Leader to Leader

Nursing Regulation & Education Together

Spring 2015

Kathy Apple Reflects on 14 Years of Leadership

In January, after 14 years of service as the CEO of the National Council of State Boards of Nursing (NCSBN), ***Kathy Apple, MS, RN, FAAN,*** *announced her retirement effective Sept. 30, 2015. Throughout her tenure, Kathy has supported the important work of U.S. boards of nursing (BONs), promoting the mandate to protect the public through the regulation of nursing practice at the state, national and international levels. We're taking a break from the "Day In The Life" feature that usually appears in this space to share some of Apple's reflections on leadership and how NCSBN's mission has helped her guide the organization.*

Kathy Apple, MS, RN, FAAN

Honoring the PAST, operating in the PRESENT, always thinking of the FUTURE.

Q: First, what is it like to be the CEO of a not-for-profit association?

There are a plethora of books written about leadership, and many of them contain useful guidance, but what's been imperative to me in my role as leader of NCSBN is to understand the purpose of the organization based on the articles of incorporation. One purpose is to unite boards of nursing to act and counsel together. I believe that dynamic has helped evolve regulation over time. Our members are energized and inspired when they come together, they start talking about what they do, what their challenges are and what they've tried as solutions. There's a synergy that comes about because they're the only ones doing what they're doing. It's more than just a peer group dynamic, so that purpose is quite fundamental.

The other purpose is lessening the burdens of government. This is a noteworthy concept because it speaks to the power of public and not-for-profit association partnerships; associations do a considerable amount of work that the government doesn't have to do or cannot do. For example, the NCLEX® Examinations are high-stakes, psychometrically sound, legally defensible exams. No state would be able to afford to create and administer such exams on its own. We put a great deal of investment into the exams. It saves the states a significant amount of money and reduces their burden. Remembering the essential purposes of the organization, for me, comes first and foremost.

continued on page 2

IN THIS ISSUE…

NCSBN
National Council of State Boards of Nursing

continued from page 1

Q: How has NCSBN's mission helped you guide the organization?

A for-profit or corporate organization is ROI-driven, but a not-for-profit association is mission-driven. It's the mission that must be driving everything. NCSBN's mission drives me to evaluate how well we provide educational services and research to meet the needs of our members, bring people together, lessen the burdens of government and, most crucially in my opinion, engage in collaborative leadership. Not only do we spell it out in the mission and lead this organization through such collaboration, but it's also one of our organizational values. I believe a good leader should know that relationships are everything. A successful leader has to build beneficial working relationships with individuals, groups and organizations. Much of my time over the years has been spent building, maintaining and nurturing those relationships.

Q: What are other qualities that you think are important in a leader?

First, an effective CEO has to be a strategic thinker who's good at execution. It's one thing to come up with ideas, but you also have to be able to execute them. A good CEO also has to be able to envision future possibilities. It's a fascinating position: honoring and learning from the past, operating in the present, and always thinking of the future. It's remarkable for me how it all comes together.

You have to know where you've been in order to know where you're going. NCSBN was formed based on a very important principle: to protect the public. When nurse regulators were part of the same professional association that protected the nurse; it was clearly a conflict of interest. The leaders, whom I refer to as the "founding mothers," set out to establish a freestanding organization, and that fundamentally virtuous principle provided the solid foundation on which NCSBN was based.

Q: How do you decide where to focus your attention?

I've always seen my role as operating in four spheres: membership, the board of directors, external relationships and staff.

Kathy Apple at the 2014 NCSBN Annual Meeting.

I believe a good leader should know that relationships are everything. A successful leader has to build beneficial working relationships with individuals, groups and organizations.

Providing members with good customer service and responding to their needs is crucial because we're really here for them. What I learned early on about working with a not-for-profit board is that I had to become an expert in board governance, so I could do the best job possible from a governing point of view. Regarding external relationships, I don't think that nurse regulators can operate in a vacuum or in silos. They do a better job when they collaborate with others. When I think of staff, one of the values I've hopefully brought here is my own personal principle — that I want NCSBN to be a comfortable atmosphere; one in which employees look forward to coming to work. Hopefully we've built a positive, safe working environment and culture here. I've always had an open door policy. I want staff to be creative, and my job is to listen so that I can balance the needs of employees and the needs of the organization. A CEO is only as successful as staff are in their decisions and every single role here has an important part to play.

These are the principles that I use to guide my leadership. Show up and be present — for me that means being focused and in the moment of whatever I'm doing, which isn't always easy. Pay attention to what has heart and meaning — when I do that, I feel I can stay focused on what's really important. Tell the truth without blame or judgment — we should be able to be vulnerable, meaning you can throw out ideas, or if a mistake is made no one gets beat up over it. Finally, be open to outcome but not attached to outcome. Sometimes we think we've made decision A, but 20 members may come up with decision B. And 10 members might come up with decision C. You can't always start out thinking you'll have a certain outcome. You have to be open to where the process and the collective wisdom take you.

Describe a challenge you faced and how you addressed it.

One significant challenge was participating in the APRN Consensus dialog. For the first three years of that four-year conversation, I was the lone regulatory voice in that workgroup. The group was made up of 23 different organizations and they had 23 views of what should happen. It was an enormous challenge, but that's what consensus building is all about. I saw my role as educating the other members of the group about how regulation really works, and informing them about what the challenges for regulators were in terms of the advanced practice issues. The consensus started to unite when people had a richer understanding of each other's issues. It was a lengthy process and in the end it came together. After about three years, we're very close to

continued on page 3

continued from page 2

complete consensus. You have to be persistent, but also listen and be respectful. The impact has been phenomenal: we have developed a model that's now being implemented across the country.

Q: As the fields of nursing regulation and education have changed, with technological advances and the crossing of international boundaries, what are your hopes for the future?

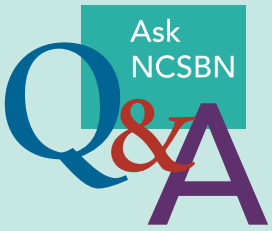
What's important, and will continue to be important, is that nurse regulators have to stay focused on their charge to protect the public. The advances in technology have changed tremendously, in terms of what we're able to offer and support. Twenty years ago, not every board had a computer. Not everyone had email. There was no central network in which everyone was connected to the Internet. NCSBN ensured that every board had a computer, built them a network and connected them. The boards were able to email and collaborate more effectively. It's almost laughable if you think about it now, but it wasn't that long ago and it has been a sea change.

The international relationships that we've built have been very important, because it's a small world, and what we've learned from all of our international nurse regulator colleagues is that they are working on the same issues and facing the same challenges. They have the same charge, to protect the public. What we've found is that there are more similarities than differences between countries, which is fascinating because I had assumed there must be more differences. Protecting the public must always be the guiding principle, regardless of how technology may change or borders may disappear.

Q: Do you have any final thoughts, as NCSBN transitions to a new leader?

Leadership is about embracing change so that things can evolve. You may get to a point where you have everything in place, but then something changes; and that's the way it should be. For me, at this point in my life, I feel like I've made my contribution and I'm proud of that, and things are going well; that's the time to step aside. I don't see it as stepping down, or stepping up. It's stepping aside. I feel that my generation is stepping aside for the next generation, to continue to move, effect change and make their contribution. When is the best time to do that? When things are good.

Apple will be honored at the NCSBN Annual Meeting, Aug. 19–21, 2015, in Chicago. ●



What are some common questions and misconceptions about the Nurse Licensure Compact (NLC)?

For answers, we turn to Sandy Evans, MAEd, RN, executive director of the Idaho Board of Nursing and chair of the Nurse Licensure Compact Administrators (NLCA) Executive Committee.

Q: Does a nurse need to obtain a new license when he or she moves to a new state?

A: Since compact/multistate licensure is premised on the declared primary state of residence, similar to having a state-issued driver's license, a nurse must obtain a new license when he or she moves and changes primary state of residence.

Q: How does a nurse obtain a multistate license?

A: A compact/multistate license is like any other state-issued license, with one big difference—when issued by a Compact-member state, the license carries a multi-state privilege granting the licensee the authority to practice nursing in other Compact states without the need to apply for and receive a license in each of those other states. A multistate license is issued to eligible applicants who legally reside within an NLC state. Applications are available on the boards of nursing's (BON) respective websites.

Misconception: Nurses often cite concerns over having to re-take the NCLEX when applying for licensure in another state by endorsement. Since the NCLEX is now the required examination for initial licensure in every state, it is only necessary to pass it at the time of initial licensure.

Misconception: Revenue loss by the BON is a common barrier cited by states or organizations opposed to or uneasy about the NLC. No state has attempted to withdraw the Compact based on financial implications, and while there is the potential for some negative financial impact, it is usually spread thin over a number of years and repercussions tend to be negligible.

Misconception: Nurses tend to think they have no voice in which states join the NLC, when in reality NLC advocacy is grass-roots-based and the initiative often comes from nurses within the state The NLC grows state by state. It is up to each individual state legislature to enact the Compact. Nurses should contact their legislators, nursing associations, and BONs in order to generate interest and legislative activity for a NLC bill to be introduced and voted upon in their state. ●

For more information, visit ncsbn.org/nlc, or contact nursecompact@ncsbn.org.

NCSBN's Advanced Practice Registered Nurse (APRN) Distance Learning Education Committee Update

As was reported in the fall issue of *Leader to Leader*, an NCSBN committee worked for two years to establish regulatory guidelines for prelicensure distance education. The guidelines were developed and model administrative Act and Rule language to support them was written. Our members adopted the model language at our 2014 annual meeting.

The prelicensure distance education guidelines were integrated into a white paper that presented some of the background and issues related to prelicensure distance education programs. Website content was created that includes the guidelines, the model legislative language and other resources on distance education. The website content also includes a link to the current prelicensure distance education requirements of each state. Knowing that it takes time for BONs to change their laws and/or rules and regulations, a timeline was developed for the BONs, stating that it is hoped that all BONs will adopt the regulatory guidelines by 2020, in line with the Institute of Medicine (IOM) Future of Nursing recommendations, thus fostering consistency among the BONs.

One of the issues the prelicensure committee identified was that distance education guidelines need to be developed for advanced practice registered nurse (APRN) programs as well. Therefore, the Board of Directors convened an APRN Distance Learning Education Committee for 2014–15, with the following charge:

Develop regulatory guidelines for APRN distance education programs, based on the regulatory guidelines for prelicensure distance education programs.

The APRN Distance Learning Education Committee has met three times in person and has had two conference calls to accomplish their charge. Some of the highlights of this year's work include:

- Literature review;
- Conference call with the NCSBN membership for understanding their issues and needs;
- Survey to our membership for learning how the BONs are currently regulating APRN distance education programs;
- Separate conference calls with the APRN accreditors and certifiers to hear about their processes; and
- Crosswalk created for accreditation standards, certification standards and NCSBN model administrative language.

NCSBN's membership reviewed the proposed APRN distance education guidelines at their midyear meeting in March. Model Act language supporting the guidelines will be voted on at the 2015 annual meeting. Stay tuned for more information about the APRN distance education guidelines in the fall 2015 issue of *Leader to Leader*!

New Videos for Your Classroom from NCSBN

As a nurse educator, you likely remember how excited you were when you first started working as a nurse, and the thrill you experienced making a difference in people's lives. Now you make a difference in the lives of students as you prepare them to be competent and caring nurses.

NCSBN wants to convey our respect for your students' accomplishments and welcome them to the profession. To reinforce what you've taught them about safe and ethical practice and professional accountability, NCSBN is creating a video for new graduates that will help them understand their nurse practice act and the responsibilities that accompany licensure. The video is expected to be available soon, and NCSBN hopes it will be a fitting final component of a new graduate's nursing education.

Also an excellent resource for new graduates, NCSBN's "Professional Boundaries in Nursing," an updated version of our most popular educational video, debuted in June 2014. The video explains the continuum of professional behavior and the consequences of boundary crossings, boundary violations and sexual misconduct. The updated video also explores internal and external factors that contribute to professional boundary issues, including social media.

NCSBN interactive videos are available here and are always a free resource.

Nurses in Nonclinical Roles

By Erin Tilley, MN, RN, FRE, policy analyst at The College of Nurses of Ontario

Erin Tilley

The traditional role of the nurse is one that provides direct patient care. In this article, these nurses will be referred to as "clinical nurses." Clinical nurses make up the majority of practising nurses. For example, in Ontario Canada, among other clinical roles, 66 percent of nurses who renewed registration for 2014 stated they were staff nurses (College of Nurses of Ontario, 2014). In this article, "nonclinical nurses" refers to nurses who have an impact on the delivery of care yet do not provide any direct patient care. Many nurse educators could be considered nonclinical nurses. Fewer nurses practise in nonclinical roles. For example, in Ontario Canada, among other nonclinical roles, 3 percent of nurses who renewed registration for 2014 stated they were academic faculty (College of Nurses of Ontario, 2014).

> Before regulatory bodies and other stakeholders can begin to consider whether there is a need for separate requirements for nonclinical nurses, there needs to be an understanding about the role.

Regulatory bodies generally govern both clinical and nonclinical nurses under one umbrella and do not have separate regulatory requirements for nurses practising in these diverse roles. Entry-to-practice and continuing competence requirements and practice standards are generally the same for all nurses.

Given that the traditional role of the nurse is clinical and the majority of practising nurses are clinical, it's no surprise that regulatory requirements are often geared toward clinical nurses. Should this be the case? Or is there a need, from a public safety perspective, to have regulatory mechanisms that are geared toward nonclinical nurses?

A literature review about nonclinical nurses gleaned very little on this topic. Aside from a handful of articles that identified different nonclinical roles, no articles were found that described the role of nonclinical nurses. Before regulatory bodies and other stakeholders can begin to consider whether there is a need for separate requirements for nonclinical nurses, there needs to be an understanding about the role. Therefore, as part of the Institute of Regulatory Excellence Fellowship Program, this study sought to gain a better understanding of the role of nonclinical nurses. The research question was: ***How are nonclinical nurses applying nursing knowledge, skill and judgment, and how are they impacting public safety?***

Eleven nonclinical nurses practising in Ontario, Canada participated in one-on-one interviews. For a more homogeneous sample, nurse administrators in roles such as nurse managers, government employees and consultants were interviewed. Participants were asked about their role and their perceived impact on public safety. Transcribed interviews were independently reviewed and analyzed by two individuals. Themes and subthemes with associated verbatim quotes were identified.

Although some of the themes and subthemes are likely unique to the nurse administrator role, there were two themes that may apply to other nonclinical nurses, including educators. The first theme is related to the value of previous clinical nursing experience. Every participant spoke about the value of their previous clinical nursing experience with respect to being effective in their current nonclinical nursing role. Participants' clinical experience ranged from 14 months to 15 years. Nurses reported that they relied on their clinical nursing knowledge, skill and judgment daily to meet role needs, support decision making and provide leadership. One participant stated, "I think you develop expertise as a staff nurse." Another said, "we are not direct clinical but we have to put our clinical knowledge into play."

There is a correlation with this theme and literature that indicates there is value in nurse educators having clinical nursing experience. Kettunet, Lukkariner, Kääriäinet and Salminet (2013) conducted a study that determined students expected their teachers to possess clinical competence. Students felt that teachers could update and develop this by maintaining their theoretical knowledge and contacts in the nursing field. There is some literature that takes this one step further, arguing that nurse faculty need current clinical competence (Wall, 2008; Williams & Taylor, 2008).

The second theme that may have a more general application to nonclinical nurses, including nurse educators, relates to their

continued on page 6

continued from page 5

impact on the public. Many participants described how their nonclinical roles had an impact on patients and on the public. One participant said, "I think this role influences the way health care is delivered." Another stated, "you have an opportunity to impact people's care." Through their preparation of new nurse graduates, one can argue that educators have an impact on quality patient care and patient care delivery.

The results of the Fellowship study provide a description of the nurse administrator role. These nonclinical nurses identified that they continue to apply their foundational nursing knowledge, skill and judgment despite the fact that they are not providing any direct patient care. Participants felt that they relied on previous clinical nursing experience to support role effectiveness and impact the delivery of patient care. Additional research may demonstrate that the same is true for other nonclinical nursing roles, such as nurse educators.

Nurse regulators are accountable for having effective requirements in place that regulate nurses in the public interest. This study gives us some information to help inform the dialogue about whether or not there is a need to develop specific requirements for nurses in nonclinical roles. Are current regulatory requirements effective in regulating the unique role of nonclinical nurses? If unique requirements are needed for public safety, what should regulators consider when regulating nonclinical roles? Let the discourse begin.

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NCSBN's Transition to Practice® (TTP) Study in Nonhospital Settings

In the fall issue of *Leader to Leader*, we presented a summary of the Phase I results of the Transition to Practice (TTP) study, which took place in hospitals with registered nurses (RNs). That part of the study was published in the January issue of the *Journal of Nursing Regulation* (Spector et al., 2015) and can be found here, along with a link to a guest editorial in the *Journal of Nursing Education* (Spector, 2015) discussing the implications of the TTP study for nurse educators. There is also a document on that web page that discusses the implications of NCSBN's TTP study for boards of nursing (BONs).

Phase II of the TTP study was conducted in 34 nonhospital settings including nursing homes, home health and public health; in three states (Illinois, North Carolina and Ohio); and with licensed practical nurses (LPNs) and RNs. The researchers had some challenges recruiting sites and new nurses for the study, even though the recruitment period was twice as long as that in Phase I (six months versus three months). However, because there is so little information on transition to practice in nonhospital settings, NCSBN proceeded with the study. This was a mixed-method comparison study using a randomized, multisite design to examine the effects of NCSBN's TTP model program versus the control sites' traditional methods of onboarding new nurses. A description of the TTP model can be found in Phase I of the TTP study (Spector et al., 2015). Because of the limited numbers of responses, inferential statistics could not be used in Phase II.

The most striking finding of the nonhospital study was the difference in turnover of new nurses (both voluntary and involuntary) in nursing homes as compared to hospital sites. In the Phase I study of hospital sites, there was an overall retention (study and control group together) of 83 percent. When the control group was split into those with evidence-based transition programs[1] versus those with limited onboarding programs, the turnover was nearly 25 percent for those with limited transition programs, 12 percent for the established programs and 14 percent for the TTP programs. In Phase II nonhospital sites, home health and public health had similar turnover percentages to hospital programs (14 percent and 25 percent, respectively), though the number of new graduates in those settings was very low so those numbers should be taken cautiously. However, the turnover for nursing homes was 65 percent for all programs, with 60 percent for those who participated in the TTP program and 71 percent for those in the control group programs. Also compared to Phase I, there was a much larger involuntary turnover in Phase II; in Phase I it was 1 percent, while in Phase II it was 6 percent for RNs and 12.5 percent for LPNs.

[1] The evidence-based transition program components that were identified included: patient safety, clinical reasoning, preceptorship, specialty content, feedback, reflection, patient-centered care, communication and teamwork, evidence-based practice, quality improvement and informatics.

The most striking finding of the nonhospital study was the difference in turnover of new nurses (both voluntary and involuntary) in nursing homes as compared to hospital sites.

Qualitative data were collected through follow-up phone interviews in Phase II to learn about the challenges of implementing a TTP program in nonhospital settings. We learned that their resources were thin. They had challenges with computer access, and even with receiving emails. While the new nurses and preceptors felt the preceptorship was key to the program, there often was not time for the preceptors and new nurses to connect. In the TTP group, the new nurses struggled to complete the modules because of work demands. Lessons learned from Phase II included:

- One size does not fit all. TTP programs need to be tailored to the type of facility where they will be used.
- Specialty content related to long-term care, home health, and public health needs to be incorporated into the program because facilities do not have the resources to add or supply this information to new employees, much less new graduates.
- Preceptorships are important and add significant value to a TTP program in nonhospital settings.
- Buy-in from the facility administration is essential. Though we supported and trained the site coordinators, we did not focus on the facility administration, which is necessary for success of the program.
- The modules were burdensome to new nurses in settings that could not allot time for them to complete the modules during working hours.

We did learn, however, that the TTP program may have had some impact on the retention of new nurses in the participating Phase II facilities. We also heard from our state coordinators (hired for the study to ensure that the study protocol was carried out correctly

continued on page 8

continued from page 7

in all 105 Phase I sites and 34 Phase II sites) that, while the resources are currently lacking to carry out an effective transition program in nursing homes, they have the potential of making a difference in new graduates' acclimation to the nursing home workplace. Further studies are needed to learn more about the impact of TTP programs on safety, competence, work stress, and job satisfaction. The results of Phase II will be available in the April 2015 issue of the *Journal of Nursing Regulation*.

What does this mean for BONs and nurse educators? NCSBN has disseminated an implications document for BONs. While the IOM Future of Nursing Committee recommended a yearlong residency program for new graduates, the time is not right for BONs to require a transition program for all new graduates. However, it is clear that evidence-based transition programs significantly decrease new nurse turnover in hospitals, and increased turnover has been linked to increased adverse events (Bae, Mark & Fried, 2010; Duffield, Roche, O'Brien-Pallas & Catling-Paull, 2009). Further, Phase I of the study provides evidence that an established, evidence-based transition program significantly improves outcomes. Therefore, the nursing community should work with nonhospital settings to increase the feasibility of implementing evidence-based transition programs.

As educators, you are well positioned to advise your students to evaluate future employers' transition programs. A preceptorship should be supported and is key to the program. There are improved outcomes when transition programs have been established within the institution and are supported by the administration. The program should contain many of the evidence-based components that have been identified in the literature. In Phase I of the study we found that the vulnerable time for new graduates is six to nine months after beginning employment, so the transition program should be at least nine months in length. Lastly, the results of Phases I and II of NCSBN's TTP study provide educators with the opportunity to partner with both hospital and nonhospital settings, share this evidence with them and collaborate with them in planning transition programs for their new graduates. ●

Transition to Practice®

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Social Media in Nursing

Understand the Benefits and the Risks

Nurses must understand and apply these guidelines for the proper use of social media.

Social media dos and don'ts:

DO

- Recognize your obligation to protect patient privacy and confidentiality.
- Maintain professional boundaries.
- Comply with your employer's policy related to electronic and social media.
- Report any breaches of privacy or confidentiality.

DON'T

- Electronically transmit any patient-related information or images.
- Share any identifiable patient information on social media sites.
- Refer to patients in a disparaging manner.
- Post disparaging or offensive comments about your colleagues.

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NCSBN Holds its First Ever Distance Learning Virtual Conference

As distance education becomes more popular than ever, educators and regulators alike are racing to keep pace, generating much discussion on the approval process and quality indicators that should be considered for this emerging trend. In an effort to elevate the discussion of distance education nursing programs, NCSBN chose this topic as the focus of its first ever virtual conference.

The April 28 event, exclusively for NCSBN Member Boards, allowed attendees to experience an entire day of information, insight, and dialogue just as they would expect at a traditional conference, but without requiring them to travel. After a keynote address by renowned nursing informatics educator Diane Skiba, PhD, RN, FACMI, attendees tuned in via the Internet to a variety of sessions exploring the topic. Plenary speaker Diane Billings, EdD, RN, FAAN, ANEF, Professor Emerita at Indiana University School of Nursing, then presented on quality indicators in distance education.

The remaining sessions provided multiple perspectives on the topic, and opportunities for attendees to begin dialogue with subject matter experts. In 2014, NCSBN's Distance Education Committee developed guidelines for prelicensure distance education nursing programs; Committee Chair Bobby Lowery, PhD, RN, FNP-BC, FAANP, and NCSBN Director of Regulatory Innovations Nancy Spector, PhD, RN, FAAN, discussed the guidelines in one of the sessions. In another session, Virginia Board of Nursing Deputy Executive Director Paula Saxby, PhD, RN, and University of Wisconsin–Oshkosh Dean Rosemary Smith, PhD, RN, discussed the regulatory and educational perspectives on distance education. Attendees also had the opportunity to ask questions during a panel discussion with several of the speakers. Later, the future of this increasingly popular modality was explored by Case Western Reserve University doctoral student Denice Reese, MSN, RN, who assisted in the development of their massively open online course; and John Lopez, director of WICHE State Authorization Reciprocity Agreement (W-SARA). W-SARA is a regional, voluntary compact intended to provide state oversight of distance learning while still increasing accessibility to higher education.

The Distance Learning Virtual Conference was the first event of this nature presented by NCSBN. Regulation and Interactive Services staff are gauging the response to this new interactive format and exploring the potential for similar events in the future with both its membership and external groups.

Fittingly, as NCSBN members explore the use of technology to increase access to nursing education, NCSBN is also undergoing a technology refresh to increase the accessibility of digital collaboration for its members. The event also showcased some exciting changes at ncsbn.org. NCSBN is upgrading to a new digital collaboration tool, known as HIVE, that will allow for easier and more intuitive networking between NCSBN members. HIVE is set to debut in late summer 2015, but the Distance Learning Virtual Conference utilized the Cisco WebEx webinar platform on which HIVE will be partially based. Members experienced a new look and feel when they logged into the conference, as well as a chat lounge for discussion with peers and extra Q&A sessions with the presenters; a resource center that puts all related documents and media in one place; and a few other entertaining new features. The format intends to replicate all the highlights of physically attending a conference as closely as possible.

The conference was the inspiration of the 2014 Distance Learning Education Committee as they developed the guidelines that would be added to the Model Nurse Practice Act and Rules at the 2014 Delegate Assembly. The model language generated much discussion and the committee discovered that existing guidelines regarding distance education nursing programs vary widely from state to state. The committee members sought an

continued on page 10

Yearly NCSBN Environmental Scan Released

Nurses make up the largest number of health care professionals and play an integral role in population health, primary care and the redesign of the U.S. health care system. As the U.S. health care system continues to meet new and ongoing challenges, nurses are on the front line.

Boards of nursing (BONs) need current and critical information about regulatory, workforce, political, economic and social issues that affect nursing, and the environment in which nurses operate.

Each year NCSBN releases an Environmental Scan in an effort to provide current, critical information for BONs in order to protect the public, respond to emerging issues and challenges, and strategically plan for the future. The 2015 Environmental Scan was published in a special January 2015 edition of the *Journal of Nursing Regulation* and is available to members as a free download.

A variety of sources were used to develop this report, including research and scholarly articles, news articles, websites, databases, peer-reviewed journals, direct communication/presentations, annual BON reports and NCSBN surveys of BONs. Certain consistent sources of data are used from year-to-year to help formulate comparisons and identify trends. New issues, problems and data on the horizon for 2015 are also included. An abundance of information was reviewed and analyzed in order to provide a report that can be used to assess the regulatory environment and guide strategic planning.

Key Findings of the Report:

- Licensed practical nurse (LPN) programs are decreasing.
- The number of APRN continues to rise, and educators are struggling to find appropriate clinical placements for their students.
- Transition to practice for APRNs is increasingly being discussed at the local, state and federal levels.
- There is a shortage of nursing faculty, and many more are near the age of retirement.
- Distance education issues continue to arise as more programs proliferate. It is important that these programs be held to the same regulatory and education standards as other programs.
- Access to care remains a key issue in the U.S. It increases the need for telehealth and for APRNs with full practice authority. It has led to discussions about the role of unlicensed personnel and staff from other professions taking on traditional nursing roles.
- Federal legislation impacting state-based licensure and the regulation of nursing is an issue calling for close monitoring and communication with members of Congress and BONs working together to provide feasible solutions.

continued from page 9

innovative way to continue the discussion while putting the collective knowledge of leading distance education faculty, regulators and administrators at members' fingertips.

In 2014, the committee's focus was on prelicensure distance education programs. The 2014 committee's work can be seen in the Model Practice Act and Rules. As a result of the committee's work, the NCSBN website now also has a state-by-state list of all current requirements for prelicensure distance education. The 2015 committee is exploring APRN distance education, and their findings and recommendations will be presented at the 2015 Delegate Assembly and perhaps at a future virtual conference!

NCSBN's Virtual Conference was recorded and is available to the public.

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