2021 NCSBN APRN Roundtable- The Influence of the Pandemic on APRN Education: Can We Go Back, Should We? Video Transcript

Event
2021 NCSBN APRN Roundtable

More info: https://www.ncsbn.org/15232.htm

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- [Michelle] Welcome back for our final session of the day, a panel discussion on the influence of the pandemic on APRN education, raising the question, can we go back? And should we?

There will be a Q&A session so you'll be able to ask our panelists questions after they finish their presentations. So please join me in welcoming our panelists. I'd like you all to join me in welcoming Carol Delville, Ira Kantrowitz-Gordon, Maribeth Massie, and Charlie Yingling.

So we're going to have Ira kick us off at this point. So Ira, take it away.

- [Ira] Thank you, Michelle. I'm a track lead for nurse midwifery education at the University of Washington in Seattle. So our experience of the COVID pandemic was somewhat, well, everyone's had

quite a challenging experience. The Seattle area was the first part of the country to identify the infections and so we had a very early experience with shutting down back in early March of 2020.

And for our nurse midwifery education program, this was both good and bad timing. Our clinical sequence actually ends in March so our students who were about to graduate just kind of snuck in without having the pandemic impact their ability to get their clinical education.

So it was good for them and they were able to graduate although we had no graduation ceremonies for them that were in-person, of course. But the next cohort was just about to start their clinical sequence and they ended up being basically shut out of clinical for at least an academic quarter as everyone reacted to the suddenness of the growing pandemic and the feeling based on…from clinical sites that they could not take students because that would just add exposures to everybody, staff, patients, and the students themselves, so at risk of catching COVID.

So we were faced with very quickly having to deal with not being able to place our students in clinical and not being able to have in-person classes either. So we had to do this rapid shift towards online education and making up for missing clinical by engaging in remote activities which included doing more online simulations, learning about telehealth and doing simulated telehealth, more case studies.

We even practiced suturing for birth lacerations on Zoom, doing one-on-one sessions with our students to really like maneuver our cameras so that they could see my hands and then, you know, they would turn their camera around so that I could give them immediate feedback. And we just did everything we could while they could not get into clinical to help them be extra prepared so that when they got into clinical, they would be able to hit the ground running with…to be able to maximize their clinical experiences.

So this was a rapid turnaround in how we delivered education and really offering…trying to offer more support to our students despite all the uncertainties. So we had weekly open forums on Zoom with our students within the midwifery track to keep it more personal but to also just, even if we didn't have the answers, we could at least say we didn't have the answers so that they would know that we were working on it, we were trying, we were trying to get them into clinical.

As the pandemic moved on, fortunately by the beginning of the summer quarter, so a quarter later, we were able to get just about all of our students back into clinical. So they were, at that point, a quarter behind and we encouraged them but did not require them to take every additional clinical opportunity they could, whether it was working extra shifts or working during their breaks between quarters to get

[inaudible 00:04:52] hours making up for. And so by the time we come around to last month where, you know, it's been a whole year and this cohort that really got their clinical education through the pandemic, 90% of them were able to graduate on time. We had one student who hard to know but likely would have needed the extra time anyway even without a pandemic.

So that, in many ways, was a great success. And now, we are just about to start our next clinical cohort and they are fully into clinical and they are all…anyone who wants to be is now vaccinated. So, fingers crossed, we have made it through this experience without major impacts on the progression of our students in terms of graduating on time.

I think, you know, if you ask them about their experience of going through this pandemic, you know, they would talk about a whole lot of additional stress. There have been some students earlier in the program who have decided because family members got laid off, as nurses, they are more able to support their families.

So some students have decided to either go part time or take a leave of absence to get through this, this tough times, with the hopes of them returning back into their program or getting back into full time education perhaps by next year. Probably our biggest challenge, like I've alluded to, has been finding placements of our students during the pandemic.

Even though the governor of Washington State was very clear that nursing students were considered essential personnel and should be allowed to continue, that message did not have any enforcement attached to it. So every institution had variable responses to that. And this was particularly acute at the undergraduate level but we had a lot of different communications where we would have, you know, at the clinic level, they may have been willing to allow students, graduate students in and midwifery students, DNP students, but then at the regional level for large healthcare organizations, they may have put out a different message about delaying the re-entry of advanced practice students.

And then also in midwifery, you have the unique challenge of our students are placed in the outpatient setting with midwifery practices but also, have to be allowed into the inpatient setting, which is, most of the time, a hospital which may be a different institution with different rules and different understandings of when students should be allowed back in.

We also saw that there was a real difference in how medical students and medical residents were treated and that they were more likely to be allowed back in compared to advanced practice nursing and midwifery students. There were also challenges at the university level where the university wanted to be very protective of students to reduce their potential for getting sick and being exposed to COVID.

So we had to take a stepwise approach to get approvals from the university to allow our students back into clinical. And at one point, this required a direct faculty supervision of students to make sure that they were wearing their PPE appropriately in clinical.

As you can imagine, that would be a huge burden on faculty to be present for every student because we don't have multiple students at the same placement usually. They're spread out. So we worked quickly to make sure that our clinical preceptors were, if they weren't already considered clinical faculty, that we would rapidly get them onboarded as clinical faculty so that we would meet this university-imposed requirement of faculty supervision for effective PPE.

Fortunately, that requirement also went away quickly as the university got used to having nursing students back in clinical and as they even got more comfortable, the rules kind of relaxed and then as we all got more comfortable with the pandemic, it become much easier and those requirements basically went away.

So I think it's been a really evolving, challenging situation but to wrap it up, I would say that many of the changes we've made in delivering our education through online, I'm very hopeful that we will…even

when we go back to fully in-person classes, hopefully in the fall, we will take with us some of the flexibility and that we have achieved through hybrid education as well as the increased accessibility that that provides for students when they can't make it to class in person.

- Thank you very much, Ira, for sharing your experiences. Now, we're going to go to Carol.

- [Carol] Hi, everybody. At the start of spring break 2020, the adult geriatric clinical nurse specialist program at UT closed for two weeks according to the students but from the faculty perspective, we had two weeks to prepare to reopen to a new world of online teaching. We are designed to be 100% in-person on campus so this was a major shift for the faculty as well as the students, and one that typically would require the Texas Board of Nursing approval to make such a program shift.

Our 36 students were spread out over 30 clinical sites, every single one of them closed that semester and remained closed to mid-summer. And then even now that the long-term care centers, assisted living, which are primary sources for gerontology experiences have remained closed. One fortunate aspect of our program is we have 615 clinical hours for our students.

So in March, when the program essentially shut down clinical sites, our graduating cohort already had over the 500 hours required but we still needed to work with those first year students who at that point, were in their acute care rotations and intensive care and in the hospitals, to make sure that they had adequate clinical experiences.

Our simulation lab was running 24/7. We have a large undergrad cohort so we did turn to some virtual case software and used those in both Teams and in one-on-one Zoom sessions to determine the competency-based evaluations and the student's ability to progress on that.

And that meant IT was just our bread and butter. We had students that lacked adequate internet, some students needed some sponsorship and grants to upgrade their internet service or loaner laptops and equipment to be able to support the complexity of the software that we were using.

And just to cap that off, when the ANCC exam sites closed and they weren't able to test, the graduating cohort said, "So how are we going to start looking for jobs?" The state of Texas actually expanded provisional licenses from 25 days to 6 months and then later, 9 months.

The problem with that, though, was prescription authority was not included in those provisional licenses and most of the positions that were open to our students did require prescriptive authority ability. So the barriers we ran into, technology access, some of our students, all of our students basically returned home and they may not have had a high quality internet accessibility at home.

For faculty flipping over classroom format, we found the ideal way was to break up those didactic lectures into voiceover PowerPoints, Panopto videos, Ted Talks, separate for each objective of the lecture so that they were very short and concise and focused. And then when we did get together for the Zoom session, we were able to do some front load survey questions and do case applications and really test the student's ability to apply the material.

The other fortunate piece for me was our students as AGCNSs are really not just focused on the patient level, we also have this nursing and the system levels. So when the pandemic hit, we paired with our clinical sites to write some of the policies and protocols and procedures that they needed for admitting patients during COVID, for dealing with PPE, staffing issues that occurred as a result of COVID infections.

The students got some real firsthand disaster nurse experience in writing those policies, procedures, and protocols. An unexpected impact of the COVID pandemic was the fact that a number of APRNs in our communities were laid off or furloughed because of the decrease in clinical site patient visits. And as a result, the employment in APRN positions for the new grads really was greatly reduced and only now, is the majority of the class employed in an APRN position.

The other thing that we've definitely noticed is that students who started with the on-campus experience have been much more engaged in these Zoom sessions. They log in early, they request additional Zoom sessions for teamwork, they actually hold Zoom lunches together. Whereas the students that have only experienced the online format this year have only really started engaging since we've been able to return to the hospital site and work one-on-one with those students.

Additional impact, one student did have to drop back a year. Both of her parents were hospitalized long-term for COVID. Thirty-three percent of our students, that first spring, tested positive for COVID and that did impact the completion date of that semester but they did…everyone had a timely graduation.

We did extend the time they could complete their clinical hours for the fall semester so they were able to start in August instead of September. So with great diligence, the faculty managed to place all of our students with clinical preceptors but whereas that would normally take between 50 and 60 contacts, it took over 600 contacts with clinical agencies to find them preceptors.

Other barriers we faced besides the technology and the impact of the pandemic was probably PPE. When all of the research labs on campus closed, they were basically stripped of all of their personal protective equipment and it was distributed to those clinics that needed…those students that needed it for simulation lab and other clinical experiences.

In the fall, we have had to provide PPE for our students in clinical sites. We check with the site as to what is their requirement for that PPE and our simulation lab has been able to do the fit-testing for both students and faculty to get that. The state really did come through for us both in that extension of the temporary licenses for our CNSs and more importantly, they didn't require us to recertify the program when we switched to the online platform.

We are planning on going back to class, fingers crossed, in the fall semester, all things willing but we have learned a lot about the flexibility of the program, felt flipping the classwork to use that class time more constructively for student evaluation and the importance of the one-on-one time with the student.

It has increased faculty burden but we feel we've gotten better outcomes from our students.

- Thank you very much, Carol, for sharing your experiences and the barriers you faced and how you've overcome them in your CNS program there in Texas. Next, we'd like to go to Maribeth Massie who will talk with us about her CRNA program.

- [Maribeth] Thanks, Michelle, I really appreciate it, and thank you for everybody here for allowing me to share our experiences here at Columbia. As you can imagine, in New York City, it was the height of the pandemic and everything was happening so quickly.

So within a week, we had our students essentially pulled out of the hospitals either because the elective cases were all canceled at that time so there weren't a lot of cases or the hospitals were just trying to get rid of all of their trainees there. So our nurse anesthesia residents were pulled out, some were able to stay. So those that were doing trauma rotations or OB rotations were still able to stay in. And what we did for them and going forward throughout the next couple of months, we created a COVID opt in-opt out sheet because some of the students had elderly parents with coexisting diseases at home or, you know, children that had some kind of a disease, or themselves they had issues.

And so we wanted to make sure that they could be out of the clinical setting if they wanted to at the sites that we were able to still send them to. They didn't have to go if they didn't want to. So that was, I think, a really big addition when we looked at the legality of it all, what could we do, what couldn't we do, and, you know, we learned a lot from that episode. And then, you know, I was concerned, we all were concerned with the health and safety of our nurse anesthesia residents.

As others said, you know, several did get COVID throughout this entire period for months but I could tell you, Columbia was really great as a whole with testing and the protocols that were put in place and then eventually, the vaccinations. So all of my nurse anesthesia residents were vaccinated, I want to say, by early January or a lot of them did get vaccinations farther outside.

But that cancellation of elective cases was really hard. So we continue didactic classes but our program is front-loaded so that means that the majority of their didactic is the first year. So for those second year students, the ones that were set to complete the program in August, they did that.

They only had like two classes. And so we moved one of their summer classes into spring, so while they were still out of clinical. We were able to get that class essentially out of the way. It was a board review class. So that helped them with testing purposes. So when we thought they'd be able to go back to clinical in the summer, then they could be there, you know, a choice is seven days a week to try to get as much clinical experience as they could.

As everybody else has said, you know, getting up to speed with virtual sessions and flipped classrooms and trying to change that all around was a little difficult. Our simulation lab closed down too and we weren't able to get back in it until late July. And that was huge because our classes in that first year, we have a lot of simulation paired with that.

So we really had to work on that. But I can tell you, out of all of this came a lot of rays of sunshine along the way. Our students are all experienced ICU nurses with, on average, three to five years of ICU experience and the majority of them all went back either to their respective ICUs where they were working to help out or they took travel assignments to other ICUs.

And all, the same time, they were taking their coursework. So that was pretty impressive that they decided to go ahead and do this. That was our first and second year students. We all got up to speed. So as far as faculty goes, we learned, you know, new things, which is always good for our neurons to keep growing along the way.

And I definitely think that we will keep some of the virtual hybrid learning ways. We're doing that, especially recording lectures so we could have more case studies, case reports, more question and answer kind of things when we're actually in with the students. We were lucky at Columbia because we were able to rearrange the course delivery. So we were able to… we changed the course times, had some courses in the evenings rather than the days so the majority of students could make classes since they were working.

And we didn't have any pushback from the university for that. One of the biggest things that I think we learned from all of this is that we got to know each other better, the students, the faculty, and the staff, because there was so much…obviously, we all were experiencing the anxiety, the isolation that went along with the pandemic. And then with the addition of everything from the social and justice standpoint, we needed to talk to each other.

So we, both Columbia and our National Association, the American Association of Nurse Anesthetists had great resources for COVID in general but also for the mental health and wellbeing of our students and of us too, right? So we ended up calling them compassion conversations and it was just a chance, you didn't have to be on there but I got to tell you, almost every single solitary nurse anesthesia resident and faculty were on these weekly calls.

They were held on early evenings so if somebody wanted, you know, a glass of wine or a cup of tea, you know, they could have that. And if you wanted to talk, you could, if you wanted to vent, otherwise, we were all there to listen and maybe give some input and advice along the way. So I can tell you right now, that is definitely something that we'll consider because one of the things, moving forward, that I'm worried about is the burnout of the ICU RNs that are going to be starting the programs.

They lived through, you know, all the pandemic, everything that happened in the ICUs, and now they're going to be starting, you know, for any of us, this applies to all of our incoming students, they're going to be living our rigorous programs and that's a worry. But just so you know, as far as clinical goes, we were able to get those senior students when they were supposed to complete the program in August, we got them back, the majority of them back in mid-May.

People that signed the COVID opt out, they decided they didn't want to go back into clinical at the time. They didn't have to so they…but everybody was back in the clinical setting by late June, early July. So all of our students were able to complete the program by the end of September.

Normally, it would have been the end of August, and they all were able to, you know, I guess, essentially view the virtual graduation in October. Because we didn't have all our clinical sites back up and running, they weren't allowing a lot of, you know, trainees back in in the New York City area.

We had to push back the start of our then second-year students until mid-August to mid-September. They were supposed to start mid-May. So out of all the students, I think they probably experienced the most stress and angst and anxiety because they didn't know when they were going to start, they didn't know when they were going to be able to finish the program.

On top of all that, starting in January of this year, we increased their clinical hours. Normally, we would say, you know, a 40 clinical-hour week but we've increased it to a minimum of 48 hours to a maximum of 64. So because they all voted, we were very democratic, and they wanted to be able to finish the program on time.

So that's definitely been a stressor along the way. We've had several clinical sites that have not come back up to speed yet and unfortunately, those are our specialty rotations like open heart, OB, and peads. And so we've had to rearrange the clinical schedule and send some of the residents farther out to clinical sites which has definitely been a burden. They're getting Airbnbs to be at a site for a month, you know, getting licenses in different states has been difficult also.

In the beginning, state boards of nursing, so like New Jersey, they would allow any license. So that wasn't a difficulty, that was for, you know, licensed CRNAs and for our students but then, it has gone back. So that's made it a little bit more difficult. So going forward, I definitely see, as others have said, a hybrid more approach to be able to have classes and I definitely see us using more of like anesthesia simulator kind of work online and fit-testing.

That was another thing that we'll have going forward. We'll have all of our classes before they start clinical fit-tested. So we have that documentation along the way too. Thank you for letting me share with you.

- Thank you, Maribeth, for sharing your lessons learned and the adaptations that your program made. Next, we're going to go to Charlie Yingling, and he's going to talk with us about his NP program.

- [Charlie] Thank you so much, Michelle. I'm Charlie Yingling. I'm the Associate Dean for Practice and Community Partnerships at the University of Illinois, Chicago. And I don't want to bury the lead so I'll start just with the title of this session, which is, can we go back, and should we. The answer is no.

We can't go back and no, we shouldn't. And I'll talk a little bit about what we experienced at University of Illinois. One of the projects that I'm very involved in is a HRSA grant funded under the advancement of education workforce or a new funding mechanism. And a key element of that project was to integrate more telehealth into our family and psychiatric nurse practitioner programs.

And I had to look back at my calendar in preparing for this conversation today because it was March 11, 2020 that we had this rather fortuitous telehealth seminar for our FNP and psych NP students. And as I recall on that day, we had heard something about this virus and we were kind of thinking like that probably is something to watch. And then it was nine days later that the governor of Illinois issued the Illinois stay at home order, which is really when, for us, when everything changed.

And so I look back on that and think, well, we really got lucky that we had them all for a day because beginning on March 20, so many of our clinical experiences were moving to telehealth. We are a health sciences university and so we never formally closed clinical sites to students, at least within our system.

But in practice, things were effectively closed because with social distancing and the lack of clarity, a lack of understanding on what was safe, it did not make sense for students to be in clinical sites. When this began, we work on a nine-month calendar and so most of our students graduate… And happily, across the NP programs, almost everyone was able to graduate between, you know, in time for that May graduation.

We did have to do some creative telehealth experiences for students to satisfy ours but as is the case with some of the other speakers, most of our programs are over that 500-hour threshold. And so we could plug in simulation as needed for whatever curriculum requirements we had in excess of 500 hours. But I do want to talk a little bit, though, about some of the benefits of being in the academic system and having a stronger [inaudible].

We refer to these as sort of our owned and operated sites, although we have a lot more latitude with our student experiences. Example is the College of Nursing, our faculty and students set up the employee health COVID screening line in partnership with employee health service. Simultaneously, another faculty member and group of students were setting up the employee testing site also in partnership with our employee health services.

And so we were able to get a lot of experiences both on the systems focused practicum as well as direct care experiences doing those COVID screenings remotely as well as doing on-site testing. Certainly, as others have mentioned, Zoom became our friend if it wasn't already. We going into this already had a hybrid program and so our…our faculty and our students were very accustomed to online learning.

Our programs are offered across the State of Illinois so we cover a wide geographic area and so it wasn't new to us to be offering distance teaching or move our case studies and course meetings to Zoom. What was really contentious and remains contentious is the use of online proctoring. And I'll spare the editorial on it but there's a lot of concern about built-in racism in online proctoring software as well as not meeting the needs of students with differing abilities.

And so that's a conversation we're continuing to have and I don't know that we'll continue to use online proctoring systems but it is something that our students and faculty alike have a great number of concerns with. So that's just kind of on the didactic side. As I referenced earlier, we did move really quickly to telehealth, particularly in our nursing faculty practice.

Happily, we had a group of students who were both trained already on how to do telehealth and so it was within that first week of that stay at home order that we moved all of our visits to telehealth. We do have a large number of psychiatric providers here and so those visits moved very naturally to telehealth. And again, happily in Illinois, we see a large proportion of Medicaid patients at our practices and our governor did authorize full payment of Medicaid rates via whether it was by telephone or video.

And I think that anyone who's used telehealth and populations that are traditionally underserved knows that there are some challenges with broadband and data plans. So phone-based telehealth was used both

in practice as well as in teaching. The other thing I would take away from all of this is the importance of our strong academic practice partnerships.

Two of our primary health system partners never stopped taking our pre-licensure students. Even at the height of the pandemic, our pre-licensure students were still doing clinicals. But it wasn't necessarily true for APRN students, though. In our community settings, those with which we…those practices with which we already had strong academic practice partnerships, be it through faculty practice experiences, be it through formal contracts, we were able to get up to speed much more quickly when we had those relationships in place.

And I think that's a key takeaway that we already know the importance of academic practice partnerships in NP education but this can improve, why we must continue to nurture those partnerships and grow them. In those settings where we had those strong partnerships, we were able to get students back into clinical in May or June, which in the family nurse practitioner program, students start their first clinical rotation this summer.

That lined up very well for them. On the psychiatric nurse practitioner program, that's usually about the middle of the year and they don't typically have clinicals in the summer. So we had a little bit of breathing room for our psych NP students. Again, as I mentioned before, most of our graduates in May of 2020 cohort made it, and the August and December 2020 cohorts, which are much, much, much smaller than May, again, most of those guys did just fine.

As others have referenced, all of our students are practicing nurses. Very few of them are full time students. And the experience of being a practicing nurse in this pandemic was brutal and I cannot say enough how resilient our students demonstrated themselves to be, one, sticking with school and continue, though, a handful did have to decelerate for reasons that others have referenced.

But it's something that the emotional toll of being a nurse throughout this time as well as being a graduate student, it's extraordinary. And the fact that they persevere really speaks to how hard these graduate students are working. One of the challenges associated with completion, of course, is getting those clinical hours in.

And we know, as it's been referenced earlier in this conference about NP education currently being attendance-based, that you do your 500 hours or more and that is basically the requirement. We don't have a competency-based education where we can break apart the specific competencies that you need to help you meet those through simulation, through activities outside of the clinical setting.

So we had to take off…we did do a lot of effort to sort of round out those hours that the students were getting because the reality was that even when they were back in clinical, the experience was not the same as it was in the before times.

They were having much more focused experiences and they weren't getting all of that sort of on the job learning that one gets just by showing up to clinicals such as how to get a prior authorization, how to deal with disability paperwork, how to deal with afterhours call. And so that was one we're really proud of how our faculty handled this.

We worked with our academic practice partnerships to really inventory the traits of what…we asked them, you know, what are the traits that you see in a new graduate nurse practitioner that tells you this person is prepared for the job? And so working from that list of traits, which we loosely would have defined as competencies, we identified the specific content that we needed to deliver to the students to help build those competencies.

And again, it's the softer elements of NP practice and often, the administrative elements of NP practice that we built into a series called community health outside the exam room. And we offered that by Zoom on Thursday evenings throughout the summer and fall semesters and we continue that with the spring semester, introducing new topics each semester to really try to round out what are functionally very constrained direct care experiences anymore.

But despite all of these challenges, there's a number of opportunities that arose. With all of our work in coordinating vaccine response and coordinating testing response, we had an array of opportunities for students, particularly pre-licensure students, but for NP students as well.

We're an all DNP program and building the plane while we're flying is very much a systems-focused practicum for our students. And so for any of our students doing DNP projects, everything became COVID overnight. And they really contributed to our college as well as our university response, and there's three of them in my clinic right now giving vaccines to hundreds of people who will be marching through this place today.

And our students and faculty really were the architects of what today is a high volume COVID vaccine clinic for our community and they're running it. Other barriers were about PPE. As everyone has said, PPE was a nightmare. I went and redid our simulation center around a weekend early in the pandemic distrained, squeeze out what it could to bring to our faculty practice and their College of Dentistry organized the clandestine order of N95s from China.

I still do not know what all went on with that but they brought a great supplier of N95s into the health system. And so as others have referenced there, those were barriers too with our smaller community partners who didn't have access to a plane to bring N95s from China. We were having to send our students with their own PPE. So I'll stop there to allow time for Q&A and again, thank you for the opportunity to lobby on this panel.

I appreciate it.

- Thank you very much, Charlie, for sharing your experiences and identifying opportunities that came from it. I appreciate that. Now, we are going to begin our Q&A session and all four of our panelists will be available to respond to your questions. We already have quite a few questions in the Q&A function but if you come up with another one, please continue to add your questions there.

So the first question, and it doesn't specify a panelist so I would just ask all of you to share your insights and input, from Sharon Friedman Yurovich, her question is, could you share which simulation software you utilized with your students to adjunct or enhance their on-site clinical experiences?

And maybe we'll just go around starting with Carol just as we see you on the screen.

- We used i-Human and Shadow Health both, but I don't think we used them exactly the way they intended.

- Okay. Ira? Ira, you may be on mute.

- Sorry about that. For midwifery… - Better, thank you.

- Welcome. Many of these platforms do not have as much of a focus on the specific kind of experiences that we would like to use in midwifery. So while we had those software platforms available for our DNP program generally, our faculty in midwifery used those less. But we developed…we worked one-on-one with students to get them other kinds of experiences where we would…we send pelvic models with fetuses and placentas to all of our student homes so that they could practice skills using those models and we would do them…we would have various activities with faculty on Zoom using those models and we did the same thing with suturing.

- Thank you. Maribeth?

- Unfortunately, there's not that much anesthesia simulation software that's out there, and what is out there is really, really expensive. But we did purchase one platform, it was called Anesoft, and it's an anesthesia simulator. And you could control all the dials, you could do all the, essentially the tasks and the skills, you can make decisions, you know, if the blood pressure is low, etc.

So that was very worthwhile and we used that with students and went over different case studies and, you know, would have a case set up for that and look at it. I know the School of Nursing did use i-Human and several other different platforms. We had looked at using Shadow Health. They don't have any anesthesia related, really applicable. I had used it in a prior position.

So we did not go there but it is good for pre-op evaluation so we did use it for that. Other than that, we would send videos and then we would dissect the videos as a class with the faculty and that would work very well also. So we were able to use, you know, piece together some of the forms for simulation.

It was just a little bit more difficult. Oh, we also purchased a regional anesthesia subscription, [inaudible 00:41:55] the New York State Association of Regional Anesthetics and that, the students were able to get a lot of information from there also.

- Thank you. Charlie?

- So our College of Nursing did subscribe to i-Human. We weren't using it as much in the nurse practitioner programs. Our simulation that we did do was working with actors over Zoom. Chicago has a rich pool of improvisational actors, many of them were happy to find work. And so we did a lot of scenarios and formative simulation rather than summative.

We did move standardized patients as well to Zoom understanding, of course, there's no physical assessment but there's plenty that we could do on that platform. We did also, for our psychiatric nurse practitioner students, purchase a product called Symptom Media, which is not an interactive simulation

platform but rather a series of recordings of specific psychiatric conditions that allow the student to use some of the assessment skills.

- Thank you. Charlie, I think this question is for you. It's from Sarah McCumber. And she asks, if students have concern about online proctoring, how are you addressing test security concerns?

- That is an excellent question, Sarah. And, you know, we are still using it for that very reason. And, you know, the reality that sort of counterpoint on this, of course, is when you go take your boards, when you go take your NCLEX or your pre-licensure, you will be in a proctored environment. It is no different than that.

What the other side of that is that there are other ways to demonstrate mastery of content aside from multiple choice examinations. And so I agree wholeheartedly that if you're using a multiple choice examination, there has to be some degree of test security. I think the flaws with the online proctoring services have to do with the artificial intelligence and the algorithms built into them but I think that the challenge to us as faculty is how can we evaluate students for mastery of content in ways other than multiple choice exams.

But I do share the opinion that when a multiple choice test is the only way to demonstrate mastery, it needs to be in a proctored environment.

- Thank you. Maribeth, I noticed you were nodding. Did you have a comment on this question?

- Thank you, Michelle. Yes. We did look at all that software from ExamSoft monitor to ProctorU and several others, but that is a big concern, is that there is an issue with the artificial intelligence especially with other races. And so we decided not to go with that and every program, essentially what we did is, and we wrote policies for this and now it's, you know, standard in the handbook, is we had them use two devices.

And so they would do their ExamSoft on their computer screen and then they have to have another device setup so we could see their work environment and we would check it. And the faculty, if you wanted more TAs or proctors, we could get that from the university. I think a lot of us in the nurse anesthesia program, the class size was, you know, 37 to 40. So we felt like we could monitor well enough on ExamSoft or on Zoom.

So they would log in to ExamSoft and then they would take Zoom from their other device and we would say, you know, "You're good to go, we see your full work environment." And then at the end, they would have to show that they were done with their exams off screen. So sure, could somebody have something on their wall? They could do that.

But, you know, I got to tell you, from looking at the grades and the way everything leveled out, it does not necessarily seem like that. But still, we technically can't be sure about test integrity but we sort of took like a much more like grass, like roots kind of level, not as fancy as it sounds like Charles had used.

- Thank you. Ira, did you have a comment?

- Yes, I think at the University of Washington, we use Proctorio, which is a, you know, a similar platform for exam security. But what we did during and continue to do during the pandemic is we have allowed our students to shift from a graded course to satisfactory, not satisfactory, without any knowledge of the faculty so that it takes some of the pressure off in an environment where our students are experiencing such extreme stress.

This was something that our university allowed us to do, to give them the freedom to take some of that pressure off. I like to think of this as really a compassionate approach towards, you know, giving them that freedom. And so, you know, many…as a faculty, I don't know who has made this choice or not.

I just grade them the same. And if they chose to go for the satisfactory or not satisfactory route, that would just be handled at the registrar level. So it's just one…it's a little thing but it really made a big difference to have that option for our students.

- Thank you. And Carol, would you like to comment on this question?

- We've been using Proctorio, added work from faculty perspective because we do require faculty to review all of the videos whether or not the program has flagged them. If we see something, we have a one-on-one with the student and we discuss anything we've seen.

The CNS program, we haven't detected anything except for one student received a phone call during the visit and she immediately picked up her phone and called the faculty and she goes, "I made a mistake and I answered my phone." So they were very upfront about it.

- Thank you. Our next question is specifically to Charlie but I would be interested in other's insights on this as well. It's from Rita D'oused and she's asking, can you discuss a bit more about the racism in online proctoring?

- Sure. I should thank you, Rita, a great question and I really should [inaudible 00:48:36] say, I am far from expert on this topic. What I have read and what I understand is that the algorithms that identify whether or not an individual is looking at their device versus turning away do not as accurately capture the movement of people with darker skin.

And so this has been a lot of the criticism that on some of these platforms, they were flagging people with darker skin as looking around the room more based on failing of the AI. The other criticism aside from the racism piece that I've heard, and again, please understand that I'm not an expert on this, the students have shared, it's just the anxiety, as was just shared of, "Oh, my goodness, I accidentally picked up my phone, I need to immediately call my faculty."

You can imagine how that changes your train of thought. And please know that I'm not advocating for or against online proctoring but rather just sharing what the conversations we've had at University of Illinois, Chicago have been.

- Thank you. I'm just going to go around the room. Maribeth, do you have any comments on that?

- No. I mean, it sounds…it is a service that is very cumbersome and as Carol was saying, you know, we were talking about we were going to have to review all the videos and we, as a faculty, just decided that that wasn't the way to go and we'd stay with our, you know, essentially do it yourself kind of techniques.

- Ira?

- I think the technology has to be critically examined and the way we…I can't imagine having to review every single video. That would be extremely time consuming. But when I've used Proctorio, I've taken a look at the scoring or the flagging of certain videos and I take a look and I always approach it with a high level of skepticism that the student has actually done anything wrong.

And I review the videos and I've never actually seen anyone do anything that looked like cheating to me. So I think the need to proctor exams is not going to go away but we have…before the pandemic, students had the option of coming to campus and just being proctored by, you know, live people in a room taking the test together or they could stay home and do it on online and be proctored by Proctorio.

And again, by giving students choices, they found what was most comfortable for them. We have sometimes distanced students who need to drive three hours to come to campus and for them, they really appreciated the ability to be proctored at home online. And for other students who really did not feel comfortable with that, who lived closer, it was much better for them to just come to campus.

So I think again, if we keep the student experience in mind and provide them opportunities for choices, even if their choice wouldn't change much, the fact that they had a choice can make a difference for how they feel about the experience.

- Carol?

- The big feedback from the students from us was online testing provided them with more flexibility. Many of them are parents or caregivers or have increased work shift with COVID. So we didn't require them to take it in a set two-hour period as be prior to the pandemic. We gave them a much more broad 24-hour period but we also lowered the stakes of those exams by having more in-class assignments and more in-class spot survey quizzes.

So we hadn't seen any change in the grading scale. The students expressed a great deal of appreciation for the flexibility. They said how much it really lowered their stress to be able to wait until the kids got tucked in the bed or that type of thing.

- Thank you. This is going to be our last question, and it's from Sean Degarmo. And he asks, are programs having trouble regaining access to clinical sites while other students such as PAs, pharmacy, medical students, and residents have been permitted to return? Why don't we start with Carol?

- Initially, I would have said yes, but we've been pairing with our sites very closely first to help them with COVID testing and now, we're helping them with the vaccine administration initially with the preceptors and then with their patient populations. So they're gradually opening up more and more. So that's a real positive.

- Thank you. Ira?

- I think where we are in the pandemic right now, we really have returned to a more normal situation with being able to place our students. I think the clinical sites have really relaxed quite a bit, particularly now that we have vaccinations coming out. So we're close to the ability to get all of our students placed. It's always been a struggle to get enough clinical placements for our students.

We always have to work really hard and probably harder than would be ideal. If I could change the world, that would be one thing that I would change was I would make it a lot easier for midwifery and advanced practice programs to place their students, you know, nationally. It was much harder earlier on during the pandemic where we were basically shut down and that's where there was inequity with medical residents, medical students having a much easier time particularly when the academic medical centers had such a much closer alignment between schools of medicine and academic medical centers than schools of nursing have with academic medical centers.

- Thank you. Maribeth?

- And I echo what Ira said. It was frustrating initially because they allowed the physician anesthesia residents to stay on doing cases and our nurse anesthesia residents weren't allowed, were told they couldn't be there. So that was somewhat frustrating. But now, they're back to the majority of our sites.

I think we have five sites that still…they're just saying, "No, not yet. We're not settled yet." And that's been frustrating but also, the positive that came out of it is we've been able to open up other clinical sites and they're ready to take our students and that's been a great opportunity. And, you know, when you talk to the sites, I mean, it's the same thing for all our programs.

When your students rotate through, that's your chance to see, you know, if you want to hire them in the future and their chance to see if it's a place they want to work at. So it's definitely a recruitment tool. And we have had sites coming to us saying, "Hey, why don't you bring your students here?" So that has been very positive.

- Great. Charlie?

- Yeah, echoing Ira and Maribeth, early on, we certainly saw a preference for medical students even within our own health system but I would say that that's largely dissipated at this point and we're far from back to completely normal, we're much further along. And I would echo Ira's sentiments that we need a federal solution to the problem of nurse practitioner in clinical learning and yeah, we scramble every semester but happily, you know, so far so good.

- Well, we want to say thank you so much to our panelists, Charlie Yingling, Maribeth Massie, Ira Kantrowitz-Gordon, and Carol Delville for a terrific panel discussion. Thank you so very much.

- Thank you for the opportunity.

- Yes, thank you very much, everybody.

- Thank you.

- We'd like to thank you all for joining us today and hopefully, we'll be able to meet in person next year. We appreciate, so very much, all the speakers that presented today.

We just felt like we had a terrific meeting. Thank you also to all the NCSBN staff that contributed to this meeting. So we'd like to just say have a great rest of your day and goodbye and again, thank you for joining us.