2019 NCSBN APRN Roundtable Innovations in APRN Education Affecting Certification and MOCs Video Transcript

Event
2019 NCSBN APRN Roundtable

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- [Maureen] So, my question for the panel this afternoon is what about maintenance of certification for APRNs? And I asked them like I did this morning with the other speakers.

Think about innovation, feel free to be provocative, but how does it serve us? What we're doing right now? How might it change in the future? And I asked each of them, "If in your organization, some things are already ongoing in terms of innovation and future progress, let's talk about that or talk about the things that you think could change."

Now, all of you, I think, are well aware that certifiers are under an accreditation process. And like anything that's credited, they have a pathway they have to follow. Their certifications have to be legally defensible, they have to be psychometrically sound. So they can't suddenly think super creative and change everything.

So, the real question is how do we feel as APRN groups that the maintenance of certification is serving us now and how might it serve us in the future? So, with that said, that's my lead in. I'm going to invite our panel up and as they're coming up, I'm going to give you introductions because this is a pretty distinguished group of individuals.

So, it's going to take a minute. So, we have Rick Meadows who's currently the Chief Executive Officer for the American Academy of Nurse Practitioner Certification Board. He's been in this position for 10 years as of April 1st and has been an NP for 45 years and has been involved with certification in various ways for 25 years.

Rick taught his first class of NP students in 1978 in the U.S. Army and has taught at a variety of colleges and universities. He's been actively involved with LACE for 10 years. So, then, following the gender identity here, our next male counterpart over there is Dr. John Preston. He's the Chief Credentialing Officer for the National Board of Certification and Recertification for the Nurse Anesthetist, NBCRNA.

Dr. Preston's been actively involved in Nursing Anesthesia Accreditation Education and Regulation for over 20 years. His previous career accomplishments include Nurse Anesthesia Program Administrator. He's chair of the council on accreditation and ANA Senior Director for Education and Professional Development. He's been a registered nurse for 34 years and a certified registered nurse anesthetist since 1994.

Now, to my left, we have Suzanne Staebler who's an APRN, an NNP, and she's currently a Clinical Professor, Specialty Coordinator for the Neonatal NP Track and the Health Systems Leadership Track Coordinator for the DNP Program at Neal Hodgins Woodruff School of Nursing at Emory University.

She continues to represent the neonatal population on APRN Consensus Group LACE, the task force and currently serves as President of the Board of Directors for the National Certification Corporation, the National Certification Board for Neonatal and Women's Health Nurse Practitioners. And last but not least, Diane Tompkins is the Certification Accreditation Manager for ANCC, responsible for the development, submission, and ongoing maintenance and compliance activities related to accreditation of ANCC's 18 certification programs.

She serves as ANCC representative at national meetings focused on APRN issues and the consensus model. She just reached a milestone, 15 years of service with ANCC. - [Participant] Congratulations. Diane's a former captain in the United States Air Force and holds a certificate in flight nursing from the School of Aerospace Medicine. She earned a Bachelor of Science degree in nursing from the University of Buffalo and a Master in Science in Nursing Education from the University of Maryland at Baltimore.

Whoo, see what I mean? So, I know that NCC, I believe if I'm saying this right, has had a recent publication in the Journal of Nursing Regulation. - [Suzanne] Yes.

- Ta da ta da. So, actually, it's available in your app. For those of you who have downloaded your app, we made that available for you guys.

- Excellent.

- So, you want to tell them a little bit about what all that was about and what else you guys might have planned?

- Sure. So, for NCC, with the endorsement of the consensus model, one of the key items related to certifiers in the consensus model was a mechanism for ongoing maintenance of certification, and it can't

just be that you pay a fee and you're renewed. The board of directors at that point was kind of like, "Okay, how are we going to do this?"

And so, what they concieved is a low- stakes continuing competency assessment. We call it RCCI initiative. And we kind of… The first time we rolled it out, it was absolutely low stakes, you can take it, you can not take it. We got some preliminary data. What were some of the kinks?

What did people not like about it? What did they like about it? When it went really well and we rolled it out not just for the NP exams, but all of our core exams, so much like ANCC, we don't just certify nurse practitioners, we certify nurses in maternal-infant specialties. So, we had nursing as well as APRNs, as well as some exams that we have physicians in, for instance, our Electronic Fetal Monitoring exam, which is a subspecialty exam.

We actually certify more physicians for that exam than nurses. So, took all of that feedback and decided that we were going to continue that process. So, in the second cycle, it became mandatory for people. And so, you renewed your certification and the way it works is you take this assessment and the assessment is broken into the core knowledge areas that the test exam is based on.

And we paid really close attention to your certification exam is the entry into practice. These are seasoned practitioners in most cases. And so, what does that competency piece need to look at? And then their CE that they have to complete for that maintenance cycle is targeted based on their assessment.

So, for instance, I always have to do pharmacology, always. I'll die doing pharmacology content, I've decided. And so, I'm okay with that. But in my CE profile, I take that assessment. I know I have to have 10 hours of pharmacology every renewal cycle and then I can have 10 hours of general CE, whatever I want to learn about.

So, we now have 10 years, 3 years of data and in all of our areas and exam areas, there is significant decrease in the number of continuing education hours, certificatants need when their CE is targeted to the knowledge areas they're weakest in.

And that kind of makes sense because, for me, if I could choose, I'm not going to take pharmacology hours. I don't like pharmacology. I want to do other things, but I'm forced to do targeted CE in the areas that I'm weakest in as a professional. So, we've had very good success with that.

Everyone is kind of on board with it now, they know it's coming. And we have our content teams who will pay attention to regular certification exam pieces as well as then the continuing competency pieces. So, that's what we're doing.

Interesting that we're having this conversation because in December, at our face-to-face board meeting, we're actually going to do some strategic planning because we want to do things a little bit differently and kind of… We like to be the front runner. And so, I'm a big proponent of Donna Wright's Competency Assessment methodology where the more control you give the people who you are assessing, the better the process is.

And I'm not quite sure what that will look like, but we've been talking about some different things. And for our subspecialty exams and certificants, we're in the process of going through accreditation right now and one of the things we're going to put before the accreditors is for the subspecialty exams, we're going to start using online proctoring so they don't have to be in person in a testing center.

We're going to contract with ProctorU to see how that works. And so, that's going to be interesting to see what the accreditors have to say about that. - [Rick] Basically, we certify about 125,000 primary care nurse practitioners and those are predominantly family nurse practitioners, Adult-Gero.

We still have adult nurse practitioners that we certify who'd continued our recertification processes. And we also have a specialty certification exam for family nurse practitioners for practice in the urgent emergent care areas. We did our continued competence, if you will, recertification study taskforce in 2014.

So, when Maureen emailed me, I think it was back in January and suggested this idea that we might want to include this with this particular roundtable, I said to myself, "It's a very timely event and we'd like to take a look at what's going on, what's been going on," and I think it's interesting that the MoCA thing came out in 2014.

It's all right along the same timeframe, so we're all looking at it at the time. But it's a timely thing for us to get involved in. Our board has been very committed in the past few years now to continuing to do research in the area of certification and recertification. And so, this will play, like I said, right along the same lines with that.

What we currently require in the way of recertification is a minimum of 100 hours of continuing education credit over a 5-year period of time and at least 1000 hours of clinical practice. Or, you can take the exam and that… You can take the exam, or you have to take the exam if you don't meet those requirements.

Has led to a lot of tears over the years. People just plain don't want to take that exam again. And I think about it. It's kind of like you got that, you know, Monopoly card, go straight to jail, do not pass go. You know, when you're told that you have to take that exam again. Interestingly enough, I had to take it twice myself because I stopped clinical practice in 2005.

I retired from public practice in 2005, so I had to take the exam twice and trust me, there was a bit of angst involved in that. Even though I was involved in a lot of the test preparation prior to that timeframe, I had to stay away from it for two years for accreditation purposes. But it's still…there's a lot of angst that goes along with that.

As far as what may be coming down the pike for AANPCB, as I said, research is what we're continuing to look at that and look at the different ways that people are approaching it. We definitely, we'll keep our ears open as far as what's going on with the rest of the profession.

The experience, and I love Maureen's analogy of "learn from someone else's mistake without having to go through the experience yourself," is very important. We don't want to repeat what happened to

ABMS or ABIM, in particular. We don't want to go through that again or we don't want to go through that.

Not again, for us. So, that's basically the approach that we'll be taking. There was one other point that I wanted to make regarding what might be coming down the road. We, even though we have a specialty certification of emergency nurse practitioner, we feel very strongly that that specialty certification exam still has to be legally defensible, psychometrically sound, and it has to be accredited.

And our certifications are all accredited by NCCA and by ABSNC. - [Diane] Well, good afternoon. Diane Thompkins and I'm going to take a little bit of a different approach to what we're looking at in certification and accepting for continual renewal, something that came out of our ANCC Accreditation Department.

As a reminder, ANCC, we have four major departments, Certification and Accreditation, Magnet and Pathway, and we also have support service and research. What was happening is that I think we can all agree that APRNs have to participate in some kind of continual professional development, whether you're an APRN or an RN.

That's just the nature. Wherever we started off, life has changed and we heard about that a lot today, especially with this explosion of knowledge that is occurring. And the traditional ways of doing things for demonstrating continual competence have always been related to time. You know? How much time did I sit here?

How much time did I go over there and how much time was I over here? We call that seat time. Well, the seat and the brain sometimes are not connected. And the seat and outcomes may not be connected, but we all got that certificate saying, "I showed up, I was there for X amount of time." And we've all been battling the question, "Well, and then what?"

Well, our department in accreditation has really come up with a model for being able to provide outcome-based continuing education credits. And that is really what I kind of want to provide you an overview on. On your tables, there is a flyer that kind of gives you a nice brief synopsis of what's happening there, but I just kind of want to cover that with you and to let you know then how are we are segueing that into the certification area.

The Commission on Certification has, which is our governing body in certification has approved the use of what we call outcome-based continuing education for category one, the renewal categories in our renewal requirements. So, we will be accepted for anyone who is producing that, but there's some caveats to that.

So, when you're looking at outcomes, you're really looking at being able to find a result back into something that you did and you got a result. The outcome-based model is really based on the work of several other individuals. You have Miller's model of continual competence in Moore's Seven Level of Continual Medical Education. And they are really just looking at that progression of from, you know, knowledge all the way up to…I call it the expert or really being able to demonstrate what you're doing.

The program was kind of built on to that. So, if you take a look at the back of the chart, you'll see those five levels that are there and these five levels with this outcome-based model, they start with the person just being able to articulate the knowledge, and we can all get that. Then you have to apply as level two, level three, you have to be able to demonstrate it in an educational setting for your integrating into practice and five, demonstrating the impact, does this really make a difference?

And so… But the key thing in this model, and you're all thinking, "Well, that one'll be easy." You can't self-report. So, this is really being managed by folks who already hold an accreditation. They're ANCC-accredited providers. There's a defined process that the program has to be developed under so that there is that intervention of did the person really articulate the knowledge?

Not that I think I did, but I can demonstrate that idea, you know? If I'm going to apply the knowledge, how is that being done and being evaluated? So, if I get a certificate saying I received level one or level two, there is meaning behind what that is. But the key thing to look at it is this is nothing about a self-report, it's really done within a defined characteristics of an educational process.

So, what you do have is a nurse planner and you have a content expert who may or may not be a nurse, depends on what the content is. You had the learners have to be actively engaged into this. So, we can't make you do it, this is going to be a learner-engaged on process. And the providers will be able to award a certificate.

And I'm not going to go into all that, but it's an official certificate. It has the statement on it. We know what's currently being used because it's… We've gotten some calls from some state boards going, "What's this?" So, we're kind of having to explain on what it is. There are outcomes that have to be driven to each of the levels that you see. You select a content forward, but within a defined controlled environment, it's going to be assessed whether you're really doing it.

So, what I wanted to do was to kind of move to an example of a couple of the levels. I'm not going to go through each of these. With 25,000 different examples, but I'm just going to start with one just to give you a sense. So, let's just say I want to learn something and level one's going to be Articulation of Knowledge or a Skill.

The first thing that has to be done is it has to be defined, what it is that I'm going to do? So, what is it that you were expecting me to articulate? Then you have to have guidelines set up to measure that, and then you have to be able to measure it. And the ways of measuring it could be something written, you know, a recall, but it's going to be in a controlled environment.

So, I can't sit there and think like, "Mm-hmm, mm-hmm, mm-hmm. Got it." Like, "Give me my certificate." That's not quite how it's going to work. So, yes it could be a written test, it could be a verbal interaction with another person. So, each of these levels will have this sense of you have to define what's going to be expected, the learner will, for whatever the content is. There's going to be guidelines for the provider to be able to say, "This is what's required for you to demonstrate that."

And then a formal evaluation of it. So, what I did is I decided to take one of those levels and we're going to go to level five and kind of walk us through an example of an issue, a topic, and then walk through each of those levels with it.

And I took one, which just happened to be random, but it seems to have been the topic for today, and that was a [inaudilble] I'm a Preceptor. And oh, my gracious, I think I have a gap. Okay? So, I've self-identified some of these learning things can be self-identified, it could be organizational-identify, but in this case, I'm self-identifying that I've got a problem being a preceptor.

And I know this because I'm getting some not pleasant feedback. And so I got some poor scores, one of the evaluation to faculty isn't happy the people I'm precepting don't… Something isn't right, but I clearly know I've got something I need to work on. So, what's my desired state?

My desired state may be to take a look at that survey I'm getting and maybe I'm going to bump myself up compared to others way up there with the top 10. So, I'm going to give myself a measure. So, you can kind of see that's my goal. And who is the target audience? Well, in this case, it's an individual. it's me, that wants to do this. So, if I want to walk this through the five levels, this is how I can do it.

First, I want to say, "Gee, I need to be able to articulate what's associated with an effective preceptor?" Well, I have to do some research on to that first, you know, what's out there in the literature? What are those pieces of information that determine what's an effective preceptor? So, then, I need to be able to demonstrate that by showing and being able to verbalize that.

And one way I can actually say that I have gained that knowledge is I can write a summary that's then evaluated within this formal process. Another case could be that, for the level two, as you can see, we are moving up, I can write two case studies. Now and I'm doing a little bit of taking something, walking it through.

It's still in the controlled environment, but it can still be evaluated that I can then apply some of this information. And then I can look at how I can demonstrate this information, and I can look at what are those critical elements in precepting somebody? Can I write those elements out? Am I being able to use those into practice? And, again, someone else is going to be using their identified criteria to evaluate that, to determine am I really doing it?

So, again, there's no self-reporting, there's always this other entity that's going to be evaluating us. And then the next thing, am I integrating it? And so, I may take a look at demonstrating that I have actually applied and gotten the skills to this. "So, are my scores getting better?" Okay? That's the one way to saying it by actually implementing it and is someone who's observing me.

Now I wrote down here the nurse, but I was also thinking about our previous conversations today, who else is observing what I'm doing during my preceptor environment? This is a good opportunity to get in an external point of view. But how can I evaluate that I was really effective? Did this really get into practice and is what I'm doing really critical? And how am I going to measure this?

Well, one evaluation at that top level five could be I'm being constantly requested the precept. The schools are after me to be the preceptor for the university. Maybe the people that I'm precepting want to come to this organization to work because of the work that I did. So, this is a way of taking one example and you kind of walked it through the different levels if a person chooses to do so.

So, as I stated before, people can present to the certification as part of their renewal. These outcome-based credits, we're only letting it be used for things for category one and we've actually developed what we call a matrix and different profiles and because we value, the commission values the higher levels, categories four and five. If you take a look at what's incorporated into those, fewer of those will be needed to compensate for category one.

And if you want to use lower levels, level one, you're going to need a whole lot more of those. But so, it doesn't get associated with time. There is a maximum number of level one, but you then we still have to do some continuing education hours because what we didn't want to do was somehow, think people, "Well, if I did X number of level one, then that's somehow, again, it throws people back into this time concept."

So, that isn't where we're going now. This has really been recently launched. We are looking forward to seeing more people do it because this is really looking at what a clinician is already doing in practice and giving some structure around how it can be evaluated, giving them credit for it that then can be utilized for their certification of renewal.

So, thank you very much. - [John] Congratulations to all of the audience. This is incredible. I can't believe almost every seat still has somebody in it. You all are meeting warriors and if I had a badge, I'd give each one of you a badge upon exit today.

So, thank you for sticking around all day long. When Maureen was giving her introduction, I knew this, but it just hit me again, our physician colleagues looked at the idea of a maintenance of certification somewhere in the early to mid-90s and I thought back to my own professional group. Nurse anesthesia has had a maintenance of certification since 1978.

And two pieces of advice for you as you think about what you might want to do relative to maintenance of certification, either in a formalized certification program or just staying current with whatever aspect of nursing and advanced practice nursing you may be involved. The first one is do not wait 35 years to change your program.

That was probably our first mistake. We were very comfortable and complacent. Our program worked well and consequently, no changes were made for 35 years. No made, no large overhaul changes. And the second one is when you wait 35 years, you need to get a flame retardant suit because they're going to come for you a little bit.

And that, really to me, demonstrates the passion of the individuals in our profession and the fact that they truly do believe themselves, and they are outstanding individuals doing outstanding work. But nonetheless, we need to be able to try to quantify that and help them to be able to defend that they are just as great as we know that they are.

And so, our certification, our maintenance of certification program really has been redesigned to help them to do that. And as I look at that as the chief credentialing officer in our organization, I look at the five big elements. The five big elements that we really aim for are practice, so individuals must engage in practice and be able to demonstrate that they are engaged in the practice for which we are continuing to certify them.

They do need to engage in continuing education and that continuing education should be somehow relatable back to nurse anesthesia. But that's a pretty broad topic. So, lots of healthcare content applies, economics content, business content. There's all sorts of things that can be pulled into that.

So, it's not to make it narrow, but just to say there needs to be a tangential link between what they do and what they're taking for their continuing ed. And the third one are professional activities. So, our new program contains a category called Class B and Class B's are professional activity units. And I explain that to our certificants by telling them, "That's the value add.In today's health care, it's not good enough just to be a great clinician."

Everybody has to be a great clinician, but you have to be able to show something above and beyond. What is the value add in addition to great care that you contribute to healthcare? And for us, those are those professional activities. We have a wide variety of them that individuals can choose from.

Many of them, they're getting naturally and automatically. In our older legacy program, there was no way for them to quantify them. In our new program, they do quantify them. And so, in essence, we had each CRNA build a build a profile, a portfolio of their accomplishments that they can present to anyone, to a board of nursing, to a credentialing department within their facility, whoever might say, "What are you doing besides that, for your continuing Ed credits that I see you doing?"

And then we have a component that addresses emerging knowledge because we realize not everyone does a great job of dipping into the literature and really finding out what is the evidence base for what you're wanting to do? And, oh, by the way, what has changed? What might I need to change in my practice?

And so, we have a component that includes four modules. We set the learning objectives for those modules, but private continuing ed vendors create the content and then they have to send that to us to review. So, we review it to make sure of a couple of things. Number one, is it consistent with the objectives that we have defined that must be included, is that content in there?

And then they have an assessment. So, we have them crosswalk the assessment to the content so we clearly can see that what they're evaluating the individual on after they complete those modules is included in the contents. So, you know, just kind of good practice for continuing education. And, you know, then they have a limited shelf life, so they have to be refreshed. And that's a five-year window.

So, we don't have a perfect solution, but I think we've got a pretty good solution to making sure as time moves on, that five-year window moves on, CRNAs are required to engage in one of each of those four modules every four years. And each of the modules corresponds with one of the domains of practice that we have identified through our professional practice analyses.

So, it's all lined up. And then the final one is assessment. So, that was the one you need to put your flame retardant suit on when you suggest that examination is going to be a required element of your program. And in the beginning, in our initial iteration, it was a pass/fail examination at eight-year periods and that received a large amount of pushback, and concern, and fear.

Fear drove probably most of the pushback that we received. And Rick is right. You know, I worked with the organization. Testing is a totally different department. But if you told me that I had to take that initial certification exam again, I would be apoplectic. So, getting at how can we assess individuals but not drive them away from us.

That was a very difficult element of the program. And our board of directors struggled with that. They struggled with that wanting to do the right thing, wanting to push our program forward. And our board of directors did a great job with that. And so, in the end, we retained the assessment component, but we took the high stakes out of that. We made that an assessment where if they do not meet a performance standard that we set, then they will get feedback and they'll be directed to take additional continuing education in any of the areas, any of the domains where they do not meet the performance standard.

And that's consistent with adult learning. You got a problem, you tell adults, "This is what you need to do to fix it." And you let adults go on about doing that and then they will be reassessed at a later point in the program. And so, those elements repeat, most of them repeat on a four-year basis. The assessment repeats on an eight-year basis. We initiated the CPC program and that's what we call that, Continued Professional Certification.

We basically, initiated that in 2009. In 2016… So, we've worked from '09 to '16. We really worked before that, but feverishly from 2009 to 2016. 2016, we converted the first half of nurse anesthesia, 23,000 people into the CPC program and they're matriculating along through the program.

In 2018, the first half, about 23,000 or so, nurse anesthetists got to their 2-year check-in. So, an eight-year program, four-year periods, halfway through the four year period, we ask them to engage with us. We ask them to verify that they're still practicing and where are they practicing? We ask them to verify their licensure.

So, do they still have state authorization to do what we're certifying them to do? We show them what we know about them. We tell them, "This is the continuing education that we know that you've completed and these are the professional activity units that you have completed in." If they have engaged in core modules, then we show them those and when testing or assessment as a component, then we will include knowledge about that.

So, we're giving them information and we're getting information from them. And then two years after that, they will go through an authorization cycle once again. And then it's a bit of wash, rinse, and repeat. We ask them to do those things. The program is a living program. Unlike our legacy program that we put into motion, it was a great program.

I am not in any way denigrating our recertification program, which is what the legacy program is called, but I am saying that our new program is designed to change. And our president, several years ago, said multiple times during his presidency, "If this program looks the same in 5 or 10 years from today, then the NBCRNA as an organization has failed. The program will look different.It will grow and it will develop based on the information that we get back from certificants as they go through the program."

So, following the timeline in 2020, then that first group that entered in 2016 will go through that reauthorization in essence process so that they can begin their next cycle. And then kind of in tandem to

that. Very early in the process, the creators of the program said, "There needs to be an evaluation and an internal evaluation process of our programs and the elements of the program to gather data to evidence that the program's actually doing what we believe it will do."

And so, we have established an evaluation, research, and advisory committee, or as we call it, ERAC. And ERAC is looking at all of the elements of our program on an ongoing basis asking the questions and then conducting the research to evidence that what we have put into place is achieving the goals that we've set for the program.

So, we're very pleased with that. And like I said, it won't be the same program in 10 years or even 5 years as it is today, but certainly, it helps us to engage with our nurse anesthesia colleagues that come to us for their certification and it helps us to feel very good that we can defend, that we have a program that supports them and supports the expectation, not only of our creditors, but really of the public that uses our services.

- All right. I'm going to start off our questions. And in the realm of being provocative, I was fascinated with [inaudible] Grande's [SP] ability to consider peer feedback in terms of the surgical suite and surgical skills.

And certainly, we talked a little bit before about 360 degree of [inaudible], which really probably belongs in the realm of your facility review, that kind of thing. But is there a place for peer comparison in maintenance of certification? Does it belong there?

Should it belong there? When I'm, you know, holding my credential over whatever number of years, how do I know where I sit in relation to my peers in my role in population? And is there a need to know? Does it fit ever in maintenance of certification that we should have some, a bit like the MOCA minute?

I mean, at least in their dashboard, they're going to see how their peers did on similar cases or questions. Is there a place for that? I'll just let you guys have at it.

- I'm going to pop in if our colleagues don't care and just give maybe a brief comment, Maureen, you know, in… Part of it might be called due diligence and part of it's just called staying current with what's going on and trying to stay ahead of the curve. We've looked at lots of things. We've looked at simulation, we've looked at how can we incorporate peer evaluation, and we've looked at longitudinal assessment.

And one of the individuals that we had speak with us about longitudinal assessment and the particular program that he was suggesting, it did something very interesting. It allowed not only individuals to say or the system itself to say, "Here's the minimal acceptable and you know, on a graph, here's where you're performing currently." And looking back at that and hoping that, you know, you're going up and staying up above the line, but it also allowed them, if they chose, to say, "I want to compare myself with the people that I work with, not by name, but by pool."

Or, "I want to compare all the people in my state that are taking this examination. How are they performing? Now, obviously, it required that those people opt-in. They had to opt in for them to

participate in that peer-to-peer recognition. But I thought that that was really one of the most interesting aspects of the individual's program. And it really kind of gets at what you're saying, which is it's all important.

How do I compare to others? How is my performance compared to the norm?

- I think it absolutely could potentially fit there. And I definitely think as we all move on to retirement and the young millennials move in to take our place, because they tend to be very comparison and competitive with one another and, "Well, she got that and she's doing this, well, maybe I need to be doing that" kind of perspective.

I'm not quite sure how to accomplish it, but I like that… We were talking at lunch and it's very natural for many of us in the APRM world to have our physician colleagues or ask our physician colleagues for that evaluation criteria and that 360 look, but very rarely is that reciprocated.

And so… But I do think there is a role.

- You know, one thing I left out when I talked about the 360 at our facility before was that patients were included. So, when you think about peer, it's not just peer, I guess, it might be broader than peer. Go ahead, Diane.

- I think you can just talk about…- Okay. I think I just talked. All right. This is one of the things that I really appreciated about the outcome-based evaluation because in taking a look at your learning opportunities, it's a wonderful structured way to get that peer evaluation. It gets away from the smiley face, gets away from the, "I didn't really want to tell her what I really was thinking about their practice,"but this was something that really struck me, was a very structured and easy way to do it.

And again, with the same thought as I'm looking at this new generation coming forward, they may gravitate towards this because this because this is what they do already. You know, they want to know how they're comparing to others. This doesn't fit well with time at all. It fits well with providing them the opportunity to say, "How am I doing?Here is how I want to present it. Am I doing it?And who do I need to get to evaluate me?"

And so, again, as we move along, I think in a continuum of what we're all doing in our renewals, you know, I never want to say never to anything because the world evolves over time. So, I think as we get more structured about it and as we say, "When it comes to accreditation, how do we work with our accreditors to make sure our standards are written in a way that permits more of this openness and ability to do it?"

Currently, all accreditors really ask us to really justify what we do and provide rationales for what we do. But you never know when you do that, how that's going to be viewed by people when it's a different concept from what we all grew up with.

- Okay. So, I'd like to respond to that as well. I'm trying to figure out a mechanism that primary care nurse practitioners would be able to utilize for the peer review component of it. And then I'm also

interested in how, when I'm looking at it, how that would help me say that this is maintenance of certification at the entry level, which is what we certify.

We certify the entry level into advanced practice for primary care nurse practitioners. So, a lot of what I'm hearing with that is actually not just maintenance of certification, it's advancing your clinical expertise and possibly going to a higher, if you will, standard, as you mentioned earlier. So, hard to say.

- Very helpful. One follow-up question to that would be for all of you, your strategies and particular sort of the novel directions is it adding cost? And if it is, are you getting pushback like ABMS did about cost?

- You all want to go?

- We did not increase our cost to the people doing the assessment and everything else. We absorbed that cost.

- It's cost us a lot and we've absorbed the cost. In fact, that if anything, we are very price-sensitive. Our prices are actually, I would almost say cheap, but they're highly economical. And nurse anesthetists are very price-sensitive.

- I would say whatever we're going to be doing, we'll be pretty much absorbing costs. It'll just be part of what we do in certification.

- Okay. Then I have… Mm-hmm. Go ahead.

- We haven't increased our costs in well over 15 years now. So, if we were to roll out something along the lines of the MOCA Minute, I would have to say there might be an additional cost, but whether or not we could absorb that cost would have to be a business proposal and a decision based on that.

- And Suzanne, you mentioned the platform, would that add cost, necessarily?

- Well, again, it was internal costs because all of that has to be designed. And our CCI platform is similar to our testing platform, but it's all internal and it uses leveling. So, the more difficult questions, if they are answered correctly, they see fewer in those categories versus the easier questions and then those are the only ones they're getting right.

They're going to see 20 or 30 of those questions. So, it is leveled in that way. So, it is costly, but you can do it.

- Okay. One more question from me and then I'm going to give the mic over to the audience for questions. The states often prescribe continuing education in certain content areas for the licensees in their state, maybe by different professional group.

In the past, sometimes it was HIV information, now it may be related to controlled substance and opioids. It often has to do with sort of a contemporary issue. In terms of maintenance of certification, do

you see any role? I mean, ABMS, of course, one of the things they saw early on was the need maybe to be rolling safety quality measures or content into their maintenance of certification.

How do you see that contrast between what states may feel they need in continuing ed and what you might require for your maintenance?

- You want to go?

- Oh, okay. Oh, they're picking my neighbor.

- I stumped the panel.

- It's whoever wants to jump in.

- Yeah.

- Yeah.

- I think it's something that we, some of us would… We have kind of like have… Kind of like talked about a little bit of that, you know, what is our role? But what do you pick? Because you have to maintain something over five years. So, what made me the thing now may not be the thing when the other person arrives. And I think that's where it gets to be one of those questions we sit back and have to really kind of think through.

You know, should the certifier be requiring certain things from everybody because remember, we do more than APRNs. So, we are certifying a wide range, you know, from administrators to the RN to APRNs. So… And trying to take a look at it's just a minimum thing that all certifiers should do? It's a challenge to that because it's not an annual thing and you're right, the states will do something because of an immediate need, but then it's gone.

Or it becomes part… And I think what happens is it becomes part of what you do. You know, HIV now is part of the expectation. There's no need for a separate module on that. And so, if tomorrow is the substance abuse, then hopefully, we'll take care of that too.

- And we already require… And not just us, but other certifying bodies as well, require a certain amount of pharmacology content based on the need for at an advanced practice level for prescribing and so forth. But in terms of saying to, say a family nurse practitioner, that, "You have to have continuing education in every area within your certification field," that's a little bit difficult, and especially if you have someone say if their specialty practice to a certain extent, say dermatology, we would like for them to get continuing education in areas other than Durham.

But at the same time, I say myself, and I thought about this this morning, if you're specializing in Durham, I would want you to get a lot of continuing education in Durham. So, if you think about it like that. So, it's a complex and I think a little bit of an issue in terms of what you actually require for the maintenance of certification.

- And, you know, in our new program, Maureen… In our old program, frequently, they were out of luck. And they were frustrated with that because they had to do that. They had to complete that and yet there was no acknowledgment from their certifier of their work. In our new program, I have to say, again, it's a Class B credit or those professional activity units. So, if it doesn't qualify for continuing education by our standards, it certainly will qualify for Class B.

And once again, it will appear in what essentially is a portfolio and they can demonstrate that they have completed that, and port that wherever they wish to take that.

- And I think for us, you know, neonatal is always special. I kind of get irritated with state boards when they make those blanket statements because, yes, we have an opioid crisis, but I don't prescribe those to adults. And so, when you're talking to opioid crisis to me, we're talking neonatal abstinence and that's a whole different thing.

And there's not CE out there for that. And so, then what do I do? Or what are the nurses in pediatrics, newborn nursery, NiQs do because none of what I am required to do really pertains to my practice? So, how do we do that differently?

- Yeah. And you know, the way some of those evolve in states is that something occurred that got constituent's attention who's gone to a legislator and it goes right on into some bill, and sometimes they are very misguided in terms of how it's going to apply to everyone.

But, yeah, you're right. Sometimes you end up needing to live with that. So, I'm going to let others take the mic. - [Tay] Well thank you, Maureen. And probably don't go too far.

Part of my question was the CE that you asked, but then take upon us with the American Nurse Practitioner, the American Academy… The American Association… Man, more coffee. The American Association of Nurse Practitioners and I'm [inaudible] affairs for them. So, one of the trends that we have been seeing for the last two years is medical societies bringing forward bills that exempt physicians from maintenance of licensure requirements, meaning… And the language of their bills say they cannot be discriminated against relicensure for reimbursement when credentialing with insurance or employment at a health or hospital system.

And so, while Maureen, in your introduction talked about their maintenance of certification as being more akin to our specialty, it's more akin to what we have requirements for someone who's already licensed and maintaining their license? So, I would be interested in hearing from the panel any thoughts that you have on how that pertains to APRNs moving towards the consensus model when we have ratcheted up this ongoing requirement for maintenance of certification through you all as certifying agencies and then if NCSBN has any comments about that differentiation between us.

Working in states like Indiana right now, on a piece of legislation requiring maintenance of certification and career-long certification for the first time where the physicians in those states have an active piece of legislation saying, "But not for us. We're exempt."

- So, Tay, I really like the fact that Georgia passed that law last year because now when I'm having those discussions about full practice authority, I can point out that we're held to a higher standard from a

competence and patient safety perspective because we have this ongoing requirement. So, I understand your concern, but doing what I do for a living on the policy side, I like that.

The legislators and the physicians don't like that, but it is the reality that they've created.

- And I would just tag in I am not advocating that we get rid of it, I just find it extremely ironic that we are unsafe, unprepared, unqualified and yet… Well, from David's presentation this morning and maintenance of competency, that is clearly not the case. But I do love hearing people have thoughts about it.

- Well, I actually would like to chime in a little bit on that too. I hope that it's a temporary state of insanity on their part. You know, the one thing too, this is not against my physician colleagues because I've worked with wonderful physician colleagues that they had different opinions than I did.

But it is against maybe organized medicine as a whole or organized groups that are taking on the idea of anti-certification movement. Those are probably self-serving interests rather than society-serving interests. And I don't really understand how it even got to that point, how you could stand up in front of individuals and say, "I don't want to demonstrate that I'm more qualified than someone else, but I do want to collect whatever billables are available out there for doing X, Y, Z."

I think part of that might be, and this is just a jainism, I don't have any data to support this, but you know, a board certification is optional for physicians. They can choose to do it or not do it. And for most of us, it's not an option. It's tied to reimbursement and/or our privileges. So, you know…- Licensure.

- And licensure, there you go. Oh, yeah, I forgot licensure. I'm sorry to all my Board of Nursing colleagues. So, I think that might be part of that too. But as an organization, that's of concern to us, I think probably of concern to all of us.

- Yeah. I think I have to agree with it. I just found it was interesting when it first came out because I'm a member of the American Board of Nursing Specialties and obviously, when this was presented to us during one of our sessions, you know, we were all scratching our heads like, "Really?You really want the public to know you're not doing anything to maintain your continual learning, especially when the public believes you're doing it and that's who they want to go practice?"

And I just kind of said to myself, "Let's not get caught into that." That, "Well, let's figure out how we can say what we're doing is demonstrating to the public that we do have standards in place that we are meeting to make sure that any nurse you're coming in RN, APRN has met a standard, is required to demonstrate that if they're holding this license.

So, please, like you say, I hope somebody just had a temporary moment and some of the legislators just are thinking, but it is something though, but I think it's an important statement Tay is saying that, "Please, everybody, watch what's going on in your state legislatures." Because this can't pop up unintentionally and people not truly understanding what we don't want is somehow nursing to get, I think driven into that conversation.

- [Karen] Karen Plaz. I have a couple of questions. First of all, for the continuing education credits, Suzanne, that the individuals are required to take for the different domain areas, do you have a passing percent? Do they have to meet a minimum pass rate in order to count those credits?

- Ask me that question differently. I'm not sure I know what you're asking.

- Okay. For the MBCRNA, we have a category called Class A credits and what we do is we have a continuum of the assessment. But, for example, in order for our online classes to count for Class A, when they take an assessment at the end of it, it has to meet that 80% pass rate that is set forth by our ANCC accreditors for CE credit.

- Okay. So, now… Thank you. So, we don't break our CE into Class A, Class B, that kind of thing. Conferences and different things get categorized and they have to… In order to count it, it has to be categorized into one of our five categories based on how they're certified.

So, for me, pharmacology's category two. And on my certificate or whatever it is I'm turning in as proof or uploading as proof, it has to say that it was so many credits of pharmacology, blah, blah, blah. So… [crosstalk].

- Yeah, there's no requirement to the assessment. Okay.

- We don't.

- Okay, - Karen, I think it sounds to me like what you're getting at is assessment-based continuing education. And no, the answer is we don't require that. We do accept certificates of continuing education. And, in fact, we accept AMA category one as well. Even though those individuals, if their nurses don't…they don't actually get the certificate that's awarded along with that category one, but they do get a certificate of attendance.

- Okay. And I would… Oh, Diane, I didn't know if you had a comment.

- We don't have a minimum. We do have within the renewals, there's a mandatory 75 continuing education hours and 25 of those were APRNs, so in pharmacology, and then there's eight additional categories that they can select from. But what we do say is it that it needs to show the breadth of the certification that the person is holding because we know people specialize.

So, if you're specializing in one thing, we need to see that you're really maintaining the knowledge, the board knowledge within that area.

- Yes. And one of the reasons we did that for our targeted education for those who do not meet the performance standard is the concern that we know the realm of CE whereas nurses go to our conference and might sign in and then go to the beach, or those kinds of things. So, we're trying to implement methods to show learning has occurred.

And you just don't get blanket credit. And then, Rick, for the examination that you talked about, is it the same exam as entry?

- If they have to take the certification exam to prove that they have continued competence at the entry level, is the examination that is currently being offered, not the one that they took 25 years ago.

- Okay. And then just a question for the audience, because I know we have a lot of credentialing representatives in the audience. How many of you have a choice for the pathway for your continued certification or recertification? Can we just have a show of hands if you do have a choice of pathway?

- By that, Karen, do you mean more than continuing education?

- Yeah, more than CE. Can you choose one or the other now? Rick has one. So, you have one. Okay.

- We do.

- Yeah, you do?

- Yeah, we do.

- Variety of ways.

- Thank you.

- Variety of ways. Yeah.

- Thank you. - [Lisa] Hi, Lisa Emrich with the Ohio Board of Nursing. My question, it sort of relates to what Maureen had said. Obviously, you're, especially Diane, you're outcomes-based CE. It's qualitative, innate in measurement and not quantitative in measurement.

Boards do have CE requirements for licensure maintenance both... I know in Ohio, for both RNs LNPs, it was for every type of licensee that we have, but it is quantitative in measurement. And it's in our statute. To change that would need a statutory change. And I was just curious just to conversations that have been held because we, at this moment in time, would not be able to accept a qualitative measurement in a CE.

- So, David's going, "Cathy, get up." Because this is the conversation that we just had. We're actually going to be presenting to the state boards this outcome-based credit system. And to Diane's point, our commission on certification developed a matrix because the reality is probably for the foreseeable future and if not forever, there's going to be some sort of blended model, right?

Because if you go to a conference, you're not going to say, "Well, you have to pass the post-test before you can leave the room.You're going to leave the room after an hour and you're going to get an hour's worth of credit." So, there's going to be that component, but then there's a lot of professional development activities that people participate in that time is completely irrelevant. And so, what we were trying to do is decouple time from the CE credit.

In some states, I think it will require statutory change.

- I don't know in all states if that's the case, but we went, for example, in our joint accreditation program to Georgia, we were asked to go for the State Board of Pharmacy there and they were looking at our inter-professional continuing education credit. And their regulations said CE credit. It wasn't a time-based system and in that or said continuing pharmacy credit, So, they didn't have to make any changes.

They could just adopt. Right. So, in some areas, I think, potentially, it could be more complicated or more lengthy, but I think it does speak to what we all know, sitting in a seat is not a measure of learning.

- And I'm not discounting that, it's just more of a… It's what's in statute.

- It's more complicated.

- Yeah.

- Absolutely.

- And certainly, that takes time to change, it's not something that can just happen tomorrow. Just because, you know, here, we look at this and know this is a good thing. We need to, you know, have that change.

- Right. And that's actually why we wanted to pilot it internally with this matrix where people could choose some sort of combination because they need to know also how much outcome-based and how much seat time am I going to be required to do. And so, to Dianne's point, we had different profiles that said, "Okay, well, here's the best mix for me and that's how they're going to…"- Very good.

Okay. Thank you very much.

- You're welcome.

- Can I make… I was going to stand up and make one comment, so while I'm standing here. In the conversation in terms of peer evaluation or best practices, people are notoriously bad at self-assessment. And there's a whole body of literature in terms of, you know, how well they can assess their own ability and those who are least competent are least able to evaluate themselves, and those are the ones that you want to focus on, right?

So, the two, Suzanne, what you had described and John, what you had described in terms of either there's a reference point, right? It's whether how you performed on a set of measures and so, there's some sort of…it's not a self-assessment. And, John, your comparing yourselves to a peer group are two really great strategies to, you know, incentivize people, put a little cognitive dissonance that they're not where they want to be and there's some objective measure of that in order to incentivize them to engage.

So, I just wanted to compliment you both on those strategies. I think they're really evidence-based and I think they speak to individualizing for somebody where their learning gap is and what they need to engage in. And I am not a fan of mandatory CE for many of the, you know, other than engaging as

appropriate for you, but saying everybody has to, you know, do fall, prevent, whatever it is, it just doesn't pass the common sense test.

And I think, Suzanne, you gave some really good examples why that mandatory five hours of put it in air quotes is not an "effective method."

- Cathy, I'll address to the fact that humans, by nature, have competitive-ism. And so, if you can make that nonthreatening competitive-ism, so they're doing that privately, it is a tremendous way to get people to do something that they naturally would not be inclined to do.

- Right. And it's hard on the ego because it's very difficult to say, "I'm not good at this." Right? You have to have a pretty healthy ego, I think, to say that. So, there's a lot of different reasons. So, thank you. Good job.

- Great point. And thank you. - [Steve] Oh, okay. I'm Steve Brandon. I'm going to go ahead and take the heat and tell you I am from Texas Tech University.

But I have a question for you all in that I'm a nurse practitioner faculty. Some of you addressed the practice hours issue. One of the dilemmas that we have in nursing education is 80% of our enrollment now is nurse practitioners in some of our graduate programs. So, we as faculty, are stretched so thin.

I am clinically-engaged currently and I know some certifications do count faculty practice hours and do the others because it's a big issue of how do you maintain, spin all those plates as well as teach your students well if you're not going to count some of my academic time towards my clinical practice?

- I think the answer for nurse anesthesia is, yes, we would count your academic time as a faculty member. So, education is a form of practice.

- With ANCC, well, we have the 75 mandatory continuing education hours and as an APRN, 25 of those. Practice hours is now one of the eight that you can select after you complete the 75 required hours.

- Our approach to the practice hours requirement is that it needs to be an actual faculty practice setting. So, in other words, you need to be the ones seeing the patient as opposed to supervising a student who is seeing the patient.

- Okay. I'm going to be the outlier here. ANCC's philosophy is that we are validating knowledge competence, not practice competence. And so, therefore, we don't look at practice hours or anything at any point.

- Hey, do you have any other questions or questions for any of our speakers today? All right. -

[Pam] Hi. No, I have one. If, for those of you who do the assessment tests… Sorry. Pam Simmons, Louisiana. For those of you who do the assessment test, and if someone were to take that assessment test and it showed that they had the knowledge level of whatever you're seeking at that time, are they still required to do mandatory CE or how is that handled?

- So for us, there's a minimum amount of continuing education that you take regardless. If you don't meet the performance standard… Okay, so, a performance standard is determined for the assessment. Then you would have to do additional continuing education in any of the four domains where you did not meet that performance standard.

So, it could be that you have to do continuing ed in all four domains if you do not meet the performance standard in all four of the domains.

- But if you met the performance standard, you may not necessarily have to do continuing education beyond the initial.

- You're exactly right. You just have to meet the minimums then.

- Okay.

- And we're the same way. Exactly. So, our renewal cycle is every three years. And so, you have a minimum of 15 but then depending on your assessment, that can go all the way up to 50 depending on what areas in your assessment you didn't meet the criteria.

- So, you take the assessment and you'll have to do at least 15 required. Okay. - [Louise] Louise Kaplan from Washington State University and my regulatory colleagues from Washington State are probably not going to be surprised to hear my question and comment.

So, I want to go back to the practice requirement issue. So, in Washington State, we still have a 250-hour practice requirement for every two years when you renew, but the state is looking at getting rid of that based on ANCC getting rid of the practice requirement as a mandatory requirement rather than an optional requirement.

And I have looked at the literature on continuing competency. I know there's really no evidence that says you must practice to be competent, but there isn't really any evidence that says you shouldn't practice to be competent.

And I'm actually very concerned about not having a practice requirement. And I think it really is a conversation that needs to be had because… So, I'm an N of one who didn't practice for four years when my children were young. And I have to tell you, going back to practice was like having had a stroke and having amnesia and not even be able to remember words.

And then, of course, medications had changed and all sorts of advances in health care had occurred. And what I'm very concerned about is that people who certify believe that they're employable when you have huge practice gaps and they're not really employable because who wants to hire someone who's been out of practice for four years?

I had to do 250 hours of supervised practice by a nurse practitioner to get my license. So, my question to all of you is how do we really look at doing some evidence-based approach to the practice requirement?

Because I don't think we have the evidence to say we should or shouldn't and I really think we need the evidence to tell us that.

- I'm going to take a quick stab at the question because, I mean, I think your question is a good one, but I also think the missing denominator is define practice. We are in an evolving healthcare environment right now. And when someone says practice to me now, I'm like, "Hm.Is that when I was an advice nurse with Kaiser?Was that when I was on the floor of the unit?Is that when I was doing this?"

I kept thinking all the different things I have gone through. Which of those would be considered practice? Well, it depends on who you talk to. Is it about also… I think the one factor we leave out of practice is to individual accountability of the clinician. I think if I have not been doing something and I'm choosing to get employed, I'm obligated to make that known to whomever I'm employed by and I'm obligated as a ethical clinician to seek out what I need to get that information.

I think we're looking for external people to force something where there are some things that are really what we call being a professional. I know full well if there's a major disaster out there, I can still find a pulse and that's probably wheat I'll be good at doing.

Okay?

- Right.

- But that's it. You know, and I'm going to leave it to the other folks to go in and do the other things. Am I practicing when I find the pulse? I think I am. I can still find a pulse. They're breathing. I can now triage them to the next person.

I found the question came into define practice because that was what we were getting asked, is what I'm doing considered practice? And I'm thinking, "That's a professional discussion." That's a bigger discussion that I think if we want to get into room to answer it, we need to get a lot of people in a room to say, "Define what is practice."

And then the question is, "Isn't that the responsibility of who licensed?" Is that, you know, I think it's a two-fold responsibility to whoever I'm seeking employment with. But I really think the burden lies with the person because I couldn't be practicing for 25 years doing the same thing for 25 years and never have integrated any new knowledge.

So, I think it's just trying to get folks in the room and just probably just having some of that deep-dive discussion. What is it that we're trying to answer when we say you must have practice? You know, what…- I'd be curious what Rick would say. Given that you still have the requirement.

- Well, actually, I agree with Diane in terms of her approach. It definitely is a professional responsibility. For instance, I haven't seen a patient as a clinician since 2005. I'm still certified because I take the entry-level certification exam and I met the requirements for taking that exam a number of years ago. Would I like at this point in time to go back into an internal medicine practice that I was in for a number of years?

No way. Not without a lot of remediation, but, again, that's a professional decision. Could I remediate in terms of the intellectual knowledge and so forth that's required? I think I could. But we, our board, likes the concept of practice being part of the requirement for recertification unless you choose to take the certification exam over again.

And Diane didn't mention, but being able to take the certification exam over again is one of the things that's always been available for those individuals who did not have the clinical practice time.

- I know. I had to do it. And it was really scary, to take.

- Sorry about that.

- Thank you, Mark.

- Mark. - [Mark] Mark Miner [SP], Texas. In this discussion, we just have been revisiting, again the practice requirement because ours is four years more. So, we looked at the board profiles and all the states are all over the place on this requirement. So, if we're going to have this discussion, I think the one group is still missing.

We have the boards, we have the licensees professional responsibility, but also the employer. And what still surprises me from a regulatory standpoint is the lack of review of licensure and status of a licensee in our data base. It still surprises people when we have imposters but I still think it's a three-way conversation.

It's the licensee, the board, and the employer.

- Right.

- It's very interesting, your comment. And I can only speak to nurse anesthesia. So, I'll limit my comments just to that. We have noticed in the last number of years that the institutional credentialing for practice is becoming an impediment to individuals. Even if they have a six-week lapse, they are questioning them as to, "Why have you had a six-week lapse in your practice?"

And so, for us, I do feel that sets the built-in buffer because they are looking at that. That's not to disregard anything that you've said. I think you're absolutely right. That's part of the three-legged stool that we have to look at in trying to make that decision about practice. - [inaudible] in Oregon.

Part of the three-leg when you have independent providers like we have in Oregon is you don't have an organization looking at, you know, what is this? What is this? You can hang out your shingle. And if my job is to protect the public, and I have these bad players who are independent providers and don't have that professional culpability to maintain and know that they are safe doing that, how do we protect the public without having some at least saying that there's some hours of practice?

- I'm going to have to agree with Diane because it boils down to a quantification and I think back, and this… I don't mean any disrespect to the conversation with this, but it goes back to individuals and their

driver's license and okay, if they're 90 years old and they tell you, "I've been driving for 79 years, well, don't tell me I'm not a good driver."

But I think we all know how that generally plays out when they get behind the wheel. And it speaks to the idea that people are not good self-assessors too. So, I hear what you're saying. I don't know that I have the answer to that other than it really relies on the ethics of the individual and their ability to be professional in their decision-making as to whether they have the KSAs that are required to fulfill the responsibilities that they're undertaking.

- I would also echo. Louise, I think you said something really important that we don't have a good evidence base in terms of what actually constitutes competence and how many clinical hours are required. So, I would argue this is a great area for search for anybody who's interested in that relationship between, you know, building that evidence base for certification.

- I'm just wondering if any of the certifiers have ever been legally challenged by individuals that didn't have the hours. Do you ever have?

- We're not required.

- Yeah. Or even… Well, that's right if you don't require it. Or boards only because there isn't really anything out there. We did the search as well to look for what's the magical number and they're all arbitrary, it appears.

- We've had individuals appeal but not legally challenge. Threaten legal challenges, but then when they get someone that has actually got a law degree, they realize that it's not going to work.

- Yeah.

- Yeah.

- Mark?

- The answer to your question is yes. The answer is yes. I can tell we've been challenged.

- Have. Okay. Any outcomes you can talk about?

- We tell them, "You must go to the board to change the rules if you have any evidence." But from that perspective, it never holds up they just want to complain, but we still look at what is the evidence. And so, even when we do the four years in Texas, we do a refresher course. It's been longer than that.

And where's the evidence to show that it makes any difference? There is none. And so, we're struggling with the regulatory piece on the evidence to show are we really protecting the public? And that's why I think if we're going to have this discussion, the employer also needs to be there with us.

- Yes.

- Yes. I think we all… I can't speak for all of them. My colleagues all agree. Yeah.

- Jay? - [Jay] Jay Douglas, Virginia Board of Nursing. I'm going to go back to what you said, John, about the credentialing folks, and also, I think human resource folks that I think are often the barriers to practice in institutions. I mean, we have weird enough laws about advanced practice in Virginia, but on top of that, there is a lot of barriers for people. I had a long conversation the other day with somebody.

She had called me because they wouldn't give her a job until she showed her transcript from her educational program. She said, you know, "I've got a license. I've been practicing for 20 years." And the person on the other end of the phone who's credentialing, "But we have to have your transcripts." So, I thought, "Well, let me get into this because this has been coming up a little bit."

So, I called the credential person and tried to understand their perspective and she was like, "Well, it'son the checklist.Well, that's, we've got to have." And, you know, I explained that, you know, us issuing the license to practice was actually… You know, we had used the transcript as the basis for issuing out a license. And, you know, clearly, I had had somebody who was just following the checklist and I'm not going to give up pursuing it because I then said to her, I mean, based on the name of the institution, I said, "You're a state facility, right?"

And I'm thinking, "Well, now who up the chain can I talk to?" And she said, "No, no, we're not." So, then, you know, I'm out on the website looking and, yes, you are, you're co-managed by a state agency. So, more to that particular situation, but to your point, I think there's a lot of barriers in the credentialing process for people, no matter what their level of licensure is.

- And I would put a pitch in there that in the last several years, we've worked pretty closely with the associations for facility credentialing or medical staff credentialing, or… They all have different names. But what I would tell you is they're pretty willing learners. The whole APRN thing has been a new learning curve for them.

And so, there's a lot that we can do to help them with that conversation and with that learning along the way because they've been influenced sometimes by misinformation from their medical staffs. Well, I think that's all the questions, the thing I see. So, thank our panel.