MARYLAND BOARD OF NURSING

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OPEN SESSION

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The Maryland Board of Nursing board meeting was held on Wednesday, September 22, 2021, at 4140 Patterson Avenue, Baltimore, Maryland 21215, commencing at 9:07 a.m., before Edward Bullock, Notary Public in and for the State of Maryland.

Job No. 56025

AUDIO RECORDING TRANSCRIBED BY: Edward Bullock, DCR

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BOARD MEMBER APPEARANCES:

GREGORY RAYMOND, RN Member, Board Secretary
KAREN E.B. EVANS, Executive Director
EMALIE GIBBONS-BAKER, APRN Member
JENELL STEELE, RN Member
M. DAWNE HAYWARD, RN Member
CHARLES NEUSTADT, Consumer Member
JACQUELINE HILL, RN Member, BS Educator
CHARLENE HARROD-OWUAMANA, LPN Member
ANN TURNER, RN Member
ROBIN HILL, RN Member, Practical Educator
AUDREY CASSIDY, Consumer Member
DAMARE VICKERS, LPN Member (via telephone)

ALSO PRESENT:

LESLIE JOHNSON, Executive Assistant
KAREN BROWN, PIA Coordinator
IMAN FARID, Health Policy Analyst (via telephone)
RHONDA SCOTT, Deputy Director
JARAY RICHARDSON, Manager, Certification
MONICA MENTZER, Manager, Practice
PATRICIA KENNEDY, Director, Education and Exams
SHEILA GREEN, Nursing Education Consultant I
AMBER HAVENS-BERNAL, Enforcement Division
BRIAN STALLSMITH, IT Technician

AUDIENCE MEMBERS:

JANET SCHRECK, Johns Hopkins University (via telephone)
MARIE NOLAN, Johns Hopkins University (via telephone)
SARAH SZANTON, Johns Hopkins University (via telephone)
TIJUANA GRIFFIN, Washington Adventist University
SHIRLEY DEVARIS, Director, Policy Analysis & Legislation (via telephone)
BEVERLY LANG, Nurse Practitioner Association
AMEERA CHAKRAVARTHY, Nurse Practitioner Association
CHRISTOPHER COX, Maryland Assoc. of Nurse Anesthetist
NINA ROA, Maryland State Department of Education
REBECCA FOTSCH, NCSBN (via videoconference)
NICOLE LIVANOS, NCSBN (via videoconference)
ANDREA BRASSARD, CCNA (via videoconference)

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P R O C E E D I N G S

MR. RAYMOND: Good morning, everyone. This is Greg Raymond. I am the Secretary of the Maryland Board of Nursing. I welcome you this morning to the September 22nd Maryland Board of Nursing Open Session Meeting. We are conducting this meeting both in person and over teleconference. I would ask everyone that is joining us via teleconference to please mute yourself at this time. It is very difficult to hear what is happening if you're joining us via teleconference if there's background noise. So, I would ask you to mute yourself, and only unmute yourself if you are joining the conversation purposefully.

At this time, I will ask Board members to please introduce themselves so we can declare a quorum. I will start to my left.

MS. POLK: Laura Polk, RN member.

MR. NEUSTADT: Charles Neustadt, consumer member.

MS. GIBBONS-BAKER: Emalie Gibbons-Baker, RN member, advanced practice.

MS. HAYWARD: Dawne Hayward, RN member.

MS. STEELE: Jenell Steele, RN member.

MS. HARROD-OWUAMANA: Charlene Harrod-Owuamana, LPN member

MS. JACQUELINE HILL: Dr. Jacqueline Hill, RN educator member.

MS. ROBIN HILL: Dr. Robin Hill, RN member, practical nursing educator.

MS. CASSIDY: Audrey Cassidy, consumer member.

MR. RAYMOND: We do have one more Board member that is joining us virtually via this conference call. I would ask that Board member to please introduce themselves.

MS. VICKERS: Damare Vickers, LPN member.

MR. RAYMOND: Thank you, Damare. And I am representing the Board as chair of this meeting today in place of our president Gary Hicks, who is not with us today.

We do have a quorum, so I will ask one of our Board members to make a motion to open this Open Session.

MS. STEELE: So moved, Steele.

MS. HARROD-OWUAMANA: Second, Harrod-Owuamana.

MR. RAYMOND: We have a motion from Steele and a second from Harrod-Owuamana. All those in favor?

ALL: Aye.

MR. RAYMOND: Any opposed?

(No oppositions)

MR. RAYMOND: We are opening this session, thank you. Let's start with our first agenda item, Ms. Evans.

MS. EVANS: Thank you, Dr. Raymond. Good morning, everyone. My first bit of good news is a little on the selfish side, but my new executive assistant is here, Leslie Johnson.

MS. JOHNSON: Good morning, everybody.

ALL: Good morning.

(Applause)

MS. EVANS: So, I've been without an executive assistant for about eight months, so I am happy to have someone here so that I'm able to get all my emails done in a timely fashion now. So, give me about a week or so and I'll have it together by then. I am just so happy to have Leslie back. She has been with the Board before. She left us, and now she's back and I'm excited.

MR. RAYMOND: We're excited for you, too.

MS. EVANS: Thank you. Also, I just want to remind

the community that our phone lines, we're still having difficulty with them. Verizon is coming out tomorrow to increase our trunk size for our phones. So, what that means is there are times when we cannot call internally or externally out to you, and you can't call into us. So, they're coming tomorrow, and once they arrive then we have to wait for another company to set up all the phones for the new trunks that we are receiving. So, I don't know what the timeline is on that, but I just wanted to let you know.

The other is, our website is still under migration with the State. We thought that would be completed on the 18th. It is still in process, so hopefully we will be up next week at the latest, but I will inform you with an update once we receive it.

That's all of the news that I have.

MR. RAYMOND: Thank you, Karen. Are there any questions from Board members for Ms. Evans?

(No questions posed)

MR. RAYMOND: All right, thank you. I appreciate the updates, Ms. Evans.

Our next agenda item will the Approval of our

Consent Agenda. All Board members should have reviewed the agenda items previous to our meeting. I will open up the floor for a motion regarding our Consent Agenda.

MS. JACQUELINE HILL: Motion for approval, Jacqueline.

MR. RAYMOND: All right. Motion for approval from Dr. Jacqueline Hill.

MS. POLK: Second, Polk.

MR. RAYMOND: Second, Dr. Polk. All those in favor?

ALL: Aye.

MR. RAYMOND: Do I hear any opposed?

(No oppositions)

MR. RAYMOND: Motion carries. The Consent Agenda is approved.

Our next agenda item is Initial Certified Nursing Assistant Programs Seeking Board Approval.

MS. EVANS: That's part of it.

MR. RAYMOND: Pardon me?

MS. EVANS: That's part of the Consent Agenda.

MR. RAYMOND: Yes, and that's already been approved.

Dr. Green, you're up for Education, Johns Hopkins

University School of Nursing, Nursing Program Administrator.

MS. GREEN: Good morning. Can you hear me?

MR. RAYMOND: Yes.

MS. GREEN: Good morning. This is Dr. Sheila Green. I am serving as Nursing Education Consultant for the Board of Nursing. We are here today in order to introduce to you Dr. Sarah Szanton, who's the new dean at Johns Hopkins University School of Nursing, and the Maryland Board of Nursing's designated for as nursing program administrator in accordance with COMAR 10.27.03.07(a) and (b). I would like to acknowledge the presence of Dr. Marie Nolan on the line this morning.

MS. NOLAN: Good morning.

MS. GREEN: And Dr. Sarah Szanton, our new dean at Johns Hopkins.

MS. SZANTON: Thank you. Good morning.

MS. GREEN: And Dr. Schreck, who is a part of the academic affairs at Johns Hopkins University; is that accurate?

MS. SCHRECK: That's correct, and I am here on behalf of Provost Kumar. So, thank you so much. Good morning.

MS. GREEN: Good morning, thank you. As the Board has the information in front of you, effective August 19th of

2021 Dr. Sarah Szanton was appointed dean for the Johns Hopkins University School of Nursing. We thank Dr. Marie Nolan for serving in that interim time period both as the dean, interim dean for the Johns Hopkins University School of Nursing as well as the appointed person previously for the nursing program administrator for April through August of 2021.

Dr. Szanton meets the qualifications as nursing program administrator identified in COMAR 10.27.02.07(a), both (a) and (d), qualifications and responsibilities. She has over twenty-three years of experience in nursing education and has assumed many administrative educational roles at the Johns Hopkins University School of Nursing. She has a very extensive background in public health policy, and served in an earlier capacity in a policy analyst role. The rest of her credentials are noted in the final paragraph there.

And we are recommending to the Board approval request for Dr. Sarah Szanton for dean of Johns Hopkins University School of Nursing to serve as nursing program administrator in accordance with our COMAR requirements. Thank you.

MR. RAYMOND: Thank you, Dr. Green. I will open the

floor for a motion.

MS. POLK: So moved, Polk.

MS. STEELE: Second, Steele.

MR. RAYMOND: I have a motion from Dr. Polk, second from Steele. All those in favor?

ALL: Aye.

MR. RAYMOND: Any opposed?

(No oppositions)

MR. RAYMOND: Motion carries. Thank you, Dr. Szanton and Dr. Green.

MS. SZANTON: Thank you. Thanks so much.

MS. GREEN: Thank you.

MS. NOLAN: Thank you, Dr. Green, for your guidance through this process. We appreciate it.

MS. GREEN: Thank you.

MR. RAYMOND: The next item is Certification. Jaray?

MS. RICHARDSON: Good morning.

ALL: Good morning.

MS. RICHARDSON: I have two resumes that the CNA Advisory have approved; Lonnette Ray as an LPN member to be on

the CNA Advisory Committee; as well as Sanarta Murray-Barry as a CMT member for the CNA Advisory Committee. We were bringing them here for your approval.

MR. RAYMOND: Do you want to do them one at a time?

MS. RICHARDSON: Sure. Lonnette Ray is the LPN member. Her certification - I'm sorry, her license does not expire until 5/28/2023. She would like to be the LPN member for the CNA Advisory Committee.

MR. RAYMOND: Do we have a motion on the floor to approve Lonnette Ray, LPN as a member of the CNA Advisory Committee?

MS. GIBBONS-BAKER: So moved, Gibbons-Baker.

MS. STEELE: Second.

MR. RAYMOND: I have a motion from Gibbons-Baker and a second from Steele. All those in favor?

ALL: Aye.

MR. RAYMOND: Opposed?

(No oppositions)

MR. RAYMOND: Motion carries.

MS. RICHARDSON: Thank you. And the next person is Sanarta Murray-Barry, she is a CMT member applying for the CNA

Second, Steele.

Advisory Committee, and she was also approved by the Committee. We just need an approval from the Board.

MS. GIBBONS-BAKER: So moved, Gibbons-Baker.

MS. HAYWARD: Second, Hayward.

MR. RAYMOND: I have a motion from Gibbons-Baker, second from Hayward. All those in favor?

ALL: Aye.

MR. RAYMOND: Opposed?

(No oppositions)

MR. RAYMOND: So moved.

MS. RICHARDSON: That's all I have today. Thank you.

MR. RAYMOND: Licensure and Advanced Practice. Shetarah, do you have anything today?

MS. EVANS: No.

MR. RAYMOND: No, she does not. We will go to Karen Evans with Legislative Affairs.

MS. EVANS: Go to the next one.

MR. RAYMOND: Go to the next one?

MS. EVANS: Yes.

MR. RAYMOND: We will go to Item 8, which is Direct

Entry Midwives and Electrology.

MS. MENTZER: Good morning, everyone. We are going to start with 8A. 8A is a request to the Board for approval of a proposed curriculum for an electrology program.

The Electrology Practice Committee and the Practice and Education Committee have received a request for review and to obtain approval for a proposed curriculum for an electrolgy program in Maryland. The proposed curriculum is being submitted by Ms. Eileen Collins, she's a licensed electrologist and a licensed electrologist instructor in Maryland for an electrology program consisting of 250 hours of theory and 400 hours of clinical. The Electrology Practice Committee and the Practice and Education Committee have reviewed the supporting documentations submitted to the Board by Ms. Eileen Collins of her proposal for a curriculum for an electrology program and have determined that the proposed curriculum for an electrology program meets the regulatory requirements in the Code of Maryland Regulations, Title 10, Subtitle 53, Chapter 6, Regulations; 10.53.06.03 for the theory program; and 10.53.06.04 for the clinical program, with recommendations from both committees to the Board for approval of the proposed curriculum.

Are there any questions from the Board?

MR. RAYMOND: Questions from Board members?

(No questions posed)

MR. RAYMOND: With no questions, I will open the floor for a motion for approval.

MS. POLK: So moved, Polk.

MR. RAYMOND: I have a motion from Polk.

MS. GIBBONS-BAKER: Second, Gibbons-Baker.

MR. RAYMOND: Second from Gibbons-Baker. All those in favor of the approvals?

ALL: Aye.

MR. RAYMOND: Opposed?

(No oppositions)

MR. RAYMOND: Motion carries.

MS. MENTZER: Thank you. Moving on to 8B, the Electrology Practice Committee and the Practice and Education Committee are seeking approval for an application for approval of a Maryland electrology education program.

The application was developed by the members of the Electrology Practice Committee based on each of the regulatory requirements in the Code of Maryland Regulations, Title 10,

Subtitle 53, Chapter 6, Electrology Programs.

The Electrology Practice Committee and the Practice and Education Committee members have reviewed the application document that will be completed and submitted to the Board along with all supporting documentation by an individual who is seeking Board approval for an electrology education program in Maryland.

The Electrology Practice Committee and the Practice and Education Committee have completed their review of the application and are making recommendation to the Board to approve the application. A cover letter will be included with the application, and you have a copy of that as well.

Are there any questions about the request for the application to be approved?

MR. RAYMOND: Any questions from Board members?

(No questions posed)

MR. RAYMOND: I will open the floor for a motion.

MS. POLK: So moved, Polk.

MS. GIBBONS-BAKER: Second, Gibbons-Baker.

MR. RAYMOND: I have a motion from Polk to approve and a second from Gibbons-Baker. All those in favor?

ALL: Aye.

MR. RAYMOND: Any opposed?

(No oppositions)

MR. RAYMOND: Motion carries.

MS. MENTZER: Okay, thank you. Moving on to 8C, this is a request for approval of a survey for substantial equivalency review for out-of-state electrology education programs.

The Electrology Practice Committee and the Practice and Education Committee have reviewed a proposed survey for substantial equivalency review
out-of-state electrology education program. The survey was developed by the members of the Electrology Practice Committee pursuant to the powers and duties of the committee as stated in Annotated Code of Maryland Health Occupations Article, Title 8, Subtitle 6(b), specifically Sections 8-6(b)-068, and 8-6(b)-16, and the regulatory requirements found in the Code of Maryland Regulations, Title 10, Subtitle 53, Chapter 6, Electrology Programs.

The Electrology Practice Committee and the Practice and Education Committee members have reviewed the document that

will be utilized by the Practice and Education members and the Board when the Electrology Practice Committee will find it necessary to determine substantial equivalency to a Maryland electrology program if an applicant seeking licensure as an electrologist in Maryland submits an application for initial licensure and has completed an out-of-state electrology education program that is not currently listed on the list of approved electrology programs posted on the Maryland Board of Nursing website.

The Electrology Practice Committee and Practice and Education Committee are submitting a recommendation to the Board to approve this survey, and a cover letter is attached to the survey for your review as well.

Any questions about 8C?

MR. RAYMOND: Questions from Board members?

(No questions posed)

MR. RAYMOND: No questions. I will open the floor for a motion.

MS. GIBBONS-BAKER: So moved, Gibbons-Baker.

MS. TURNER: Second, Turner.

MR. RAYMOND: I have a motion from

Gibbons-Baker to approve, and a second from Turner. All those in favor?

ALL: Aye.

MR. RAYMOND: Opposed?

(No oppositions)

MR. RAYMOND: Motion carries.

MS. MENTZER: Moving on to 8D.1, we have fourteen requests for review of approval by the Board of the renewal applications for licensed electrologists in Maryland, and that includes the review of their submission of documentation of the required number of CEUs. I will go through each one individually.

The first one, 8D.1, is a request from the Electrology Practice Committee pursuant to their duties and powers in the Annotated Code of Maryland Health Occupations Article, Title 8, Subtitle 8-6(b), Sections 8-6(b)06 and 8-6(b)14(d)1 through 4, 8-6(b)14(e), and 8-6(b)14(f). Reviewing the supporting documentation on the renewal application for Brian Boston, licensed electrologist, E01475. Initial electrology license was issued to Brian Boston on 1/27/2021. The continuing education has been reviewed by

the Electrology Practice Committee on September 16th.

The committee recommends to the Board that the Board accept the renewal application with continuing education units of the required number for the initial review period for the 2021 renewal of licensed electrologist Brian Boston, E01474, as meeting the requirements in the Code of Maryland Regulations, Title 10, Subtitle 53, Chapter 4, specifically 10.53.04.01 through 10.53.04.04. Noting COMAR 10.53.04.03(d)1, states the total number of CEUs required is prorated for an individual for whom one of the individual following actions takes place within a renewal period issuance of an original license, which does apply in this case.

Request to the Board to approve the renewal application with CEUs for Brian Boston.

MR. RAYMOND: Are there any questions from Board members about the request for CEUs for Brian Boston?

(No questions posed)

MR. RAYMOND: I will open the floor for a motion for approval.

MS. ROBIN HILL: So moved, Dr. Robin Hill.

MS. TURNER: Second, Turner.

MR. RAYMOND: I have a motion from Dr. Robin Hill for approval, and a second from Turner. All those in favor?

ALL: Aye.

MR. RAYMOND: Any opposed?

(No oppositions)

MR. RAYMOND: Motion carries. Monica, I am going to hold you for a second on the rest of these.

For Items D2 through 14, are there significant differences in the reporting of the CEUs and any other recommendations other than approval for the CEUs?

MS. MENTZER: No. The only item, Item Number 6, Ellen Johnson, she also falls into the same category as Mr. Brian Boston. She was issued her initial license on January 27, 2021, so she only required eight. All the rest of the applications and the supporting documentation for CEUs have been approved and recommended by the Electrology Practice Committee, and twenty is the normal level that's required for renewal if they don't fall under one of those categories that I just mentioned.

MR. RAYMOND: What I would like you to do then is report out for D2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, and 14

all as one.

MS. MENTZER: Okay.

MR. RAYMOND: And then we will go back and report out for D6 as a separate one, and the Board will vote for approval on those so that we don't have to repeat each one individually. Does that make sense to you what I'm asking?

MS. MENTZER: Sure.

MR. RAYMOND: Okay.

MS. MENTZER: So, the Electrology Practice Committee has reviewed the renewal applications and supporting documentation for the required twenty CEUs for the following renewal applicants to be presented to the Board with the recommendation from the committee to approve the licenses as meeting the requirements in the COMAR for the following individuals.

So, D2 is Sohelia Biria, licensed electrologist, E01402; Eileen Collins, licensed electrologist, E01343, she also does hold the licensed electrology instructor and the request to renew that is with the application for renewal for the licensed electrologist.

MR. RAYMOND: Understood.

MS. MENTZER: That's Number E10476. Helen Cichan, licensed electrologist, E01366; Maria Denmark, licensed electrologist, E01217; Maria Moreira, licensed electrologist, E01381; Unchol Rohrer, licensed electrologist, E01428; Nancy Willis, licensed electrologist, E01062; Amber Wood, licensed electrologist, E01149; Donna Yaglom, licensed electrologist, E01134; Jacqueline Lagare, licensed electrologist, E01379; Elizabeth Spagnolo, licensed electrologist, E01366; and Sophia Redmiles, licensed electrologist, E01128.

Request to the Board from the recommendation from the Electrology Practice Committee to approve these renewal applications with supporting documentation for twenty CEUs.

MR. RAYMOND: Thank you. Any questions from the Board members on those renewals?

MS. JACQUELINE HILL: I do.

MR. RAYMOND: Yes, Dr. Hill?

MS. JACQUELINE HILL: Number 13, Elizabeth Spagnolo, is that a typo, LD instead of LE?

MS. MENTZER: Yes, it should be LE, sorry.

MR. RAYMOND: Thank you for noting that, Dr. Hill. Any other questions from Board members?

(No questions posed)

MR. RAYMOND: Hearing no questions. I will open the floor for a motion.

MS. POLK: So moved, Polk.

MS. STEELE: Second, Steele.

MR. RAYMOND: I have a motion from Polk, and a second from Steele to approve the CEU requirements for D2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, and 14. All those in favor?

ALL: Aye.

MR. RAYMOND: Any opposed?

(No oppositions)

MR. RAYMOND: The motion carries. Now we will do D6.

MS. MENTZER: Okay. D6 is a request to approve the renewal application, and it's an initial renewal for Ellen Johnson, licensed electrologist, E01475. The initial electrology license was issued on 1/27/2021. The continuing education has been reviewed by the Electrology Practice Committee on September 16, 2021.

The committee recommends to the Board that the Board accept the renewal application with continuing education of the required number of eight CEUs for the initial renewal period

for 2021 of Ellen Johnson, E01475, as meeting the requirements in the Code of Maryland Regulations, Title 10, Subtitle 53, Chapter 4, including 10.53.04.01 through COMAR 10.53.04.04.

MR. RAYMOND: Any questions from Board members about this request for CEUs approval?

(No questions posed?

MR. RAYMOND: Hearing no questions. I will open the floor for a motion.

MS. POLK: So moved, Polk.

MS. GIBBONS-BAKER: Second, Gibbons-Baker.

MR. RAYMOND: I have a motion from Polk and a second from Gibbons-Baker. All those in favor?

ALL: Aye.

MR. RAYMOND: Any opposed?

(No oppositions)

MR. RAYMOND: Motion carries. Monica, we will do the same thing for E. If those are all the same from the committee then we will do them all as one.

MS. MENTER: Yes, okay. The Direct Entry Midwifery Committee met on September 3, 2021 and has reviewed the 2021 renewal applications with the documentation with at least

twenty continuing education units required for renewal of a license to practice as a direct entry midwifery licensed midwife in Maryland for Monica Karaosman, licensed direct entry midwife, License Number DEM00026; for Katrina Nakao, licensed direct entry midwifery, License Number DEM00023; and Amy Miller, licensed direct entry midwifery, License Number 00013.

The request to the Board that these individuals with their renewal applications meet the requirements in COMAR 10.64.01, specifically 10.64.01.17 and 10.64.01.18 for renewal.

MR. RAYMOND: Thank you. Any questions from Board members about this request for approval?

(No questions posed)

MR. RAYMOND: Hearing no questions. I will open the floor for a motion.

MS. GIBBONS-BAKER: So moved, Gibbons-Baker.

MS. TURNER: Second, Turner.

MR. RAYMOND: I have a motion from Gibbons-Baker and a second from Turner for approval. All those in favor?

ALL: Aye.

MR. RAYMOND: Any opposed?

(No oppositions)

MR. RAYMOND: Motion carries. Thank you, Monica. We appreciate your time.

MS. MENTZER: Thank you.

MR. RAYMOND: We're going to go back to Item Number 7 on the agenda, Legislative Affairs. Iman, are you with us?

MS. FARID: Yes, good morning. Can you hear me?

MR. RAYMOND: I can hear you just fine. Good morning, Iman.

MS. FARID: Perfect. Good morning, everyone. Today I will be presenting COMAR 30.08.17, titled, Comprehensive Stroke Center Standards. So, these regulations were proposed by MIEMSS, the Maryland Institute for Emergency Medical Services Systems, and these regulations are open to public comments until September 27th. These regulations were brought to the Board's attention because there's a particular section that would accept nurse practitioners working within a stroke center.

So, I would like to direct your attention to Page 4 where you will find a highlighted section for your review. And

for those that don't have the regulations in front of them, I will read the sentence. So, it reads as follows: Nurse practitioners who care for stroke patients shall have an agreement with the Maryland State Board of Nursing, which states, that the nurse practitioner has the scope of practice that includes patients with acute neurological disease.

So, this sentence does not reflect the Board of Nursing's current practice. The Board did not have any agreement that outlines specific scope of practice issued, rather, nurses are directed to practice within the scope of their education, training, and standards specifically set by the American Association of Nurse Practitioners.

So, the recommendation after reading this particular sentence, the recommendation for the Board to consider is to submit a public comment to the appropriate individual that's cited in this document to eliminate this highlighted sentence. I would be happy to clarify or provide more context, or if there is any discussion or questions, I would be happy to answer them.

MR. RAYMOND: Hold on for just a second, Iman. We are trying to pull the file back up so the Board members can take a look at it.

MS. DEVARIS: Good morning. This is Shirley Devaris. Can you hear me?

MR. RAYMOND: Hi, Shirley. Good morning.

MS. DEVARIS: I would like to contribute when it's time to discuss this. I have some background on it from before.

MR. RAYMOND: Go ahead.

MS. DEVARIS: MIEMSS has a habit of overreaching when they do these policies in trying to regulate other practices. We had someone on that Policy Advisory Committee. I used to sit on it. I don't remember who we appointed after that, but we sort of watched out for this kind of thing happening. Because I feel that it is not appropriate for them to set rules for our practice. Thank you.

MR. RAYMOND: Thank you, Ms. Devaris. I appreciate that comment.

Iman, just so I can make sure that the Board members understand the recommendation, or what Shirley is commenting on, the recommendation is that that language be removed, that sentence that's highlighted be removed because it is inconsistent?

MS. FARID: Yes, that's correct.

MR. RAYMOND: Okay.

MS. DEVARIS: I have another comment. I think these are the same regs I looked at this week earlier. There is also a required CEU provision in there for nurse practitioners.

MR. RAYMOND: Do we need to make comments on the CEU provision?

MS. DEVARIS: I think so.

MR. RAYMOND: Isn't the CEU provision something that has existed already though, Shirley?

MS. DEVARIS: No, this is specific to the Stroke Center.

MR. RAYMOND: Correct.

MS. DEVARIS: I think it's five CEUs, and that's above of what we require. Well, actually, the nurse practitioners are required to have a higher number of CEUs for renewal of their national certificate. But this requires, I believe, it's five CEUs in stroke management. And I don't think it says, you know, how often or when. I can see training in stroke management as a provision of qualifying for that position, but I don't know that they should be able to

dictate CEUs.

MS. EVANS: It's still on the same page under .14. Does everyone see it?

MR. RAYMOND: I do, yeah. It's right above it.

So, the request from Iman is that we make comment to strike the sentence that's highlighted. And, Shirley, what is your recommendation regarding the CEU language?

MS. DEVARIS: I think that we should strike that, but I think we should instead substitute revision that the nurse practitioner be qualified in stroke management; professionally, educationally, and experience. You know, something to the effect that they need the education and experience necessary for the position.

MR. RAYMOND: Isn't there language somewhere else in that document that requires the bedside nurses to also have continuing education as stroke specific?

MS. DEVARIS: If there is, I missed it. I just looked at the nurse practitioner part of it. If there is, we should not support that either because, you know, we're routinely opposed to set requirements for CEUs. The other thing, as I say, how often does the CEU renew or whatever.

Because we could get to the point where pretty soon we're bogged down with CEUs if somebody decided it was there pet project, and then they have no room for other CEUs that are really necessary for their practice.

MR. RAYMOND: Thanks, Shirley. Yes, please? Introduce yourself, please

MS. LANG: I'm Beverly Lang. I'm the executive director for the Nurse Practitioner Association of Maryland. We have in our audience today the president who is on faculty in the Acute Care Program. And I appreciate Iman bringing this that was published in the Maryland Register. It was brought to our attention through our legislative consultants, and they also recognized that, number one, we don't have an agreement, quote/unquote, with the Board of Nursing to practice. And I think Ameera wants to address the fact that stroke care is included in the Acute Care Nurse Practitioner Program.

MS. CHAKRAVARTHY: It is. It's a requirement for our programs to have it. So, I'm concerned if we're going to do this stroke, we would have to do this for almost every acute diagnosis. Just going back to say, commiserate with your training and certification and scope of practice should be

sufficient. We have to assure that when they graduate that that area they are working in will have certain requirements above and beyond what it is that they have had as a foundation in their graduate medical training.

MR. RAYMOND: Can I point out to all of you that this is a comprehensive stroke center certification for the State and specific to a very complex designation, and not for every center in the state. There's only currently four comprehensive stroke centers in the state. It's not even a primary stroke center. So, for a comprehensive stroke center be given designation, they have to meet very strict requirements and guidelines. They are setting these guidelines for that requirement. It's not set in the requirements for every area where stroke patients are cared for, specifically comprehensive stroke center designations, correct? Am I correct in that statement, Iman and Shirley?

MS. FARID: I'm not sure about that. I might have to defer to Ms. Devaris.

MR. RAYMOND: My understanding is that this is a comprehensive stroke center designation requirements. This is not requirements for every center in the state that's caring for

stroke patients, this is specific to a comprehensive stroke center designation by the State, which is above and beyond care for primary stroke centers, beyond care for stroke patients anywhere in the state. This is a specialty certification for a hospital?

MS. DEVARIS: I think that's correct, but I am so concerned that they are setting CEU requirements, educational requirements without - I see the point in it, but I think we need to be very careful of approving things like this. Now, we could find out from MIEMSS if this is a national requirement for stroke centers. But if it is, it needs to be worded in a different way if they would have substantial, you know, CEUs in the area or whatever.

MR. RAYMOND: Yeah, and so, that will be my recommendation. Because there is a Joint Commission in comprehensive stroke center designation, and I would be careful that the Board not make comment to remove language from the State's recommendation for comprehensive stroke center that would then not map correctly to a national requirement for comprehensive stroke center designation. The comments on that would not be good.

MS. DEVARIS: I would agree. We need to find out what the national standard is. But what also concerns me though is if they do not have CEUs for physicians, it's only nurses.

MR. RAYMOND: Let's first do a little more digging, and what I will direct you to is the Joint Commission, comprehensive stroke center designation requirements.

MS. DEVARIS: But in the meantime, you can send in a letter saying that you have real concerns, that you want these held until this is resolved. That's perfectly all right.

MR. RAYMOND: I think that's fair.

MS. DEVARIS: Otherwise, you may not be able to meet the 30-day comment period, which ends in five days.

MR. RAYMOND: Yeah, I think we could probably make comment on the original asked by Iman about the statement, D2. However, since that specifically mentions an agreement for the Board of Nursing, which would not map directly to a national requirement, right? So, if we take the CEU requirement off the table for now for comment, and we could sub-note that in our comment to say that we also want to review CEU requirements against the national certification requirement, but the statement for D2 we respectfully request that be removed from

the requirements because it is not matched with the requirement from the Board of Nursing. I think that would be the correct way to go at this time. Does that fit well, Shirley and Iman?

MS. DEVARIS: I think it does.

MR. RAYMOND: Iman?

MS. FARID: Yes, that's perfect.

MR. RAYMOND: Okay. Do the Board members have any questions about the direction I'm suggesting?

ALL: No.

MR. RAYMOND: Is anybody in disagreement?

MS. DEVARIS: I would suggest we do this, too, that we copy the Governor's Legislative Office on this because they often get left out of the loop, and they need to know when regulations are involved and they have a problem.

MR. RAYMOND: All right. Any further comment from those that are joining us today?

MS. CHAKRAVARTHY: I just had a thought. I mean, if it's for a stroke designated center, which I couldn't appreciate in the language in the way it was written. That's why I couldn't answer your question.

MR. RAYMOND: No problem.

MS. CHAKRAVARTHY: My next question would be, if we're doing it for that then there are multiple other sectors as well. So, I'm trying to understand. So, if we're going to do it for stroke, we're going to do it for transplant, and we do it for heart centers? And then that opens up a can of worms with regard to tracking CEUs and the rest of what goes with it. Just my question.

MR. RAYMOND: Agreed, and typically what happens in my experience -- so, those who are listening in and hearing this dialogue, my background is in hospital administration in specialty areas as well, especially in certifications. It's the organization's requirement to meet those special requirements, and the regulating body for that specialty area comes in and asks for the organization to provide documentation of the CEUs. So, it doesn't fall on the regulatory body like the Board of Nursing to follow the CEUs. It falls on that particular organization in order to fulfill the requirements for that special designation to provide. So, that's what happens.

Yes, sir?

MR. COX: I am Christopher Cox. My question would be, wouldn't that be an institutional requirement and not a

State Board of Nursing requirement?

MR. RAYMOND: Correct. That's why we're asking that the language on D2 be removed because it does pull the Board of Nursing into that language. And we're asking that we go back and review the mapping facts, the national requirement for the CEUs and not make a specific comment on the CEUs at this time. Because if it maps strictly the national, we may not even want to be a part of that conversation regarding the CEUs because it becomes an institutional issue related to the certification and not the Board's business.

MR. COX: Thank you.

MR. RAYMOND: Fair enough? Yes, ma'am?

MS. MENTZER: I just wanted to make one comment. When you were talking about CEUs for RNs, and I don't know if that part of this, I thought I heard something mentioned about just the nurses working in this specialty area as well. And I just wanted to bring your attention to COMAR 10.27.09.04, Specialty Practice; (a), states the registered nurse functioning in a specialty practice shall have additional education, training, and experience. The specialty practice does not include advanced practice nursing.

So, again, that covers, you know, individuals maybe working in a specialty area such as critical care stroke center, transplant unit, or whatever.

MR. RAYMOND: Agreed. I think we can have dialogue and debate about whether or not a specialty certification, like a stroke center -- a comprehensive stroke center designation falls within the scope of the Nursing Practice Act because it's a specialty certification, like a VAB program or a comprehensive stroke center program.

So, I think there's more dialogue that we have about that, specifically around the continuing education, perhaps, but certainly to reiterate and to restate what I think our position is. And we still need to have a motion on the commentary is that we are respectfully asking that they remove Statement D2 from the proposed comprehensive stroke center regulations as they've been provided because they do not match well with the Board's scope regarding nurse practitioners, and that we ask that they hold on the continuing education requirements for nurse practitioners and nurses at this time until we have opportunity to study the national requirements for CEUs for comprehensive stroke center designation, and understand the

position of CEUs for those that are in our jurisdiction.

Does that follow? Does that track for everybody? If that tracks for everybody, and we'll be able to follow that, I would open the floor for a motion.

MS. GIBBONS-BAKER: So moved, Gibbons-Baker.

MS. HARROD-OWUAMANA: Second, Harrod-Owuamana.

MR. RAYMOND: All right. I have a motion from Gibbons-Baker and a second from Harrod-Owuamana on the comment of what I just said. All those in favor?

ALL: Aye.

MR. RAYMOND: Any opposed?

(No oppositions)

MR. RAYMOND: The motion carries. Iman, are you good with that?

MS. FARID: Yes, thank you so much.

MR. RAYMOND: You're welcome. I appreciate the dialogue. Thank you very much.

We are going to go to Item 10, simulated formatted clinical practices in place of students going to clinical sites.

MS. EVANS: I have Nina here. She is the director

of finance and legislation for Career Programs for the Maryland State Department of Health, Division of Career and College Readiness and Office of Leadership Development and School Improvement. She has a question a question for us.

MS. ROA: Yes, thank you. Good morning, and thank you for having me. So, back in last spring, I think March/April, there was guidance from the Board of Nursing to certified nursing programs of which we have several in our school systems, almost one in every single jurisdiction if Maryland. That because of the pandemic the Board was accepting simulated hours for clinical rotations because we really couldn't send people into the clinical sites. So, our school systems don't require students to be vaccinated. And we have students in our CNA programs that - well, they're eligible to be vaccinated, are not vaccinated, and their clinical sites are saying in order to come here you need to be vaccinated. So, I am fielding a lot of questions from the nursing instructors in our CNA programs, what can they do? Because the directive from the Board of Nursing said that the acceptance of the simulated hours expired 30 days after the State of Emergency, which has ended.

So, I'm just curious how to guide our school systems for the students in their CNA programs who are not vaccinated and who can't do their clinicals.

MR. CONTI: We may have to look at that for a second.

MS. EVANS: Okay. Nina, can you just stay around for a few more minutes?

MS. ROA: Absolutely, yes.

MS. EVANS: So, if we can, table it for right now while our Board counsel can look at the Practice Act for us, I would appreciate that.

MS. ROA: That's fine.

MR. RAYMOND: Thank you for bringing that forward. It will take a few minutes to do a little background work on that.

MS. ROA: Sure. Thank you for giving me the time. If I do have to leave before the Board gets to it, I will just give you a call. Hopefully your phone lines are working, or I will send you an email, Karen.

MS. EVANS: I will email you or call you.

MS. ROA: I can stay around for a little while.

Thank you.

MS. EVANS: Thank you, Nina.

MS. ROA: Sure.

MR. RAYMOND: All right. We have a request from the Maryland Department of Health?

MS. EVANS: Yes. Again, good morning, everyone. I am bringing you a request from the Maryland Department of Health for consideration to the Board of Nursing. As you well now, the Executive Order ended on August 15th, and then the 30 days, September 15th. From that, nurses from out of state that are not part of the compact - remember, we have thirty-five that have implemented the compact, and we have three others that are having enacted, but have not implemented, as well as Guam and the Virgin Islands, have enacted, but not implemented yet.

So, their question is, we can use COMAR 10.27.01.03(a)3, which states, approved registered nurses or licensed practical nurses who hold a current active license in any other state or jurisdiction may render nursing care for the duration of the Federal COVID-19 Public Health Emergency Declaration. So, they would like for the Board to approve this request, just with the hospitals with the shortages and other

things that are going on as well with the State, just to make sure that we have enough nurses in the state. If we can just approve this. And this has a timeline on it, it is till the duration of the Federal COVID-19 Public Health Emergency Declaration. So, they are asking for our approval.

MS. TURNER: I have a question.

MS. EVANS: Yes.

MS. TURNER: So, how does that affect other things that expired on the 15th, like licensure and things like that, if we are going to extend it for this particular reason?

MR. CONTI: This wouldn't actually be extending any kind of licenses. So, this is a provision in the regulations that permit the Board to allow folks who have a current active license in another state. So, it really doesn't apply to compact states because those folks already have a multi-state privilege to work here. So, this really would only be applicable in states that are not compact states. So, let's take California for instance. If somebody has an active current license to practice in California, under this provision for the duration of the Public Health Emergency declared by the Federal Government, that person would be able to come into Maryland and

practice in our state.

MS. TURNER: Okay.

MR. RAYMOND: Dr. Polk, did you have a question?

MS. POLK: I just wanted to comment, do we want to allow thirty days after that like we've done with the other State of Emergency, or would it really end on the day that the Federal State of Emergency runs? I just wanted to put that out there for the group to think about.

MR. CONTI: Well, I mean, the regulation says during an emergency situation. So, I think that lends itself to after termination of the Public Health Emergency that ability would terminate.

MR. RAYMOND: My question was more of practicality, if there is a practice issue with an individual who's licensed in the non-compact state while they are practicing in Maryland under a license. I am going to use a Pennsylvania nurse, for example, since they are out of another compact.

MR. CONTI: Well, they've adopted it, they just haven't enacted it.

MR. RAYMOND: At this point they haven't enacted it.

MS. EVANS: They haven't implemented it.

MR. CONTI: Right.

MR. RAYMOND: Bad example.

MS. EVANS: No, that's still a good example.

MR. RAYMOND: So, there's a practice issue with a nurse in Maryland while we are under this, what is our recourse?

MR. CONTI: Well, the most clear recourse would be to refer that matter to the Pennsylvania Board of Nursing, and they would have jurisdiction to take action.

MS. DEVARIS: Again, for license, but we ought to have action just like we do with the compact. If you're here and it's a compact, we can take action in our state against the privilege? We can't take action against the license. Pennsylvania is the only one who could do that. So, we still have the right to tell them to stop practicing, you know, or whatever.

MR. RAYMOND: So, we could still do that?

MR. CONTI: Yeah.

MR. RAYMOND: Any other questions from Board members?

(No questions posed)

MR. RAYMOND: I will open the floor for a motion

regarding this request from the Maryland Department of Health.

MS. GIBBONS-BAKER: So moved, Gibbons-Baker.

MR. RAYMOND: So, Ms. Gibbons-Baker, considering Dr. Polk's suggestion do you want to be specific about your motion?

MS. GIBBONS-BAKER: With reference to the 30-day extension, I would include that.

MR. RAYMOND: Okay.

MR. CONTI: My recommendation would be to adhere pretty closely to the language that's in the regulation, which says, "During an emergency situation." So, I don't think that gives much room, if any, for extending it beyond the Public Health Emergency Declaration.

MR. RAYMOND: So, not with the 30-day extension?

MS. GIBBONS-BAKER: And not have that, as stated.

MR. RAYMOND: Okay.

MS. STEELE: Second to the motion.

MR. RAYMOND: So, I have a motion from Gibbons-Baker to approve the request from the Maryland Department of Health to approve registered nurses or licensed practical nurses who hold a current active license in any other state or jurisdiction to render nursing care for the duration of the Federal COVID-19

Public Health Emergency Declaration until such time that declaration is removed, and I have a second from Steele.

MS. STEELE: Correct.

MR. RAYMOND: Sorry?

MS. STEELE: Correct.

MR. RAYMOND: All those in favor?

ALL: Aye.

MR. RAYMOND: Are there any that are opposed?

(No oppositions)

MR. RAYMOND: Motion carries. Are we ready to go back?

MS. EVANS: Yes, it's B. I can take care of this.

MR. RAYMOND: Did you want to go back to A?

MR. CONTI: Yeah, we can talk about that.

MR. RAYMOND: So, Nina, we're going back to your agenda item.

MS. ROA: Sure.

MR. CONTI: This is a question about whether or not the Board can accept simulated clinical practices for CNA/GNA students. Under our regulations, under 10.39.02 in COMAR, it defines clinical facility as meaning a setting where clients are

present and that provides facilities for clinical experiences of nursing assistants with the faculty of the program responsible for planning, implementing, and evaluating these experiences. It also defines supervised clinical training as meaning, training in a clinical facility in which the trainee demonstrates knowledge and skills while performing tasks on an individual under the direct supervision of an RN or LPN. And then under the curriculum requirements, under 10.39.02.07, it indicates that forty hours of the curriculum shall be devoted to clinical training experiences in a clinical facility.

So, based on those regulations it doesn't appear to be any room to completely eliminate in-facility clinical training.

MS. ROA: I'm sorry, could you repeat that? We're looking at high school students, and they have labs in their high schools but there are no real patients there. So, and I know that there are other types of CNA programs that take place in facilities. So, they would have an opportunity to work with clients, but some of our high school students would not.

And, I'm sorry, it may have just been that I couldn't actually hear what you said.

MR. CONTI: So, where do high school students take their clinicals?

MS. ROA: So, in good times, they all have clinical partners where the students go do their clinical. But the issue is, that the clinical partners can and do require their staff, which would be, you know, our students would be considered staff doing their clinicals to be vaccinated. And we do have some high school students in our CNA high school programs that are not vaccinated because it's not a requirement of the school systems. So, we have of a group of twenty students, eighteen can go to clinicals, but two can't because they're not vaccinated and/or they won't submit to the ongoing testing. So, parents are calling the schools saying, 'Well, why is my child being excluded from doing their clinicals?' And the schools are saying, 'Well, last year we were allowed to do virtual, but that of course expired September 15th with the end of the State of Emergency.'

MR. CONTI: Right, and because there's no declaration of the State of Emergency there is no authority for the Board now to waive any of those current requirements in its regulation.

MS. ROA: Okay. I will take that back to the school system. I was just looking for guidance. I really do appreciate it. And then I will just deal with the consequences, but thank you very much. I do appreciate it.

MS. GREEN: This is Dr. Sheila Green. May I ask one other question regarding this?

MR. RAYMOND: Absolutely, Dr. Green. Go ahead.

MS. GREEN: Thank you. With regard to the particular agencies, what does the clinical affiliation agreement say of the requirements and what's accepted between the program and the clinical site? If I am missing an assumption, and if I'm off keel let me know. Does the clinical affiliation agreement signed by the public schools, if the particular agency - there is usually language about immunization and other requirements, and has that been addressed today as it relates to COVID? Because these individuals, of course, would be eligible for vaccines, but they are still minors and they would have to have the permission of the parent. So, what is your clinical affiliation agreement say? That may be a guidepost to look at.

MS. ROA: Yes, and each school does have an

agreement, but these are different times. And while most of these students are of the age to be eligible, and they may have other required immunizations. It is really just around this specific COVID vaccination at this point from, you know, the conversations I've been having with our school systems. That is also what I have recommended that they work directly with their clinical partner. But since there was this guidance from the Board of Nursing, they had asked me to come and ask you all.

So, I have my answer. I am happy to go back and express it.

MS. EVANS: Thank you.

MS. ROA: It's very much appreciated. We might be talking some more, Karen, but I really appreciate your time.

MS. EVANS: No problem.

MS. ROA: Thank you all very much.

MR. RAYMOND: So, we can go to the APRN Compact Presentation from the National Counsel?

MS. EVANS: Yes.

MR. RAYMOND: Okay.

MS. EVANS: I just want to make sure that Rebecca and Nicole, are you on the call?

MS. FOTSCH: Yes.

MS. EVANS: So, I have asked Rebecca Fotsch and Nicole - Nicole, pronounce your last name so I don't mess it up. Nicole?

(No response)

MS. FOTSCH: She can't hear you?

MS. EVANS: Oh, you can't hear me.

MS. LIVANOS: It's Livanos.

MS. EVANS: Livanos, okay. Thank you, Nicole.

So, both of them work with NCSBN. Rebecca is the Director, State Advocacy and Legislative Affairs; and Nicole is the Associate Director, State Advocacy and Legislative Affairs.

As we are going through COVID over the past eighteen, nineteen, twenty months we have had a lot of movement as far as throughout the state having APRNs and having nurses go throughout. So, I know there's a potential bill that one of the senators would like to present, and that's for the APRN. But I thought because there was a lot of misunderstanding when it first came around, I thought it was important for us to revisit this and have NCSBN provide us with the information. So, if there's any questions or answers for us to not proceed forward

to the next step would be the stakeholders, then we want to get whatever questions you have out now. I've also invited Bev here as well in case she has questions she might have. I've invited her as well, and others that are on the call.

So, I would like for them to present. I've given them thirty minutes to present, and then after that, questions. I just want to make sure there's clarity on this topic as far as APRN and compact.

The other is, that Delaware has now enacted APRN compact. I know Virginia is looking at it. There's three other states outside of that for the APRN compact. And just with the challenges of the past year and what we can do to bring more people in, and especially in our rural areas; Western Maryland, the Eastern Shore. We want to make sure that we have enough APRNs as well as nurses to come in. We are already part of the NLC, we were the original state to implement it in 1999.

Just hold on for one second, Nicole. I just want to make sure we are up.

MS. FOTSCH: I can hear you.

MS. EVANS: I was just getting ready to ask you that.

MS. FOTSCH: Are you able to see the presentation?

MS. EVANS: Yes.

MS. FOTSCH: Wonderful. So, we can get started. Hi, everyone. Again, my name is Rebecca Fotsch, Director of State Advocacy and Legislative Affairs at NCSBN. I have been working on the compact since I began here helping states get the compact passed. And now, over this last year, we are embarking on this new APRN compact. So, thank you for letting us present to you. I think that it will be helpful for us to kind of paint a clear picture because, as Karen had said, there are some new conceptions surrounding the compact. So, hopefully this will clarify everything for you. So, let's begin.

So, I know that you are all very familiar with NLC, but I'm going to do a very, very quick Compact 101 just in case everyone is not as familiar as some other Board members. I know there's a lot of transition over the years. And then, we will take about the main features of the APRN compact. You may remember there was a variation of the APRN compact that was approved at the same time that the NLC was approved, but there were issues, so we will talk a little bit about what those issues were, and we will talk specifically that impact on

Maryland that the APRN compacts have. And then, we will finish up with some of the advocacy that has already taken place; stakeholders that we have worked with in other states and from national stakeholders; and talk about what the resources are that we can provide Maryland if Maryland chooses to support and move forward with the legislation.

The Compact 101, and again, I will go through this very quickly. I'm sure many are already familiar with this. But essentially, a compact is a statutory agreement, so it's a bill that needs to be passed through the legislature between two or more states, and it's to fix a problem that is of multi-state concern. Essentially, fixing a multi-state problem without getting the federal government involved. So, each state needs to sign-on or pass a bill that has the same language, because they've all been signing on to the same contract, if you will, with one another. So, sometimes difficult things about the compact when there is a bill introduced is that there is very little wiggle room for amendment or changes based on the states because every state compact to agree to the same terms in order for the compact to operate legally, but also efficiently. The APRN compact is modeled after the NLC, which is also modeled

after the driver's license compact. And we always like to kind of bring up the driver's license compact because it's something that kind of impacts everyone's life. It helps to conceptualize the way that the neutral recognition models licensure work in that you were issued the license that you reside in, where you are able to use that license across state lines.

Our resident of a compact state is issued a multi-state license that they use to practice either physically or telephonically or, you know, telehealth. In other words, it's all compact states. In order to be eligible for a multi-state license for the APRN compact, an APRN must be a legal resident of the compact state and meet the uniform licensure requirement for a multi-state license. So, again, the same as the NLC that you are already participating in. Again, same as the NLC, and I know there were already discussions at the Board meeting, the remote state maintains authority over the license, and a remote state can still take adverse action and discipline that licensee's privilege to practice within that remote state. So, again, just to reiterate, everything up to this point is the same as the NLC. They operate in the same way.

So, here are the main features of the APRN compact. How to obtain a multi-state license? First, like the NLC, you have to meet the state licensure requirements for your state of residency. So, again, same as the NLC. You also can meet uniform licensure requirements. Same concept as the NLC, except if you can imagine the requirements are different for the APRN compact. First and foremost, all the consensus model elements are incorporated into those uniform licensure requirements.

As for CBC, criminal background check, is required. There can be no active discipline or current participation in an alternative discipline program. And again, similarly that's the same as the NLC.

And lastly, and this is the requirement that has kind of led to some confusion and concern, is the 2080-hour practice experience requirement. So, the nurse must first complete 2080 hours of practice experience. This is not a collaborative agreement. This does not have to have any oversight by a physician. And we will talk about later in the presentation why that licensure requirement was added, and what that kind of accomplishes for the APRN compact to move forward.

The practice under the APRN compact. The APRNs who

hold a multi-state license has full independent practice, but they do still need to follow all parties statewide when it comes to nursing. So, it's similar to the way that the NLC operates that a nurse when she travels across the state line, she needs to abide by the laws of the state that she is practicing in, and that is the same for the APRN compact, except that in addition to, it does grant a multi-state license holder that full independent practice.

Prescribing under the APRN compact. Multi-state licensees may prescribe non-controlled substances in the home state and the party state. So, non-controlled substances may be prescribed across the board in the compact. Further, multi-state licensees do need to follow all controlled substance laws and regulations in the state where they are currently practicing. So, wherever is the location of the patient is staying. And that is because controlled substances are regulated by the federal government, and a compact really can't supersede or speak to controlled substances in that way. So, in areas where the compact can control a non-controlled substance, multi-state licensees will be granted that prescriptive authority for

non-controlled, but with controlled substances it will be state-by-state.

Governance is going to be - well, we anticipate it to be identical to the nurse licensure compact, where within the APRN compact is identical to the NLC. Of course, there will likely be changes based on the fact that it is a different type of license with a different scope of practice. But the Commission, the rulemaking, the way that the licensure and enforcement affects work will be the same as the NLC. So, as kind of Karen already mentioned, you already have twenty years of experience with that so that should be an easy transition.

So, why isn't the APRN compact in operation right now? There have been multiple previous versions of the APRN compact. I think that everyone can kind of recognize that APRN practice is very different than RN practice in that it is just not standardized across the country. That is where a lot of the issues came when drafting and implementing an APRN compact. When you have all of these various APRN laws it's difficult to have an operational compact because the compact needs uniformity.

So, there were previous versions and they hit

roadblocks. The main roadblock, and this is the one that we had found with the most recent version of the APRN compact that which was adopted at the same as the NLC, is transition to practice. So, many states have transition to practice in their law.

So, the hours that need to be filled, typically with oversight from the physician sometimes, or an APRN, and before a nurse can have that full practice authority. The time to reconcile that would be language of the compact. The compact was superseded those transitions to practice. The original language, not the current language I'm talking about right now, but the one from that was passed at the same time as the NLC. And that was problematic because for a lot of these transitions to practice their legislators have recently adopted them, and it was likely a compromise between the nursing community and medical community, but the legislature found to be, you know, the best way for the compact to move forward. So, the states weren't willing to entertain the idea of an APRN compact because it meant that it was going to eliminate their, you know, many very recent transitions for practice which they thought as a kind of good compromise for their state.

Additionally, there continues to be organized group oppositions. At the state level that's usually in the state medical societies or the anesthesia specialty groups at the national level, the AMA and ASA, are opposed to the APRN compacts probably for many reasons. Well, for many reasons, but first and foremost because the compact would grant the sole practice authority, which they are very must against.

So, going back to that transition for practice. The transitions for practice are really political tools. I've heard it said that they were kind of added as a compromise to get to full practice authority. The political normality of passing legislation means sometimes there does need to be compromise. There are temporary periods of supervisory relationships with a physician, but it sometimes an APRN, and it's prior to - so, this is prior to retiring of the contractual relationship. So then, at the end of that - at the end of the transition to practice that nurse would have full practice authority to be able to continue practicing. They have been around for a very long time. It was first enacted in Maine in 1995, and currently there are twenty states that require a TTP, that's transition to practice for short, for one or more APRN in full practice

prescribing or both. So, even within the TTPs there's a lot of variation.

Again, as to why the barrier to the APRN compact. The APRN compact allows multi-state licensees to practice without the supervisory or collaborative relationship. So, the TTP, the compact language would be trumped, essentially, by the compact legislations.

Here's a list of the TTPs. Maryland, we highlighted Maryland with 18-month TTPs for nurse practitioner. I also wanted to add that this is the current list, however, really haven't seen release states to get full practice authority without implementing the transition to practice in order to get that full practice authority. Sorry, that was a very backwards way. But all of the release states that where their APRNs are gaining full practice authority, it's coming with a transition to practice. To then kind of talk about the political position here, this wasn't seen as a problem that the TTP was something that was going to be going away, instead it's really increased year after year. So, it requires the compact to become effective for the compact that all states can participate in because that is the way a compact is effective, all the states

should be participating in it. So, we needed to find a way to deal with to essentially accommodate these transitions to practice.

MS. LIVANOS: So, thank you, Rebecca. As Rebecca said, you know, we are looking at the policy environment and seeing that these transition to practice periods were so prevalent. A lot of them were recent enactments, and so the lawmakers that negotiated these TTPs were still around. They still remember the negotiation that they had. A lot of these states were newly implementing the TTPs, and state lawmakers generally don't like when legislation can supersede their existing state law and so it created that roadblock for us. At the time when the APRN Compact Committee was looking at this issue, the most common transition to practice hours was 2080 hours, which is equivalent to about one year of full-time practice. I would say that now, unfortunately, that number is probably closer to 3,000, if not 4,000. So, there really has been a prevalence and an increasing number of hours required. That seems to be the trend.

So, the solution that was presented and adopted into the APRN compact that is current today, is to implement a

2080-hour practice requirement as a uniform licensure requirement in order to obtain a multi-state license. This 2080-hours has to be done as a licensed APRN, and you can be an APRN in any state. All of this is governed that single-state license that you hold. The compact doesn't state how those hours are done. I say that because it's not a transition to practice, which Rebecca covered, require collaborative or supervisory agreements with either an APRN or most commonly a physician. The APRN does not govern that. It simply says that in order to apply for a multi-state license you have to have completed the 2080 hours of experience as an APRN that is required under the compact. Importantly, it does not impact the ability for a licensee to obtain one or multiple single-state license.

So, it doesn't impact the current process today. So, if you are a new grad that doesn't yet have 2080 hours of practice, you can still obtain as many single state licenses as you qualify for, you just will not be eligible for that multi-state license, which we know will save you a lot of time and money until you have your 2080 hours of practice behind you.

Also, important to note, that about ninety percent

of APRN licensees in every state, so I would assume it would be the same for Maryland, will need this 2080-hour practice requirement on Day 1. So, the compact does not say that you need to have 2080 hours additionally once the compact is enacted, it simply that you would demonstrate to the State that you have practiced for 2080 hours at, you know, at some point in your history of being licensed as an APRN, again, either in your state or if you were previously licensed in another state. You demonstrate that, and then you're eligible to join the APRN compact - or, to get a multi-state license.

So, what the solution really did was increase the pool of states that were politically able to enact the APRN compact. The COVID-19 has demonstrated, as Karen mentioned, that there's a new pro-mobility for healthcare professionals, and APRNs fit into that as well. And so, we saw a lot of states that were issuing waivers waiving collaborative agreements, which was great, so APRNs could be more mobile for. We saw licensure waivers as well. It is important for public safety that the compact be enacted so that we could have safe and reliable mobility for APRNs going into the future. We need it,

quite frankly, now, if not yesterday.

So, here is a little diagram that I'm hoping doesn't confuse people more, but rather clarify by going through the scenario of how the 2080-hour of practice requirement would work in Maryland today. And I am using this from the perspective of the Nurse Practice nurse who needs that 18-month transition to practice requirement. Again, if you're a CNRA or any of the other APRNs roles and not subject to that, then I will explain how it works for you in this context. So, a Maryland license, so let's say Maryland enacts the APRN compact today, a Maryland licensee with over 2080 hours of experience would obtain a multi-state license and have full practice authority, continue to have full practice authority in the state. So, again, this would be about ninety percent, if not over, that of the licensees who would meet that requirement on Day 1. If you're a new grad working within the compact you would obtain a single-state Maryland license. If you're an infectious nurse, and again this would only apply for them, and turn to a CPA, collaborative practice agreement, with a nurse practitioner or a physician. And after you obtain that 2080-hours, you would then be qualified to obtain a multi-state license. And that

multi-state license, upon that 2080-hours of experience grants you full practice authority in the state.

So, what does it look like for a new grad nurse practitioner without the compact in Maryland? You would obtain a single-state license, again entering into that collaborative practice agreement with the nurse practitioner or an M.D., and after 2080 hours, no change. You have to continue to be in that CPA until eighteen months. At the eighteen-month mark in Maryland that's when the transition to practice ends, and that's when the APRN has full practice authority. So, we can see that the timeline has shifted up for those practicing, of course, you know, full-time for a year that you would be eligible after essentially twelve months to obtain full practice authority under the compact versus under the current statutes in Maryland.

For the last one in the licensee working in other states today without the compact. So, this would be a new graduate who came with a single-state license, entered into that collaborative agreement with either a CNT or an M.D. After that 18-month period the transition to practice ends, and then that APRN is granted full practice authority. If they would like to practice in multiple jurisdictions that, kind of, anywhere in

this process they would have to obtain multiple licenses in those jurisdictions, and they would full practice authority in full practice jurisdictions, such as Delaware. They would have to hold the collaborative practice agreement in restrictive jurisdictions, such as, we'll say, Alabama. Under the compact though, the multi-state licensee would have full practice authority in their home state, which would be Maryland, as well as all the states party to the compact so there wouldn't be this mix-match of practice status across the state. As long as they are part of the compact, full practice authority will be had in all the jurisdictions that are party to the compact.

So, I will cover a little bit about the advocacy, especially the progress the APRN has had in the last year. So, this compact was adopted in August of 2020. So, we are just over a year after having this approved by NCSBN's delegate assembly, and we had our very first year of the COVID-19 legislative year to introduce the APRN compact, you know, the new APRN compact into state legislatures.

So, two APRN compact bills were introduced in 2021, and that was your neighbor Delaware, as well as North Dakota. Both of those were enacted into law with nearly unanimous

support. So, it's really great to see that happening. I also want to note, just real quick, that in Delaware in addition to the APRN compact bill, Delaware was able to file a companion bill to the compact, so the compact really spearheaded the ability for Delaware also introduce a companion, which removed the transition to practice, which is a 24-month transition to practice requirement in Delaware, as well as remove Board of Medicine oversight from APRNs who owned their own business. So, Delaware still had a couple of restrictions in place. They were able to use the APRN compact for their need for mobility that was definitely heightened by COVID. It made for greater access to care for patients, and to also help spearhead removal of some of these additional barriers in the state. So, that was incredibly great to see, and we are really encouraged by how the APRN compact was able to help facilitate that.

Also, importantly, there are seven state enactments needed for the compact to come into effect. So, right now there are two, so we need five more. We're anticipating more than five introductions in the 2022 legislative session. Now, again, I hate saying these types of things because we really don't know what the session will even look like with COVID, but we do,

right now, have interest from many states for introducing the APRN compact.

So, what is kind of the environment for the APRN compact as it gets introduced to the state legislature? So, we will start with nursing stakeholders. So, from the national level there's the American Organization of Nurse Leaders; National Associations of Neonatal Nurses; National League for Nursing; and the Oncology Nursing Association are just some of the national support that we have gotten so far. I should say that this list kind of changes on a weekly - or, on a monthly basis, rather, as we continue to educate and talk to stakeholders and offer education sessions like this to garner support for the APRN compact. We are really encouraged by that.

At the state level, and so these examples are from North Dakota, certainly; from Delaware, certainly; but also, from other states that we've been working with as we advocate for the APRN compact. We've seen support from state nursing associations; state organizations for nurse leaders; CNRA Association; Centers for Nursing; and nurse practitioner groups as well. And so, we see a broad level of support from the nursing community, which is really great.

Now, we will talk a little bit about nursing oppositions. So, the National Nursing Association has expressed at the time of adoption of the APRN compact, concerns an opposition to meet 2080 hours of practice requirement. The concern that they expressed is that this 2080-hour practice requirement is to attend to a TTP, transition to practice, which will encourage, they believe, restrictions for APRNs in those states that do not have transitions to practice. So, definitely that was a concern that was expressed and shared amongst these groups. And this was, again, prior to the 2021 legislative session when were able to see how the APRN compact was received in state. And the two things that we were able to gather, you know, I have evidence for moving the APRN compact forward, is that actually in Delaware the APRN compacts spurred the removal of additional barriers for APRNs, and that included the transition to practice. So, actually, their APRN compact didn't encourage to keep their transition to practice on the books, rather it helped them to remove it completely even though the APRN compact has that 2080-hour practice requirement. So, that was incredibly encouraging. And, of course, that bill also removed Board of Medicine oversight, which is incredibly

important as well. In North Dakota, we have a state that has a history of full independent practice, no transition to practice requirement, or any full roles for practicing for prescribing of both. And they did not have opposition recommending that suddenly a transition to practice be placed into North Dakota law and have North Dakota APRNs need to have a transition to practice period with a physician prior to practicing. So, we were encouraged again that the APRN compact, though it has a 2080-hour practice requirement, did not encourage the State Medical Society or lawmakers to think, 'Hmmm, the 2080-hour requirement, maybe we should adopt this and then add physician supervision into our existing APRN statutes.'

So, those were two really great examples, and I am surely glad that Delaware and North Dakota were the first two states to look at the APRN compact because it did allow us to get a lot of feedback, as well as validation, that the 2080-hour requirement was not going to be equated to a transition to practice, which requires supervision. And, in fact, in the case of Delaware, could be used as a motivator to remove more barriers in the state.

So, for other stakeholders, which are always very

important for getting an APRN bill passed, which I'm sure many stakeholders in Maryland know. We've also received national support from telehealth organizations, such as the Alliance for Connected Care, whose board members include; Amazon, CVS, Walmart, and others. We had direct support from Amazon in Delaware's bill; the American Telehealth Organization; Cross County Healthcare; and, of course, the National Military Family Association, as compacts are viewed as very favorable for military families to help promote mobility for military families.

For the state level support, we received state support from AARP with Delaware; and the North Dakota Hospital Association; Home and Community Care Association. You can see the list here. Many facilities came and spoke out. And, again, a lot of the conversation and the need for this did mention the COVID pandemic and people's experience with the difficulty in not being able to get practitioners quickly, and to be able to vet them and ensure that they have met basic requirements.

So, as Rebecca mentioned, there was physician opposition before, and shocking, there is physician opposition today. The 2015 and '18 APRN compact was opposed by the

American Society of Anesthesiologists. There was an AMA resolution and a stakeholder meeting to come up with plans and dedicate resources to opposing the APRN compact, and NCSBN did receive a letter in 2018 to change the compact. And it is important to note what the ask was, and many of you will not be surprised by this, but the ask of 2015 as well in 2020's APRN compact version, is to remove full practice authority from the APRN compact. Essentially, if the full practice authority was removed from the APRN compact, the APRN compact would essentially be waiving licensure fees, waiving renewal fees, but nothing more than that. They would still need to, quote/unquote, stop at every state border that has a restriction in place, the transition to practice in place, collaborative practice agreement in place, and enter into that agreement with the physician from that state in order to practice there. So, the APRN compact would essentially not enhance mobility as APRNs. It would be very cumbersome. And, of course, you know that collaborative practice agreements are not necessary for patient safety, and therefore the APRN compact needed to include full practice authority to ensure greater access to care for patients and for providers alike.

So, I will just touch on some resources. One resource, real quick, is APRNcompact.com. I know some of the materials were provided for the Board members today, a one-pager and a key resource document as well as the model language. You can access all of this on APRNcompact.com. There's an interactive legislative introduction and enactment map, so you can see kind of where we are with the APRN compact at any point during the session. And there's downloadable resources that you can access that I just mentioned. And also, the APRNcompact.com has a take action voter voice capability where you can send a pre-written customizable letter of support to lawmakers to show that you support Maryland joining the APRN compact, and you encourage organizations, facilities, and practitioners alike, and patients, to advocate for support through that means.

So, I put my email address on here. You are welcome, Rebecca, so you can buzz me. If you have any follow-up questions, we are always happy to answer them if something pops up after today. But we can take questions at this time. Thank you.

MS. DEVARIS: This is Shirley Devaris. I have some questions.

MS. LIVANOS: Yes, go ahead, Shirley.

MS. DEVARIS: Well, I think first of all, I just want to discuss what you call a collaborative agreement for a mentor for eighteen months of an M.D. in Maryland. It's really not a collaborative agreement. I worked on that legislation and duked it out with the Medical Society, and you're right, its opposition is strictly political. We were not needed otherwise. But we typically have to name a mentor in Maryland that we're going to collaborate with as needed. It's not an ongoing thing like, you know, every day or every week. You have an agreement on which you're going to collaborate for. So, just to clarify that, you should not be referring to it as an agreement, only naming a mentor that you will consult and collaborate with.

MS. LIVANOS: Thank you, Shirley.

MS. DEVARIS: So, you know, just be careful when you look at these. We got rid of the collaborative agreement in 2010, and I certainly don't want it called that again.

Anyway, I want to talk about qualifying for joining. We are now in the process, we have two APRN practices that we are going to introduce to legislation this year that will give them prescriptive authority. And it's my understanding that we

cannot use prescriptive authority unless a home state has granted it first; am I wrong?

MS. LIVANOS: I can answer that question. So, I think what you're referring to is whether or not an APRN that has a multi-state license can prescribe in a state that doesn't offer prescriptive authority. As Rebecca mentioned, non-controlled substances, the APRN compact does grant non-controlled substance prescribing for multi-state license holders. So, that is across the board, all multi-state license holders will be eligible to have non-controlled substance prescribing. However, if the state where the patient is located does not allow or restrict, in any way, controlled substance prescribing, that practice will need to follow the laws where the patient is located. So, for your example, if an APRN law in Maryland is not eligible to prescribe controlled substances in Maryland, no multi-state licensee that is practicing, and the patient is located in Maryland, will be able to prescribe substances to that patient until Maryland authorizes controlled substance prescribing. So, it's not a barrier for joining the APRN compact, it would just be a barrier until Maryland is able to change those laws. That's when practice will be impacted for

that multi-state licensee.

MS. DEVARIS: Okay. So, if for instance, right now our clinical nurse specialist cannot prescribe anything in Maryland. If the went to Delaware, they recognize them, if they were part of the compact, they could prescribe in Delaware even though they don't have prescriptive authority in Maryland?

MS. LIVANOS: Yes, and that would work just how it does today, Shirley. Those individuals can get a Delaware license, single state license today and they're eligible for the scope of practice that of a Delaware practitioner as long as they are treating a patient in Delaware.

MS. DEVARIS: All right. But what if both states were members of the compact? Let's assume that Maryland got in and we still haven't given prescriptive authority to clinical nurse specialist. Can they still prescribe in Delaware even though they're not allowed to prescribe here?

MS. LIVANOS: Yes, as long as Delaware - because they can follow Delaware's state laws for prescribing controlled substances. They would be eligible just as they would be today if they got that single state Delaware license to prescribe for patients in Delaware. They would not be able to prescribe

controlled substances for those patients who are in Maryland. So, their Maryland prescribing authority for controlled substances remains unchanged until Maryland changes their own laws.

MS. DEVARIS: Okay. And hopefully that will happen this year.

MS. GIBBONS-BAKER: Yes.

MS. DEVARIS: Thank you.

MS. LIVANOS: Thank you.

MS. EVANS: Are there any other questions?

MS. LANG: Just a comment. My name is Beverly Lang, and I'm the executive director for the Nurse Practitioner Association of Maryland. And while I agree with the concept of a licensure compact for APRNs, I'm not exactly sure I agree with the restrictions. And first and foremost, I was wondering - my question is, is there an APRN work group that is working with the National Counsel to adopt these regulations that you've just delineated? And if so, how many are on the board, and do all the specialty areas, are they all represented?

MS. EVANS: As I stated early, Bev, that after this presentation we would do a stakeholders meeting.

MS. LANG: I was asking that of them when they adopted the 2020 regulations.

MS. EVANS: For Maryland?

MS. LANG: No, for the National Counsel?

MS. LIVANOS: Yeah, so, in development of the 2020 APRN compact, NCSBN, who approved and adopted these contacts with the NLC laws, the APRN compact put together a committee and that committee consisted of NCSBN members which represented executive directors of boards of nursing, represented practice consultants. There were APRNs represented on that committee, as well, who were NSBN members. And the states that were represented were fully restrictive states, such as Texas; a fully independent state without a transition to practice, such as North Dakota; as well as a state that does have a transition to practice, Minnesota. Until we were able to get a wide variety of states, and these are regulatory issues, and so a wide variety of states that have different regulations in place for APRNs. There was a stakeholder meeting, I believe it was in November of 2019, that brought together APRN groups from across the country in order to discuss some of the recommendations that the committee was going to have and present to NCSBN.

Ultimately, the board of directors did agree, the NCSBN board of directors did agree to bring the APRN compact proposal to our NCSBN Delegate Assembly where, you know, all of our members which represent the boards of nursing and regulation across the country were able to debate and to ultimately approve the APRN compact draft today. So, there was a process that we went through for all of the versions of the APRN compact as well as the nurse licensure compact to get to where we were today.

MS. FOTSCH: If I could add, just as far as APRN representation on the commission. I'm sorry, I was having a little hard time hearing exactly all of your comments. But I think you were concerned about future regulations, future rules, and the impact on the profession. So, just to kind of clarify, again, the commission will be set up just like the NLC. Right now with the NLC every - the commission member is the head of the board of nursing. Sometimes that's an RN, sometimes it's not an RN, depending on who is the executive director. So, the rules of the commission are between the commission and the rules that come from the commission. They cannot affect any sort of kind of scope of practice or anything along those lines. That's why the experience requirements that's like a prescriptive

authority, it's all in the actual statute. The rules can only - they only speak to the implementation of the compact. So, they are procedural type of rules, not scope of practice rules. So, I think, you know, there is no - in the statute, there is no requirement for APRNs to be on the commission, just like there's no requirement in the NLC that RNs have to be on the commission. Because it is a regulatory issue and, you know, not a professional one.

So, that being said, there had been a lot of discussion that once the compact comes into existence that there may be - I mean, I would say, maybe - probably even likely be a committee, an APRN committee that will be composed of APRNs that could advise the commission on matters. That's certainly well within the commission's power to create and create a committee like that. I'm sure it would be very useful.

MS. LANG: Right. I also wanted to ask a question about the practice hours. All the literature that I've ever reviewed based the quality of the nurse practitioner's care on the graduation, which was the 500 hours of clinical time that they spend. So, all those quality measures, you're saying are not good enough, you have to have 2,080 more hours to prove

quality and effectiveness. Because, essentially, if we would adopt this in Maryland we are going backwards in time and making the NP have to practice before they can, you know, be a member of this compact. Whereas today, if a student graduates, they can get a dual license. They can get a license in Delaware; they can get a license in Maryland; they can get a license in any other state and practice across the lines.

So, I'm wondering, number one, where's the data that supports the 2,080 hours?

MS. LIVANOS: Yeah, so thank you for your question. The APRN compact does not speak to, you know, any supervisory relationship required with the physician. And so, it does not say and in no way express that 2080-hours of practice is required for an APRN to be safe. Quite the contrary, the APRN compact, itself, says that multi-state licensees should be able to practice in the compact with sole independent practice. So, it codifies the consensus model right in the language itself.

As Rebecca mentioned, what we were looking at was the policy environment for states, such as Maryland's, and I know that the collaborative practice agreement may be required in Maryland, but there is an 18-month period for nurse

practitioners where you do have to have that mentorship and you do have to have a physician or a nurse practitioner's name associated with your practice. The APRN compact will actually supersede that. And so, once an NP is able to have a multi-state license, they no longer are subject to any of those restrictions.

I also want to comment that when it's mentioned that an APRN, you know, today can get a single state license in Maryland and then in Delaware and then in Virginia, that continues to be the case. The APRN contact does not prevent an APRN from getting a single state license in all fifty states, if that's what they wish. We believe they are safe and independent providers from the moment they graduate and are certified by a national certifying body, and NCSBN is one of the authors that we know of, of these consensus model, and so that is the policy that we stand behind. The reason for the 2080-hour experience requirement was because of the current legislative environment and the necessity to get an APRN compact off the ground for more mobility for APRNs. It is a policy of practical solution. It is not claiming that there is any sort of need for an APRN to have more experience in order to be safe. The Maryland Board of

Nursing is the enforcer or licensure in Maryland and determines when an APRN is eligible to have a single state license, and therefore practice out in the community and treat patients safely.

MS. LANG: My other comment has to do with online clinical sites that are in close proximity and functioning in Maryland. And I think it's interesting that this morning as I came in, on talk radio there's a lot of going on about the nursing shortage. And, of course, that affects APRNs as well. So, I think an unintended consequence of this compact could be that clinical sites will be swallowed by all those who are members of APRN compacts, and our brick-and-mortar schools here located in Maryland, who we should really be an advocate for, they will be drying up. And we have trouble finding clinical sites today for all of our APRNs who are graduating from our schools of nursing. So, that was another point that I wanted to bring out as just something that I thought of as an unintended consequence.

MS. LIVANOS: I may not be understanding correctly exactly what would be drying up in Maryland if they join the APRN compact. The APRN compact does not impact education

programs or clinical sites whatsoever. You're not eligible for a multi-state license until you are a licensed APRN with, again, 2080 hours of experience and you meet all of the other requirements that mirror the consensus model.

MS. LANG: But clinical faculty who are teaching across state lines and have clinical students in Maryland and Delaware and North Carolina and South Carolina, they would be putting more students in the clinical sites that are currently available. That's my comment on academia. And also, I think it's interesting that - I have in my hand and I will share it with the Board here, a position statement from the American Association of Nurse Practitioners, which oppose. They do not endorse the multi-state licensure compact as it is written today. And also, I have a letter from the American Association of Nurse Anesthetists, who are against it. And I find that curious that the largest nurse practitioner association in the nation, having over 325,000 members, is against this.

MS. LIVANOS: Yeah, and we had covered that in the presentation. I apologize if you didn't see that. But the organizations did express oppositions when the NCSBN Delegate Assembly was considering adoption of the APRN compact in August

of 2020. Since then, as I mentioned, we've been encouraging states and the association, as well as the CNRA Association and others have supported the legislation. We understand and we have responded to ANPNA and had many conversations with them about the 2080 hours, which is their main concern, and we have had conversations about why that was necessary for the APRN compact, and why we believe it's actually more necessary today in order to get the APRN compact off the ground in an environment like COVID that's exposed so many vulnerabilities and complications in the system for APRNs.

MS. LANG: Thank you.

MS. BRASSARD: This is Andrea Brassard. I'm going to say that if we so the compact that it will difficult for me because I'm a rare exception. It would be an M.D. after my Ph.D., and I have never practiced full-time. The most I've ever practiced, because I've been in policy, is one day a week. I think I will be able to scrape up the 2080 hours in case I want to move from Maryland. My professional career for the past ten years has been advocacy. And this is a political compact that at AANP, when we supported different states with transition to practice, we held our noses and we went with it. And I - the

only thing that this will do is, it will make it difficult for a new APRN to move. In the long run, the compact, I believe, will help states like New Jersey. So, Bev, I am going to go on record because of the statement here going against AANP, and ask MCAN to be filing on this. I think this make political sense. I am very happy to hear what happened in Delaware, and I think this would really, really help some of the other states. Even though this is going to be tough for me. Because I just looked in my file cabinet, do I have a tray of records from when I was a volunteer in New Jersey, and I think I do, to scrape together the 2,800 hours. This is making NPs and other APRNs mobile. Thank you for listening.

MS. DEVARIS: I have a comment on that last caller. You are practicing nursing, and it does not require clinical in the compact. I, too, was in administration. I was not doing clinicals in the last twenty years, but I was still practicing nursing and it still requires you to have a nursing license. It's part of your job. You're practicing nursing.

MS. LIVANOS: If I could just comment on one thing that Andrea said about for new grads making it more difficult for them. The APRN compact, actually, for those new grads that

have less than 2080 hours of experience, or anybody, I should just say new grads. Those who have less than 2080 hours of experience, the system for them getting multi licenses across states and practicing state lines is exactly the same as it is today. So, the compact isn't adding any sort of layer of difficulty for them. It's actually going to be the status quo of what it is today until they can get that 2080-hours of practice experience, and then they get the benefit of the multi-state license and full practice authority being able to practice across state lines. I just wanted to clarify that. But thank you, Andrea, for your comments.

MS. FOTSCH: There has also been some comments about this could set things back. There really is no setting back because it would just be what status quo. So, there's no change for a new grad for what they go through today. And as Nicole had pointed out, all it is, is an added benefit for ninety percent of your licensees if they choose to pursue a multi-state license. So, there's no more additional difficulty, there's no setting back. It's really just moving forward if your licensees choose to.

MR. RAYMOND: All right. Rebecca and Nicole, thank

you for bringing this topic to the Board. I want to thank everyone for their comments.

MR. COX: Hello, my name is Christopher Cox. I just have a comment to make. Can you hear me?

MR. RAYMOND: The Board isn't taking a position on this today. We're going to continue to study this issue. We are not taking a position on this topic today. I think there is a whole lot more that we need to study. I will allow one more comment, and then we're going to close this topic. Go ahead.

MR. COX: So, my name is Christopher Cox. I was in there a little earlier. I think the more practical approach would be what actually is out there in the data. Where it shows that APRNs have actually improved affordability, access, and quality of care. So, instead of adding stuff that really isn't data driven, we should actually follow what we are telling schools and use that data that's actually there. That's all I have to say.

MS. LIVANOS: Thank you. And I think that - yeah, thanks.

MR. RAYMOND: You can respond to that. Go ahead.

MS. FOTSCH: I was just going to mention that the

evidence-based data that APRNs don't need proficiency supervision. It's codified in the APRN compact for multi-state licensees, and that's been something NCSBN has supported since the consensus came out in 2008. I would say that the data that we were looking at in order to get an APRN compact off the ground was the prevalence of the TTP hours or the mentorship hours, such that Maryland has, and we made it to make a political compromise for this legislation. I mean, this is legislation that needs to be enacted by state lawmakers and signed by governors. So, that was the evidence that we were considering when looking towards creating a policy solution.

MR. RAYMOND: All right. Thank you, Rebecca, and thank you, Nicole. And really a big thank you to everyone who was aboard to make comments and provide their thoughts regarding this topic.

That completes the agenda. In a moment I'm asking to ask if there's a motion to close the Open Session, but first I am going to walk us through the written statement that is required by the Open Meetings Act to ensure that all board members agree with its contents.

As documented in the written statement, the

statutory authority to close this Open Session and meet in Closed Session is General Provision 3-305(b)13, which gives the Board the authority to close an Open Session, to comply with the specific statutory requirements that prevents public disclosure about a particular matter or proceeding. The topic to be discussed during the Closed Session is applications for licensure and/or certification. The reason for discussing this topic in Closed Session is to discuss confidential matters that are prohibited from public disclosure by the Annotated Code of Maryland, Health Occupations Article, Sections 8-303(f), 8-320(a), and 1-401, and General Provisions Article, Section 4-333. In addition, the Board may also perform Quasi Judicial and administrative functions involving disciplinary matters during the Closed Session.

Is there a motion to close this Open Session pursuant to the statutory authority and the reasons cited in the written statement, or any discussions thereof?

MS. ROBIN HILL: So moved, Dr. Robin Hill.

MR. RAYMOND: A motion from Dr. Robin Hill.

MS. CASSIDY: Second, Cassidy.

MR. RAYMOND: A second from Cassidy. All those in

favor?

ALL: Aye.

MR. RAYMOND: Any opposed?

(No oppositions)

MR. HICKS: Motion carries. We will move out of Open Session and go into Closed Session. We will take a 10-minute break as we move to the Closed Session. Thank you, everyone. Please come back at 11:25.

(Whereupon, at 11:14 a.m. the Open Session was concluded.)

CERTIFICATE OF NOTARY

I, EDWARD BULLOCK, a Notary Public of the State of Maryland, do hereby certify that the proceedings were recorded via audio by me and that this transcript is a true record of the proceedings. I am not responsible for inaudible portions of the proceedings.

I further certify I am not of counsel to any of the parties, nor an employee of counsel, nor related to any of the parties, nor in any way interested in the outcome of this action as witness my hand and notarial seal this 22nd day of September, 2021.

_____

Edward Bullock, Notary Public
in and for the State of Maryland

My commission expires: May, 13, 2023

Script for Closing Open Session
September 2021

In a moment, I am going to ask if there is a motion to close the open session, but first I am going to walk us through the written statement that is required by the Open Meetings Act to ensure that all Board members agree with its contents.

As documented in the written statement, the statutory authority to close this open session and meet in closed session is General Provisions **§ 3-305(b)(13)**, which gives the Board the authority to close an open session to comply with a specific statutory requirement that prevents public disclosure about a particular mater or proceeding. The topic to be discussed during closed session is applications for licensure and/or certification. The reason for discussing this topic in closed session is to discuss confidential matters that are prohibited from public disclosure by the Annotated Code of Maryland, Health Occupations Article, sections 8-303(f), 8-320(a), and 1-401 *et seq*., and General Provisions Article section 4-333. In addition, the Board may also perform quasi-judicial and administrative functions involving disciplinary matters during the closed session.

Is there a motion to close this open session pursuant to the statutory authority and reasons cited in the written statement or any discussion thereof?

MARYLAND BOARD OF NURSING

Presiding Officer's Written Statement for Closing a Meeting under the Open Meetings Act (General Provisions Article § 3-305)

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1. **Recorded vote to close the meeting:** Date: 9/22/2021 Time: 11:15 am
Location: 4140 Patterson Avenue, Baltimore, MD; Conference Call Line
Motion to close meeting made by: R. Hill Seconded by Cassidy
Members in favor: Polk, Nuestadt, Gibbons-Baker, Hayward, Steele, Owoyemana, J. Hill, R. Hill, Cassidy, Raymond, Vickers, Turner
Opposed: None Abstaining: None
Absent: Hicks, Dillon, ~~Redacted~~

2. **Statutory authority to close session.** This meeting will be closed under General Provisions § 3-305(b) only:

(1)___"To discuss the appointment, employment, assignment, promotion, discipline, demotion, compensation, removal, resignation, or performance evaluation of appointees, employees, or officials over whom this public body has jurisdiction; any other personnel matter that affects one or more specific individuals"; **(2)**___ "To protect the privacy or reputation of individuals concerning a matter not related to public business"; **(3)**___ "To consider the acquisition of real property for a public purpose and matters directly related thereto"; **(4)**___ "To consider a matter that concerns the proposal for a business or industrial organization to locate, expand, or remain in the State"; **(5)**___ "To consider the investment of public funds"; **(6)**___ "To consider the marketing of public securities"; **(7)**___ "To consult with counsel to obtain legal advice"; **(8)**___ "To consult with staff, consultants, or other individuals about pending or potential litigation"; **(9)**___ "To conduct collective bargaining negotiations or consider matters that relate to the negotiations"; **(10)**___ "To discuss public security, if the public body determines that public discussion would constitute a risk to the public or to public security, including: (i) the deployment of fire and police services and staff; and (ii) the development and implementation of emergency plans"; **(11)**___ "To prepare, administer, or grade a scholastic, licensing, or qualifying examination"; **(12)**___ "To conduct or discuss an investigative proceeding on actual or possible criminal conduct"; **(13)**__X__ "To comply with a specific constitutional, statutory, or judicially imposed requirement that prevents public disclosures about a particular proceeding or matter"; **(14)**___ "Before a contract is awarded or bids are opened, to discuss a matter directly related to a negotiating strategy or the contents of a bid or proposal, if public discussion or disclosure would adversely impact the ability of the public body to participate in the competitive bidding or proposal process." **(15)**___ "To discuss cybersecurity, if the public body determines that public discussion would constitute a risk to: (i) security assessments or deployments relating to information resources technology; (ii) network security information . . . or (iii) deployments or implementation of security personnel, critical infrastructure, or security devices."

3. For each provision checked above, disclosure of the topic to be discussed and the Maryland Board of Nursing's reason for discussing that topic in closed session.

Citation	Topic	Reason for closed-session discussion of topic
§ 3-305(b) (**13**)	Applicants for Licensure/Certification	To discuss confidential information that is prohibited from public disclosure pursuant to Md. Code Ann., Health Occ. §§ 8-303(f), 8-320(a), and 1-401 *et seq.*, and Gen. Prov. § 4-333.
§ 3-305(b) ( )		
§ 3-305(b) ( )		

NOTE: During the Closed Session, the Maryland Board of Nursing may also perform quasi-judicial and administrative functions involving disciplinary matters.

4. This statement is made or adopted by _____, Presiding Officer, Maryland Board of Nursing.