Past Event: 2026 APRN Roundtable - The Role of RN Experience in APRN Program Entry: Insights and Implications Video Transcript

Event
2026 APRN Roundtable

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- [Peggy] Welcome to the "NCSBN APRN Roundtable Insights for Impact." My name is Peggy Benson. I'm the executive officer for the Alabama Board of Nursing. And many of you are aware that Alabama recently implemented rules for APRN licensure requiring RN experience.

So one of the things that I will talk to you about is our journey and the genesis of why we wanted to do these rules. Well, the background began with employer complaints related to new graduate CRNPs. These complaints dealt with little to no previous RN experience, dismissal from employment due to patient safety concerns.

The employers called, and they were very upset and wanted to know what the Board of Nursing was going to do about the lack of preparation. And they shared with me that they had hired... I'll give you one example, was four CRNPs recently hired, and none of them had had previous RN experience. Unfortunately, they had to dismiss all four APRNs from employment.

We also started receiving physician and trade association complaints related to inadequate preparation of the advanced practice nurse. These complaints were related to lack of clinical knowledge, a role application in the clinical setting for the advanced practice nurse, and obviously, patient safety concerns that they felt were strong and needed to be reported to the Board of Nursing.

All of this came to us having a deeper look into advanced practice nursing applications. And one of the first things we wanted to define is what is direct entry into advanced APRN. And we defined that as little to no previous RN experience required prior to APRN program entry, graduation, and APRN approval in the state of Alabama.

Now, everything that I'm talking about is related to Alabama. And I know that it probably affects other states across the country. So, when we started looking at what is an advanced practice nurse, one of the things that we clearly identified, it is an RN who goes on for more education. It is a registered nurse who

continues their education, but they begin with the foundation of being an RN and having that experience as an RN to move forward.

Obviously, we looked at several different definitions, and there are many more out there, but the key component was always the registered nurse. We looked at the APRN consensus model, the National Council of State Legislators, the National Cancer Institute, and, of course, nurse.org. And they all defined it as a registered nurse who has completed advanced specialty training to develop skills, knowledge, and experience for set and determined specific patient populations.

So, we took it a little bit deeper. What is the problem here in Alabama? What do we want to do? And what do we want to identify as these issues? So, we conducted an internal licensure review of direct entry applicants. And we also decided to look at the Alabama APRN educational programs and mission requirements in the state.

And the findings that we observed were an increase in direct entry CRNP applications since 2020. We also saw that they had graduated frequently from many online programs. And we saw a lack of consistent education program entry requirements within the state. And I think you're going to find that that is nationally as well.

So, looking a little bit further into the APRN mission criteria here in Alabama, we had one CNM program that requires no prior RN experience whatsoever. We have 12 universities. And out of 12 universities with APRN educational programs, only 3 had experience requirements. One in Central Alabama had an FNP program only who required one year.

One program in North Alabama had 1,000 hours before the first clinical. That is the requirement across the board. And then, of course, the one program in South Alabama had all eight population foci, and they did require two years of experience as an RN prior to entry. And, of course, our CRNA programs, I think everybody knows that this is required the same nationally, one to two years of critical care experience.

And it shows on the CRNAs when they graduate that they have that experience. Of course, all programs for the neonatal met all the requirements from the certification bodies and the national standards, which required previous RN experience. So, taking that, we wanted to think, "Why would experience matter? Why would we want to have the RN with experience going on for their advanced practice education?"

We recently pulled up two articles. One was "The Impact of Clinical Experience on Advanced Practice Nursing Education— A Cross-Sectional Study of Norwegian Advanced Practice Nursing Perspectives." The second was Latrina Walden, founder and the CEO of Latrina Walden Exam Solutions. And both of those concluded in their summaries that it was essential to have the RN experience to contribute to their training and their education, and moving forward.

They drew from that experience in their advanced practice role, and it made a huge difference for them for the future. I can quote Ms. Walden, as the "RN experience historically provided the context, for the bedside nursing is built upon a pattern of recognition, patient communication skills, and comfort with uncertainty. These elements are essential for developing the type of clinical thinking rewarded, not by just exams, but by the real-world practice."

And that's what we're talking about today, when we're talking about the direct entry nurse who has never really worked as an RN at the bedside, who has gone through the clinical experiences of learning from a

critical care patient or a stable patient, what to do next, and seeing all the outcomes that come from medical decisions.

So when you're looking at all of that, you know that that experience that you bring into the advanced practice role is the baseline that you pull your application from in everyday practice. So our purpose for these revised rules, and I think it needs to be clear that we didn't just do rules to just be doing rules.

Our purpose was one, public protection, because that's what we're here for. Patient safety. It ensures that you have the context from which to practice from for the future. And we want to establish consistency and entry pathways for education and licensure. And the Alabama Board of Nursing truly felt strongly that the APRN student needs to be experientially prepared to be an advanced practice nurse.

You cannot be an advanced practice nurse if you have no context from which to draw from because it builds on the experience. Yes, you may have all the clinical learning, and you may have all the theory learning, but you've not applied nursing experience, and you do not have that to move forward, to draw from as an advanced practice nurse.

So moving forward, what the Board of Nursing did after several months of looking at this, I believe we introduced it first in July at the Board of Nursing, and in November, we certified the rules, and the Board voted to document 3,000 hours of RN experience prior to APRN licensure in the state of Alabama.

That is only 18 months. It is not too much to ask. The rule changes took effect on January the 10th, 2026, with a delayed date of being operative until January 31st of 2027. We wanted to be sure that we allowed plenty of time for nurses to know that these rules were coming, so that they could be working part-time when they're in a nursing program or if they were wanting to enter the nursing program, that they would be able to do that.

Pursuant to a subsequent agreement with Board staff and the Chairman of the House Health Committee, the Board has decided that we would withdraw the rules with the expressed intent to re-establish those rules after we've convened an ad hoc committee. This is an election year, and we want to be consistent with everyone and have every stakeholder feel like they have a voice.

But we do have the legislative support, and we do have the support to require the clinical hours of the RN experience before we have the APRN licensure in Alabama. I know that this is not new across the country. Several states have been looking into this as well. So this is something that we will be continuing with in the near future.

We will convene an ad hoc committee of stakeholders that will include the Hospital Association, the Nurse Practitioner Association, the Alabama State Nurses Association, the Nursing Home Association, some educators, and some CNOs, if necessary, in order to address what is the number of hours that we need in the state of Alabama to move forward and to ensure public protection?

In summary, the Alabama Board of Nursing will establish clinical experience requirements for APRN approval. And as we move forward, we are committed to public protection and patient safety. I also want to note that if this is left unaddressed, the prevalence of inadequate experience will interfere with independent practice.

We appreciate this opportunity to speak with you today, and I thank you so much for being here. And with that said, I do want to pass it on to Gina. Gina Dennik-Champion, the CEO of the Wisconsin Nurses Association, is here and will be telling you what all is going on in Wisconsin. Thank you so much.

Gina.

- [Gina] Oh, thank you, Peggy. Hello, everybody. My name is Gina Dennik-Champion, and I'm the executive director of the Wisconsin Nurses Association and one of the lobbyists for WNA. I'm really glad that I'm having the opportunity to talk a little bit about our journey on getting this APRN bill across the finish line.

And specifically, I know there's interest in that part where we needed to say yes to two years of demonstration of clinical, RN clinical experience, and two years of collaboration with a physician prior to being able to practice independently.

So let me get started for you. First, always, as we kind of go through this long journey for us, as you know, when we start working on policy, that it always starts with problems. And I can share with you the problem that we were seeing.

Probably the one that really got us going was there were clinics that were established in Wisconsin, where registered nurses were using the title Nurse Practitioner. And we thought it would be an easy fix, but found out that it would need to be a legislative change because we did not have title protection in Wisconsin for any of those four roles.

So that was the problem. We began to work with our other coalition, what we called our coalition partners, APRN, so the other four roles, and thought we could just get together and talk about we were experiencing this, but where are you in your title protection?

As we began to look at proposed solutions. And always, it's about politics, as we began some of that journey. So we were calling it the Wisconsin APRN Modernization Act. What you see on the upper part of that, that infographic, this is 1995, when we had a state statute and law enacted that created the title Advanced Practice Nurse Prescriber.

With that, the criteria that was necessary in order to be called an APNP. That gave us prescriptive authority. In 2000, we ran into an issue with our Board of Nursing, and in order to get done what we wanted to have done, collaboration was entered into the rules.

And there we were. So our goal in this case was, number one, we wanted to achieve APRN licensure. We wanted to get rid of the APNP. People didn't quite understand that. The other piece, when you look at the top again, you see a group under the APNP umbrella, but there were those that were choosing not to prescribe or didn't meet the criteria, but were still...you know, or chose not to prescribe, that they were kind of left out there.

What do we call them? So our goal was APRN licensure. We also wanted to achieve independent practice. We also wanted all four roles under the umbrella and preserved that prescriptive authority that we had in 1995.

So that's sort of that background about how, yes, APNPs were prescribing, but it was, you know, eventually with collaboration. We know that politics and policy are never separated. So the policy was all the good things that we wanted in this legislative bill. The politics along the way, which was included a lot of different stakeholders, so to speak.

And that's kind of what we continued to run into as we were working on this legislation. What I show you here is the five-year journey that, at least once we got a legislative bill drafted and a number, you know, assigned, was in 2017, we had our lobbyists and myself and others trying to...

In 2017, a lot of legislators did not know who are APRNs or who are APNPs. They were not... They just heard names, maybe like a CRNA or maybe the NP, maybe the midwives, but really not understanding, because the midwives had their own license at this time.

But where are the rest of these folks? And they couldn't quite understand what is this APNP. Many of them thought it stood for Advanced Practice Nurse Practitioner, as did a lot of our own colleagues. So we started this process in 2017. We had the idea, we had a bill draft, but that's as far as it got. We tried to shop it, so to speak.

There was still a lot of misinformation about who we are, which took a lot of education, we realized, more than what we thought we had. We came to the end of that legislative session and knew we were going to have to start over. So we had the time in between to work on another bill. So I now want to show where we are with our 2019 journey.

What's going across here is obviously our legislative process and kind of how that works. We have two Houses, both the bills have to be identical in order to get passed by both Houses in order for the Governor to either sign into law or veto. So, where we were in 2019, we did work over the 2018 end of the year to continue to work on legislation.

We did meet with some of the stakeholders throughout that process, but they had their own issues, and, of course, they weren't really interested in helping us get going. As we headed into 2019, it was the end of the legislative session, we kept trying to meet and working on some negotiations.

Collaboration was a huge one, but needless to say, got to the end of the session. And it's a great strategy, don't negotiate, just keep talking. And sure enough, we ran out of time. And the issue with the nursing education, the needs for two years of clinical nursing practice in the two years of collaboration, we were still in the fight for getting rid of collaboration altogether, and the education piece hadn't started at all.

Okay, so we're now into the year 2021 of our journey. And we had legislation, but the Governor wanted two years of RN clinical experience and two years of physician collaboration.

We were opposed to that. And what happened was it got to the Governor, despite all of the support that was happening both within the consumer side of folks contacting the Governor, as well as ourselves. And the Governor vetoed the bill for that particular reason.

There was also his concerns about interventional pain management. So these were kind of two of the bigger issues that we said no to. 2023, the Governor... We had two legislative bills. The Governor included the language that he wanted in his budget, that two years of RN clinical experience and two years of collaboration with a physician.

Our legislative bill, we tried to negotiate for, was...and our bill sponsor was like a bulldog on this. He did not agree with needing two years of RN clinical experience as a means of being able to get to independent practice.

What he proposed, however, was three years of collaboration. And we, as our nursing coalition, and our educators that we worked with, I liked the idea of not having the RN clinical experience. And we were all ready to settle for three years of collaboration.

Again, there was other information in the bill, not information, but other language that was also objectionable to the Governor. So this time around, his budget language got pulled out of the whole budget process.

And that came out of our joint finance committee, pulled out that. So it was left with the legislative bill, which got adopted by... You know, again, passed both Houses. But again, the Governor vetoed for the reasons... He focused not so much on the education side, but he focused on the pain management, pretty much tried to tie together the fact that opioids, you know, can be a big cause for accidents, vehicle accidents, and deaths.

And he was trying to connect the dots that APRNs are not safe prescribers, pain management prescribers, and connected that dot, and what can happen is they're on these opioids, and these people can cause accidents, which didn't sit well with any of us. But knowing we were going to have to work with him to get this bill passed, we put out our press release.

And, again, also just trying to share who advanced practice nurses are, and what we bring to healthcare when there is a shortage of physicians, and our rural counties were in desperate need of providers.

On to 2025. Again, we really spent time before the session started with the Governor's office. The Governor staffers proposed language that we thought we could live with, and it did include the two plus two.

And it's not exactly two years to two years. We actually lowered the actual amount, considering that nurses do get time off, so they should not make it a full two years if you see our bill. The other piece had to do with the pain management piece. We did begin to move forward.

As we were hearing from schools of nursing, is that many of their students were already working, had the experience, were gaining the experience, or the time of working two years in a clinical RN role. They were doing that before they started the APRN education program, and they were continuing to work.

By the time they graduated, we saw that most of the individuals that were currently enrolled were meeting that two-year mark. That two years of physician collaboration is not what we wanted.

It's what we agreed to. And the same with the pain management. So this year, in 2025, the bill sailed through the committee hearing, it sailed through both floors, and presented to the Governor, and he signed our bill into law in August of 2025.

So we were quite excited and really wanted to celebrate what happened after all these years, so to speak. I want to just share in terms of when we first started out looking at this legislation, how you could see where the growth was just starting to happen.

Prior to that, again, we were trying to share with legislators who APNPs are. You could just see that the numbers were just beginning to grow. Even the consumer maybe knew who an NP was, maybe a CRNA. The recognition was because the growth was just starting to become more prevalent.

And as we began to grow, you could see that there was much more awareness of who all these APRNs are, and what they were capable of doing, especially again, in our rural areas.

So factors to consider as we were working on getting this bill passed. We started our journey back in 2002. And again, it started, like I said, with the title protection for the name NP. And we also found that the APRN consensus model was gaining traction. And we wanted to implement what was in the consensus model into our legislative bill.

So that took a few years, but we got to it. And that helped, again, once we really...as a coalition, to get through the language and agree to the language. The bill was over 72 pages.

And that is because in 2013, we had a legislator, a nurse legislator, that we went through the statutes. And wherever the word physician, or podiatrist, a DO was listed, we added APNPs. So when legislators first looked at this legislation, they thought, "Oh, my God, it's 72 pages. What all do you want?"

And some of it was just, you know, having to do with the technical changes. But the consensus model, we agreed to, we created our definitions, you know, what would it take, and, you know, where we needed to stand our ground. And that, again, was part of that process. We had COVID, which was interesting, because during the years of COVID, the Governor waived the collaboration agreement with physicians.

And we all know the world didn't fall apart because of that. There were no incidents, events that were caused by APRNs. And we were surprised again when the Governor vetoed our bill, which we found, I would say, it wasn't an argument that we could use that worked.

We had a lot of influencers trying to oppose this language. Those were...we had... The Board of Nursing at the time had a lot of requirements that they wanted to see in the language, which really weren't adopted, as it was found to be a little excessive.

We had our organized medicine also weighing in. In particular, one really good example was the fight between the anesthesiologists and the CRNAs. There's always that battle. So there was a lot of...

The pain management issue was pretty much a lot of their fight that we all needed to pay attention to. And then we also had the Hospital Association, which eventually became neutral on our issue. They were beginning to hear about the value of having these APRNs in primary care, serving as the hospitalists.

They knew the experience of what was happening within their organization, and therefore became mutual. And as hard as the organized physician tried, by the time this bill in 2025, negotiations with organized medicine, even with the Governor, had stopped.

So we kind of had that pathway. So we did factors to consider, the old policy versus politics. So this was the political sort of scenario throughout the time we were trying to get this bill through. The Republicans had the majority in the Senate and the Assembly.

They were the ones that were really supporting our intent, supporting the legislation, along with some Democrats, but most were following the line of what the Governor wanted.

And the Governor was a Democrat, so there was contention all the time. It was a contentious environment. We did, as we looked at the two plus two, does two years of RN clinical experience improve nurse competencies when they become APRNs?

And couldn't find a lot of data or research to use. You know, when you looked at the outcomes of APRN practice, we're not there when the new APRN enters the workforce in terms of did they need more precepting or mentoring. And so it was a little hard to, you know, work on this one.

Also, the legislature knew, as did the Governor, that for CRNA practice, they are required to even enter the program, an education program, that they need two years of critical care nursing experience. And so there was your precedent.

And the other three roles, really, you know, hadn't adopted that or didn't think it was necessary. And those are our educational programs, the graduate-level programs. So, as we really got into 2025, they stayed neutral on this for getting the bill passed.

They saw it was important to go with the two plus two, but not requiring it. It's still up to that individual nursing student to achieve the two years of RN clinical experience. If they don't achieve the two years of RN experience, they then have to...let's say they only have one year, then they have to add on a year under physician collaboration.

There were other compromises, like I alluded to. Interventional pain management was huge, or pain management in general. And it was mostly our CRNAs that had independent practice, well, collaboration with a physician. There was concern about pain management, and it was interventional. But there was agreement on if the CRNA was working within a health system or had privileges within a health system to, you know, conduct or perform interventional pain management, they did not need collaboration with a physician.

If it was a freestanding interventional pain management clinic, so to speak, and they didn't have...they weren't under an umbrella and did not have that sort of admitting privileges, then they needed a collaboration with a physician. This not only impacted CRNAs, but if CRNAs also hired other APRNs, any of those APRNs would have needed a collaborative agreement with a physician with experience in pain management.

Lastly, part of our fight earlier bills was the physicians added to the bill that they wanted title protection for physicians that had the suffix -ologist. And you can see why they wanted this because of, again, the fight with the CRNAs who, at the national level, were changing their name to nurse anesthesiologist instead of nurse anesthetist.

And that really rankled those physicians. So they did get rid of the name -ologist. And there was a lot of testimony from a lot of folks that were not physicians, but you had the term -ologist, psychologist, right?

Or there were specialized...maybe your chiropractors that had specialized and were now -ologists. So the Governor's part of those negotiations in 2025, that was one of the things that got pulled out, was that particular language.

As we know, the goal through all of this, through all of our years, it was the goal of APRN licensure. We also wanted that pathway to independent practice, and also knowing that nothing needs to be forever in a statute.

So we know that we can, in the future, work on some of those legislative laws that we can work on getting amended. And part of that could is that two plus two. But for us, it was more important to really start working on and having this licensure. Again, we can collect data in the meantime to get more of that information about nurses, APRN nursing students, and again, if there's any issues that come forward.

We do know that our health systems, they're doing fellowships. So when the new APRN graduates, they're in a two-year, three-year fellowship. Others are getting the mentoring and the precepting. And others are getting that onboarding.

So it's not like they just are thrown into the wolves within that health system. Thank you. That's all that I have right now in terms of sharing our journey. It was a long one. I am looking forward to hearing from you. We have the live Q&A if you've had any of these sort of circumstances where the two plus two was part of the agreement.

Thank you for your interest. And again, I look forward to talking with all of you. Thanks.

- [Emily] Hello, Peggy and Gina. Thank you for joining us. And thank you for both providing such wonderful information about how your states got to this RN experience requirement.

So the first question is actually for both of you, but I'm going to pose it to Peggy first. Does the required amount of RN hours have to be completed prior to entry into the APRN program, or can it be in combination with, or just prior to graduation, and then entering into practice?

- It can be either way. They can have it before they go into the program or during the program. One of the things that we're hoping will come from this is that the nursing employers will work with some of the schools in order to give them a schedule that they can work with while they're in the program, and they can attain those hours if they don't have quite enough to finish that.

- Thank you, Peggy. And Gina, same question to you. Is that requirement prior to entry into the education program, or is that before graduation and then entry into practice itself or licensure?

- Yeah. So in terms of the two years of clinical experience, the schools are looking at, as they're coming in, what experiences they have. And we know that admission to a graduate program is not just what are you doing now, but what are the other sorts of things that you will be able to bring as an advanced practice registered nurse?

So it was only, like I said, the graduate CRNA programs where they want before they enter the educational program where the two years of...and it's critical care nursing that counts. So there may be some schools, I'm not sure, that would, like...where they wanted the clinical, but I'm not hearing anything.

I didn't hear much about that, I should say. And currently, our Board of Nursing hasn't. They're working on the rules as we speak.

- Understood. Thank you, Gina. So, sort of along those same lines, do either one of you have any thoughts about whether that RN experience differs by whatever APRN education program that student is entering, acute care versus primary care, or do you have any sort of regulations around what this would look like?

And I'll start with you, Gina.

- Currently, I know our Board of Nursing, because we have, it's more that you have your National Board Certification, and that's where your specialty lies based on that exam. I believe the schools of nursing, that they'll pick the track of where they want to land. So if it's family FNP practice, they'll get the primary care and that FNP.

If it's acute care, then they're taking the acute care route. And so, as I understand it, that they can gain that specialization while they're in their educational [inaudible].

It's sort of what is it the student, the APRN student would like, where they'd like to see themselves when they graduate.

- And the same question to you, Peggy. Is there any thought or regulation around what type of RN experience would be "required" for entry into specific or particular APRN education program tracks?

- We're pretty much not going to make it certification experience. We think that the clinical experience really should be in the acute care setting. You know, already, you have the CRNAs that require critical care. You have the neonatals that require NICU experience, but what we do want to be sure is the experience is not a death job, and it's not an administrative role.

We want them actually in a clinical setting doing clinical experience, because that's where you're going to get the knowledge transfer and the recognition on how to apply certain skills and things that you have related to that. So we will have some specific rules related to that.

- Thank you, Peggy. So, when looking at these requirements and considering how we balance patient safety with access and equity, how can we avoid unintentionally creating barriers for RN entry into APRN practice? What are your thoughts on that?

And I'll start with you, Peggy.

- Well, I really don't think there will be a barrier because you're going to have the workforce space that's going to need the nurses at the clinical bedside, regardless, even while they're in the programs. But I do believe that what you're going to get from this is nursing experience, competency, and not just the competency, but where you feel more comfortable in your role in applying the things that you've learned to the patient population that you're taking care of.

So I see this as a win-win, not for just the nurse, but for the patients as well. So I really don't see this as a barrier for the future at all. You have programs already that require the experience for entry-level. So no, I don't really think it'll end up being a barrier. Actually, it may be a win-win for the employers and the programs.

- And same to you, Gina. How do we avoid unintentionally creating these barriers with putting this requirement in place?

- Well, as I said in my presentation, and maybe I just didn't look in the right place, but looking for the data that actually show that two years, three years, four years of clinical RN experience while you're, A, being able to get into a program or to be able to accomplish the two years while you're in the program, does that make a difference?

Because in Wisconsin, again, we don't know the research, but I haven't found the research. And I'm hoping that some folks, and hopefully, I didn't miss that today, where there is the evidence that shows that the RN experience in two years will make a better NP. And again, we don't want to.

And I think that's kind of... Like I said, as we look to wanting to maybe change that statute, just what is it we're looking for, for these nurse candidates that want to get into a program? I know we have a lot of long-term care registered nurses that would like to, I think, because of their experience and their liking long-term care, wherever the setting, that bringing them in, I just...

I think it might be a difficult role for maybe a public health nurse, but we don't know, or a school nurse. But we know patient safety is very important, as do our educational programs know that it's important and that we're graduating a nurse with competencies and that there is that expectation of continuing with those, where the employer also provides the support.

- Thank you, Gina. So we have a lot of people on this call that are listening, and maybe external stakeholders. They may be members of Boards of Nursing. What recommendations would both of you have, and I'll start with you, Peggy, about how to sort of move this work forward as Alabama just did?

- Well, we just recently had our ad hoc advisory committee, and one of the recommendations coming out of that is 2,000 hours, which we will take into the Board in May for us to consider for those rules. And as far as moving it forward, we obviously would have to be talking to the educational programs, the employers in the state, which we've already begun talking with them, and they were part of the ad hoc committee that we recently put together.

And they had a firm belief as well, is that they wanted experienced nurses who had...advanced practice nurses who had previous RN experience. They just felt like it made a more professional nurse at the bedside, and that it ensured a firm foundation for them to begin their practice with. I think we just still have to continue that dialogue with them.

Like I said, meet with the employers and hash out how we're going to do this and how they can be supportive of implementing the experience factor. That won't go away. Our role as a regulatory board is to have those dialogues, and we have a very strong relationship with the hospital association here and with the CNOs across the state, as well as the associations. And so we would be talking with all of those individuals and also rolling it out to the licensees and being sure that the advanced practice knows of all the changes that are coming and that should be coming.

It would be nice if we saw some of the educational programs look at upping the experience factor from the get-go, so that they know prior to entering that program that they would have that. If we could get more of the programs in Alabama doing the experience factors prior to entering the program, then we could develop rules that would require the out-of-state programs to meet those same admission criteria.

Those are things that would be a challenge for the future, but I see that as a positive move if we could do that, because we really need to get everybody on the same playing field so that you're not going out

there and taking every direct entry a nurse wants to further their career, because you don't want to have the experience factor.

You want to go straight from school. We want to help you be successful. We want to help you become advanced practice nurse, but we need to know that you have that firm foundation in order to move forward and that you make good decisions when you do.

- Thank you, Peggy. The same question to you, Gina. What recommendations would you have for our members, Boards of Nursing, or external stakeholders that would like to move something like this forward?

- Well, first of all, I would like to see the data is there. And again, currently, as they enter the nursing program, if they're already working clinically as an RN, what does that...? Does that make a difference?

And I think maybe faculty could tell you about maybe that. That could be some good research. And then again, the employer themselves being able to look at the outcomes of that nurse, that APRN that's entering the workforce. And I think, you know, it's sort of like our nurse residency programs, RN nurse residency programs, where employers have noticed that, you know, they really try and focus on some of those additional skills and those competencies.

But not every nurse that gets in there, that gets hired, is eligible for that program. I think it's a preceptor sort of thing. Obviously, the cost of having to continue with gaining those additional hours. Right now, there are some of our health systems where the student needs to pay the system, the health system, a certain amount of dollars in order to get precepted there.

So, it is a huge dynamic, and maybe the experiences Boards of Nursing look at the complaints that are filed. Is there a trend, any kind of trend that is emerging that could also help tell us that additional hours of clinical experience might be in their education, during their education?

Would that be helpful to providing a more competent APRN when they get out?

- Thank you, Gina. Peggy, did you have something to add?

- Yes, what I wanted to add was this is really not about competency of skills and competency that you learned in the program. This is about being able to apply the skills based on your experience. I want to be sure that people understand that. We're not saying that you're not putting out competent individuals, but if you have no basis from which to pull that experience from, you will miss opportunities, and patients' protection will suffer from that.

And this is about giving them that professional foundation to become more competent and competent in that role. And that's what I wanted to stress today about that. Thank you.

- Thank you. Thank you very much, Peggy. And thank you very much, Gina. I appreciate both of you being here and presenting this information and joining us in the live Q&A. We're going to move into a break right now. We will resume at 2:50 with our final, last but certainly not least, topic on "Medical Spas and IV Hydration Clinics." See you soon.