Past Event: 2025 NCSBN Annual Meeting - Regulation of APRN Education Video Transcript

Event
2025 NCSBN Annual Meeting

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- [Michelle B.] So good morning, everyone, and welcome to the APRN Education panel. My name is Michelle Buck. I am the APRN senior policy advisor for NCSBN. We are incredibly honored and thrilled to have this expert panel joining us today to provide an update to each of you on the current state of APRN education across all four roles.

So clinical nurse specialist, certified nurse midwife, certified registered nurse anesthetist, and certified nurse practitioner. It wasn't all that long ago, and a lot of you probably remember, 25, 30 years ago, when APRN education requirements for licensure varied significantly across jurisdictions and across roles. Some states required graduate education, some didn't.

Some required national certification, others didn't. There was the criteria for entry into advanced practice, and certification exams accepted for entry-level competence. Assessment also lacked uniformity, as did scopes of practice and legally protected titles. Some referred to it as the Wild, Wild West of regulation.

In 2008, after years of effort by leaders of NCSBN and regulators, the APRN community from educators, certifiers, accreditors, and professional organizations, the APRN consensus model was adopted. And for the first time, there was agreement and commitment across a broad spectrum of stakeholders to a framework for the regulation of APRNs.

The consensus model, as you all know, called for the education of APRNs to be at the graduate level in one of the four roles and one of the six population foci. The model called for APRN education to be

broad-based and include three separate graduate-level courses, and what we all know now as the three Ps: advanced physical assessment, advanced pharmacology, and advanced physiology, pathophysiology.

And the programs had to require appropriate clinical experience. The model required that all developing APRN education programs or tracks go through a pre-approval, pre-accreditation, or accreditation process prior to admitting students. Programs are to be housed within graduate programs that are nationally accredited, and they must prepare students to be eligible to sit for the national certification exam, which would then be used as a requirement for licensure for APRNs.

Certification exams are to assess competencies of the APRN core role and at least one population focus area. The consensus model also called for national certification programs to be accredited. And the exams had to be psychometrically sound and legally defensible.

Somebody said that yesterday, and I had to laugh, because that was Maureen's mantra, Maureen Cahill, if any of you remember her. Over the past 17 years or so, APRN education, certification, program accreditation, lawmakers, and U.S. nursing regulatory boards have moved towards full alignment with the elements outlined in the model. Currently, all boards require graduate education in an accredited program in order to grant APRN authority to practice, most commonly through an APRN license.

And nearly every jurisdiction requires national certification in the APRN role and population as a condition of licensure. Alignment with the consensus model provides for public protection through regulatory continuity across U.S. jurisdictions. A patient in Montana should be able to travel to another state and be treated by an APRN provider, and believe that that person has met all the same licensure requirements as their trusted provider in Montana.

As you all know, there's still work to be done to fully align with the consensus model, in particular in areas, as you all know, full practice authority, prescriptive authority, and multi-state practice and licensure through the APRN compact. Currently, around half of the boards of nursing regulate and approve APRN education programs in their jurisdictions.

We all know that boards of nursing are really under assault by external entities who are seeking to regulate APRNs. As recently as 2023, the American Medical Association passed a policy amendment recommending joint regulation of APRNs by boards of medicine and boards of nursing. Some of you in this room know all too well about joint regulation.

Alabama, North Carolina, and Virginia have joint regulatory structures in place now for APRNs. And others of you have faced ongoing legislative challenges to your authority to regulate APRNs just in the past year. We at NCSBN know that nursing regulatory boards are the most qualified and should be the sole regulators of APRN practice and education.

It may be more important now than ever for you to be engaged in every aspect of APRN licensure, and this includes the regulation of APRN education programs. Evaluating program quality through oversight and approval and holding programs accountable for outcomes, such as national certification exam pass rates, fulfills the mission of safeguarding the public.

We hope this panel will augment your work in the regulation of APRNs and help you to fulfill your mission. So we're going to move to the panel, and we asked our panelists to respond to a series of questions. Some of them are frequently asked questions that we get at NCSBN, and other things are areas that we know that they collect data for, and we think that you would be interested in hearing about.

And then after the presentations are done, we're going to open the floor to questions. So please, if you've had burning questions you've wanted to ask an educator, please come to any of the microphones, and we'd love to hear what you have to ask. And so now I'd like to introduce our panelists. They don't get a walk-up song, sorry, guys.

So let me start with Dr. Christopher Gill. He's a dual-certified CRNA and nurse practitioner with a track record of leadership across clinical, regulatory, and executive domains. As chief credentialing officer at the NBCRNA, he oversees national certification programs impacting over 60,000 nurse anesthetists and 9,000 student nurse anesthetists.

His career spans trauma and academic anesthesia practice to strategic oversight of credentialing innovation and policy. He also currently serves as the president-elect of the Illinois Society for Advanced Practice Nursing, driving legislation and professional advancement. He brings a systems-level perspective to APRN leadership, grounded in data, governance, and a commitment to public trust.

Next, we have Dr. Shannon Idzik, a tenured professor and associate dean for the DNP program at the University of Maryland School of Nursing. She serves as president of the National Organization of Nurse Practitioner Faculties, and has previously served as the president of the Nurse Practitioner Association of Maryland, and maintains an active clinical practice at Upper Chesapeake Medical Center.

Dr. Idzik has over 50 publications, 100 presentations, 101 now, is actively engaged in more than $20 million in funded projects advancing nurse practitioner practice. She's a fellow of the American Association of Nurse Practitioners and the American Academy of Nursing. Her work in NP education, health policy, and diabetes care has impacted practice nationally.

Next, we have Dr. Peter Johnson. He's president-elect of the American College of Nurse Midwives and a national leader in midwifery and global maternal health.

He is a professor at the University at Buffalo School of Nursing, where he advances midwifery education and practice. Dr. Johnson is a retired chief nursing and midwifery officer of the Jhpiego, a global health NGO affiliated with Johns Hopkins University. In that role, he led international initiatives to strengthen midwifery and nursing capacity in over 25 countries.

His work bridges U.S. and global perspectives to elevate maternal and newborn health worldwide. And Dr. Jennifer M. Manning is a prominent nursing leader, serving as associate dean and CNS program coordinator at LSU Health Sciences Center in New Orleans and as a clinical nurse researcher at LCMC Health.

She's the immediate past president of the National Association of Clinical Nurse Specialists and is current vice president of the Louisiana Board of Nursing. With 25 years of experience, she is a board-certified adult health clinical nurse specialist. Dr. Manning has delivered numerous presentations and authored over 30 articles and several books. She is dedicated to advancing nursing through education, research, and service to improve healthcare in Louisiana and beyond.

Please join me in welcoming our esteemed panel. And we're going to begin with Dr. Gill.

- [Dr. Gill] Thank you. Good morning. I've prepared a couple of slides here to go through the CRNA role and some of the questions that Michelle spoke to. So the first one I'll kind of start with is our current enrollment and trends. So my work at the NBCRNA is similar to your work as a regulatory body.

So I feel a strong connection to all of you in the audience, because that is a challenging role to play. And I know that all too well, talking to CRNAs who want to be able to do what they want to do, but we need to make sure we measure their knowledge, skills, and abilities, and can prove that to you all to issue licenses.

So the NCE is the National Certifying Exam. In terms of first-time examinees, we have seen a slight downtrend between 2023 and 2024. I think that's actually more of an aberration ultimately, because what's more likely at play right there is the fact that, and I'm going to speak to this, is the educational training that individuals are getting.

So a number of programs in moving to that doctoral level actually went a class without a cohort, without filling a cohort. So there are some people that... We're going to see that number go back up. So the number in 2024, and all my data that I'm going to present to you as a year in arrears, is 2,740 individuals who were first-time examinees. Our total test takers that took the NCE in 2024, again, down just a small amount from '23, 3,279.

And so that just reflects a small decrease between first-time and total examinees in this first year. So as we see more programs move, well, and I'm going to speak to that specifically, we've seen all of our nurse anesthesia programs get to the doctoral level, and this was accomplished in 2022.

And I'm going to show you a trend graph. And that is something we are particularly proud of. We do see that some of the individuals coming through to take that National Certifying Exam still are being prepared at the master's level, and that just represents a holdover from previous cohorts, where they may have completed coursework late or had it incomplete.

But we now are seeing 96.4% of individuals that come through with a doctoral degree. So much of the data that I'm presenting to you is co-owned between the certifier, the NBCRNA, and the Council on Accreditation, and so I'll just speak to that very briefly.

I am fortunate to have great colleagues, Frank Gerbasi, Ph.D., CRNA, who is the CEO of the Council on Accreditation, which is located here in Chicago, Illinois, and he was gracious enough to provide me with some of this information. So in terms of answering the call, we feel very, very proud that nurse anesthesia has answered the call to move to the doctoral level.

And so we achieved that in 2022. So that's something we're particularly proud of. When we talk about the background of the typical individual enrolling in a nurse anesthesia training program, they come with a ICU background, so we say critical care, and that is a COA requirement when they are enrolling in an anesthesia program.

They're required to have at least one year. We typically see individuals coming with far more than one year. Every program kind of has a different model student that they look for, but the average that we're seeing right now is 2.9 years, and some individuals are coming with 3 to 5 years, may have had a break, worked in a different area, come back to critical care with the intent to pursue anesthesia.

So the data that you see in front of you is, I just want to say, self-report. We ask individuals when they enroll in a nurse anesthesia training program what their background is. So oftentimes, we get their breakdown provided. And so most commonly it is ICU and cardiac care unit, followed closely by the medical intensive care unit. Trauma ICUs represent a significant share, and surgical ICUs.

Although some programs will allow some OR or PACU time, I would say that is the minority of programs that are looking at that. And this is kind of interesting. Fourteen, 15 years ago, when I was finishing anesthesia school, neonatal and pediatric ICUs were not really thought of as highly sought after, and the kind of typical thinking at that time was the likelihood to be putting in invasive lines.

Using vasopressors or managing ventilators was far less in those pediatric populations. I'm proud to say that a number of programs have now changed their thinking on that. And having worked as a faculty member, I can tell you that the individuals that come with those backgrounds are stellar individuals.

And so I think that's just rounding out the profession and keeping us even more broad than we previously were. When we talk about the ratio of online to in-person, the Council on Accreditation does define distance education as when programs are looking to do greater than 50% of their instruction through some form of technology.

But this statistic is not perfectly fine-tuned. We did see an increase in the number of programs that were looking for this type of waiver, not surprisingly, go up during COVID because they had to rapidly evolve, just like we all did in different ways. And so after COVID, the Council on Accreditation looked to formalize that more robustly. And so the data that we're seeing right now is that 83% of programs, 112 out of the 154 that currently exist today, are using some form of distance education.

Very few are using them for the entire curriculum. They're still requiring their students to come on-site to do simulation and other key portions, skills check-offs, but there is a significant increase in the utilization of that technology. And then we have 21 completion programs. So for CRNAs that may have been trained at a baccalaureate or master's level, we have 21 of those programs that are relying on distance education.

And so this just reflects kind of the rapid change from 2019 on, where those programs did formally ask the Council on Accreditation for this type of waiver and approval, and so we see that trend moving up, consistent with other APRN programs. I am personally very proud of this.

Our clinical hour requirements and averages that individuals are getting is significantly over the minimum requirement that the Council on Accreditation sets. We see in 2024, the average number of anesthesia cases that a nurse anesthesia trainee will care for or manage as 911.

So we're very proud of that. The total number of anesthesia hours where they're actually providing, so we break out the clinical time separate from the actual provision time of anesthesia itself, as being 1,800. Total clinical hours, 2,700. And so we're seeing programs really exceed the minimums by a significant margin. And as I always say to individuals that are in a training program, although it is long days and many hours, you know, it's 10,000 hours to expert.

So there's only one way to get there. And so I frequently tell them, you know, "It's not that we necessarily want you to stay to do another endoscopy when you've done many of those, but when you see good cases, you need to stay and do those cases, because that is what's going to prepare you to be leading in the perioperative space. And I'm sure this is going to mirror many of my colleagues' data, but in terms of preceptor and clinical site status and challenges, we are seeing an increased competition for clinical sites.

I think this is driven by a number of factors. One is the number of programs that has increased over time. So when I was in training, I believe there were close to 112 programs. We're now at 154. So there are

now more programs vying for the same clinical sites and the same clinical exposure. There are, not surprisingly, preceptor shortages.

This is really retirement and burnout. It is both a blessing and a curse to work with a student every day when you've done that. It's something that I personally take as a mandate for myself, but if you've done that for decades, then you do want to get a break every now and again. And so the last thing is COVID-19 disruptions and some backlog effects that we're seeing with clinical sites that are now starting to even out.

In terms of providing clinical placements, CRNA programs do have the unique perspective or aspect that the clinical sites are secured for the students. It's not to say that if you want to do some specialty rotation or if you want to get a certain exposure to an employment setting that you may not have to work a little bit.

But when you enroll in a nurse anesthesia training program, your clinical site placements are set. And so I know, having gone back to school to pursue my nurse practitioner after my CRNA, there was a difference there. And I was working very diligently on my own to help secure that clinical placement for myself. But in terms of...

With CRNA programs, we are seeing that they are now being denied access to some clinical sites. There are some political aspects of that. There are also some employment aspects, where clinical sites or systems are saying, "You know, we will accept your student. In return, we look to hire so many or a percentage of them." So there is a negotiation that is now going on there that we previously didn't see kind of with that level of vigor.

There are some clinical sites and programs that have severed relationships. If a program was the only program in that region or that area, they now have maybe moved to a new program where they have a relationship. And so we're kind of seeing some of that data come through and working through those challenges. Just showing you kind of over time, so this has been more recently tracked by the Council on Accreditation, and they are closely monitoring this.

So getting to the access to clinical sites, there's really three key issues. They are denied access outright, they report more difficult access, or they ended their relationship. And so the one that really has increased over time is denied access. And we are now seeing recruiters, systems, and other practices try to form an employment relationship with a nurse anesthesia trainee much sooner in their school.

When I was in a program, it was really three to six months before graduation is when you would start kind of putting feelers out there, interviewing. Now I would say that's happening very early on in the first year of the program, where recruiters are forming a relationship from either a private equity-backed management company or a system. And so they are really getting in there much sooner because they understand that it's a tight employment market.

Faculty status. We have the same challenges that all other APRNs in nursing programs have. We have faculty that is tenured and retirement concerns, and we're looking to get new people into those faculty roles. I can tell you, having worked in both capacities, the compensation, much like with other roles, is different.

There is a delta between a clinical practice role where your compensation is at market comp, hopefully, and when you're working in a university, you're faced with the inherent challenge of being measured as

a assistant professor or associate professor across the university setting. And depending on what clinical background you have, your clinical compensation may be very misaligned with that.

And so I think schools are really having to be very innovative and flexible with how they work through faculty arrangements, whether that's fractional faculty or whether they're hiring faculty. I know a number of friends of mine who are faculty members full-time. They get a clinical release date during the week, and I think that's mutually beneficial. It helps kind of alter the delta in terms of compensation that they're seeing in their full-time role, but it also keeps them clinically relevant.

So I think we're seeing more flexible and innovative things happening. And again, not surprisingly, there is difficulty recruiting DNP or Ph.D.-prepared CRNAs into academia for many of the reasons I've highlighted. Current technology and trends that are going on within nurse anesthesia. As a certifier, we have adopted alternative exam formats, owing to the content and the knowledge base that we expect CRNAs to graduate with.

We look to elicit their knowledge through multiple correct responses, you know, choose three out of six, short answer, drag and drop, hotspot questions, where you're actually putting an X on a nerve plexus or reading an ultrasound image or a radiograph, because those are expectations of when you finish or even an EKG.

We do see programs increasing the utilization of simulation. We do require that...the Council on Accreditation requires that, for completion of a nurse anesthesia training program that individuals have at least five central line placements. I'm sure that this is not surprising to many of you, but we've definitely seen an increase in the number of PICC lines that are placed and other ultrasound lines that are placed by registered nurses or other individuals.

So that is decreasing the availability of central lines. We're also seeing changes in cardiac anesthesia and other specialties like transplant, liver transplant, where maybe a central line isn't being used for that case because they figured out a way to do it differently. So that is something that we're seeing more utilization of simulation for. I'll just kind of wrap up with this summary.

So our enrollment is at 2,740 at this point. Slight decrease. We believe that to be because of the number of programs that have gone to a doctoral background. That number has moved up. All programs, as of 2022, have moved to the doctoral level. Our individuals that are pursuing anesthesia training come with a ICU critical care background, averaging 2.9 years prior to enrollment.

We're seeing increased use of distance education in some form. And that also... I didn't touch on this before, but I will say it. As clinical site placement becomes slightly more challenging and individuals are being asked to go greater geographical distances, that's another reason we've seen an adoption of distance education. Our minimum case numbers far exceeds what we set at 600.

We think that is a strength and a benefit to preparing the nurse anesthetists for clinical practice and safe care. Much like other colleagues, competition for clinical site placement, retirement, and COVID-19 has caused some changes in the site and preceptor arena. Faculty.

We're continuing to work to build doctorally prepared faculty to take on faculty roles and fill those much-needed seats. And then finally, simulation use, ultrasound use, has really gone up in our field. So I appreciate the time, and I'll pass back to you.

- Thank you.

- Thank you.

- Thank you very much, Dr. Gill. And now we'd like to welcome Dr. Shannon Idzik.

- [Dr. Idzik] Good morning, everyone. So nurse practitioner education is growing rapidly, as many of you know. In this slide, there's just 2 data points, but you can see that from 2020, in the pandemic, to 2024, we've continued to have growth in nurse practitioner programs, both master's level programs, post-master's programs where our nurses already have a master's degree, maybe in education, or maybe even in a nurse practitioner role and they are changing, and a significant growth as well in doctoral-level nurse practitioner education.

Over the past four years, there's been an increase in programs. When we look at specifically graduation and enrollment, there was a little dip post-pandemic, as many people know, and I think we all know for a variety of reasons, our registered nursing workforce was busy doing lots of things.

And some of it was work, and some of it was traveling to different states, and some of it was taking care of children and a variety of other things, which did have a little bump or decrease in enrollment over the years. We have seen a growth across all areas.

These are master's programs preparing nurse practitioners. We've seen a significant increase in post-master's certificate enrollment. This is... We can look at the data, but it is largely impacted by psych mental health, post-master's enrollment. So, for example, family nurse practitioners returning for a psych mental health certificate.

We are also seeing a substantive growth in master's-prepared nurses returning to nurse practitioner programs that graduate them with a doctoral degree. And this is, again, largely driven by an increase in doctoral programs and programs that don't have post-master's certificates, but have post...they're requiring them to earn a doctoral degree as they grow.

So significant growth and enrollment in those programs. And continued growth in BS to DNP programs that take baccalaureate-prepared nurses, prepare them as nurse practitioners, and they graduate with their doctoral degree. There are lots of reasons why schools are not taking additional students. There is a significant demand, and most schools are not taking all qualified applicants.

The most common reasons for schools not taking qualified applicants is insufficient clinical sites, as I'm sure many of you have heard. So one of our challenges, I believe, or probably, in my opinion, our largest challenge in NP education, we'll talk a little bit more about this, but is data. And so the American Association of Colleges of Nursing does an amazing job of collecting data on education, and we are actively working with them at all times to try to refine that data specific to NP education.

We do have specific data for master's NP programs, and they say 47.6% of them are not taking all qualified applicants because of insufficient clinical sites, and 31% because of insufficient faculty. The DNP is grouped all DNP. It's not necessarily specific to NP education, but we're continuing to work on refining that data.

There's the other group of people, which is a little bit confusing when you think about it, but there are people who are not taking all qualified applicants, but there are people who have a shortage of faculty,

but they don't have any vacancies, right? So they know they don't have enough people, but they don't have a slot to hire them into. And there's a variety of reasons for that as well, but predominantly it's insufficient funding to hire higher faculty.

Top issues related to NP faculty recruitment or faculty recruitment. I should clarify that because it is not, again, specific to NP faculty. You might not be surprised again. It's non-competitive salaries, as Dr. Gill mentioned. In academia, the salaries are not necessarily competitive with the clinical environment, so it is very difficult to recruit experienced clinicians to come back and teach when the salaries in the clinical environment are sometimes $20,000, $30,000, $40,000, $50,000, $60,000 more than they would earn in a faculty role.

It's also a challenge sometimes finding faculty with the right mix, right? You can find a doctorally prepared faculty, but you might not be able to find a doctorally prepared CRNA or a doctorally prepared pediatric acute care nurse practitioner, which is the person that you're trying to recruit for. Again, a variety of other reasons, but salary seems to be the most common reason that we're struggling to find the faculty that we need.

Online versus in-person. So we are seeing also a significant growth in online programs. And as you can see, more than 75% of programs have between 50% and 100% of their program online. Again, when you look at this data, the DNP data is all DNP programs.

We do know that the majority of post-baccalaureate to DNP programs are NP programs. The other large quantity of them are our nurse anesthesia colleagues. But still, nonetheless, almost 75% of those programs are running 50% to 100% online, with a smaller portion of them less online. We do find that the programs that are running...

In-person programs are typically running their diagnosis and management or their clinically-focused coursework in-person, and some of their other coursework, evidence-based practice leadership, or the courses that they're doing online, trying to make it more competitive and easier for the students to maintain work and life. So this data, Admission Requirements, is not something we capture nationally.

And so in order to find this data, I had to spend some time digging in the literature, and I did find a study from 2023 that looked at admission requirements across nurse practitioner programs across the globe. I found this very fascinating data, and our colleagues found that in the United States, the majority of programs require GPA of 3.0 to 3.24 as the base GPA for admission, which is different, as you can see from the programs in Canada and Australia, which seem to kind of have a lower admission criteria for GPA.

They also looked at clinical hours, and this is where we differ in the U.S. as well. Our colleagues in Australia and Canada require significantly more clinical hours on entry into nurse practitioner practice than our U.S. schools. The majority of U.S. schools have no practice requirement or a year, 1,900 hours. Almost 90% of programs require less than two years.

Very few programs require more than two years in the U.S., which is really exactly the opposite from our colleagues in Canada and Australia. So speaking of practice hours, practice hours in the program, though, are a different thing, right?

So we have practice hours prior to entry, and then we have practice hours during the program. The American Association of Colleges of Nursing, as you know, recently published Essentials document, the

new Essentials in 2021. And in that document, it states that post-entry level, so post-baccalaureate nursing programs, should have 500 practice hours as the base for education, but that those hours provide the foundation for additional time-based requirements for specialty, or role, or population.

So 500 is the base, and programs should have additional hours for specialties. They go on to say that some but not all of those hours may overlap, which basically is saying that it's more than 500, 500 would be not enough. Some of them could overlap, right, if you're trying to assess whether or not a student is able to meet ethical competencies, and those are baseline doctoral-level competencies.

They could do that while seeing a patient, or they could do that in a simulated environment, and you might be able to assess those in both practice areas. The National Task Force standards say that programs should have 750 hours at a minimum. That document, the National Task Force standards, was endorsed by 18 national organizations, and that says that programs would have 750 hours of direct patient care clinical experience to meet the National Task Force standards.

The nurse practitioner programs should have that many hours. What we found recently, so our credentialing colleagues did a study last year, that only 39 to 53, depending on the specialty area, were currently meeting those National Task Force standards.

Recently, thinking about simulation and technology, that's probably the big question about hours. And that's why the next slide is really here about simulation, is can simulation count for direct patient care clinical hours.

And this recent study in 2022 was a qualitative study of faculty. And really, the majority of participants in the study felt that simulation could not be used in lieu of, but should be used. And they cited that we need more data, we need studies, we need the NCSBN to support a study like we have for entry-level education to really determine whether or not simulation can be effectively used in advanced practice education to meet those clinical hour requirements.

The faculty felt that simulation was an excellent bridge between the theoretical components of education and the clinical, kind of bridging those cognitive and psychomotor skills. So clinical sites, as you heard earlier, that is the biggest challenge in NP education. The majority of schools would take additional students and could educate students in a quality way if there were additional clinical sites.

It's much more easy to put a bunch of students in a classroom. It is much more difficult to find them a preceptor to learn. And I will say we can say that simulation might be an effective way to educate them as well. It's also very expensive. If we can get them into clinical sites, it's less costly. We are not currently collecting data, but in 2013, I can tell you the state is not improving, so it's very old, but I can tell you it's not getting any better.

Everyone is concerned about clinical sites and preceptors. And this was a study between AACN, AAMC, DOs, and PAs. And as you can see, everybody was concerned about clinical sites, and preceptors, and nurse practitioner programs were particularly concerned.

Had the largest issue with clinical sites of all of our colleagues. Almost 95% of them were concerned about clinical sites. So there wasn't really much room to go to 100%. I would dare say it's 100% at this point. I don't know of anyone I've ever talked to that says they're having a swell time finding sites for their students.

So the other thing is payment. So because of those huge issues with clinical, we are continuing to hear more and more about payment of preceptors. And unfortunately, it's seldom payment by schools, or sometimes, I shouldn't say seldom, it is not always payment by schools. It is sometimes payment by students.

So students are paying people to be their preceptors, which, you can imagine, in my opinion, has ethical concerns. And so we know, at the time of this study, there were not tons of schools paying preceptors, but I can tell you this has gone up exponentially, and we are hopeful to get this data into the future, but we definitely are seeing and hearing data about students and schools paying preceptors.

So in 2024, Dr. Stager and a bunch of colleagues looked at how many direct patient care clinical hours were in DNP-NP programs. They only did DNP-NP programs, but we did look at the number of hours at that time, I say we, them, looked at the number of hours in DNP-NP programs at that time.

And as you can see, the majority of those DNP programs were over 750 hours on average. I recently... This has not been published. This is the first time we are talking about it because we just evaluated the data this summer, but we recently did a study on direct patient care clinical hours and pass rates.

And we asked all of the nurse practitioner programs in the country to share with us their clinical hours and their certification pass rates, and domain scores. We actually asked them to upload their certification reports and documents. One hundred out of that, about 500 schools uploaded their data and their documents, and we had 748 years, school years, of data.

So 100 schools, but some of them have multiple programs, and we only looked at FNP and adult gero, multiple programs across multiple years. We looked at five years. So 748 years of data, 100 programs. And what we found in this study was that on average, programs had just under 700 hours.

We found that master's programs had around 600 hours, post-grad programs a bit more, DNP programs a little over 800 direct patient care clinical hours, and pretty consistent between certifiers.

What we found as well is independent of degree. There is a correlation with hours and school certification exam pass rates. We looked at hours. We looked at faculty ratios.

We looked at telehealth hours. We also looked at simulation hours. Simulation and faculty-to-student ratios were not predictive, but clinical hours were predictive of pass rates. I also want to share this data. Our colleagues at AANP Certification Board published their data on certification exam pass rates, and we've seen, over the past five to six years, a pretty substantive decline in certification exam pass rates, and this is true not just with AANP, we've seen a decline across many of the certifiers and a recent bump up.

So we also see a difference in certification pass rates between 5% and 10% between master's and doctorally prepared graduates. So students who graduate from DNP programs are more likely to pass their certification exam than students with a master's degree. So what are the current trends we're seeing, kind of in summary, like Dr.

Gill? We see significant interest in nurse practitioner programs. And we know there is a shortage of primary care providers, and there's a shortage of acute care providers, and certainly a shortage of mental health providers. There are increasing program growth, an increase in enrollment, an increase in graduation, which is amazing.

There is variation in clinical hours across the programs. NP programs differ widely in the requirement of clinical practice hours, creating inconsistencies in the training for future nurse practitioners. We've seen recent decline in certification pass rates, but also this past year, a slight improvement, which is hopeful.

We definitely have a shortage of faculty clinical sites and preceptors, and that is predominantly due to funding issues. Probably the biggest challenge, and, you know, any support that we can have throughout this process, is a lack of central, accessible, transparent data on nurse practitioner programs, nurse practitioner certification, nurse practitioner practice.

There is no central tracking number for providers that goes back to their school, unlike our physician colleagues, who have a...they used to call it the master file, and now it's called the physician something or other. There is no way to track students. So often, people will say, "Well, what are the outcomes? What are the outcomes of DNP education?

What are the outcomes of clinical practice hours in the programs? What are the outcomes of various things? There is no way to track that. We cannot tie a school and a student education to their practice. So we desperately need that. We need that for all of nursing. We desperately need that, I think, for NP education.

The same with schools. There is a significant number of online programs, which certainly makes school accessible. The majority of programs have more than 50% online. One of the things I think is concerning in NP education is there is no standard requirement for student verification. So we know who is taking the exam when they get out, but we don't necessarily know who the student is in the program.

I think AI, and I hope we'll talk about AI a little bit more as we go on, is super exciting for the world of healthcare and patient care and many, many things. I think the impact of AI on NP education at this point is unknown. We're not sure how things are going. We are certainly working on things in NP education, and I think all of nursing education, but the impact of that on online programs right now is unknown.

I'd just like to close with saying, you know, I am super supportive of standardization. I think we know in healthcare, standardizing things, whether it's the timeout in the operating room to make sure that you're working on the right leg, or if it's the 5 rights or the 12 rights or the 27 rights that we have now, we know that standardizing practice improves outcomes, and we need desperately standardization in NP education as well as benchmarks for accountability.

And that, to me, is very important for patient safety. And we'll do questions afterwards. Thank you.

- Thank you, Dr. Idzik. And now we will welcome Dr. Peter Johnson. Thank you.

- [Dr. Johnson] Good morning. I fear I have been sitting too long here. Got to stretch a little. I'm going to start out by acknowledging that my presentation here is going to follow a little bit of a different format than what we've seen before, but I also promise that I'm going to do the best that I can to answer each of these questions that were posed to us as part of my presentation.

So what I'd like to speak to you about... I just can't speak in front of a group of nursing regulators from across this many states and not talk about midwifery in a broader context, and I'm going to take the prerogative of doing that this morning.

So we are facing an unprecedented challenges in maternity care right now in the United States. We have a shrinking provider workforce that includes both midwives and obstetricians. And if you think about it from an obstetrical standpoint, those physicians that are prepared to care for women, deliver babies, and do high-risk perinatal care, they are 22 years old, at least by the time they graduate from their bachelor's program.

They're 26 from the time that they get out of a residency, that they get out of medical school, and 30 by the time they're graduating from their residency. Almost exclusively, obstetricians and gynecologists are female, are young women. They are growing their families, and we are finding that their length of full-scope practice is less than 10 years, on average, before they stop doing births and move to either a hospitalist practice or a primary care-only practice.

So provider availability is shrinking. We have growing maternity care deserts. In my home state of Virginia, I'm in southwest Virginia, we have women traveling over 100 miles to give birth in a hospital setting because rural hospitals are closing. We are trying to keep hospitals open with midwifery coverage, but regulation in this state, until recently, hasn't allowed that.

And... I just...Oh, not yet. Thank you. And the other thing is that midwives are key parts of the solution, but our ability to meet the nation's needs is really hampered by a fragmented regulation of midwives, uneven educational pathways that we have, and unnecessary barriers to entry into the practice.

And this is where I need to speak to our midwifery workforce and the diversity in our midwifery workforce. Over 20 years ago, I sat at the LACE APRN consensus table, and I remember having conversations about midwifery having 1 foot in nursing and 1 foot out of nursing, and things have continued to develop that way.

I don't know how many people watch "Call the Midwife." Okay. It's done lots to garner attention for our profession, but the folks... What I think about with "Call the Midwife," going back to the 1950s and 1960s, is they were nurses and they were midwives. They were public health nurses taking care of the community, and they were midwives.

And they used the terms, not necessarily interchangeably, but as was needed to define what their role was at a given time. So in 1989, we... So let me start out with certified nurse midwives. Certified nurse midwives are probably the midwives that you're most familiar with. They're licensed in 50 states, D.C., and territories.

They have a graduate degree both in nursing and midwifery, and they're certified by the American Midwifery Certification Board. Okay. I think they're the bulk of our profession. But in 1989, the American College of Nurse-Midwives, with our partners, the Accreditation Commission for Midwifery Education, our accrediting body, and our certifying agency, the American Midwifery Certification Board, developed a pathway for certified midwives.

And these folks have a graduate degree in midwifery. They're licensed in 11 states. And their competencies and standards, and this is important, their competencies and standards are equivalent to the certified nurse midwife. No difference in terms of their scope of practice. Unfortunately, our growth of the certified midwife over time has been super, super slow.

And the reason for that has been we don't have a lot of education programs. And the reason that we don't have a lot of education programs is we don't have regulatory pathways for them. But we could. In my

home state of Virginia, we now do regulate certified midwives and certified nurse midwives under the Board of Nursing.

We are, in terms of the certified nurse midwife programs, really happy to say, and this is the answer to one of the questions, that we've had recent growth in the uptakes of our number of programs. For a long time, the number of midwifery graduates has gone up, largely on the back of some very, very large midwifery programs, midwifery education programs.

Frontier Nursing University is one of the largest. But just recently, we've seen a uptake in the number of programs applying for pre-accreditation. We're nearing 50 programs right now. We should go over 50 accredited programs very soon. And we are really pleased that we have programs that are being established in HBCUs, or Historically Black College, University.

It's really important, we believe, to manage disparities in the country, to have a workforce that looks more like the people that midwives are serving. Now, I also need to speak just a little bit about the certified professional midwife. And I can't speak for the certified professional midwives, because they lie outside the purview of the American College of Nurse-Midwives.

They're not accredited by our accrediting body or certified by our certifying agency. But they're important because they are licensed in 37 states right now, and their licensure is growing very quickly. They have a scope of practice that's limited to out-of-hospital birth only. They can't be credentialed in hospitals right now. I'm not exactly sure why.

But they also limit their care to women during childbirth, pregnancy and childbirth. Whereas the certified nurse midwife and the certified midwife, we say we're primary care providers for women, and we will care for women from menarche all the way through the end of their lives. So there is a lot of confusion at the regulatory standpoint, from the standpoint of the public, on the different roles of midwives and what their competency sets are, what their level of autonomy ought to be.

This regulatory patchwork means that the title midwife can mean a lot of different things to different people, depending on the state. And it creates a lot of confusion for consumers, creates barriers to the mobility of midwives from state to state, and inefficiencies in workforce deployment. We need uniform regulation.

We need it really badly. I'd like to really call for all midwives, whether it be CNMs, CMs, or certified professional midwives, to be regulated under the same board, including the boards of nursing in states. This would promote consistent standards, quality, and safety for midwifery care that's received.

It would enable mobility and help address regional workforce shortages. And it would allow the public to better understand who midwives are and what different midwives can do. The fragmentation of midwifery only delays access to care. Uniform oversight could accelerate expansion of safe, high-quality maternity care.

We're the only developed nation in the world that has a maternal mortality rate that is going in the wrong direction. And it is because of lack of care providers. Now, I'd like to speak to the DNP debate, as I would call it.

And we have a huge DNP debate in the midwifery world. We have been caught in the broader expansion of APRN or APRN transition to the doctorate nursing practice. And while we acknowledge that the

DNP has great value as an academic and a leadership credential, quality improvement credential, we implore you not to make it a licensing requirement for midwives, given the maternal care shortage that we have.

Evidence shows that the DNP would reduce entry into the profession at a time when we need midwives more than ever, not fewer midwives. We also know from the International Confederation of Midwives' work that the majority of high-performing countries with better maternal outcomes than we have do not require a doctoral preparation for midwives.

We believe that flexible, graduate-level pathways is essential to meet our workforce needs. We're going to continue to see more and more DNP midwives. And that's a really, really good thing.

We believe that's a good thing. But it can't be our only approach. So with that, I'm going to transition to our kind of this deep connection to, if not, a little bit of a...sometimes a little bit contentious connection with nursing that we share even in our own ACNM association.

We've been talking for about 30 years now about whether we should change the name of our organization from the American College of Nurse-Midwives to the American College of Midwives. And every decade we do another survey of our members, and every decade we have about 50% of the people saying, "Yes, we should. We should acknowledge that there are other midwives that aren't nurses."

And 50% of the people say, "No, we're nursing. It's really important." So that continues, and it's a continued internal debate. But nevertheless, we recognize and acknowledge that about three-quarters of midwives find their way to midwifery through a connection to nursing, whether they be labor and delivery nurses, whether they're public health nurses.

But a quarter of them don't. And some of those nurses find their way to midwifery and get that nursing experience as their only option to become a midwife. We have a pervasive debate in academia about whether or not you need to have nursing experience to enter midwifery education.

My own personal experience in 40 years of educating midwives is that there's as much to be unlearned to transition from the role of labor and delivery nurse or maternity nurse to midwife as there is to not be learned. So I think it's kind of a wash, to be honest with you. Different learning needs, but I think it can be done with or without.

Nevertheless, many of our programs do require some degree of maternity or public health nursing experience in order to get into midwifery. While we acknowledge that nursing will continue to be an important pathway for housing midwifery education, we believe that it can't be the only approach.

We need a two-pronged approach that acknowledges pathways to...expands pathways to graduate midwifery outside of nursing. And we'd like to really focus on expanding graduate-level CM programs, or certified midwife programs, to reach individuals from other health and science backgrounds from outside of nursing.

And I'll give you an example of this here. I'm helping... I'm on faculty, as we mentioned, at the University at Buffalo. We are establishing a midwifery program, a DNP program, housed in the School of Nursing. And one of our clinical sites asked, in exchange for supporting us in our work, whether or not we could take a few of their PAs that wanted to be midwives, that had worked in their practice, and they wanted to expand their practice to do deliveries, and they wanted them to come.

And we could have... Our school wasn't ready to do this at this moment in time. But certainly, from an accreditation standpoint, it wouldn't have been impossible, it wouldn't have been challenging to add a postgraduate certificate program and put them side-by-side with family nurse practitioners and other APRNs that are interested in doing a postgraduate course in midwifery.

So we need more of those programs alongside of the nursing programs. So I'm going to... And those folks that have graduated from CNM programs, CM programs, we need them leading to that unified licensing parity that will give them the ability to fully practice upon their graduation. I'm going to transition to answer some of these questions that were given to me.

And in terms of program structure, we did a workforce study in ACNM last year, and many of these questions come from that. In that survey of faculty and students, we found that one-third of the programs are online right now.

Another one-third are a hybrid of online and some on-site, largely clinical, simulation, and assessment. And a third of the programs remain traditional on-site programs. We're a little bit different in terms of the hours based. We do acknowledge that in our programs that are housed in CCNE-accredited programs, we have to adhere to documenting the hours that are required.

But I think Chris mentioned this a little bit. I think we're a little bit similar to them in that our programs are competency-based. And our students have to be able to demonstrate competency in order to complete their program. And we look at clinical exposures, numbers of births, the number of prenatal examinations, the number of newborn care experiences that folks have as resources that will be required to gain competency, recognizing that people come in with different experience sets, and they may take less or more in order to be able to gain that competency.

So that's the best I can say about hours. I can echo what everybody has said about clinical sites being a pervasive challenge. We are having the same problems with preceptors beginning to expect payment or demand payment. And it is sometimes directly from students.

We also have some programs that have begun to pay preceptors or pay stipends for preceptors. And that's kind of upset the balance for those programs that still feel that it ought to be a professional responsibility. And we do know from that survey that 57% of the students that were surveyed believed that it is their primary responsibility to find their clinical site.

Our accreditation criteria say that 100% of programs need to be able to find and need to be able to ensure that the clinical site is appropriate. It doesn't mean that the student can't let the schools know what resources that they have, what connections that they have.

And then we desperately need a graduate nursing education system that parallels medicine. We need a broader solution. And it's becoming very, very apparent to me. In terms of technology, simulation is becoming a major part of technology. Nothing different than what people have said.

And I'll just finish off by saying that AI has been the biggest professional game changer that I've seen in my whole career, in my whole life right now. And I think we are just at the nexus of understanding what it means and what we might be able to do with it. It is going to be something that our students have to be able to use in practice when they graduate. And their teachers are going to be using it.

Their preceptors are going to be using it. We have to figure it out. And I'm excited about it. And then in terms of faculty, we have the same challenges that everybody else...the pay parity, being able to make more money in practice than in the educational world. It's a strange phenomenon, but it's the way it is.

I am going to finish by just giving you a call for action from the ACNM standpoint. We need more midwives yesterday. And it's desperate. We need it to serve vulnerable populations, to close those gaps in maternity care deserts. And the regulation is important in order to be able to develop practice parity so midwives can serve in those places where they need to be served without undue supervision for care within their competency.

We have to address persistent racial and geographic disparities. And we can only do it with more functional midwives. To make this happen, ACNM and I would like to urge the National Council of State Boards of Nursing to support uniform regulation under Boards of Nursing, where it is under Boards of Nursing, expand that scope from certified nurse midwives to all midwives, oppose making the DNP a licensing requirement, not now, and promote both nursing and non-nursing graduate-level pathways to midwifery.

We encourage states to license CMs alongside CNMs to rapidly expand the workforce. And while I said I can't speak for the CPMs, I would remain ready to support the CPMs. The NACNM and ACNM are in dialogue around a future holistic midwifery presence in the U.S. and policy presence in the U.S.

So remain ready for that. We'll be in touch. With your support, we can strengthen the midwifery profession, grow our workforce, and improve access to high-quality maternity care for every community. So thank you.

- Thank you, Dr. Johnson. And now we have Dr. Jennifer Manning.

- [Dr. Manning] Okay, thank you. Thank you, Michelle. I want to begin by stating how appreciative I am to be up here with esteemed colleagues. We share some common challenges, and I'll attempt to wrap those up in my presentation. So I'm here to talk about clinical nurse specialists.

I come to you as a past president of the National Association of Clinical Nurse Specialists and a coordinator for clinical nurse specialist programs at Louisiana State University Health Sciences Center. In the world of clinical nurse specialists, we have had some recent enrollment trends that are similar to some of my colleagues. In the master's prepared programs, there has been some declines.

Those have been regionally located. And so it gets a little confusing when we talk about it at the national level because some of our states, where we have the most clinical nurse specialists, like California and New York, they have increased in programs, but in some of our states with lots of rural areas, they have had a decline in programs.

So what we try to do with the national level is to paint a picture of where that lies for each individual state. We have seen a recent increase in DNP-CNS programs. And in the case of master's programs, in the last year or two, we are starting to see a rebound. It's quite interesting to follow.

I'm not really sure. We're still trying to ascertain why some are opting for a master's rather than a doctoral program. I think there's two main points there. One, they want to get the CNS degree completed quickly so they can get into the workforce. And two, they are challenging us. What is different about the DNP in terms of compensation, and what I'm going to learn in that program?

And so we are looking at those factors very closely at the national level. In terms of degrees awarded, only master's and doctoral are currently available for CNSs. And there are some increase in online learning options. In the case of some of those schools that are closing, it's the in-person programs. Those online programs and hybrid programs are the ones that are maintaining robust student populations as well as growing and expanding.

Another is concerns about Ph.D. enrollment. Due to the unique nature of clinical nurse specialists, where we focus on three different spheres of care in our training, at the system level with nurses, and with direct care patients, we have many CNSs who get their master's, but then they go on to get their Ph.D. And we are trying to encourage them to do that because much of our role is in the research realm, and we are very saddened to see the decline in Ph.D.

enrollment nationwide and have our eyes on that as well to try to increase more going into that area, as well as the DNP, to meet the needs of the population. From a workforce needs standpoint, when I was president last year of the organization, I spent much of my time talking to hospital leaders who wanted clinical nurse specialists in their systems, but they had trouble finding them.

And so we tried our best to link the two together, the graduates from the schools of nursing with the CNOs who were trying to fill those positions. The other thing that we talked about in terms of workforce needs is clarifying the role of what the CNS can do for the organization. So we work very closely with those hospital leaders who are either forming positions or trying to fill those positions to explain how the CNS can make differences in their healthcare organizations.

Where we are sometimes unique is many of us work in several different places. We may have a couple of days a week in direct care, but then a couple of other days where we are maybe at the system level or we're working with the nursing population. And so that makes us, to me, uniquely positioned to make a wide variety of differences for the organization, and we wanted to convey that very clearly to them.

In terms of CNS program admission requirements, you have to have, obviously, a BSN. The minimum GPA requirements vary slightly across the country. Prerequisite coursework, again, varies a little bit. Unencumbered nursing license.

Clinical nursing experience. Many CNS programs do not require experience. One can go right into the program right after graduating with their BSN. But typically, we don't encounter that. Most students admitted have some years of experience as a registered nurse before coming to us. The ratio of online to in-person programs is about 60% are online and about 40% are hybrid.

We just have a very few number of in-person programs, and those are having a lot of challenges. I anticipate to see more growth of online programs because they're meeting the needs of a larger geographic location. And then the hybrid programs are meeting a need in a regional area. Hybrid programs are definitely growing because there is that definite preference for many to have some face-to-face experience.

For the minimized supervised clinical hours, right now, we are at 500 for those master's degree programs, as stated by the NACNS organization, and 1,000 for the DNP. When we survey the master's prepared, meeting the 500 is 100% achieved, and we have had some discussion of increasing that, especially coming out of the NOF criteria in 2022. But right now, we stand at 500 for our master's.

State board requirements do vary quite broadly across the nation, and so the best we can do is rely on NCSBN as well as our national organization for clinical nurse specialists to spell out the requirements across the different states because they do widely vary in terms of full practice authority and etc. Preceptor challenges for us are also very similar to our previous colleagues.

One of the things we hear a lot, in addition to the incentives, meaning they're wanting pay, they're also asking us for more information about what do you want me to give to the CNS? And I think that speaks to our unique role. We need a wide variety of preceptors to meet all of the different areas that we train our students in. And so that does create a challenge.

And so in terms of preparedness, our preceptors are looking to the schools for some sort of preparation. And at LSU, we are trying to fill that need so that if they do sign up to do that role, we can give them some early preliminary training so that when they do work with the students, they meet the need. Clinical site challenges is also a limit because we do need that wide variety of experiences for the CNS students.

And the faculty status, we have the similar problem, shortage of faculty, some recruitment and retention difficulties, and some lack of preparations for clinicians who come out of CNS training knowing how to be a CNS but not so much about the educator skills that are needed. Current trends in technology.

Of course, with the changes in healthcare and innovation that we see in this country, we are working to incorporate all of the new ways, including telehealth, online learning platforms, artificial intelligence, into our CNS programs, and that is something we talk about at a national level with all of the programs when we meet monthly.

And then the trends in programs is addressing the workforce challenges. Peter had touched on those. As a country, we are very good about leading in medical innovation and technology, but when it comes to ranking in patient outcomes, specifically maternal health, but also in chronic conditions, and in the case of preventative care, unfortunately, we fall short.

And that's where I feel very passionately that APRNs can make a difference as well as RNs. Trends in CNS programs. We are working very hard to use the data-driven technology available to really drive where the CNSs are, where they are needing to be hired, etc. And the reason I want to mention that is one of the unique things about the CNS is we don't always have clinical nurse specialists in our title.

In my case, I'm the clinical nurse researcher at my hospital, so when we try to survey ourselves, we do have a challenge in terms of collecting the data, and that's why we really rely heavily on boards of nursing and AACN to look at the licensing that is being measured across the country. That helps us to better capture our numbers. And so those are key surveys that we rely on for our data management each year.

And that might be my last one. Okay, thank you, and thank you so much for your time this morning.

- Thank you very much, Dr. Manning. And now we're going to go to the Q&A portion of our program, so if anybody wants to make their way to a microphone, we will have our experts address your questions. Carol, good morning.

- [Carol] Good morning. I'm Carol Moreland from Kansas, and I guess I don't really have a question. I just have some feedback for everyone. Kansas made some changes this year in our curriculum requirements, preceptor requirements, and then some of our licensure requirements.

And how this all came about is in 2022, we got full practice authority for APRNs in Kansas, except for CRNAs. We could not get those yet, but anyway, there was no practice hours. And so there was some concern about that. So our board looked at that, and actually, two of our APRN programs came to the board and asked them to consider following the NTS standards.

And so they did as far as curriculum. So what that means now is we are requiring 750 direct clinical hours, and preceptor, we changed that a little bit. The first 750 hours have to be done with an APRN or a physician, and then any direct clinical hours that are greater than 750 can be with another interdisciplinary licensed healthcare professional at a master's level or above.

And then, as far as licensure, for initial licensure in Kansas, and that would also be for endorsement, we're going to require the 750 hours. And I wish I could stand up here and say this was positively received across the nation, but that's not been the case.

There was a lot of negative feedback given. They didn't really understand some of this because, again, this would pertain to schools in Kansas as far as the curriculum. That's the only authority that the Board of Nursing has is for the schools in Kansas that they approve. So some of the schools out of state was calling me and saying, "How can you tell us what to do?"

We didn't tell you what to do. We didn't. But we are telling you, as far as licensure, that this is what's going to be required. Now, there was a lot of concern also, like, okay, is this the cutoff point? Right now, they have to have 750, even though they've been in a program that required 500.

So basically, what we're saying is anybody who is enrolled in a program prior to March 1st of 2025 will be required to have 500 clinical hours. Anybody who enrolls on March 1st or after will be required to have 750. We did a lot of communication on our website and our newsletter, and all that.

But anyway, I just kind of wanted to share that because it was something different.

- Thank you, Carol. I appreciate that. We're going to go over here.

- [Natalie] Hi. Thank you. I am Natalie Baker from the Alabama Board of Nursing, and I am a retired professor, nurse practitioner education. I have a specific question for Jennifer Manning. In Alabama, we, I think, only have one CNS program, and, you know, like you mentioned, so many of our CNSs in our state isn't in a CNS role per se, so it's very hard to gain information about that.

As we continue in our very restrictive APRN state, trying to see how we can best utilize our APRNs, the question comes up often, how many direct care clinical hours do CNSs have? Because I know you all have somewhat of a different approach, and you're looking at the three spheres.

Can you help educate me on the clinical, the direct patient care aspect of your training?

- Sure. Happy to do that. And it's a very good question. And I will say, in the last decade at least, many of the CNS programs have ensured that they have approximately half of the hours in the clinical program, whichever the program they're attending, are direct care.

And that is a result of the licensing exam that they take, and that we have seen that those questions are related to direct care. So we knew they needed them in order to pass their certifying exams. So at LSU, we don't have, you know, a metric that we follow, but I think that's an excellent question for the national organization to provide some guidance. But we have made sure that at least half of those hours are direct care to ensure those students are ready for the profession and for the certifying exam that they will be taking.

I'm talking specifically about the adult gero exam, because that's the program we have. But I would think for the other tracks as well, it would be a similar approach. Does that help answer your question?

- It does. We're finding that many opposed CNSs being able to prescribe. And again, I'm not saying that's my opinion. I'm trying to determine how to best explain to others the vital role of a CNS. And if they're not receiving at least the minimum of 500 direct patient clinical hours, you know, how can we best advocate for their abilities to prescribe?

I know they have the three Ps, but, you know, any suggestions that you might have for the audience regarding that issue?

- I think my suggestion is we probably need to turn to the national organization. And I don't think we've gotten that comment, at least in my time on the board and at the president level for the last three years. I think that is a fair question that NACNS should provide some guidance to. I know boards of nursing would look at that as well as programs when they're developing them. And so that's, to me, the guidance I would suggest, is to inquire and ask the national organization to come out with a recommendation to ensure that they are fully prepared for practice, the licensing exam, and meeting the needs of the patients they'll care for.

- Thank you so much.

- You're welcome.

- Thank you. So we're not going over here. I'm looking for Joe. Okay. So microphone number six.

- [Roberta] Yes. This is Roberta Hills from Colorado. We have a situation where a graduate nurse who is certified as a SANE nurse, prior to us adopting the uniform guidelines from NCSBN, was successful in getting on our registry. And over the years, there was a glitch for her, and she failed to renew.

And so when she came back to reinstate, we don't acknowledge the SANE certification. And so it was denied. And she's pretty upset.

But my understanding was funding for her is connected to being on the registry. And I'm kind of curious if anyone else has had that situation in their state.

- No.

- I don't know.

- This is separate.

- I don't know if any other board member could address that for you. It's not something that I'm aware of, but certainly somebody in our group will be able to respond to that for you. Thank you.

- I can [crosstalk 01:23:52.121].

- Okay. Go ahead, Peter.

- And then we have one more question, and we need to wrap up, and we're going over here, too.

- I can't speak directly to your question. I mean, SANE certification is a specialty role, not an advanced practice nursing role. But I will tell you that in response to a workforce demand for SANE-certified nurses or practitioners in the western New York community where I practice, we have incorporated SANE certification in our DNP midwifery pathway, with a plan for every graduate from the program being SANE-certified or well on the road to SANE certification by the time they graduate.

So I'm hoping that more and more APRN programs, women health, and midwifery, particularly, will take that on.

- Thank you.

- Thank you. Last question, over at number 11. Thank you.

- [Michelle J.] Thank you very much. Michelle Johnson, Nevada State Board of Nursing, director of nursing education. So we have been looking at regulating APRN education because we do not currently regulate it in our state. So in doing so, I met with all the APRN programs. So the programs overall were in opposition of state boards of nursing coming in and regulating their programs.

So I'd like to ask the panel, and I know we're running out of time, what do you think are the pros and cons of an additional level of regulation from the state boards of nursing?

- Great question to end on. Thank you. Go ahead.

- I'll speak to my thoughts. I think any time we add additional barriers, there's obviously a cost, right? So I think about education, there's a cost. Every time we increase the number of things, we have the hoops, jumps we have to go through, there's a cost.

And I know the cost of education is a huge national concern. I will speak, though, from the NP perspective, and probably people have heard me say this. I've said many times in NP education, we either need to figure out how to regulate ourselves, or someone is going to regulate us. And we may be at that spot in NP education.

We have three different accreditors. We have five certification exams, multiple national organizations. And despite a national consensus document on the standards for NP education, as you can see by my data, we're not following it. So we may be at the place where regulation of APRN education or regulation of NP education is warranted. That would be the pro, is it would be standardization.

And I'm here in part because I like teaching, but I'm really here because I care about patients, and to me, that's the end goal for all of us, is what creates the best provider, the best safety, and access as well to quality care for the people of our world.

- Any other panelists would like to add something?

- I mean, I would maybe just comment that if there's a void, it needs to be filled. When it comes to the CRNA role, there is a robust accreditation process from the academic program level, but there is a discrepancy across the board within the APRN roles.

And so where there's a void, as was said by my colleague, patient safety is the number one thing, and that is what we're all centrally focused on. So that needs to be cautiously, I think, explored in terms of creating duplicative processes or creating a process when there isn't one firmly in place.

- Thank you. Well, I apologize for going over, but how could we limit what these amazing people have to say? So please join me in thanking them.