Past Event: 2022 NCSBN APRN Roundtable- The APRN Compact: Advancing APRN Licensure Mobility Video Transcript

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Event
2022 NCSBN APRN Roundtable

More info: https://www.ncsbn.org/16412.htm

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- [Nicole] Hello and welcome to the APRN Compact: Advancing Licensure Mobility. My name is Nicole Livanos, and I'm the associate director of legislative affairs at NCSBN. The targets I hope to address today include the growing number of health care compacts, the APRN Compact fundamentals, including the compact's relationship to the Consensus Model, the progress and growing support for the APRN Compact, its opposition, and our path forward.

There is no doubt that healthcare professionals and other licensed professionals are looking to interstate compacts to mobilize their workforce and modernize regulation to meet today's demands. This map shows the number of healthcare compacts enacted in each state. The darkest orange color shows those states with six or more healthcare compacts.

Those include the Nurse Licensure Compact, the longest operating healthcare compact for registered nurses and licensed practical nurses, and compacts for psychologists, physical therapists, occupational therapists, physicians, and others. On the horizon are compacts for physician assistants, social workers, and dentists. The APRN Compact looks to provide this coveted mobility, increased access to care, and reduced duplicative regulatory processes for APRNs and patients across the country.

The structure and operations of the APRN Compact are modeled after the Nurse Licensure Compact. The compact follows the mutual recognition model, meaning an APRN would hold one multi-state license in their primary state of residence and have the privilege to practice in other states that are party to the compact.

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In order to obtain a multi-state license, the applicant would need to first meet their home state licensure requirements and then also meet the uniform licensure requirements of the compact. Again, identical to the NLC, the governing body is a commission made up of one voting member of each party state. The body will govern the operations of the compact and have no role in multi-state licensee scope or other practice issues.

The commissioner shall be regulators of APRNS in each state as is appropriate and common for compact governing structures. Many of the uniform licensure and practice requirements in the APRN Compact will look familiar. The Consensus Model elements are codified in the uniform licensure requirements an applicant must meet in order to obtain a multi-state license.

An applicant must be licensed as a registered nurse, authorized to practice as an APRN in a role in one of the six population foci. They must be educated at graduate level or higher, passed a national certification exam, and hold current certification. Multi-state licensees can practice independent of a supervisor or a collaborative agreement with a healthcare provider.

For prescribing, a multi-state licensee can prescribe non-controlled substances. For controlled substances, however, the licensee must follow all statutes governing controlled substances in the state where the patient is located. In addition to the licensure requirements above, an applicant must have practiced for 2,080 hours as a licensed APRN.

This requirement does not require an APRN to have supervised or collaborative practice but rather complete 2,080 hours of practice under their single-state license or multiple licenses. The 2,080 hours was a solution to the prevalence of transitions to practice. Those periods of supervised practice that many states have enacted in hard fought battles many of us here are involved in.

The practice hours have no impact on holding a single-state license in the primary state of residence nor multiple licenses across states. It's also important to note that about 90% of APRNs would meet this requirement on day one. So let's talk advocacy. The 2021 legislative session was the first since adoption of the new APRN Compact model language.

There were two introductions and two enactments in 2021. Both Delaware and North Dakota enacted the APRN Compact with nearly unanimous legislative support. Stacey Pfenning and Pam Zickafoose will share their experiences from Delaware and North Dakota and share some lessons learned from the process.

In 2022, two more states introduced the APRN Compact, Maryland and Utah. Both bills have been supported by large and diverse coalitions. Utah unanimously passed the APRN Compact, and we're anxiously awaiting the signing by the governor. In Maryland, supporters including APRNs, the Department of Defense, and the APRN bill sponsor testified to the benefits of the APRN Compact and encouraged Maryland to lead the way on the APRN Compact as they did with the NLC over 20 years ago.

In order for the compact to come into effect, seven states must enact the legislation. We're hopeful our momentum will continue so licensure mobility for APRNs can become a reality soon. Since Pam and Stacey will cover Delaware and North Dakota, I will share some lessons learned from the process thus far in Utah.

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The Utah Nurse Practitioners Association led the charge in Utah. After careful consideration of the provisions of the compact, the group decided to move forward with introducing the bill and leading a coalition that included the Utah Nurses Association, CRNA Association, University of Utah School of Nursing to name a few.

There was opposition from two organizations. The Utah Medical Association opposed the full practice authority provisions in the compact, and the American Association of Nurse Practitioners who continue to have concerns over various provisions of the compact also opposed. Despite the opposition, Utah nursing stakeholders united behind the compact.

They propelled the bill to be passed with unanimous support in both the House and Senate. I want to take a moment now to appreciate the growing support for the APRN Compact among nursing, business, patient, and military family organizations. Nursing support at the state and national level include support from the American Organization of Nurse Leaders, National League for Nursing, State Nurses Associations, APRN role associations, and boards of nursing.

Interstate compacts benefit from having diverse coalition groups. This slide highlights many of our non-nursing stakeholders who support or have endorsed the APRN Compact. These organizations include telehealth minded organizations such as the American Telemedicine Association and the Alliance for Connected Care whose board members include Amazon, CVS, and Walmart to name a few.

The Department of Defense-State Liaison Office continues to be a strong partner in our NLC and APRN Compact work, advocating for licensure mobility for military families that is high on the military's priority lists along with many lawmakers. At the state level, we have partnered with AARP state groups, hospital associations, and facilities across rural and urban areas.

To date, over 40 nursing and non-nursing organizations support the APRN Compact. We're confident that number will continue to rise. Turning to opposition to the APRN Compact, first, it will come as no surprise to many that physician organizations at the national and state level have opposed the APRN Compact.

A formal request from the American Medical Association to remove full practice authority provisions for multi-state licensees went unanswered. Full practice authority is key for the mobility of practitioners and aligns with our support for the Consensus Model elements.

Next, various nursing organizations have expressed opposition to the APRN Compact. The main source of opposition is to the 2,080-hour practice requirement. We continue to believe the practice hour requirement, which requires no physician supervision or collaborative practice, is necessary for the compact success as long as transitions to practice are still widely adopted and supported in states.

So I want to close by sharing my thoughts on how we move the APRN Compact forward. I think first and foremost, we do it through continuing to engage and educate APRNs on what the APRN Compact could mean for their practice, the future, and their patients. Three surveys over the last two years demonstrated robust support for the APRN Compact.

In Wyoming, 45% of APRN surveyed responded that they currently hold active licenses in more than one state. Seventy-two percent of survey respondents indicated they support adoption of the revised APRN Compact. In Maryland, a survey conducted by the board of nursing found 92.57% of participants would be supportive of a 2022 introduction of the APRN Compact.

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And most recently, in Arizona, 65% of APRNs responded that they had a need to provide APRN care or educational services to individuals living or traveling outside of the state. 92.5% of APRNs in Arizona responded that they are in favor of Arizona adopting the compact. The surveys confirm what we are finding.

When we are able to have conversations with state APRN organizations and nursing leaders, they get it. They see the benefit of licensure mobility, the prevalence of compacts in their states, and that APRNs cannot be left behind. In partnership with nursing organizations, state regulatory boards, and diverse coalition partners from business, the military, and patient groups, we are confident the APRN Compact will be successful for many years ahead.

Thank you. And next up, we have Stacey Pfenning who will be talking about lessons learned in North Dakota.

- [Dr. Pfenning] Nicole, thank you for all you've shared and all your assistance with the APRN licensure compact. And I'd like to say hello to everyone. I'm excited to be here to share North Dakota's story of success enacting the APRN Compact in 2001. I'm Dr.

Stacey Pfenning. I'm the executive director for the North Dakota Board of Nursing. I've been a family nurse practitioner since 2002 with experience in a variety of settings, lots of different settings throughout North Dakota, and also a variety of roles as an Advanced Practice Registered Nurse. I'm also in my fourth year as vice chair for the Nurse Licensure Compact. My contributions to the presentation today include a description of the political strategies and experiences leading to the enactment of the APRN Compact in North Dakota, including how we went about building support and overcoming opposition.

In addition, I'll also lead an exploration in the strategic activities to promote licensing mobility for advanced practice nurses across the United States. To start with, North Dakota is a very rural state in the Midwest. North Dakota embraces interstate compacts, especially professional interstate compacts for healthcare, and has implemented compacts in the Nurse Licensure Compact, physical therapy, and medicine.

In fact, the North Dakota Century Code 43-51-07 provides law allowing for professional licensing boards to enter compacts. To give a little bit of history, the new APRN Compact passed delegate assembly in August 2020. And this slide shows the legislative process for House Bill 1040, which was the Advanced Practice Licensure Compact, what was a state agency pre-filed bill in October of 2020.

Since North Dakota was already a member of the original Advanced Practice Licensure Compact, the legislative council required moving forward with amendments versus repeal and reenactment of the bill. So, we did as a board go through and do the highlighting and the writing out to making read the new pieces of the compact.

So this is a great picture of North Dakota Board of Nursing sharing and celebrating the enactment with Lt. Governor Sanford and Governor Burgum. The board had a great opportunity to share key points and provisions of the compact, including the enhanced mobility of the workforce among member states without regulatory barriers, which included redundant processes, fees, and more importantly loss of valuable time to licensure when mobilizing workforce was heightened during the pandemic.

There was lots of question and answer. We spent 45 minutes with the governor and lieutenant governor. It was just a beautiful opportunity. So getting into the political strategy, keys to success leading to the

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enactment of the Advanced Practice Registered Nurse Licensure Compact in North Dakota included early and consistent building of support among nursing and other healthcare-related special interest groups. Education on compacts and rationale for the changes in the legislation became important points of exploration and clarification for stakeholders including policymakers.

Another key feature for the success and successful movement or momentum of the legislative process in North Dakota was addressing the act of opposition through transparent and consistent education and that transparent and consistent messaging. So in building of support, early and consistent education, I had stated, was a key.

The North Dakota Board of Nursing staff and board members do annual reports related to the compact for all the nursing associations across the state on an annual basis. And so this has been going on for several years, and any time there's anything new with the compacts or even just a refresher, we always bring that to our associations. There's also a podium presentation that we do across the states for facilities, and for stakeholders, and also for any conferences that come up that are nursing-based.

And we have the opportunity to present on the compacts. That's always included in our presentations. And also we have quarterly newsletters that we always include updates on the compacts. And once we had our pre-filed agency bill submitted in October of 2020, we also held two public open forums that were sponsored or hosted by the North Dakota Center for Nursing.

And this provided a really great overview of the changes in the advanced practice licensure compact from the original that was adopted in North Dakota and enacted in North Dakota in 2017, and just what those changes were, what they meant, the rationale for the changes, and provided a question and answer opportunity for the stakeholders that attended. And that was done in December of 2020.

And the next slide shows the great pictures of our North Dakota Association of Nurse Anesthetists. They were a very supportive group. We also had support and testimony from the North Dakota Nurse Practitioner Association, the North Dakota Center for Nursing, and also the North Dakota Nurses Association. In a real grassroots effort, we were able to visit with each of these entities and develop letters of support and full support from each of them.

Some other support that I'd like to mention, National Council of State Boards of Nursing was definitely a phone call away or an email away. And thank you, Nicole, for being so responsive. We had times when she answered the phone for me at 7:00 at night, and she truly did help us through the entire process. We also received some national support letters to North Dakota legislators from Cross Country Healthcare, from American Telemedicine Association, and the National Military Family Association.

And there were other interstate compact support that's general support for compacts across the nation that were included. And in overcoming the opposition, the opposition in North Dakota emerged after the first bill passed the House Human Services Committee in January of 2021. The American Association of Nurse Practitioners president and lobbying team reached out to me to discuss communications that they had received from the American Association of Nurse Practitioners and described the request to have the North Dakota Nurse Practitioners Association oppose the bill due to the practice hour, you know, from licensure requirement.

The AANP and the North Dakota Nurse Practitioner Association held meetings together to discuss this concern. After the meetings, the North Dakota Board of Nursing representatives met with the North Dakota Nurse Practitioner Association and provided clarification, and rationale, and reassurance. The

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practice hours was a regulatory common denominator for a uniform licensure requirement that would enable more states to join, which would allow.

The compact to succeed, which was very important in this time of pandemic. Much discussion and education was provided. Regulation and scope of practice differentiations were highlighted. It's very important to show that this common denominator of a practice hour is not supervised practice. It's not a transition to practice.

It was a common denominator to allow more states to be able to be included in the company. So North Dakota as a plenary state does not have a minimal practice hour requirement for supervised practice. And this would not change with adding a multi-state level of licensure once the 2,080 hours was met by the advanced practice nurse in the compact state.

And this was another important point that actually came up during the legislative hearing on the Senate side, and that was actually...the Senator asked, "Does this change our North Dakota hours once they graduate?" and I said, "Absolutely not." Our North Dakota nurse practitioners can graduate and go into full practice immediately.

And so I said this is just how they get that second layer of a multi-state license to be able to move about other states in a uniform manner. Ultimately, the North Dakota Nurse Practitioner Association and the other nursing organizations supported the Board of Nursing agency bill and reiterated their desire to have a functioning licensure compact for the state.

So moving on to how can we make our advanced practice nurse profession mobile across the United States. The first topic I wanted to touch on was the NCSBN Taskforce. The taskforce was between 2018 and '19, and I think we did a little work after that. But the taskforce was really charged to explore any necessary changes in the policy of the previous compact to allow for forward movement and successful implementation of the Advanced Practice Compact.

There was recognition that there were certain parts of that compact that just were not going to allow for forward movement. There were in-person deliberations with a diverse team of executive officers, legal counsel, special interest groups, and stakeholder guests throughout the taskforce. There was provided recommendations to ensure achievable common denominators within uniform licensure requirements to promote the forward movement of the compact.

There are really great deep dives. I think we did not leave a rock unturned during that taskforce. I was on the taskforce representing North Dakota and the deliberations were very, very detailed. There was a lot of research looked at, a lot of special interest groups brought in to discuss across the nation.

It was just such a very intense group, but there was a lot of, kind of, eye-opening things that came to light during that group. And ultimately the revised compact was approved by the NCSBN delegate assembly in 2020. So the NCSBN taskforce was definitely a key talking point when I did my visits with the Nurse Practitioner Association and some of the other entities that had questions about where the 2,080 hours came from and how that truly was a compromise and negotiation a common denominator to help reduce the barriers of mobility for our profession.

And the last piece to bring up about just, kind of, how can we become more of a mobile workforce across the United States? And I was able to dive into a policy analysis on the Advanced Practice

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Compact. According to Bardach and Patashnik's Eightfold Path. And there's a picture of my book, and that is my taco sign and the paper that I had written on the policy brief.

And really when you look at a policy analysis, you look at what is the problem, what does the evidence show, what are alternative actions, and the deep dive really needs to be in the alternative actions, and then evaluating what are the evaluative criteria, what do we need to look at for cost analysis, cost risk analysis, benefit analysis, and what would some projective outcomes be of each of the different alternative actions, what the trade-offs are.

And at the end, what is our decision as a profession? So during this time of healthcare crisis with the pandemic, thinking outside the box and outside of our comfort zone is essential. The APRN licensure compact and alternative ideas all lend to a more mobile workforce with positive impact to cost inefficiencies, which are much needed in this time of healthcare challenges across the nation.

Of all the options discussed and all the alternative actions looked at, the APRN licensure compact presented the most achievable policy change that's actually right at our fingertips. And this is just a little bit of an overview of the policy analysis. In the height of the pandemic, it was clear that the APRN profession needed to find a solution to enhance efficiency and licensure and promote mobility of the workforce due to the expanding telehealth services.

Telehealth just blossomed during the pandemic. And we also needed to have interstate practice without loss of precious resources of time. Time became such a valuable resource when you're looking at waiting six weeks to two months to be licensed in each state where you're needed, that is too precious of time to lose. And the fees also at each border became expensive for providers to do telehealth. More states implemented executive orders during the declared state of emergency to allow for interstate practice, but these executive orders are temporary.

Many of them have already been repealed, but not all of them but many of them have been. In addition, a functioning nurse licensure compact proved to be a great asset and regulation for the member states as licensed and vetted nurses within the nurse licensure compact moved freely to the areas of greatest need across the nation without the burdensome barriers of regulation.

Unfortunately, this worked for the RNs and LPNs but did not work for our APRMs. So in looking at possible alternative actions as outlined by my policy analysis, one option is to remain the status quo, which is licensing the APRN in each border. However, it has become apparent that the status quo is inefficient and is producing barriers to the needed mobile workforce of this important profession, especially when we have expansion of telehealth, distance education, and the need for help in areas of disaster and pandemic surges.

According to current fees, an APRN with a license in six states would pay about $1,800 for initial licensure in those six days and 600 per year to maintain. And this would take six weeks to two months for the license. Imagine if that was 12 states. So federal action and national licensure did come up in the literature as other ways or alternative actions, but that really takes the power or the oversight away from the profession and gives it to the federal government.

And that national regulation takes sovereignty away from the states. Other things that came up that I thought were interesting was the deregulation or deferring to a third-party certification. And that I thought was interesting, but those were less likely to be politically feasible. You'd have to have buy-in from the profession and the states and even federally, which I think would be a difficult thing.

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And we also know that the executive orders, as far as that being an option, they're temporary. So they do not totally fix the problem. And state-based regulation will even lead to more lack of uniformity among states. So the most feasible option to meet the environment and healthcare needs of the United States is by providing the agile and mobile APRN workforce is the APRN licensure compact.

The compact has been vetted, revised for success, and has been enacted in seven states now. The APRN Compact can become a reality soon if states continue to move forward with the legislation. The time is now and the nation needs our advanced practice registered nurse workforce to be mobile and agile and ready to assist.

So in summary, early and consistent building of support is a vital key to success. And this includes education, transparency, and rationale for why the changes were made. Overcoming opposition through open forums and addressing misconceptions was very key as well. And as far as how can we get our APRNs mobile and agile across the United States, the APRN Compact in the policy brief became the most politically feasible and most doable option.

It's been vetted. It was revised to meet modernization of practice and codify the Consensus Model, and it's ready to pave the way to a mobile and agile workforce for APRNs across the United States. And I do have a few references. And at this point, I would like to invite Pam to join us.

She's going to be sharing lessons learned from the Delaware journey. And thank you for listening.

- [Pam] Thank you, Stacey. I am Pam Zickafoose from Delaware, and I'm going to be speaking about the APRN Compact journey in Delaware. The first part of our journey actually began in 2011. Although it's not on this slide, we reconvened, at that time, what was called the APN committee, and we started working on the Consensus Model and lace pieces of the Consensus Model.

So, all in all, our timeline has really been about a 10-year journey. In 2011, we did a lot of education. We started out teaching about the Consensus Model. We spoke with nurse practitioners and all of the different types and roles of APRNs in Delaware.

We spoke with legislators. We spoke with the hospitals and our medical society. And that was the beginning of our journey. Also, during that time, we conducted a survey of the APRNs in Delaware to see what their thoughts were about Consensus and whether or not we should try to eliminate the collaborative agreement.

And that was almost a unanimous decision. Yes, all of the APRNs thought that we should move in that direction. And our journey culminated in 2015. We had Sen. Bethany Hall-Long at the time, who was a nurse, sponsored two bills for us in the Senate.

And on September 1st, 2015, these bills were signed. This legislation at that time also attempted to eliminate collaborative agreements, but we couldn't quite get as far as we wanted to. The medical society and the Board of Medical Licensure and Discipline did not want to give up their control at that time.

So we came to a negotiation, and we basically agreed to eliminate collaborative agreements for everyone except new graduates who had not practiced a minimum of 2 years and 4,000 hours. This new bill in 2015 did grant full practice authority and the ability to sign death certificates. However, it created an APRN committee which consisted of physicians, a pharmacist, and APRNs.

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And the sole purpose of that committee was to grant independent practice. So in March of 2017, we granted our first independent practice application to an APRN. At that time, the bill also required us to have a report to the general assembly that was required to be sent four years after we started this process of granting independent practice.

We work collaboratively with the Board of Medical Licensure and Discipline, and we submitted a report on March 19th of 2019 that was signed by both the Board of Medicine and the Board of Nursing. At that time, we had granted 137 applications for independent practice, and we had zero disciplinary actions.

We also had zero applications that have been denied. So based on those statistics, the nursing board recommended that we go ahead and change the language for independent practice and, in essence, to remove it. And of course the medical bsoard opposed. So the next part starts our journey into the 2021 legislation.

And I have to say that this really started in 2018. At that time, the National Council of State Boards of Nursing was working on the compact for APRNs, and I went ahead and contacted, at that time, a representative and still Rep. Melissa Minor-Brown, who was also a nurse in Delaware.

I said we need to get this APRN Compact in Delaware and I want you to sponsor the bill when we have the language. She said, "Absolutely." So in 2018, she agreed to do that. We also began the journey then, and finally, the APRN Compact was approved by the delegate assembly in August of 2020.

Once that was approved, we had our DAG for the board, put it into legal terms, and it became House Bill 21, the APRN Compact. So we went to our first hearing from the House and before the House and Legislative Affairs Committee. And during that first initial hearing, the nurse practitioners in our state, as well as the medical society, opposed the compact.

And as you've heard from the previous two presentations, I believe the nurse practitioners mostly opposed the 2,080 hours of practice, thinking it was more of a transition to practice as well as the fact that we didn't have them on the committee that basically would oversee the compact licensure.

So at that time, we went to plan B, and I had already written the language, sort of, for what we now call the Companion Bill to basically lift everything that we wanted—to get rid of the collaborative agreements, to get rid of independent practice and grant it with licensure.

So we brought that out as the Companion Bill to House Bill 21, and it became House Bill 141, which Melissa Minor-Brown also sponsored. Like I said, it does align the nursing statute with the compact language. It removes the collaborative agreements, and it removed the process for independent practice, basically giving the Board of Nursing full authority for licensure of APRNs in the state of Delaware.

It also changed the APRN committee, and that made it all APRN where we have two representatives of each role and then one additional. So there are nine APRN members on that committee. In the process of all of this, trying to communicate with the nurse practitioners as well as the medical society was a big part of our goal before this went before the House and then the Senate.

So we did conduct town hall meetings. We had a lot of support from all of the nursing associations in our state, all the roles of APRNs were now in support of the Companion Bill in particular, because of the removal of the collaborative agreement. So we're very happy to gain that support by bringing out the Companion Bill.

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Of course, the day before...well, actually now two hours before we had our hearing in the House for the Companion Bill, I received the letter from the American Medical Association opposing both bills.

So that was two hours of craziness trying to come back with rebuttals and information so that when we got before the House committee for the House Bill 141, I was prepared to answer questions. Both bills passed out of the House and the Senate almost unanimously, and the bills were signed on August 4th of 2021.

I cannot say enough about the teamwork and how everyone worked together to get this accomplished. And thank you to everyone who did. So I think it's important that we go over some of the strategies for success that I think were helpful here in Delaware. And the first thing I have to say is that we had the legislator who sponsored the bills both in 2015 and 2018.

And I believe having a nurse as the sponsor is very important because they can talk both nursing and politics, which is really, really good. Communication, communication, communication. So vitally important. And we did try to share... One message is that this compact and this legislation, its whole purpose, was to increase access to care. Also, I think it was very important that we kept all of our stakeholders informed.

Whenever I found out that there was going to be the hearing, I would send an email out to the eight Delaware AARP to all of the nursing associations within the state or Delaware Nurses Association. They were just vitally, vitally important. And then they spread the word even further out to their membership and those nurses and the membership went to their legislators.

They talked with them. They educated them. They asked them to vote. And I think that that was...again, the communication, the collaboration, and the grassroots efforts were just vital in getting this legislation passed. Also, we had some pretty big national supporters. It's important I also think to have facts and data to support APRN prescribing practices and your disciplinary actions.

Having that information was also very helpful. And also remember this has been a slow process. It's not something that happens overnight. In essence, it took us 10 years to get to this point. These are all the letters of support. I've already mentioned many of the organizations that were supportive of our APRN Compact and the Companion Bill here in Delaware.

And these are all of the letters that were sent to every legislator. So we inundated them with communication, both verbally and written and in person. And it was very, very helpful. I think it was helpful to be in the compact and the NLC compact first, but I want to point out this is not mandatory.

Basically for us it ensures that when we do go live with the APRN Compact licensure, that we have the system in place for licensing people with compact licenses. The Consensus Model and title protection is needed and is part of the APRN Compact. This ensures that the licenses issued are synonymous with the four roles and the populations of APRNs.

It provides standards for all states who are members of the compact and licensing their licensees. You also need your board of nursing support for the compact as well as your division if you're an umbrella agency, which we are here in Delaware.

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We have many other boards and commissions. We're very small. We have very limited staff and resources. So by having my staff on board, they understand compact licensure, and they're able to talk to people who call in and provide information to inquirers regarding compact licensure.

You also need the support of your nursing associations. I think I've emphasized that pretty heavily in this presentation. I hope I have. I can't say enough about trust and collaboration. I think it's important. You know, I've been in this role for quite a number of years. I've been a nurse in Delaware for over 40 years.

So I have I believe good trust within the nurses in Delaware, and I think that we collaborated exceptionally well in order to be able to get this legislation passed. And the other piece is that the leadership of all the organizations, it says a lot for them as well as how they work together and everyone came together again with the common message of increasing access to care.

We educated, educated, educated, first, the APRNs, then the legislators, other stakeholders. And the other thing is when you do have hearings, your legislators like to hear stories from your constituents like, "I went to my nurse practitioner and I had excellent care. She took the time to talk to me and explain everything, and I just really enjoy my nurse practitioner visits."

We had those kinds of people ready and waiting to testify as necessary. I also think it was important that your key expert witness who speaks at the legislative hearings has a knowledge of the compact and nursing.

I think that the questions that were asked of me in particular... I was the expert witness for Rep. Minor-Brown. And the questions that were asked during the hearings were questions more on how does it really work in the real world, what happens if you have a Maryland nurse who's working in Delaware and she commit some kind of unprofessional conduct, how does that discipline really look.

And I was able to explain to them how it works currently in the NLC, Nurse Licensure Compact, and how I would anticipate it would probably work in the APRN Compact. And they asked some pretty tough questions, especially at the Senate committee. They were very tough questions I felt, but I also was able to answer them with confidence and competence, I thought.

So I also have to say, yes, we did have opposition. I mentioned about the AMA letter and the nurse practitioners. And to counteract that opposition, these are some of the measures that we used. First of all with the nurse practitioner opposition, we brought out the Companion Bill, which basically eliminated the collaborative agreements, which made the NPs very, very happy.

We also conducted town hall meetings. And in these town hall meetings, I really emphasize that this APRN Compact is a licensure model for regulation of nurses. It has nothing to do with changing the scope of practice.

And that is why the committee composition, who will be the oversight of the APRN Compact, those administrators or whatever they end up being called, are usually representatives from the boards of nursing. And the purpose of that is because the people, nurses don't really understand compact licensure. That's evident every day in my work that people don't understand, "Oh, well, I live in Florida. I have to get my license in Florida."

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So that was something else that we explained to them. We also have APRNs who are executive directors in several states so they can also have that input. In Delaware, the other piece that we did was changed the composition of the APRN committee, and the purpose of that committee is now to provide guidance on rules, regulations, emerging practices, and things that APRNs can bring to the board, which we also have two board members who are APRNs.

And then when it comes to the board, then I, as the executive director, can take that information back up to the council or the administrators and the APRN Compact. The second big, big opposition was the American Medical Association. And like I said, I received this letter two hours before the House hearing for the Companion Bill.

So I had to do a lot of quick data collection as well as thoughts and ideas to counteract basically what the AMA letter was saying. They said that we were going to remove physicians from practice. No.

They said that we were changing our scope of practice. This whole thing was to preempt scope of practice. No. Many things in this letter were so erroneous. So what I ended up doing after that hearing, I wrote a letter of rebuttal back to the AMA allegations, and I sent it to every House representative and state Senator. So we did share that with them before we went on forward before the House floor, and before we went to the Senate hearings, and then to the Senate floor.

Of course, anesthesiologists were in opposition. And I did receive one in particular letter from an anesthesiologist. So I contacted her. We did a Zoom meeting where we discussed her concerns, and I believe that we were able to squelch some of the misconceptions that were actually there.

And then last was the Medical Society of Delaware. As I said, in 2015, we met with them many, many times. We drove several hours to get to the meetings in Wilmington at 5 a.m. to meet with them so that we could be there when they were available. And we made negotiations back in 2015, but this time, I stood the ground.

I said, no, we're not making any changes in these bills. This is what we need to go forth with, and that is what we did. So I'm very happy to say again that we did. We were successful in getting these bills passed. So that basically concludes my part of the presentation.

And now I believe we're going to go into a question and answer session with all three of us. Thank you very much.

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