities?

- Great question. Remember I talked about resources? You guys work in the state government so you understand. Unfortunately, we do have the challenge of limited budget. The surgeon general's office has a limited budget. And that's why this is a collateral duty for me. We have to...

That's the best way we can get things done. So the best that we can do from the surgeon general's perspective is share information. And as I mentioned, please go to the website because they have done a tremendous job of developing toolkits. Resources. There's a paper there. They have addressed some of the issues, like you mentioned. how it impacts vulnerable populations. So information and preparing those toolkits is the most that we can really do with our limited resources.

And hopefully it's taken into the community. Those tools are used and that's why I'm sharing it now. That's why he goes around and he shares it as well. And that's probably not the best answer, but it is the government.

- Considering that it's impacting the social determinants of health where you work, live, play, and pray, do you believe that this misinformation should be something that is, kind of, paramount and moved and amplified, kind of, to the top of that stage?

- Yes, I agree. Yes, I do. So if you have thoughts on how to do that, take it back to the D.C. government. Talk to your... I can't remember who it is that heads up your health... It's somebody new, I think, that heads up your...

- She just came from San Francisco.

- Yes.

- Our new director of D.C. Health.

- Yes. Yeah, take it back to her. Like I said, there's plenty of information available that you can use and take. That's a starting point and take it from there. But, yes, it's a priority.

- Thank you so much.

- Mm-hmm. Yes, ma'am. Number 6.

- [Jay] Jay Douglas from Virginia and president of NCSBN. Just to follow up a little from my colleague Roberta Hills from Colorado on the internationally educated nurse. She is correct that many jurisdictions of the U.S. have different requirements and different countries have different requirements for who might be international nurses coming into the jurisdiction. But it's all based on that evaluation of their credentials and education and looking at comparability.

And there are various organizations that do that credentials review for nurse regulatory boards and some of our associate members have their own different entities that evaluate the education to determine comparability.

What's important in getting that and then of course there may be that competency examination, the NCLEX or whatever it might be in the country where the individual is going, some of the work that

NCSBN has been doing in collaboration with some other countries through the International Nurse Regulator Collaborative is also looking at comparability and mobility between countries where there's some similarities in our education.

So we are still, you know, doing that work. You mentioned or raised the issue of who's recruiting those individuals. And I think we all are certainly concerned that, yes, we have our own workforce needs in each of our jurisdictions in each of our countries, but being mindful of the fact that what is the impact on those countries.

But typically those nurses are recruited by employment agencies who may contract with employers who they see a need and they say, "Oh, well, let's go after this population and solve our problem here." So we are certainly trying to engage in conversations, both with employers with other countries around ethical recruiting and looking at the issues that are created for one country when there's extensive recruiting from them that might impact their ability to deliver healthcare.

- Thank you, ma'am. And WHO has also put out really good guidance on how to do that, how to work with other countries, and recognizing that they don't want to restrict anyone who wants to come to the United States or to Canada or to any other country, but there just needs to be some oversight of that and tracking of that and, as you said, sensitivity to the impact that it has on the country that's losing the nurses.

No other questions? No? Okay. Is that it? All done?