VERMONT SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
OBSTACLES TO RECRUITMENT AND RETENTION OF QUALIFIED NURSE EDUCATORS

This report evaluates the appropriateness of applicable standards for nurse educators in Vermont nurse education programs. It finds that the Vermont Board of Nursing, like peer boards throughout the United States, has codified rules calling for universal master's-level preparation that are incompatible with graduate attainment within the population of registered nurses. Unrealistic regulations may have the perverse effect of diminishing program quality by eliminating selective hiring and provoking irrational allocation of program resources. We recommend that the Board manage program quality by relying less upon the direct prescription of degree requirements and more upon the robust evaluative criteria applied and assessed by national accrediting bodies.

The State must ensure that Vermont's nurse education programs are optimally equipped to prepare the next generation of registered nurses (RNs) and licensed practical nurses (LPNs) to meet growing labor-market demand. Vermont nurse education programs, however, report difficulty attracting and retaining nurse educators, particularly *clinical* nurse educators—those who introduce students to real-world practice.

Throughout 2019, the Vermont Talent Pipeline Management[1] and several Vermont nurse education programs prevailed upon the Vermont Board of Nursing to adopt a waiver policy relaxing regulatory standards respecting the educational qualifications of clinical nurse educators. Castleton University proposed that a short clinical-educator orientation course might provide a suitable alternative to requiring that all clinical nurse educators hold graduate degrees or be enrolled in graduate studies. The Board considered and rejected these requests, provoking stakeholders to request legislative review of the Board's regulatory standards.

Hoping to better understand the challenges confronting Vermont's nursing programs, the General Assembly has directed the Office of Professional Regulation (OPR) as follows:

> *(a) The Office of Professional Regulation, in consultation with the Vermont Board of Nursing, Vermont State Colleges, the University of Vermont, Norwich University, and other interested stakeholders, shall review statutory, regulatory, and accreditation standards for nursing programs within the State and nationally with the purpose of identifying barriers to recruitment and retention of nurse educators in nursing education programs.*
>
> *(b) The Office of Professional Regulation shall evaluate the appropriateness of the level of credential and experience currently required for nurse educators in clinical settings.*

[1] Vermont Talent Pipeline Management (VTPM) is an employer collaborative integrated within the Agency of Commerce and Community Development. See https://accd.vermont.gov/economic-development/programs/vtpm.

> *(c) On or before December 15, 2019, the Office of Professional Regulation shall report its findings, including recommendations for any statutory or regulatory changes, or economic development initiatives, to facilitate recruitment and retention of nurse faculty, to the House Committees on Commerce and Economic Development and on Government Operations and to the Senate Committees on Economic Development, Housing and General Affairs and on Government Operations.*
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> *- 2019, No. 80, § 8.*

I. Stakeholder Outreach

This assessment benefitted from the extraordinary insight, intelligence, and generosity of the State's nurse leaders. The Office noticed and convened two stakeholder meetings at the Office of Professional Regulation in Montpelier, one October 28th, the other November 6th, and both available by webcast to participants who could not travel to the capital. Among more than twenty participants were chief nursing officers from the State's hospitals, college deans, directors from the State's four nursing programs, representatives of Vermont hospitals and clinics, and members of the Vermont Board of Nursing, including its Chair. OPR's Executive Officer for Nursing and Senior Policy Analyst investigated the experiences of executive nursing officers in other states and benefitted from the excellent research library maintained by the National Council of State Boards of Nursing. All four Vermont program directors generously submitted to individual telephone interviews and spoke candidly and at length about the challenges confronting them. Some participants feel very strongly about preserving regulatory requirements. A significant majority, however, found existing regulations insufficiently flexible and recommended reforms.

II. Statutory Basis of Board of Nursing Regulation Oversight of Education Programs

Each conventional, State-licensed profession is an artifact of Title 26 of the Vermont Statutes Annotated, wherein each distinct licensing program is assigned a chapter. Nursing is governed by chapter 28 (26 V.S.A. § 1571 *et seq*. (popularly, the "Nurse Practice Act")). In most respects, chapter 28 resembles its Title-26 counterparts: it defines the marketplace activity to be regulated (*id.* § 1572(2)); creates a board to oversee the regulation (*id.* § 1573); defines various categories of licensure by title and essential characteristics; and empowers the board having jurisdiction to make administrative rules fleshing out details (*id.* § 1574). But the Nurse Practice Act is dissimilar to other professional-regulation chapters in two important respects, both related to education.

First, by prohibiting any person, corporation, or association from "conduct[ing] a nursing education program unless the program has been approved by the Board," the Act establishes direct Board oversight of preparatory programs. 26 V.S.A. § 1584(6). The Board is expressly empowered to "Adopt rules setting standards for approval of … nursing education programs in Vermont, including all clinical facilities," to "require reimbursement for actual and necessary costs incurred for site surveys," and to "deny or withdraw approval or take lesser action" as necessary to enforce compliance with standards. 26 V.S.A. § 1574(a)(3).

One will find nothing like this in chapters governing dentistry, physical therapy, pharmacy, or engineering. To be sure, those chapters and their derivative regulations define acceptable degrees, usually in relation to recognized accreditors, but none operates like the nursing chapter, which places

the Board of Nursing squarely in charge of issuing permission for, and standards applicable to, any preparatory program operating within the State's borders. The Board, in other words, performs tasks more commonly assigned to a non-governmental accreditor.

Second, the Act defines "[t]eaching the theory and practice of nursing" as one of the express forms of "[r]egistered nursing," meaning one must be a Vermont-licensed RN to teach in a nursing program within the borders of the State, even if the teaching occurs in a lecture hall and never involves a patient. 26 V.S.A. § 1572(2)(J). This characteristic is unique as well. One may teach the principles of engineering at a Vermont engineering college without being a professional engineer. Vermont nursing faculty, however, not only must be licensed somewhere, but must be licensed here.

The uncommon statutory role of American boards of nursing in directly regulating nurse education programs and their faculty is efficiently explained by the profession's history and nature.[2]

With regard to history, early RN programs were run by hospitals as necessary to train nurse employees in a world where substantial elements of the degree-granting higher-education system were unwelcoming to women. Absent the structure of a college or university with an established system of deans, faculty, and curriculum development, it would have been rational and necessary for licensing authorities to assume a prominent role in oversight of the curricular content and instruction predicate to licensure or certification, simulating a college for lack of one. Improvements in gender equity in higher education ushered nurse education programs out of the hands of employers[3] and into the broader college and university system. Today, accrediting bodies operate in nursing as in other health-science degree programs, but boards of nursing have not fully receded from the scene.

With regard to the nature of practice, nurse education necessarily involves hands-on patient care and therefore the actual doing of the licensed activity by the instructor. In that context, licensure is not an unreasonable expectation. As didactic and clinical instruction became more sharply distinguished with institutionalization in the university system, didactic instruction, where the obligation to hold a practitioner's license would appear less necessary, simply was not distinguished in law. Thus do boards of nursing throughout the United States maintain a more active legal and practical presence in professional education than is typical among credentialing authorities, up to and including deciding who may teach theory in a lecture hall and what specific populations within the larger universe of already-licensed RNs may provide clinical instruction to a nursing student.

III. The Board's Regulatory Requirements

Having surveyed the statutory origins of board authority over nursing education programs, we turn to the particular requirements applied by the Vermont Board. Pursuant to the Administrative Rules of the Board of Nursing (ARBN), CVR 04-030-170, the Board works through an Executive Director who "surveys nursing education programs to determine approval status." ARBN § 1.17(d).

As elsewhere in the United States, the Board recognizes and relies upon accreditation, but remains a shadow accreditor. The Board conducts site visits prior to program approval and as it deems necessary

[2] Or, in a dimmer view, patriarchy and the economic self-interest of last century's hospitals.

[3] In general, an employer will prefer that an employee train for work on his own dime. In one telling, incorporation of nursing education into the world of baccalaureate and graduate degrees looks like social progress, and is. In another, it looks like a transfer of preparatory costs from employers to employees.

thereafter. ARBN § 4.3. "Nursing education programs shall be conducted in an accredited state-approved school. Accreditation may be by the New England Association of Colleges and Secondary Schools or another accrediting body recognized by the Board." ARBN § 4.1(c). Furthermore, with the adoption of its current Rules, in January 2015, the Board set a deadline by which programs must attain national accreditation: "Effective July 1, 2020 all Vermont pre-licensure nursing education programs must be accredited by a national nursing accreditation organization approved by the Board." ARBN § 4.1(d). The approval and review criteria set out in § 4.6, which do not sunset in any respect upon the July 1, 2020 achievement of universal national accreditation, include evaluation of a statement of mission and purpose, curriculum, policies, outcomes, program-administrator qualifications, organizational structure, faculty qualifications, feasibility, facilities, and financial resources—the things that would interest an accreditor.

The heart of Vermont's regulatory requirements for nurse educators is ARBN §§ 4.20-25:

> *Section 4.20 Nursing Program Faculty.*
> *As used in this Part "nursing faculty" means nurses hired to teach in any capacity in a Vermont nursing education program.*
>
> *(a) Nursing faculty must be sufficient in number and expertise to achieve the program outcomes.*
>
> *(b) Nursing faculty shall hold a current unencumbered license to practice as a registered nurse in Vermont.*
>
> *Section 4.21 Faculty Employment Descriptions and Personnel Policies.*
>
> *(a) Each program shall have an employment description for each faculty position. The employment description must clearly identify teaching responsibilities, scholarship responsibilities, service expectations, and nursing practice requirements.*
>
> *(b) Each program shall have written faculty personnel policies.*
>
> *Section 4.22 Faculty, Graduate Degree Programs.*
>
> *(a) A graduate degree nursing education program shall have a majority of faculty holding earned doctorates from accredited institutions.*
>
> *(b) All faculty must possess a master's degree or greater in nursing.*
>
> *Section 4.23 Faculty, Bachelor and Associate Degree Programs.*
>
> *(a) The nurse faculty of baccalaureate and associate degree nursing education programs who teach theory must hold a master's degree or greater in nursing or a related field approved by the Board and clinical experience relevant to the areas of instruction.*
>
> ***(b) Nursing clinical instructors must hold:***
>
> ***(1) a master's degree in nursing; or***
>
> ***(2) a bachelor's degree in nursing and a graduate degree in a related field approved by the Board; or***
>
> ***(3) a bachelor's degree in nursing and be enrolled in a graduate program in nursing or a related field approved by the Board which must be completed within 3 years of initial faculty appointment; and***
>
> ***(4) have clinical experience relevant to the areas of instruction.***
>
> *Section 4.24 Faculty, Practical Nursing Programs.*
>
> *(a) The nurse faculty of practical nursing education programs who teach theory must have at least a bachelor's degree with a major in nursing and clinical experience relevant to the areas of instruction;*

> *(b) Nursing clinical instructors must hold, at a minimum, a bachelor's degree with a major in nursing and clinical experience relevant to the areas of instruction.*
>
> *Section 4.25 Faculty from Other Disciplines, All Programs.*
> *Faculty from other academic disciplines who teach theory courses shall have advanced academic preparation appropriate to the area of instruction. They are not required to hold a nursing degree.*

Though each category of faculty requirements is relevant to "identifying barriers to recruitment and retention of nurse educators in nursing education programs," the General Assembly has called specifically for assessment of "the appropriateness of the level of credential and experience currently required for nurse educators in clinical settings"[4] —the requirements codified in § 4.23(b) and set off in bold above. Its substantive import is simple: To teach nursing students in a clinical setting, an RN must himself be at least enrolled in a master's-level (MSN) nursing education program, and must finish it within three years. If there is a regulatory pebble in the shoe of Vermont's nursing programs, it is that one, which has provoked three of the State's four nursing programs to request a waiver to hire clinical faculty ineligible under the rule.[5]

Board rules have been updated three times in the past fifteen years: in 2004, 2011, and 2015. Concern about the § 4.23(b) master's-enrollment requirement has come to a head relatively recently, but problems were not unanticipated when the master's requirement was implemented in 2004. At the time, the *status quo* requirement of nursing faculty was that a bare majority have a master's degree. It is not clear that participants in the 2004 rulemaking grasped how ambitious was their effort to achieve universal master's preparation among faculty.

Although education stakeholders involved in the 2004 rulemaking process—viz., the University of Vermont, Norwich University, Southern Vermont College,[6] Vermont Technical College, and Castleton—at the time supported a straight master's requirement for faculty, the Vermont Department of Health and the Vermont Organization of Nurse Leaders expressed concern about the requirement's rigidity. In response to those concerns, the 2004 rule was modified to embrace not only MSN degrees, but also graduate degrees in "nursing-related" fields. Today's § 4.23(b)(3) represents a further concession to supply limitations, allowing mere enrollment in a master's program to stand in for completion. In other words, subparts (b)(2)[7] and (b)(3)[8] represent sequential historical concessions to the difficulty of achieving the original, 2004 goal of universal MSN preparation among faculty, including clinical instructors. In this sense, the Board has not been obdurate in response to stakeholder input so much as it has been reluctantly backing away from a fifteen-year-old nonstarter.[9]

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[4] See Act 80, excerpted at p.1, *supra*.
[5] Of the three requests, two were denied, and one was granted for the pending semester only.
[6] Southern Vermont College has since closed. Some of its nursing students were absorbed by Castleton University.
[7] Permitting related-field degrees.
[8] Accepting enrollment in an MSN program in lieu of the accomplished degree.
[9] We will discuss, *infra*., how Vermont's experience is a microcosm of a national, even global effort to leverage licensing and program requirements to promote graduate nursing education. The Vermont Board was not out of step with its peers in 2004. Jurisdictions throughout the United States made similar attempts, encountered similar problems, and quietly made similar concessions to the employment market.

IV. Accreditation Standards

ARBN § 4.1(d) requires that programs attain national accreditation by July 1, 2020. The "national nursing accreditation organization[s] approved by the Board" (ARBN § 4.1(d) are the Commission on Collegiate Nursing Education (CCNE), the National League for Nursing's (NLN) Commission on Nursing Education Accreditation (CNEA), and the Accreditation Commission for Education in Nursing (ACEN).

CCNE's *Standards for Accreditation of Baccalaureate and Graduate Nursing Programs*[10] set out faculty requirements in terms consistent with, but considerably more flexible than, those in Vermont's Administrative Code:

> *Faculty are:*
> *• sufficient in number to accomplish the mission, goals, and expected program outcomes;*
> *• academically prepared for the areas in which they teach; and*
> *• experientially prepared for the areas in which they teach.*
>
> *Elaboration: The faculty (full-time, part-time, adjunct, tenured, non-tenured, or other) for each degree and post-graduate APRN certificate program are sufficient in number and qualifications to achieve the mission, goals, and expected program outcomes. The program defines faculty workloads. Faculty-to-student ratios provide adequate supervision and evaluation and meet or exceed the requirements of regulatory agencies and professional nursing standards and guidelines. Faculty are academically prepared for the areas in which they teach. Academic preparation of faculty includes degree specialization, specialty coursework, or other preparation sufficient to address the major concepts included in courses they teach.* ***Faculty teaching in the nursing program have a graduate degree. The program provides a justification for the use of any faculty who do not have a graduate degree.***
> *Faculty who are nurses hold current RN licensure.* ***Faculty teaching in clinical/practicum courses are experienced in the clinical area of the course and maintain clinical expertise. Clinical expertise may be maintained through clinical practice or other avenues.*** *Faculty teaching in advanced practice clinical courses meet certification and practice requirements as specified by the relevant regulatory and specialty bodies. Advanced practice nursing tracks are directly overseen by faculty who are nationally certified in that same population-focused area of practice in roles for which national certification is available.*
>
> --CCNE Standard II-E (emphasis added).

The CNEA *Accreditation Standards for Nursing Education Programs* take an even more flexible approach, recognizing that an "appropriate faculty complement" will be "dependent upon the institution's mission … and thus will vary amongst institutions and programs.":

> *Well-prepared faculty are essential to fostering quality learning experiences in academic programs, as it is the faculty's expertise and creativity that determine the program's potential for creating excellence in the learning environment (Halstead, 2009). Defining the appropriate faculty complement (i.e., teachers, clinicians, and researchers) for a nursing program is dependent upon the institution's mission (NLN, 2004), and thus will vary amongst institutions and programs. To maintain competence as a nurse educator,* ***faculty pursue continuous quality improvement in the role and commit to lifelong learning (NLN, 2005, 2012). Faculty are provided with opportunities***

[10] As amended in 2018; available at: https://www.aacnnursing.org/Portals/42/CCNE/PDF/Standards-Final-2018.pdf.

> ***and resources by the institution and program to engage in professional development and maintain role effectiveness.***
>
> --NLN CNEA Standard III: Culture of Excellence and Caring -- Faculty (emphasis added).[11]

CNEA interpretive guidelines illustrate the feedback effect between board-based program standards and accreditation standards, calling for faculty who "at a minimum, meet qualifications set forth by state and other relevant regulatory agencies and professional nursing organizations."[12] Under CNEA guidelines, universal graduate credentialing of program faculty remains an express goal, and programs are obligated to "develop and implement policies regarding the academic degree qualifications of faculty"; however, the aspiration is stated as such, rather than as a fixed requirement:

> **… All program types are expected to continually strive to employ full and part-time faculty who hold a graduate degree in nursing or a field related to their teaching responsibilities.*
> ** Programs that employ faculty without the graduate degree credential design and implement organizational development plans with a goal of demonstrating trending progression toward achieving a full complement of faculty who are prepared at the graduate level.*
> ** The majority of faculty who do not hold a graduate degree document evidence of active and steady progression toward achieving a graduate degree in nursing or a related field within a defined timeline.*
>
> --NLN CNEA Standards, Interpretive Guidelines, p. 17.

By contrast with Board Rule 4.23(b), which requires matriculation in a master's program as a fixed prerequisite to service as a clinical instructor, CNEA Interpretive Guidelines accept that active pursuit of a graduate degree will not be universal among qualified faculty. "The majority of faculty who do not hold a graduate degree" should be in active pursuit of one, but not all.

Finally, the *ACEN 2017 Accreditation Manual, 2nd Ed (2019)*[13] sets out requirements for baccalaureate faculty and staff, requiring that "[t]he nursing education unit is administered by a nurse who holds a graduate degree with a major in nursing and is doctorally prepared." *Id*., p. 22 of 33 (numbered Baccalaureate -1-). Like its counterpart accreditors, ACEN incorporates "state requirements" as applicable, but does not impose any independent degree minimums on individual instructors.

Readers are encouraged to skim the full CCNE, CNEA, and ACEN standards linked in the footnotes, and then to compare those to the shorter and more rigid requirements embodied in ARBN §§ 4.20-25.[14] While accreditation standards clearly are more flexible than anything a regulatory board might create and enforce, they are also much more detailed, and few would find them less rigorous. Because accreditors are more specialized and better resourced to undertake global assessments of quality, they can monitor educational quality without resort to the rigid proxies and absolutism necessary when the task is attempted by a governmental body whose primary focus is monitoring the qualifications and conduct of individual licensees.

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[11] Approved February 2016; available at: http://www.nln.org/docs/default-source/accreditation-services/cnea-standards-final-february-201613f2bf5c78366c709642ff00005f0421.pdf?sfvrsn=12.
[12] Id., p. 16
[13] Available at: http://www.acenursing.net/manuals/SC2017.pdf.
[14] Excerpted at p. 3, *supra*.

V. Appropriateness of Credential and Experience Requirements for Clinical Educators

To determine the "appropriateness" of credential and experience requirements set out by the statutes, rules, and accreditation standards described above, one must identify a benchmark. Ours is found in Title 26, chapter 57 (26 V.S.A. § 3101 *et seq*.), Vermont's statutory policy on the legitimate purposes of occupational and professional licensing.

> *It is the policy of the State of Vermont that regulation be imposed upon a profession or occupation solely for the purpose of protecting the public. The General Assembly believes that all individuals should be permitted to enter into a profession or occupation unless there is a demonstrated need for the State to protect the interests of the public by restricting entry into the profession or occupation …*
> *If such a need is identified, the form of regulation adopted by the State shall be the least restrictive form of regulation necessary to protect the public interest. If regulation is imposed, the profession or occupation may be subject to review by the Office of Professional Regulation and the General Assembly to ensure the continuing need for and appropriateness of such regulation.*
> --26 V.S.A. § 3101.

Appropriateness is therefore synonymous with fitness to the underlying protective purpose of licensing registered nurses, or in the case of educator requirements, dictating who may be one. We consider, among other express criteria, "the extent to which a regulatory entity's actions have been in the public interest and consistent with legislative intent," "the extent to which the scope of the existing regulatory scheme for the profession is commensurate to the risk of harm to the public," and "the extent to which the profession's education, training, and examination requirements for a license or certification are consistent with the public interest," and "the extent to which a regulatory entity has sought ideas from the public and from those it regulates, concerning reasonable ways to improve the service of the entity and the profession or occupation regulated." *Id*. § 3104.

a. Statutory Requirements

The statutory requirements for nurse educators are sufficiently spartan that it would be impossible to call them inappropriate. Vermont statutes defer all particulars to the Board of Nursing through several grants of rulemaking authority. To the extent the Nurse Practice Act might be improved, an improvement would come in the form of a clear articulation of the Board's mission and purpose vis-à-vis education programs. Vermont nurse education programs have handily beaten the FY2021 deadline for national accreditation. All four have long been nationally accredited. If the Board is to remain in the field at all—and we will argue that it should—its authority and purpose for being there should be more crisply defined in law.

b. Accreditation Standards

Accreditation requirements imposed by CCNE, CNEA, and ACEN are similarly reasonable. They reflect a national consensus, of consistent application across the states, as to the essential elements of nurse education genuinely necessary to ensure the educational preparation of nursing graduates to practice competently. The requirements are notably more detailed and holistic than their regulatory counterparts, approaching quality and continuous improvement from multiple perspectives, and reaching beyond curriculum and degrees to inquire into programmatic elements beyond the sight of government regulators, such as institutional learning culture, diversity, and student voice in governance.

National accreditation by CCNE, CNEA, or ACEN does not mean that the State can wash its hands entirely of program monitoring. An accreditor visits programs infrequently, and much can go wrong between visits. And as just as accreditors must hold education programs accountable, state regulators must hold accrediting bodies accountable. When state legislatures and executive regulators neglect this duty, it is possible for an accreditor whose blessing is legally hitched to the license eligibility of a program's graduates to quietly set up a fiefdom, charging captive programs extortionate fees or writing ever more requirements at the behest of interest groups. In the case of nursing, accreditor overreach is not a problem. The accreditors' standards are reasonable, nationally consistent, and suitably tailored to the task of ensuring the educational preparation of program graduates to practice nursing safely.

The CCNE, CNEA, and ACEN standards uniformly set an expectation that nursing faculty will obtain graduate education, and they set that expectation in a manner that is appropriate, calling for continuous pursuit of that goal while recognizing that marketplace, population, and program context matter as well.

c. Regulatory Standards

The regulatory requirements of ARBN §§ 4.20-25, excerpted at p. 3, *supra*., attempt to achieve the aspirations embodied in CCNE, CNEA, and ACEN standards, but they do so in an inappropriately rigid manner, fixating narrowly on graduate-degree attainment in a way that disqualifies a majority of registered nurses from teaching. In the presence of consistent, reasonable, national standards overseen by credible accreditors, the appropriate role of the Board of Nursing is to see that accreditation is working, not to simulate or repeat the function in parallel with accrediting bodies. But State regulatory standards do a bit of the latter, setting up an ersatz governmental version of accreditation, which by dint of the regulator's limited capacity, must rely heavily on a small set of inflexible proxies for quality and preparation to teach, of which the graduate degree is the unrivaled favorite.

The Board of Nursing issues three core credentials: It licenses practical nurses (LPNs), registered nurses (RNs), and advanced-practice registered nurses (APRNs).[15] The three credentials denote genuinely distinct educational preparation and authorize practice within genuinely distinct and sequentially scaled scopes of practice.[16] When establishing educator qualifications, however, Vermont regulation is not content to rest on the three legal tiers of licensure that actually emanate from the Board. Instead, the ARBN attempt to parse licensed RNs into subpopulations eligible and ineligible to educate others toward licensure, based on graduate degrees that are not required for licensure itself. The effort is not intuitively unreasonable in theory, but it operates in a world we wish we had rather than the world we do have.

According to the Area Health Education Centers (AHEC) 2019 Board of Nursing Relicensure Survey, prevailing educational attainment among Vermont RNs is 42% associate; 42.2% bachelor's; 6.6% master's degree, and 0.5% doctoral.[17] Consider what that means on the ground.

[15] The Board also regulates licensed nurse assistants (LNAs), but the program is not relevant to instant analysis.
[16] The LPN executes plans of care but does not develop them independently; the RN has considerable autonomy to independently evaluate and develop plans of care for complex cases; and the APRN is a primary-care provider who may practice independently, with full prescriptive authority.
[17] A concise snapshot from the AHEC survey is available at https://www.med.uvm.edu/docs/ahec_rn_81419/ahec-documents/ahec_rn_81419.pdf?sfvrsn=bea53a9e_2.

AHEC finds that 49.3% of non-APRN RNs hold a bachelor's or higher. Applied to our actual population, ARBN § 4.24(b), which provides that LPN clinical instructors "must hold, at a minimum, a bachelor's degree with a major in nursing," categorically disqualifies more than half of the *registered nurses* licensed in Vermont from providing clinical instruction to students of *practical nursing*, regardless of other experience, qualifications, or preparation to teach.

AHEC finds that 6.6% of RNs hold a master's degree in nursing. Doctoral degrees are held by half of one percent. And approximately 4% of RNs reported current enrollment in a master's program. It follows that ARBN § 4.23(b), which provides that RN clinical instructors "must hold a master's degree" or be on their way to getting one, categorically disqualifies almost nine of every ten registered nurses licensed in Vermont from providing clinical instruction, regardless of other experience, qualifications, or preparation to teach, and even on hospital floors where they may have practiced for years. [18]

Absolute degree minimums exclude extraordinary ratios of otherwise-qualified registered nurses from eligibility to provide clinical instruction. This kind of rigidity may have been defensible on the basis of necessity prior to national accreditation by others with superior information and more nuanced evaluative criteria. Today, with universal national accreditation achieved, the requirements are no longer justified by any reasonable expectation that they will materially improve the quality of nursing care provided by Vermont nursing program graduates. Indeed, by decimating the universe of registered nurses lawfully eligible for hire as clinical instructors, unrealistic regulations may have the perverse effect of diminishing program quality by eliminating selective hiring. In the world regulators imagine, an infinite supply of master's-prepared nurses will materialize and present themselves to the hiring committees of the State's nursing programs. In the world, as it actually exists, a nursing-program director seeking a clinical instructor has to hire the first legally-qualified person willing to do the job, even if the program director is personally aware of a dozen bachelor's-prepared registered nurses more qualified on the merits yet unwilling or unable to matriculate in a master's program.

The nexus between a clinical instructor's degree and the quality of a graduate's future practice is loose and speculative; fixation on degrees as a proxy for pedagogic quality is dubious; and the entire enterprise relies upon the conceit that Vermont nursing programs are the exclusive preparatory channel for practicing Vermont nurses, when we know that only 39% of Vermont RNs were educated in Vermont programs under the idiosyncratic strictures of Vermont's Administrative Code.[19]

When a registered nurse educated outside Vermont presents himself for licensure, we exhibit no suspicion at all that he is underprepared for the clinic. We apply no special test of clinical skill beyond that required of the RNs we mint. We require no supplemental clinical training.

Similarly, the 2015 concession in ARBN § 4.23(b), allowing clinical instruction by those enrolled in MSN studies they have not completed, illustrates that our requirements of individual clinical instructors really are not about the qualifications of those individuals or the quality of the training transmitted to their

[18] Because the Board will recognize master's degrees from nursing-related fields, and AHEC surveyed master's degrees in nursing, a sliver of nurses with master's degrees in public health, for example, could be eligible for degree recognition without enrolling in an MSN program. Anecdotally, requests that the Board recognize nursing-related master's degrees are very rare, though they have been liberally granted. The related-degree provision would not be expected to enhance actual eligibility within the population by more than one percentage point above AHEC's figures, which focus on nursing degrees.

[19] Because only 39% were educated in Vermont. 2019 Board of Nursing Relicensure Survey, linked *supra*.

individual students. It does not matter that the MSN training hasn't been accomplished; it matters that the instructor is *the kind of RN* who would *enroll* in an MSN program.

We hand a license to the nurse trained out of state, or to the nurse who received in-state clinical instruction from someone who was himself enrolled in his very first semester of MSN study, unbothered by contradiction, because we know that our graduate-degree rules for clinical educators do approximately nothing to ensure that individual RN program graduates are more qualified to provide care to the public than would be the case without those rules. The rules do not exist for the legislative purpose imagined. They exist to serve very broad and very important socio-professional goals held by senior nurse leaders; goals which, if achieved, unquestionably would accrue to the benefit of the public health. Those goals are not to be belittled, but our ability to implement them in isolation is. The American Association of Colleges of Nursing estimates that there are 996 BSN programs operating in the United States.[20] Vermont has jurisdiction over three[21] of them. Using our Administrative Code to drive systemic change from this posture regrettably does not serve Vermonters or the programs we hope to improve, but instead stands as a weird flex; a highly local display of piety from a flea that imagines itself to be wagging a dog. For these reasons, MSN degree and enrollment mandates for nurse educators are not appropriate to accomplish the regulatory purposes of Board oversight of nurse education programs and should be eliminated to the extent they supervene national accredidation standards. Programs will still prefer graduate-prepared faculty, because accrediting standards look for graduate-prepared faculty. But programs will be freed to make individual hiring decisions on the basis of broader merit from within the RN workforce that actually presents itself.

d. Misperceptions Concerning Standards Prevailing Nationally

Nurse leaders value graduate education very highly.[22] There is every reason to think that the future nursing workforce, the hospitals and clinics who will employ that workforce, and the patients who will receive care from that workforce, will benefit from enhanced degree standards for nurse educators. However, we find that aspirations have outpaced attainment, such that boards of nursing throughout the United States cannot and do not enforce the faculty requirements on their books.

Individual state boards generally are unaware of the extent to which their peer boards have made concessions to marketplace reality. Consequently, each state board asked to waive or relax nurse-educator or clinical-nurse-educator requirements is given to feel that doing so would let down a national standard that, unknown to each board, is largely illusory. Remarkably, a state board executive undertaking one of the first comprehensive studies of faculty waivers has concluded that, of 48 state boards of nursing that approve education programs, 42 issue faculty waivers.[23] In other words, Vermont's faculty rules make the jurisdiction one of the strictest in the country, even as Board members

[20] See https://www.aacnnursing.org/Nursing-Education-Programs/Baccalaureate-Education

[21] UVM, Norwich, and Castleton offer pre-licensure BSN Programs; VTC offers an associate degree in nursing (ADN), as well as a post-licensure RN-to-BSN.

[22] See, e.g., the National Council of State Boards of Nursing Faculty Qualifications Committee's 2008 defense of aggressive graduate-degree mandates, available at https://www.ncsbn.org/Final_08_Faculty_Qual_Report.pdf. Even as it argued for a credentials escalator, the Committee, at p. 4, reported more than a decade ago that 25 of 36 state boards surveyed "were allowing waivers for their RN faculty requirements for those nursing programs that provided evidence that they couldn't fill their positions with qualified faculty members."

[23] Buchholz, T. (2019). *Board of nursing rules permitting use of educationally underqualified nursing faculty: An exploratory study of use and possible impact on outcomes.* (Unpublished manuscript).

asked to consider waivers worry that the grant of one would make the State a laggard. Waivers are not the exception; they are the norm.

VI. Identified Barriers to Recruitment and Retention

The specific standards review called-for by Act 80 is completed above. The report now turns to "identifying barriers to recruitment and retention of nurse educators in nursing education programs" more generally. We transition from the specific to the general with a caution to policymakers: Although nurse-educator regulations can and should be reformed, that reform reasonably can be expected to provide only modest improvement to the training capacity of Vermont's nurse education programs, enhancing net RN training capacity by perhaps 30 seats in the approaching semester. Chief nursing officers, program administrators, and regulators are keenly aware of multiple other challenges that make code revision look easy by comparison.

a. Inadequate Compensation

Wages, modified by working conditions and benefits, are the price of labor. A workforce shortage is what one gets when an employer is asked to describe a wage shortage. The concepts are of a piece, though the former is much more popular in legislative discourse, where the people who buy and supply professional services[24] tend to outnumber the people who provide those services.[25]

The prevailing hourly wage for clinical nurse educators is as little as half the prevailing hourly wage earned by a nurse of equivalent experience in a hospital. Were that salary delta to vanish, so too would the clinical-faculty shortage. To a BSN nurse, matriculating in an MSN program for the purpose of qualifying as a nurse educator is an economically irrational move. In terms of barriers to recruitment and retention of nurse educators, pay is not just a factor, it is *the* factor. In one sense, this report represents an effort to talk about anything but the most obvious impediment to recruitment and retention: a registered nurse with the credentials expected of a nurse-educator can make more money doing almost anything else.

The curious question is why nurse-educator compensation has not increased as necessary to entice supply. The answer, so far as we can discern, is that nurse-educators must be program faculty, and faculty salaries cannot float to meet the market, but instead are determined through rigidly-structured contracts established through collective bargaining and more closely oriented to ensuring institutional predictability and consistency of faculty compensation across fields. Hospital administrators and program directors are aware of the need to improve clinical-faculty compensation and have found creative means to do so, most prominently, through the use of dual-track contracts wherein hospitals subsidize faculty pay in order to bring it closer to market.

b. Finite Clinical Sites

Of the State's four nursing programs, three report that clinical-site limitations would constrain program growth even if clinical faculty were plentiful. Traditional clinical sites are in short supply, because

[24] Colleges, universities, hospitals, clinics, insurers, and payers such as DVHA.

[25] Working nurses, who, though capably organized, tend to press their demands through collective bargaining with employers, rather than the direct lobbying of elected officials.

today's hospitals retain fewer inpatients. Ambulatory patients tend to be on their way home, and non-ambulatory patients tend to be in intensive care. The middle-intensity patient who used to be the focus of a great deal of clinical learning no longer tends to be found on the floors of a hospital.

The State's nursing programs understand this problem and dedicate considerable attention to building and tending relationships with novel clinical sites. And all programs have begun to think more broadly about what constitutes a clinical site, as nurse leaders are aware that the future of nursing increasingly will be found outside the hospital.

There is consensus that the maximum reasonable ratio of clinical instructors to students is 1:8. But because programs are under pressure to find clinical sites, they sometimes must assign clinical faculty to settings where ratios are much lower. This is not an optimal use of already-scarce clinical educators.

c. Aversion to Educational Costs and Burdens

Online MSN programs have significantly improved notional access to graduate nursing education, and we know from AHEC survey results that approximately 5% of RNs are actively pursuing graduate studies. That number will have to grow significantly if we hope to maintain an adequate supply of nurse educators qualified as contemplated by national accreditation standards. Even as stakeholders emphasized the importance of graduate education, they recounted their own frustrations financing lifetime learning and balancing work and family obligations so as to make that further education possible. To an RN who has just begun to repay educational loans in his or her late twenties or early thirties, the prospect of taking on new educational debt is distinctly unappealing, particularly when the investment can be expected to do little for earnings.

Finally, if we hope to encourage early-career professional nurses to pursue graduate studies, we must ensure that they have the social supports necessary to make those further studies possible. Childcare figures prominently in nurses' aversion to returning to school. It is one thing to pay hundreds of dollars weekly for care enabling one to work and earn; another to buy care necessary to undertake studies that are not themselves income-generating. There may be a role for healthcare workplaces in structuring nurse schedules and peripheral supports so that the work environment is conducive to the pursuit of graduate studies.

d. Environmental and Cultural Challenges

Clinical sites can take only so much disruption, and students are a form of disruption. As workforce issues drive turnover and hospitals rely on traveling nurses to fill vacancies, hospital-based nurse educators and incumbent nurses find themselves dedicating ever more bandwidth to orienting their own newcomers. Consequently, program directors report that some sites have found it necessary to limit or eliminate clinical access to nursing students as they attend to their own operational needs.

Nurse educators sometimes find it challenging to integrate themselves and their students into a working nursing floor. Existing familiarity with a site is a significant advantage for a clinical instructor, but it is not one recognized by degree-focused eligibility criteria. We find that, just as existing regulation relies excessively upon graduate education as a proxy for preparation to provide clinical instruction, existing regulation does not sufficiently credit a prospective clinical instructor's familiarity with the clinical site.

VII. Recommendations

Although many of the challenges to faculty recruitment and preparation arise from factors beyond the State's control, the Board's struggle with nurse-educator standards does lead us to recommend discrete "statutory or regulatory changes, or economic development initiatives, to facilitate recruitment and retention of nurse faculty."

a. Eliminate Duplicative Oversight of Faculty Requirements, but Retain Appropriate Board Involvement in Program Approval, Oversight, and Support.

The Board's requirement that all Vermont pre-licensure nursing education programs achieve national accreditation by July 1, 2020, embodied in ARBN § 4.1(d), represents an important and laudable milestone in establishing consistent standards for nurse education programs. Not incidentally, that achievement renders vestigial direct Board involvement in the qualifications of program faculty. Continuing to occupy that space as-was, after working hard to occupy it with a third-party enforcer of nationwide standards, would represent a form of regulatory overstaying, unjustified by any conceivable benefit to the public health, safety, and welfare. Statutory clarification of the Board's role vis-à-vis nurse education programs could restrain intrusion upon faculty appointments and moot questions of reasonableness relative to Rules like 4.23(b).

Although the Board of Nursing should not in principle have or need authority to draft shadow accreditation standards, the Vermont board's role is not unusual nationally. This means that nurse-program accreditors have matured in a world where government has been unusually ready to catch what they may miss. Even among the strong majority of participants who believe the Board should not micromanage educational programs, there is a sense of alarm at the prospect of outsourcing all oversight. As demand for nursing education grows, and federal student-aid dollars are easily had, states outside Vermont have seen fraudulent or grossly deficient schools of nursing spring up within their borders. The Office recommends that the Board continue to hold high-level monitoring and approval authority, but that its mandate be clarified and narrowed to exclude direct control of faculty qualifications not otherwise required by accreditors.

b. Establish a Waiver Standard and State Supervision of Grants and Denials

The Board's resistance to engaging the questions put to it by stakeholders arose in part from uncertainty about the body's legal authority to grant waivers. Vermont's Administrative Procedure Act provides that:

> *No agency shall grant routine waivers of or variances from any provisions of its rules without either amending the rules or providing by rule for a process and specific criteria under which the agency may grant a waiver or variance in writing. The duration of the waiver or variance may be temporary if the rule so provides.*
> --3 V.S.A. § 845(b).

The current ARBN do not specify a waiver process and criteria, meaning the Board is without an orderly means of using the discretion and flexibility made possible by § 845(b). Although OPR opined that waivers of nurse-educator requirements lawfully could be issued on a non-routine basis, so long as the Board was working in good faith on amending the relevant rule, a majority of the Board did not appear to support future amendment. In the absence of objective criteria for determining when a waiver

should be granted, members expressed slippery-slope objections and felt that they would be accused of arbitrary decision-making if granting some waivers and denying others.

The next iteration of administrative rules for nursing should articulate a process and specific criteria for handling waiver requests. Alternatively, the General Assembly could set waiver criteria specific to the Board of Nursing by amending the Nurse Practice Act.

Similarly, although the enumerated powers and responsibilities of the Office of Professional Regulation, set out in 3 V.S.A. § 123, provide for active state supervision of the affirmative acts of boards,[26] the section contemplates staying a board action but does not include a robust mechanism for affirmatively placing before boards questions they may prefer not to engage. The Title 3 could be improved by establishing an avenue for the Director to certify a question for board determination.

Respectfully submitted to the to the House Committees on Commerce and Economic Development and on Government Operations and to the Senate Committees on Economic Development, Housing and General Affairs and on Government Operations.

STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION

BY:

December 16, 2019
Gabriel M. Gilman — Date
General Counsel

APPROVED:

December 16, 2019
S. Lauren Hibbert — Date
Director

[26] "The Director [of Professional Regulation] shall actively monitor the actions of boards attached to the Office and shall ensure that all board actions pursued are lawful, consistent with State policy, reasonably calculated to protect the public, and not an undue restraint of trade." 3 V.S.A. § 123(i).