4th AGENDA

BOARD OF NURSING
August 29, 2013 – 8:15 a.m.
Room 474 (Fourth Floor)
Heber M. Wells Building
160 E. 300 S. Salt Lake City, Utah
This agenda is subject to change up to 24 hours prior to the meeting.

ADMINISTRATIVE BUSINESS:

1. Sign Per Diem
2. Call Meeting to Order.
3. Administer Oath of Office to new Board members
4. Review and approve July 11, 2013 and August 8, 2013 minutes
5. Connie Call, compliance report, probationer requests/miscellaneous

BOARD BUSINESS:

- **8:25 a.m.** - Denise Ward, Emergency Department employment of acute care APRNs
- **8:45 a.m.** - Mitchell Jones, discussion regarding burden of proof in criminal versus administrative hearings.

PROBATION INTERVIEWS:

Please note: The compliance report, report from Committees and probation interviews may result in a closed meeting in accordance with §52-4-205(1)(a).

- **9:00 a.m.** Christopher Singer, probation interview

	Group 1 Room 474	**Group 2 Room 475**
9:30 am	Toni Pettit, New Order	Brian Stokes, New Order
10:00 am	Nina Manning, out of compliance	Traci Johnson, out of compliance
10:15 am	Break	Break
10:30 am	Sara Calderas, New Order	Christy Proctor, New Order
11:00 am	Todd Powell, New Order	Peggy Van Dam, New Order
11:30 am		Jacob Tanner, New Order
12:00 pm	Colleen Stephens, telephone interview	Julie Horyna, New Order
12:15 pm	Michael Gearheart, his request	

WORKING LUNCH: 12:45 P.M.

- **12:45 pm** - Report from Committees
  1:15 pm – Environmental Scan
  - Letter from NCSBN in response to the Department of Veterans Affairs
  - Discussion regarding Utah Controlled Substances Act Rule – Continuing Professional Education for Controlled Substance Prescribers
  - Review handout regarding what happens to complaints of Unlawful or Unprofessional Conduct

- Review letter from 2012-2013 NCSBN Board of Directors regarding post-board meeting update
- Discussion regarding Stipulation and Order section that does not allow a Respondent to contact by telephone or other manner any pharmacy or drug supplier for the purposes of filling a prescription order.
- Report regarding NCLEX test scores
- Report from Ms. Brown and Ms. Rall regarding NCSBN Annual meeting

FYI:

- NCSBN annual review of emerging issues and trends that impact nursing regulation

2:00 pm - Break

	Group 1 Room 474	**Group 2 Room 475**
2:15 pm	Lauren Moger, out of compliance	Mathew Clyde, out of compliance
2:30 pm	Ian Gowans, out of compliance	Susan Cluff, out of compliance
2:45 pm	Sandy Piatt, out of compliance	

NEXT MEETING: September 12, 2013 – Dusti Jo Hall, Informal Adjudicative Proceeding; Debbie Webster, Formal Hearing

Meetings scheduled for the next quarter: October 10, 2013 – five informal adjudicative proceedings scheduled; November 14, 2013 and December 12, 2013.

Note: In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify, Dave Taylor, ADA Coordinator, at least three working days prior to the meeting. Division of Occupational & Professional Licensing, 160 East 300 South, Salt Lake City, Utah 84115, 801-530-6628 or toll-free in Utah only 866-275-3675

REVISED CHECKLIST FOR PUBLIC MEETINGS

(Fill in the blanks to correspond to each respective board, commission, or committee.)

Close @ 8:51
open @ 9:03

___ I am, PEGGY BROWN, chairperson of the BOARD OF NURSING.

___ I would like to call this meeting of the BOARD OF NURSING to order.

___ It is now (time) 8 : 22 (am / pm) on AUGUST 29, 2013.

___ This meeting is being held in room 474 of the HEBER WELLS BUILDING in SALT LAKE CITY UT.

___ Notice of this meeting was provided as required under Utah's Open Meeting laws.

___ In compliance with Utah's Open Meetings laws, this meeting is being recorded in its entirety. The recording will be posted to the Utah Public Notice Website no later than three business days following the meeting.

___ In compliance with Utah's Open Meeting laws, minutes will also be prepared of this meeting and will be posted to the Utah Public Notice Website. Appropriately marked "pending approval" minutes will be posted no later than 30 days after the close of the meeting and "approved" minutes no later than three business days after approval.

___ The following Board members are in attendance:

		YES	NO
PEGGY BROWN	, Chairperson	☑	☐
RALPH PITTMAN		☑	☐
CESCILEE RALL		☑	☐
MEGAN CHRISTENSEN		☑	☐
JAMIE JO CLINTON-LONT		☐	Excused
DIANA PARRISH		☑	☐
CALVIN KREMIN		☐	☐
ALISA BANGERTER		☐	Excused
BARBARA JEFFRIES		☑	☐
SHERI PALMER		☐	Excused
(VACANT)		☐	Not Excused

___ The following Board members are absent: (Refer to the above list.)

___ The following individuals representing DOPL and the Department of Commerce are in attendance:

		YES	NO
Mark B. Steinagel	, Division Director	☐	☑
Debra Hobbins	, Bureau Manager	☑	☐
Shirlene Kimball	, Board Secretary	☑	☐
Connie Call	, Compliance Specialist	☑	☐
Irene		☑	☐
		☐	☐

✓ We welcome any visitors and interested persons at this time. Please be sure to sign the attendance report for the meeting and identify yourself before speaking.

✓ As a courtesy to everyone participating in this meeting, at this time we ask for all cell phones, pagers, and other electronic devices to be turned off or changed to silent mode.

✓ Board motions and votes will be recorded in the minutes.

___ Let us now proceed with the agenda.

✓ (End of the Meeting) It is now (time) 3:32 (am / pm), and this meeting is adjourned.

SWORN STATEMENT
SUPPORTING CLOSURE OF BOARD MEETING

DOPL-FM-010 05/02/2006

I Marguerite P Brown acted as the presiding member of the Utah Board of Nursing Board, which met on August 29, 2013

Appropriate notice was given of the Board's meeting as required by §52-4-202.

A quorum of the Board was present at the meeting and voted by at least a two-thirds vote, as detailed in the minutes of the open meeting, to close a portion of the meeting to discuss the following:

- ☒ the character, professional competence, or physical or mental health of an individual (52-4-205(1)(a))
- ☐ strategy regarding pending or reasonably imminent litigation (§52-4-205(1)(c))
- ☐ deployment of security personnel, devices, or systems (§52-4-205(1)(f))
- ☐ investigative proceedings regarding allegations of criminal misconduct (§52-4-205(1)(g))

The content of the closed portion of the Board meeting was restricted to a discussion of the matter(s) for which the meeting was closed.

With regard to the closed meeting, the following was publically announced and recorded, and entered on the minutes of the open meeting at which the closed meeting was approved:

(a) the reason or reasons for holding the closed meeting;
(b) the location where the closed meeting will be held; and
(c) the vote of each member of the public body either for or against the motion to hold the closed meeting.

If required, and/or kept or maintained, the recording and any minutes of the closed meeting will include:

(a) the date, time, and place of the meeting;
(b) the names of members present and absent; and
(c) the names of all others present except where such disclosure would infringe on the confidentiality necessary to fulfill the original purpose of closing the meeting.

☐ Pursuant to §52-4-206(5), a sworn statement is required to close a meeting under §52-4-205 (1)(a) or 52-4-205(1)(f), but a record by tape recording or detailed minutes is not required.

- ☐ A record was not made
- ☐ A record was made by: ☐ Tape Recording ☐ Detailed Written Minutes

☐ Pursuant to §52-4-206(1), a record by tape recording is required for a meeting closed under §52-4-205(1)(c) or 52-4-205(1)(g), and was made.

- ☐ Detailed written minutes of the content of a closed meeting although not required, are permitted and were kept of the meeting.

I hereby swear or affirm under penalty of perjury that the above information is true and correct to the best of my knowledge.

Marguerite P Brown
Board Chairman or other Presiding Member

Marguerite P Brown
Date of Signature

Closed	opened
8 51	9 03
9 45	10 04
15 00	3 20 15th

Guests - Please sign

Date: 8/29/2013

BOARD OF NURSING

NAME: (Please Print)	REPRESENTING
Denise Ward	Univ of Utah Con
Jody Larson	Michael Gearheart
Christian Friden	Michael Gearheart
Will May	Michael Gearheart
Tracy Karp	Tracy Karp

Guests - Please sign

Date: 8-29-13

BOARD OF NURSING

Group 2

NAME: (Please Print)	REPRESENTING
Jennifer Tanner	Jacob Tanner

2 changes

MINUTES

UTAH
BOARD OF NURSING
MEETING

July 11, 2013

Room 474 – 4th Floor – 8:30 a.m.
Heber Wells Building
Salt Lake City, UT 84111

CONVENED: 8:08 a.m.	**ADJOURNED:** 12:21 p.m.
Bureau Manager:	Debra Hobbins
Board Secretary:	Shirlene Kimball
Conducting:	Peggy Brown, Chair
Board Members Present:	Peggy Brown Cescilee Rall Diana Parrish Ralph Pittman Barbara Jeffries Sheri Palmer John Killpack Marie Partridge
Board Members Excused:	Alisa Bangerter Sue Kirby
Division Staff:	Irene Woodford, Division Investigator Connie Call, Compliance Specialist
Guests:	Linda Hoffman, Intermountain Medical Center

TOPICS FOR DISCUSSION	**DECISIONS AND RECOMMENDATIONS**
ADMINISTRATIVE BUSINESS	
May 9, 2013 Minutes:	Ms. Parrish made a motion to approve the May 9, 2013 minutes with corrections. Ms. Rall seconded the motion. Ms. Partridge abstained. All other Board members voted in favor of the motion.
Julia Gillingham, New Order:	Ms. Gillingham explained the circumstances that brought her back before the Board. She indicated she

received a DUI after moving back to Utah and reported the DUI at the time she renewed her license. Ms. Gillingham's therapist indicated therapy was not necessary, but Ms. Gillingham would benefit from attendance at 12-Step and PIR meetings. Ms. Jeffries questioned Ms. Gillingham if she is an alcoholic. Ms. Gillingham stated she has made bad decisions and it is best for her to stay away from alcohol. Ms. Parrish again questioned if Ms. Gillingham is an alcoholic. Ms. Gillingham answered she is an alcoholic. Ms. Gillingham sated she has a sponsor and speaks with her sponsor once or twice a week. Ms. Gillingham stated she has been attending AA meetings twice a month and just recently began attending PIR meetings. Ms. Parrish questioned what changes Ms. Gillingham has made that is different from her first probation. Ms. Gillingham stated she is much happier now. She indicated she exercises daily, attends counseling and her daughters are doing well. She stated the first time on probation she was not in a good place, and feels she is in a better place now. She reported her sobriety date is February 23, 2010. Ms. Gillingham stated she is not taking any medications not lawfully prescribed for her.

Ms. Gillingham requested her Order be amended to allow for access to controlled substances. She indicated she would be working at Salt Lake Behavior Health, working with seniors on the psychiatric unit. She indicated her co-workers would be supportive. Ms. Jeffries made a motion that Ms. Gillingham does not need to attend therapy; however, she will be required to attend at least two PIR and two 12-Step meetings per month, and continue with urine screens. Ms. Jeffries also indicated the motion would include lifting the restriction and allow Ms. Gillingham to have access to controlled substances based on the recommendation of the therapist and continued Board monitoring. Mr. Pittman seconded the motion. All Board members voted in favor of the motion. Ms. Jeffries strongly recommended Ms. Gillingham work the steps with the sponsor and read the "big book". **Ms. Gillingham is in compliance with the terms and conditions of her Order.**

Connie Call, Compliance report:

Ms. Call reported the following:
-**Christopher Singer** has not complied with the

request of the Board to submit the following additional information: A letter from his attorney clarifying the number of DUI's received and the date the DUI was issued. Obtain and submit a BCI report. Submit a Substance Use Disorder Evaluation that was completed after the June 2012 DUI charge; and to attend 12-step meetings once a week until the Substance Use Disorder Evaluation has been reviewed to determine whether continued attendance at 12-Step meetings and therapy would be beneficial. Ms. Jeffries made a motion to refer Mr. Singer for an Order to Show Cause Hearing. Mr. Pittman seconded the motion. All Board members voted in favor of the motion.

-**Betsy Ross** has been sent a surrender document.

-**Katie Blackham** has not renewed her RN license and the license will remain suspended.

-**Mark Hancock** submitted his reports late, did not submit a self-assessment report, only attended one PIR and one 12-Step meeting and needs to submit a copy of his prescriptions. Board members recommend Mr. Hancock be referred for an informal adjudicative proceeding. All Board members voted in favor of the recommendation.

-**Monica Murdock** has been referred for an informal adjudicative proceeding.

-**Sam Ballacommo** had several abnormal urine screens for low creatinine. He was late submitting his therapist report.

-**Vaiola Panter** needs to submit a prescription. Ms. Panter continues to be out of compliance and Mr. Killpack made a motion to issue a $100.00 citation for continued non-compliance. Mr. Pittman seconded the motion. All Board members voted in favor of the motion.

-**Karrie Larson** had a positive urine screen for morphine. She stated to Ms. Call that she took either over-the-counter medication or poppy seeds. The Division requested Affinity run a GCMS on her test and are awaiting the results. Mr. Pittman made a motion that if the GCMS comes back positive; refer Ms. Larson for an informal adjudicative proceeding. Mr. Rall seconded the motion. All Board members voted in favor of the motion.

-**Traci Johnson** needs to submit a copy of a prescription.

-**Lyndi Slack** has been referred for an informal adjudicative proceeding for non-compliance.
-**Sara Calderas**, new order. Ms. Calderas was sent a non-compliance letter because she has not contacted Ms. Call to review her Order. If Ms. Calderas does not respond to the non-compliance letter, she will be referred for an informal adjudicative proceeding.
-**Toni Pettit**, new Order. Ms. Pettit was sent a non-compliance letter because she has not contacted Ms. Call to review her Order. If Ms. Pettit does not respond to the non-compliance letter, she will be referred for an informal adjudicative proceeding.

Ms. Call reported the following probationers have requests:
-**Suzanne Menatti** requested access to controlled substances. Board members made a motion to grant the request. All Board members voted in favor of the motion.
-**Ty Hazelton** requested that his access to controlled substances be returned. A motion was made to deny the request because it is too early in the probation. The motion was seconded. All Board members voted in favor.
-**Dale Hullinger** is requesting he be allowed to work with a home health care facility. Board members requested a letter from the facility indicating Mr. Hullinger's responsibilities before considering his request.
-**Destine Banta's** therapist report indicated therapy is no longer necessary, but she would need to continue to attend 12-Step and PIR meetings. All Board members voted in favor of the therapist's recommendation.
-**Tina L'Estrange** therapist report indicated therapy is no longer necessary. All Board members voted in favor of not requiring therapy at this time.
-**Joanne Somers'** therapist report indicated Ms. Somers does not need to attend regular therapy appointments. Board members indicated she would not be required to attend therapy at this time; however, if the Board deems it necessary that she return to therapy, she will be required to attend and submit documentation of attendance.
-**Teresa Williams** requested she be allowed to have three prescribing practitioners. Board members made a motion to approve the request.

-Julie Willardson. Board members made a recommendation at the last meeting to refer Ms. Willardson for an informal adjudicative proceeding. The Division questioned why she was referred. Mr. Killpack stated she has not been working in a clinical setting and he is concerned with her attitude that the "Board is evil". It does not appear she has made any changes in her thought process. Dr. Hobbins indicated the Order does not require her to practice in the clinical setting as an APRN and we cannot hold her to a condition that is not in her Order. Ms. Rall stated Ms. Willardson made her case, however, Ms. Rall stated she does not deny there are other issues, but the Board needs to stay within the conditions of her Order. Mr. Killpack stated he could withdraw the recommendation to refer her for an informal adjudicative proceeding, but would still like to see her practicing in the clinical setting as the APRN. Mr. Pittman stated Ms. Willardson should be held accountable. She has been non-compliant, used alcoholic and has a self-defeating attitude when meeting with the Board. Mr. Killpack stated that a nurse practitioner has additional responsibility and authority and would like to know that she will not abuse that authority. He stated he has the concern because of her attitude. Board members indicated she may be sabotaging her progress, but it is not the role of the Board to fix the self-sabotage. Dr. Hobbins suggested that Ms. Willardson be invited to meet with the Board at the next meeting.

Special Requests:

Ms. Call reported that the Division approved the special requests for Ms. Menatti Irish, Ms. Banta, Ms. L'Estrange, Ms. Somers, and Ms. Williams. The Division denied the request for access to controlled substances from Tyge Hazleton. Mr. Pittman made a motion that the Board accepts the special requests approved by Division. Ms. Jeffries seconded the motion. All Board members voted in favor of the motion.

Adjourned to Kevin Blachely Hearing at 9:00 a.m.:

Default Hearing was held.

Reconvened from Hearing at 9:48 a.m.:

Rules discussion,
Jennie Jonsson, Administrative Law Judge
present at 10:18 a.m.:

Dr. Hobbins indicated the Rule could list those functions that are not considered to be solely nursing functions to allow nurses to delegate. It does not require training or education and would be a temporary fix until the statute is changed.

Board members reviewed the proposed Rule. Judge Jonsson indicated definition (10) was reworded. Board members suggested taking out the word "nurse" in definition (12) to read, "to perform a task that, according to generally accepted industry standards, does not require a nursing assessment as defined". The registered nurse would have to create the comprehensive assessment and develop a plan of care.

Board members discussed the responsibility of the nurse who is delegating. Judge Johnson stated it could be added that the nurse that delegates in accordance with employer policy would not be liable if he/she can show they followed the policy to the letter, and immediately reported any problems. The licensee will be judged by what the licensee did. Judge Jonnson stated the wording is legal, but it would not insulate an individual in a criminal or civil law suit. Ms. Brown stated that co-signing something that you did not do is a problem, and agencies do put pressure on nurses to sign. Mr. Killpack stated he would like to see facility policy that nurses delegating a task to non-licensed persons according to facility internal policies would not be held responsible. Ms. Hoffman stated that facilities should not be delegating anything that the individual is not competent to do. Ms. Brown stated she understands, however, there may be a facility that says you do this, or lose your job. The ability to make a choice has been removed and it is dictated by the facility. Ms. Brown stated it should not be about institution policy, but about competency.

Judge Jonnson indicated that she would reorganize the section regarding graduates of foreign nursing programs and list the required steps for RN and LPN.

Judge Jonnson explained the Rule making process. Ms. Jeffries made a motion that the suggested changes be made and the Board will not need to review the rules again once the changes have been made. The Division can move forward with the proposed Rules.

Mr. Pittman seconded the motion. All Board members voted in favor of the motion.

Next meeting: The next meeting is scheduled for August 8, 2013.

Note: These minutes are not intended to be a verbatim transcript but are intended to record the significant features of the business conducted in this meeting. Discussed items are not necessarily shown in the chronological order they occurred.

Date Approved — Peggy Brown, Chair, Utah Board of Nursing

Date Approved — Debra Hobbins, Bureau Manager, Division of Occupational & Professional Licensing

MINUTES

UTAH
BOARD OF NURSING
MEETING

August 8, 2013

Room 474 – 4th Floor – 8:30 a.m.
Heber Wells Building
Salt Lake City, UT 84111

CONVENED: 8:07 a.m.	**ADJOURNED:** 1:11 p.m.
Bureau Manager:	Debra Hobbins
Board Secretary:	Shirlene Kimball
Conducting:	Peggy Brown, Chair
Board Members Present:	Peggy Brown Cescilee Rall arrived at 8:55 a.m. Diana Parrish Ralph Pittman Barbara Jeffries Sheri Palmer Alisa Bangerter
Board Members Excused:	Megan Christensen Calvin Kremin Jamie Clinton-Lont
Division Staff:	Irene Woodford, Division Investigator
Department of Commerce:	Jennie Jonsson, Administrative Law Judge
Guests:	James Patterson, Nightingale student Brandy Durk, Nightingale student Brooke Peterson, Nightingale student Lisa Van Wagoner, Nightingale student Vicki Clay, Nightingale student Jamie Markosian, Nightingale student

TOPICS FOR DISCUSSION	**DECISIONS AND RECOMMENDATIONS**
ADMINISTRATIVE BUSINESS July 11, 2013 Minutes:	Ms. Parrish made a motion to approve the July 11, 2013 minutes. Ms. Jeffries seconded the motion. Ms.

Bangerter abstained. A quorum is not present at this time and the minutes will be tabled.

Rachel Driggs,
Informal Adjudicative Proceeding:

The informal adjudicative proceeding on Rachel Driggs was canceled.

Rules discussion,
Jennie Jonsson, Administrative Law Judge
present at 8:10 a.m.:

Judge Jonsson stated the Statute change in subsection 58-31b-601, allows for Medication Aide Certified and LPN education to be appropriate for licensure if "equivalent". Equivalency is not an option for the RN; however, subsection 58-31b-303, graduates of a non-approved program allows an individual to be licensed by endorsement if they hold a current active license and have passed the NCLEX examination. This section is inconsistent with 58-31b-601, minimum standards for nursing education programs, that was changed during the last Legislative session. Judge Jonsson stated she spoke with Mr. Steinagel and he indicated that the intent of the legislation change was to remove dual oversight of education programs. The Division will continue to license by endorsement unless otherwise directed by the Legislature. Mr. Pittman questioned how those who challenged the NCLEX examination, such as individuals in the military who are licensed in California, would be affected if they move to Utah. Judge Jonsson stated the statute does state that the individual has to be a graduate of a nursing education program. However, the Rule will define an education program.

Judge Jonsson indicated she rearranged the rules in order by license type. Under each license type, she listed the educational, examination and experience requirements. Judge Jonsson stated this clarified and strengthened the rules. The subsection lists the requirements for an applicant who has never obtained a license in any state, education requirements, examination requirements and background check requirements. The section further lists the requirements for those individuals who have a current license in good standing in another state and the acceptable education, examination and background check requirements. It then lists the requirements for an applicant who has been licensed previously in Utah, but whose license has expired or lapsed; and the requirements for an applicant who has been licensed in

	another state but whose license has lapsed. The foreign educated nurse requirements are listed in a separate section. Board members thanked Judge Jonsson for her help in writing the Rules.
Adjourned to the Steven Booth Hearing at 8:57 am:	The Hearing was held.
Next meeting:	The next meeting will be held August 29, 2013.

Note: These minutes are not intended to be a verbatim transcript but are intended to record the significant features of the business conducted in this meeting. Discussed items are not necessarily shown in the chronological order they occurred.

8/29/2013
Date Approved

Peggy Brown, Chair, Utah Board of Nursing

8/29/13
Date Approved

Debra Hobbins, Bureau Manager, Division of Occupational & Professional Licensing

L MITCHELL JONES (U.S B. 5979)
Assistant Attorney General
MARK L. SHURTLEFF (U S B 4666)
Attorney General
Commercial Enforcement Division
Heber M. Wells Building
Box 146741
Salt Lake City, UT 84114-6741
TEL. (801) 366-0310

BEFORE THE DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

OF THE DEPARTMENT OF COMMERCE

OF THE STATE OF UTAH

IN THE MATTER OF THE LICENSE OF	)	
COLLEEN STEVENS	)	**STIPULATION AND ORDER**
TO PRACTICE AS A	)	
REGISTERED NURSE	)	CASE NO DOPL 2012-458
IN THE STATE OF UTAH	)	

COLLEEN STEVENS ("Respondent") and the **DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING** of the Department of Commerce of the State of Utah ("Division") stipulate and agree as follows

1. Respondent admits the jurisdiction of the Division over Respondent and over the subject matter of this action.

2 Respondent acknowledges that Respondent enters into this Stipulation knowingly and voluntarily

3 Respondent understands that Respondent has the right to be represented by counsel in this matter and Respondent's signature below signifies that Respondent has either consulted with an attorney or Respondent waives Respondent's right to counsel in this matter

4 Respondent understands that Respondent is entitled to a hearing before the State of Utah's Board of Nursing ("the Board"), or other Division Presiding Officer, at which time Respondent may present evidence on Respondent's own behalf, call witnesses, and confront adverse witnesses. Respondent understands that by signing this document Respondent hereby waives the right to a hearing, the right to present evidence on Respondent's own behalf, the right to call witnesses, the right to confront adverse witnesses, and any other rights to which Respondent may be entitled in connection with said hearing Respondent understands that by signing this document Respondent hereby knowingly and intelligently waives the right to all administrative and judicial review as set forth in §§ 63G-4-301 through 63G-4-405, and Utah Administrative Code R151-46b-12 through R151-46b-15 Respondent and the Division hereby express their intent that this matter be resolved expeditiously through stipulation as contemplated in Utah Code Ann. § 63G-4-102(4)

5 Respondent waives the right to the issuance of a Petition and a Notice of Agency Action in this matter.

6. Respondent acknowledges that this Stipulation and Order, if adopted by the Director of the Division, will be classified as a public document. The Division may release this Stipulation and Order, and will release other information about this disciplinary action against Respondent's license, to other persons and entities

7 Respondent admits the following facts are true

a. Respondent was first licensed to practice as a registered nurse in the State of Utah on or about March 22, 2002

b. On or about August 11, 2012, while working at a hospital in Utah, Respondent diagnosed and treated a individual who had not been admitted as a patient to the hospital Respondent obtained the prescription drug Toradol from an AcuDose machine belonging to her employer and treated the patient. There was no order or prescription issued by a prescribing practitioner for Toradol fort the patient

c In August 2012, while working at a hospital in Utah, Respondent diagnosed and treated a individual who had not been admitted as a patient to the hospital. Respondent obtained the prescription drug Basa Cream belonging to her employer and treated the patient. There was no order or prescription issued by a prescribing practitioner for Basa Cream for the patient. Respondent used other supplies belonging to her employer to treat the patient Respondent also used her own over-the-counter medical supplies.

d In August 2012, while working a shift at the hospital, Respondent pierced the noses of two other hospital employees using expired hospital supplies

e On or about August 28, 2012 Respondent's employment at the hospital was terminated

8 Respondent admits that Respondent's conduct described above is unprofessional conduct as defined in Utah Code Ann § 58-1-501(2)(a) and (h), § 58-31b-502 (5) and (6), and unlawful conduct as defined in Utah Code Ann § 58-1-501(1)(a) and (f) Further Respondent agrees by engaging in such conduct the Division is justified in taking disciplinary action against Respondent's license pursuant to Utah Code Ann § 58-1-401(2)(a) and (b). Respondent agrees that an Order, which constitutes disciplinary action against Respondent's license by the Division pursuant to Utah Administrative Code R156-1-102(6) and Utah Code Ann § 58-1-401(2), may be issued in this matter providing for the following action against Respondent's license

(1) Respondent's license shall be publicly reprimanded for the conduct described above

(2) Respondent shall pay a fine of $2,000 00 (two-thousand dollars) to the Division, pursuant to Utah Code Ann. § 58-31b-503 and Utah Administrative Code R156-31b-402 to the Division within 90 days of the effective date of this Stipulation and Order.

(3) Respondent shall successfully complete the following continuing education courses available online at the NCSBN website. Critical Thinking and Skills; Documentation; Ethics of Nursing, Professional Accountability, and Legal Accountability. The courses shall be completed within six months of the effective date of this Stipulation and Order.

9. This Stipulation and Order, upon approval by the Director of the Division, shall be the final compromise and settlement of this non-criminal administrative matter Respondent acknowledges that the Director is not required to accept the terms of this Stipulation and Order and that if the Director does not do so, this Stipulation and the representations contained therein shall be null and void, except that the Division and the Respondent waive any claim of bias or prejudgment they might otherwise have with regard to the Director by virtue of the Director having reviewed this Stipulation, and this waiver shall survive such nullification

10 Respondent agrees to abide by and comply with all applicable federal and state laws, regulations, rules and orders related to the Respondent's licensed practice

11 This document constitutes the entire agreement between the parties and supersedes and cancels any and all prior negotiations, representations, understandings or agreements between the parties regarding the subject of this Stipulation and Order There are no verbal agreements that modify, interpret, construe or affect this Stipulation. Respondent agrees not to take any action or make any public statement, that creates, or tends to create, the impression that any of the matters set forth in this Stipulation and Order are without factual basis. A public

statement includes statements to one or more Board members during a meeting of the Board Any such action or statement shall be considered a violation of this Stipulation and Order.

12 The accompanying Order becomes effective immediately upon the approval of this Stipulation and signing of the Order by the Division Director. Respondent must comply with all the terms and conditions of this Stipulation immediately following the Division Director's signing of the Order page of this Stipulation and Order. Respondent shall complete all the terms and conditions contained in the Stipulation and Order in a timely manner. If a time period for completion of a term or condition is not specifically set forth in the Stipulation and Order, Respondent agrees that the time period for completion of that term or condition shall be set by the Board Failure to complete a term or condition in a timely manner shall constitute a violation of the Stipulation and Order and may subject Respondent to revocation or other sanctions

13 If Respondent violates any term or condition of this Stipulation and Order, the Division may take action against Respondent, including imposing appropriate sanction, in the manner provided by law. Such sanction may include revocation or suspension of Respondent's license, or other appropriate sanction

14 Respondent understands that the disciplinary action taken by the Division in this Stipulation and Order may adversely affect any license that Respondent may possess in another state or any application for licensure Respondent may submit in another state

15 Respondent has read each and every paragraph contained in this Stipulation and Order Respondent understands each and every paragraph contained in this Stipulation and Order Respondent has no questions about any paragraph or provision contained in this Stipulation and Order

DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

RESPONDENT

BY: _____

DEBRA F. HOBBINS, DNP, APRN, LSUDC
Bureau Manager

DATE. 11/5/12

BY: _____

COLLEEN STEVENS
Respondent

DATE: 10-29-12

MARK L SHURTLEFF
ATTORNEY GENERAL

BY. _____

L. MITCHELL JONES
Counsel for the Division

DATE 2 Nov 12

ORDER

THE ABOVE STIPULATION, in the matter of **COLLEEN STEVENS,** is hereby approved by the Division of Occupational and Professional Licensing, and constitutes my Findings of Fact and Conclusions of Law in this matter. The issuance of this Order is disciplinary action pursuant to Utah Administrative Code R156-1-102(6) and Utah Code Ann. § 58-1-401(2) The terms and conditions of the Stipulation are incorporated herein and constitute my final Order in this case

DATED this 7th day of November . 2012

DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

MARK B. STEINAGEL
Director

Investigator Sandra Hess

NCSBN
National Council of State Boards of Nursing

111 E. Wacker Drive, Suite 2900
Chicago, IL 60601-4277

312.525.3600
www.ncsbn.org

July 24, 2013

Robert A. Petzel, M.D.
Under Secretary of Health
Department of Veterans Affairs
810 Vermont Ave.
Washington, DC 20420

Will A. Gunn
General Counsel
Department of Veterans Affairs
810 Vermont Ave.
Washington, DC 20420

Dear Sirs:

On behalf of all state boards of nursing, this is a response to your letter dated April 3, 2013 that was sent to Executive Directors of State Boards of Nursing.

We are appreciative and enthusiastic about the Department of Veterans Affairs (VA) pursuing a policy that would recognize the full practice ability of all VA advanced practice registered nurses (APRNs) and promote the ability of VA nurses to use protocols in the delivery of patient care.

At a recent meeting of Executive Directors of State Boards of Nursing, your letter was discussed and questions raised. There are two statements for which we seek clarification. The first is your reference to the United States Code (USC) Title 38. We would appreciate the specific citation within the USC to improve our understanding as well as that of our respective legal counsel and state attorneys general. The second issue is not as black and white. In the letter's fourth paragraph you note that "to be employed by the VA, health care practitioners must be licensed in a state in order to practice." There is no doubt regarding this requirement and in fact, we believe and understand that a VA health care professional must be licensed in a U.S. jurisdiction (to include territories as well as states.)

Where we seek clarification however is in the second sentence where you state "this (licensing) is a statutory requirement only, and does not authorize states to regulate the conduct and activities of VA health care practitioners in the performance of their federal duties." What we believe the intent of that statement to be is that state boards have no jurisdiction over federal duties assigned to nurses in VA facilities. What ***may*** be implied from the statement is that once a nurse receives authority to practice nursing from a state or territory (as evidenced by the granting of a license) and is then employed by the VA, then the state that licensed that nurse no longer has regulatory authority over the VA nurse regarding professional conduct and competence. We would disagree with this interpretation. The jurisdiction that issued the license has the authority (and responsibility) to renew, reinstate and revoke the license if violations of the law regulating the practice of nursing are established through sufficient evidence and exercise of due process.

Thank you for considering our comments and our desire to seek a mutual understanding of this important issue. Please do not hesitate to contact me (or Kathy Apple, CEO, NCSBN) should you have any questions.

We look forward to your clarifying response.

Very truly yours,

Myra Broadway, JDS, MS, RN
President, NCSBN

Enc.

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

APR 0 2 2013

Executive Director
State Board of Nursing

Dear Executive Director:

The Department of Veterans Affairs (VA) is pursuing national policy that will recognize the full practice status of all VA Advanced Practice Registered Nurses (APRN) and the ability of VA nurses to use protocols in the delivery of patient care.

The National Council of State Boards of Nursing (NCSBN) *Consensus Model for APRN Regulation* will provide the foundation for VA's qualification requirements for all APRN employment including: Completion of an accredited post-graduate program; board certification by a VA approved accrediting body; and demonstrated ongoing competence in the area of practice. APRNs currently licensed in states with collaborative practice agreement requirements will have the opportunity to request additional time (up to 2 years) to transition to independent practice through a formal program that may include mini residencies, continuing education, and formal preceptorships. Nurses other than APRNs will receive additional education and training to ensure they can safely and effectively engage in protocol-driven practice as authorized elements of practice.

The authority for this national policy is title 38, United States Code, which authorizes VA to prescribe all rules and regulations which are necessary and appropriate to carry out its statutory role as a provider of a national health care system for the Nation's Veterans. This includes the authority to establish the qualifications of its health care practitioners and regulate their professional conduct. With the exception of controlled substances prescribing, which by Federal law requires adherence to state licensure requirements for such prescribing, VA determines the elements of clinical practice for its health care practitioners.

In order to be employed by VA, health care professionals must be licensed in a state to practice their profession. This is a statutory employment qualification only, and does not authorize states to regulate the conduct and activities of VA health care professionals in the performance of their Federal duties. As a matter of comity and cooperation, VA has adopted a policy of compliance with state law where it would not interfere with VA operations or the activities of its employees acting within the scope of their Federal employment. However where Federal and state law conflict, per Article VI of the U.S. Constitution (Supremacy Clause) the Federal law must prevail. Thus, VA health

regulations are more expansive or otherwise inconsistent with their State Practice Acts.

VA recognizes that states have an important interest in the health and well being of their residents. As a matter of policy, VA will cooperate with inquiries from State Licensing Boards (SLB) concerning clinical problems with a licensed VA practitioner's patient care. VA also will notify SLBs when it determines that the clinical practice of a licensed health care professional during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

VA national and regional officials will continue to work closely with individual State Boards of Nursing to ensure that there is a clear understanding of VA's policy and practice, and to make clear VA's commitment to cooperation and collaboration with state boards as official licensing bodies. VA's Office of General Counsel would be happy to discuss this matter with counsel for the state boards and State Attorneys General.

Sincerely,

Robert A. Petzel, M.D.
Under Secretary for Health

Sincerely,

Will A. Gunn
General Counsel

Utah Controlled Substances Act Rule

R156-37-402. Continuing Professional Education for Controlled Substance Prescribers.

In accordance with **Section 58-37-6.5**, qualified continuing professional education requirements for controlled substance prescribers are further established as follows:

(1) All licensed controlled substance prescribers shall complete four hours of qualified continuing professional education during each two year period of licensure.

(2) Qualified continuing professional education hours for licensees who have not been licensed for the entire two year period will be prorated from the date of licensure.

(3) Continuing education under this section shall:

(a) be prepared and presented by individuals who are qualified by education, training and experience to provide the controlled substance prescriber continuing education;

(b) have a method of verification of attendance and a post course knowledge assessment or examination; and

(c) teach content as set forth in Subsection 58-37-6.5(2).

(4) Credit for continuing education shall be recognized in accordance with the following:

(a) continuing education shall be presented by an organization accredited to provide continuing medical education as set forth in Subsection 58-37-6.5(1)(b)(ii) and be approved as set forth in Subsection 58-37- 6.5(1)(b)(iii); and

(b) unlimited hours shall be recognized for continuing education completed in blocks of time of not less than 50 minutes.

(5) A licensee shall be responsible for maintaining competent records of completed qualified continuing professional education for a period of four years after close of the two year period to which the records pertain.

Utah Controlled Substances Act

58-37-6.5. Continuing education for controlled substance prescribers.

(1) For the purposes of this section:

(a) "Controlled substance prescriber" means an individual, other than a veterinarian, who:

(i) is licensed to prescribe a controlled substance under Title 58, Chapter 37, Utah Controlled

Substances Act; and

(ii) possesses the authority, in accordance with the individual's scope of practice, to prescribe schedule II controlled substances and schedule III controlled substances that are applicable to opioid narcotics, hypnotic depressants, and psychostimulants.

(b) "FDA" means the United States Food and Drug Administration.

(c) "M.D." means a physician and surgeon licensed under Title 58, Chapter 67, Utah Medical Practice Act.

(d) "D.O." means an osteopathic physician and surgeon licensed under Title 58, Chapter 58, Utah Osteopathic Medical Practice Act.

(2) Beginning with the licensing period that begins after January 1, 2014, as a condition precedent for license renewal, each controlled substance prescriber shall complete at least four continuing education hours per licensing period that satisfy the requirements of Subsections (3) and (4).

(3) As provided in Subsection 58-37f-402(8), **the online tutorial and passing the online test described in Section 58-37f-402 shall count as 1/2 hour of continuing professional education** under Subsection (2) per licensing period.

(4) A controlled substance prescriber shall complete at least 3.5 hours of continuing education hours in one or more controlled substance prescribing classes, except dentists who shall complete at least 2 such hours, that satisfy the requirements of Subsections (5) and (7).

(5) A controlled substance prescribing class shall:

(a) satisfy the division's requirements for the continuing education required for the renewal of the controlled substance prescriber's respective license type;

(b) be delivered by an accredited or approved continuing education provider recognized by the division as offering continuing education appropriate for the controlled substance prescriber's respective license type; and

(c) include a postcourse knowledge assessment.

(6) An M.D. or D.O. completing continuing professional education hours under Subsection (4) shall complete those hours in classes that quality for the American Medical Association Physician's Recognition Award Category 1 Credit.

(7) The 3.5 hours of the controlled substance prescribing classes under Subsection (4) shall include educational content covering the following:

(a) the scope of the controlled substance abuse problem in Utah and the nation;

(b) all elements of the FDA Blueprint for Prescriber Education under the FDA's Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy, as published July 9, 2012, or as it may be subsequently revised;

(c) the national and Utah-specific resources available to prescribers to assist in appropriate controlled substance and opioid prescribing;

(d) patient record documentation for controlled substance and opioid prescribing; and

(e) office policies, procedures, and implementation.

(8) (a) The division, in consultation with the Utah Medical Association Foundation, shall determine whether a particular controlled substance prescribing class satisfies the educational content requirements of Subsection (5) and (7) for an M.D. or D.O.

(b) The division, in consultation with the applicable professional licensing board, shall determine whether a particular controlled substance prescribing class satisfies the educational content requirements of Subsection (5) and (7) for a controlled substance prescriber other than an M.D. or D.O.

(c) The division may be rule establish a committee that may audit compliance with the Utah Risk Evaluation and Mitigation Strategy (REMS) Educational Programming Project grant, that satisfies the educational content requirements of Subsection (5) and (7) for a controlled substance prescriber.

(9) A controlled substance prescriber class required under this section:

(a) may be held:

(i) in conjunction with other continuing professional education programs; and

(ii) online; and

(b) does not increase the total number of state-required continuing professional education hours required for prescriber licensing.

(10) The division may establish rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section.

State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

GARY R. HERBERT
Governor

FRANCINE A. GIANI
Executive Director

MARK B. STEINAGEL
Division Director

August 7, 2013

Re: Controlled Substance Prescriptions

This letter is being sent out as a courtesy to educate controlled substance prescribers and pharmacies regarding concerns found during routine pharmacy inspections conducted by DOPL Inspectors. The three most significant concerns are:

1. Schedule III-V prescriptions being filled without the prescriber's manual signature being attached to the prescription. Typically, inspectors are seeing a digital image of a signature attached to the prescription. Upon closer look at the signatures, pixilation can be seen, and by viewing several prescriptions at the same time the signatures appear to be identical. Most of the prescribers submitting these prescriptions have some type of e-prescribing system, but the prescriptions are being sent to the pharmacy by facsimile and do not meet the Utah Code requirements according to the definition of an electronic signature as outlined below:

- **"Electronic signature"** means a trusted, verifiable, and secure electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.
  UCA 58-17b-102(27) (http://le.utah.gov/code/TITLE58/htm/58_17b010200.htm)

- Except for emergency situations designated by the division, a person may not issue, fill, compound, or dispense a prescription for a controlled substance **unless the prescription is signed by the prescriber in ink or indelible pencil or is signed with an electronic signature of the prescriber as authorized by division rule, and contains the following information:**
  (i) the name, address, and registry number of the prescriber;
  (ii) the name, address, and age of the person to whom or for whom the prescription is issued;
  (iii) the date of issuance of the prescription; and
  (iv) the name, quantity, and specific directions for use by the ultimate user of the controlled substance.
  UCA 58-37-6(7)(d) (http://le.utah.gov/code/TITLE58/htm/58_37_000600.htm)

- Federal law also requires that an electronic prescription must be transmitted from the practitioner to the pharmacy in its electronic form. At no time may an intermediary convert an electronic prescription to another form **(e.g., facsimile)** for transmission.
  21 CFR, Section 1311.170(f)
  (http://www.deadiversion.usdoj.gov/21cfr/cfr/1311/subpart_c100.htm#170)

2. Incomplete controlled substance prescription records where information such as patient's address, age, and DEA number is missing. Inspectors have seen multiple incomplete controlled substance prescription records where information such as the patient's full name and address, age, and DEA registration number is missing. The minimum information required on a prescription can be found at:

- ***UCA 58-17b-602*** (http://le.utah.gov/code/TITLE58/htm/58_17b010200.htm)
- ***UCA 58-37-6(7)(d)*** (http://le.utah.gov/code/TITLE58/htm/58_37_000600.htm)
- ***21 CFR, Section 1306.05(a)*** (http://www.deadiversion.usdoj.gov/21cfr/cfr/1306/1306_05.htm)

3. Each prescription for a controlled substance may contain only one controlled substance per prescription form and may not contain any other legend drug or prescription item. Please refer to:

- ***UCA 58-37-6(7)(f)(vi)*** (http://le.utah.gov/code/TITLE58/htm/58_37_000600.htm)

The Division's pharmacy website, http://dopl.utah.gov/licensing/pharmacy.html, may be useful to ensure you have a clear understanding of these and other statutes, rules, ethical and professional standards that apply to your practice.

Thank you for your assistance in complying with the State's laws and rules. If you have any questions email doplinvestigations@utah.gov or call 801-530-6630 to speak with a member of our pharmacy investigations team.

Sincerely,

David P. Furlong

David P. Furlong, Chief Investigator
Bureau of Investigation

Complaints of Unlawful or Unprofessional Conduct

What Happens to Them?

An Explanation of the Complaint Handling Process for the Division of Occupational and Professional Licensing, Utah Department of Commerce

PLEASE NOTE: *This information provides only a general overview of the process by which a complaint or other report of unlawful or unprofessional conduct is reviewed by DOPL. The information may be thoroughly reviewed in Title 58 of the Utah Code and Title R156 of the Utah Administrative Code.*

Every day the Utah Division of Occupational and Professional Licensing (DOPL) receives complaints regarding the conduct of individuals practicing in regulated occupations and professions. Complaints are received from many sources including the general public, co-workers, licensing board members, professional associations, other state agencies, and federal disciplinary databases.

DOPL is legislatively responsible to investigate acts or practices inconsistent with generally recognized standards of conduct, unlicensed practice in regulated professions or occupations, allegations of gross negligence or incompetence, and patterns of negligence or incompetence.

Complaints are confidential in nature and are not generally available to the public. However, in certain situations, the information contained in a complaint may be shared with other governmental agencies, if the other agency demonstrates a legal basis for the sharing of such information.

Upon submission, all complaints are entered into an investigative database in order to analyze patterns of behavior. Each complaint is then reviewed by DOPL's chief investigator or an investigative supervisor who makes one of three initial determinations:

- no violation
- violation which does not meet DOPL's criteria for investigation
- violation which does meet DOPL's criteria for investigation

No Violation

If it is determined that the complaint does not involve a violation, the complaint is closed and no action is taken. Additionally, no public reporting of the information will occur.

Violation which Does Not Meet Criteria for Investigation

When a complaint involves a violation, but does not meet DOPL's criteria for opening an internal investigation, the DOPL may choose to take any or all of the following actions:

- refer the complaint to another local, state, or federal agency
- invite the involved individual(s) to participate in an informal, educational interview
- issue a letter of concern to the involved individual(s)

At times, DOPL is legally unable to investigate or take action on a complaint due to lack of jurisdiction or authority. In other situations, DOPL may determine that the complaint would be better handled by another local, state, or federal agency and will refer the complaint to that agency for further review.

An educational interview provides an opportunity for the respective licensing board and the involved individual to obtain and provide information about the situation. Educational interviews usually occur during a regularly scheduled board meeting.

A letter of concern is a means of informing the individual of the reported allegations, of DOPL's concerns regarding the truth of the allegations, and of the applicable regulations -- without imposing a disciplinary sanction on the individual's license. A letter of concern also offers the individual an opportunity to respond and explain his or her side of the situation.

Educational interviews and letters of concern are non-disciplinary actions and do not affect an individual's professional license. Essentially, these two options are proactive methods of stopping inappropriate activity before public safety is compromised and before action must be taken against the individual's license.

Violation which Does Meet Criteria for Investigation

Finally, if a complaint is determined to involve a violation and is within DOPL's jurisdiction, the complaint will be prioritized and assigned to an investigator. Investigators use their experienced judgment and established procedures to determine the type of investigation to conduct. An investigation may include any of the following elements:

- interviewing complainant(s)
- interviewing witness(es)
- interviewing involved individual(s)
- obtaining appropriate records or documentation (subpoena)
- gathering other evidence
- obtaining input from applicable experts
- drafting petitions which include a statement of the allegations

At any time, the case may be reviewed by any or all of the following: the Utah Attorney Generals Office, an expert in the respective occupation or profession, DOPL's enforcement counsel, or DOPL's bureau manager responsible for the regulation of the respective occupation or profession. DOPL may also determine that a criminal complaint is warranted and will then notify the appropriate authorities of the situation.

A case is usually resolved in one of two ways under the Utah Administrative Procedures Act (UAPA):

- **informally**
- **formally**

Unless specified otherwise in an order, all cases are public and reportable.

Cases designated to be handled **informally** are resolved in one of three ways:

Administrative Citations: A citation is the imposition of a fine or a cease and desist order, or both, in response to unlawful or unprofessional conduct, or both. Citations are issued when proper authority is established in statute and a citation is determined to be the appropriate response to a violation.

Citations are normally issued by the investigator who has been assigned the case. Practicing without a license, exceeding the scope of a license, and hiring someone who is required to be licensed who is unlicensed are citable offenses for all professions and are good examples. Some professions have additional fine and citation authority.

Citations may also be issued by a bureau manager for violation of probation or other violation of the terms of an order governing a license. This is normally tracked and identified for the bureau manager's action by DOPL's Compliance Unit. It may be issued as part of a probationary interview before a licensing board.

Citations become the final order of the Division after the passage of 20 calendar days unless the citation is challenged. Each citation is issued together with a notice of response that has four options:

- I admit the citation and hereby pay the fine without contesting the citation.
- I admit the citation and hereby pay the fine with a written explanation of the circumstances of the offense, and a request that the fine be reduced.
- I admit the citation and request a hearing to explain the circumstances of the offense (with a written response requested).
- I deny committing the offense and request a hearing to contest the citation (with a written response requested).

Informal citation hearings are held monthly. Notices of hearing are sent in advance. A presiding officer for conducting the hearing and entering final orders is designated by the Director. Normally parties represent themselves at such hearings, but occasionally parties retain counsel. The hearings are informal, somewhat analogous to traffic court, with the presiding officer gathering from the parties the necessary information to enter an order. Citations may be affirmed, dismissed or modified by the presiding officer. Orders are announced by the presiding officer at the hearing while the citation coordinator completes a template written order.

Stipulated Agreements: A stipulated agreement is a written settlement accepted by all applicable parties with regard to the involved individual's license. It may include any combination of the same actions that are possible during an informal adjudicative proceeding. A stipulated agreement may also be the result of the voluntary surrender of an individual's license.

No hearing is held for such actions. A stipulated agreement must be approved by the director of DOPL in the form of a stipulation and order.

Informal Adjudicative Proceeding: An informal adjudicative proceeding is a case initiated by a notice of agency action and decided or resolved by a file review as opposed to a hearing, unless a right to a hearing has been established by statute or rule, such as in the case of citations. These matters should be fairly straightforward and reasonably easy to resolve, and hence their designation to be handled informally.

Misconduct that has been designated as to be handled by informal adjudicative proceeding includes:

- violating the terms of an order governing a license such as probation (U.C.A. §58-1-501(2)(o));
- engaging in conduct that results in a conviction, plea of no contest, a plea held in abeyance with respect to crimes of moral turpitude or any other crime, that when considered with the functions and duties of the occupation or profession for which the license was issued or is to be issued, bears a reasonable relationship to the licensee's or applicant's ability to safely or competently practice an occupation or profession (U.C.A. §58-1-501(2)(c));
- engaging in conduct that results in disciplinary action by another licensing or regulatory authority having jurisdiction over the licensee or applicant in the same occupation or profession if the conduct would, in this state, constitute grounds for denial of licensure or disciplinary proceedings (U.C.A. §58-1-501(2)(d)); and
- surrendering licensure to any other licensing or regulatory authority having jurisdiction over the licensee or applicant in the same occupation or profession while an investigation or inquiry into allegations of unprofessional or unlawful conduct is in progress or after a charging document has been filed against the applicant of licensee alleging unprofessional or unlawful conduct (U.A.C. §R156-1-501(1)).

The applicant or licensee has their opportunity to be heard in writing as opposed to a hearing. As permitted by rule, the notice of agency action requires a written response to be filed with the Division within 30 days and specifies that a party's default will be entered should they fail to submit the response as required.

In practice these types of cases will normally be placed on a board meeting agenda for discussion by the board and recommended action to the Division. The licensee or applicant involved may attend the meeting and provide public comment. However, the matter is an agenda item, NOT a hearing.

A recommended and final order may include any of the following actions or a combination of these actions:

- revocation
- revocation with a stay of enforcement
- indefinite suspension
- indefinite suspension with terms and conditions to be met to lift the suspension
- suspension for a specific period of time
- suspension for a specific period of time followed by a term of probation
- suspension with a stay of enforcement and probation
- probation for a specific period of time with terms and conditions
- probation with restrictions
- restrictions
- fine (if allowed by statute)
- public reprimand

Cases designated to be handled **formally** are resolved in one of two ways:

Stipulated Agreements: A stipulated agreement is a written settlement accepted by all applicable parties with regard to the involved individual's license. It may include any combination of the same actions that are possible during a formal administrative hearing. A stipulated agreement may also be the result of the voluntary surrender of an individual's license.

No hearing is held for such actions. A stipulated agreement must be approved by the director of DOPL in the form of a stipulation and order.

Formal Administrative Hearings: Similar in some ways to a civil court hearing, administrative hearings allow both sides to present information and testimony regarding the situation. An administrative law judge rules on all evidence, procedures, and legal issues. The respective licensing board receives the submitted evidence and may question all witnesses. DOPL is represented by an assistant attorney general, and the involved individual may be represented by personal legal counsel. Each may present information and evidence in response to the case.

At the conclusion of a hearing, the licensing board considers the evidence and makes a recommendation regarding the status of the individual's license. The recommendation is submitted to the director of DOPL who may accept the entire recommendation or may issue a modified or supplemental order. A recommended and final order may include any of the following actions or a combination of these actions:

- revocation
- revocation with a stay of enforcement
- indefinite suspension
- indefinite suspension with terms and conditions to be met to lift the suspension
- suspension for a specific period of time
- suspension for a specific period of time followed by a term of probation
- suspension with a stay of enforcement and probation
- probation for a specific period of time with terms and conditions
- probation with restrictions
- restrictions
- fine (if allowed by statute)
- public reprimand

Review after Entry of an Order: Any individual who has action taken against his or her license has rights of appeal specified under UAPA. An appeal must first be may be made to the Department of Commerce Executive Director (agency review) and then to the appropriate court for judicial review (Informal: District Court – de novo review) (Formal: Court of Appeals – review on the record).

2012 Environmental Scan

Annual review of emerging issues and trends that impact nursing regulation

NCSBN
National Council of State Boards of Nursing

INTRODUCTION

Regulators are in the midst of an environment that is filled with economic, social and political influences. They must deal with nursing regulation and health care issues while watching the state budget, working with the state legislature and being impacted by external forces in the world around them. Throughout 2012, issues, threats and opportunities have emerged for state boards of nursing (BONs). This environmental scan attempts to capture the majority of these influences while detailing the current milieu in which regulators work, base decisions, confront challenges and generate new ideas. This report is also intended to be a historical document that captures the essence of 2012 for nursing regulators including their achievements, accomplishments and issues they deal with on a daily basis. Most importantly, it is intended to describe the present *state of the state boards of nursing*, provide a glimpse into the next year and serve as a catalyst for strategic planning.

The following questions guided this analysis:

1. What is the current state of nursing and nursing regulation?
2. What are the economic, social and political influences impacting nursing and BONs?
3. What are the achievements, accomplishments and advancements of nursing regulators during 2012?
4. What are the emerging issues, risks, opportunities and threats that exist in the regulatory environment?

Methods

A variety of sources were used to develop this report, including news articles, websites, databases, peer reviewed journals, direct communication/presentations, annual BON reports and Web surveys. Certain consistent sources of data and graphs are used from year to year to help formulate comparisons and identify trends. New issues, new problems and new data characterizing 2011- 2012 are also included. An abundance of information was reviewed and analyzed in order to provide a report that can be used to assess the regulatory environment and guide strategic planning. Not all applicable information and data can be captured in this report; however, every attempt was made to produce a well-documented comprehensive report describing the state of BONs and the regulatory environment.

THE NURSING WORKFORCE

This report begins with one of the most relevant issues of 2012: employment and workforce. There are approximately 311 million residents in the U.S. (Bureau of Labor Statistics, 2012). Serving this population are more than 2,724,570 registered nurses (RNs) (Department of Labor, 2012). Nurses represent the largest segment of the health care workforce in the U.S., and are one of the 10 largest occupations, accounting for 2.1 percent of the total employment in the U.S. (Bureau of Labor Statistics, 2012). As of November 2012 there were more than 3,927,092[1] licensees (RN and licensed practical/vocational nurses [LPN/VNs]) in the U.S. and its territories (NCSBN, 2012).

While the last two years have recorded some of the highest unemployment rates in U.S. history, employment in nursing has remained consistently robust. Nursing employment figures for 2012 have not been released, but statistics recently published by the Department of Labor indicate that nursing experienced a small, but substantial increase in hiring in 2011, during a time that was considered one of the worst economies since the great depression.

RNs

A closer look at nursing employment trends is shown in Table 1, which describes the number of employed RNs reported annually by the Department of Labor.

Table 1: Total Number of Employed RNs: 2000-2011

	2000	2004	2008	2010	2011
Number of Employed RNs*	2,201,813	2,442,593	2,596,399	2,655,020	2,724,570

*The 2010 and 2011 statistics depicted above were taken from the semiannual Occupational Employment Statistics (OES) survey published by the U.S. Department of Labor. The 2006 and 2010 were taken from Findings from the 2004 and 2008 National Sample Survey of Registered Nurses (2006 and 2010).

To examine the number of registered nurses per 100,000 capita in 2011, the most recent statistics from the Dept of Labor, please see Appendix A.

[1] Does not include states that do not participate in Nursys (as of November 2012).

Table 2 indicates the top five settings that employed nurses in 2012. As indicated, the majority of RNs continue to be employed by general medical and surgical hospitals.

Table 2: Distribution of RNs by Employment Setting in 2012

Employment Setting	Number of Nurses Employed	Percent of Nurses Employed in Setting
General Medical and Surgical Hospitals	1,556,930	29.98
Offices of Physicians	235,710	10.06
Home Health Care Services	156,730	13.92
Nursing Care Facilities	138,080	8.27
Outpatient Care Centers	95,180	15.56

(Department of Labor Statistics, 2012)

Employment for New Graduates

While employment for experienced RNs was steady throughout 2011 and 2012, there were many anecdotal reports of new graduates having difficulty obtaining employment. The California Board of Registered Nursing reported approximately 22 percent of its 2011 graduates had difficulty finding an RN position. To assess the actual employment conditions for new graduates, two studies were conducted. The first study, investigated by the National Student Nurses Association (NSNA), surveyed 2011 RN program graduates (n= 3,733) and found that 36 percent of the May-June graduates answering the survey did not have a job offer at the time of graduation and were still unemployed in the fall of 2011.

While this is a significant unemployment statistic, nursing graduates fared considerably better than graduates in other disciplines. In a survey conducted by the National Association of Colleges and Employers (2012) to assess the employment rates of 2011 college graduates from across disciplines (N=50,000), only 25.5 percent of those surveyed had a job at the time of graduation.

NSNA followed up with a survey to those who did not have jobs as of April 2012. Approximately 50 percent of those who were unemployed in the fall of 2011 still did not have jobs as an RN. As illustrated in Table 3, those having the most difficulty finding positions were graduates from accelerated bachelor of science in nursing (BSN) programs and associate degree programs (Griswold, 2012; Mancino, 2011).

Table 3: Percentage of 2011 New RN Graduates Employed by Type of Nursing Program[2]

Employed as an RN	Associate Degree	Diploma	Baccalaureate Generic	Baccalaureate Accelerated	Total
Yes	61% (864)	69% (117)	68% (1, 150)	54% (200)	64% (2,331)
No	39% (543)	31% (52)	32% (531)	47% (177)	36% (1, 303)
Total	**1,407**	**169**	**1,681**	**377**	**3,634**

(Mancino, 2011)

NSNA also asked new graduates to report what they perceived to be the reasons for the lack of RN positions. These data are reported in Table 4.

Table 4: Reasons Reported by New Graduates for Lack of Open RN Positions

- Employers filling positions with experienced RNs (80%)
- Older RNs are not retiring (78%)
- Too many new graduates are flooding the market (69%)
- Hiring BSN graduates over associate degree graduates (63%)
- RNs working full-time are also working in other RN positions part-time (58%)
- Hiring per diem nurses without benefits (55%)
- RNs who are currently employed are now working harder (52%)
- Nurses who were formerly working part-time are now working full-time (51%)
- Hiring freezes (45%)
- Hospitals are hiring travel and agency nurses (40%)
- Long-term care facilities are hiring new graduates (40%)
- Hospitals discontinuing new graduate orientation and residency programs (30%)
- Hospitals are closing departments (23%)
- Home care and community health agencies are hiring new graduates (22%)
- RNs are being laid off (20%)

(Mancino, 2012)

The economy has effected nursing employment over the last few years. Fewer positions have been available for new graduates because experienced nurses have been returning to work. This was noted by the Nevada Board of Nursing, which is experiencing an increase in nurses returning to the workforce and renewing their licenses due to the economy.

[2] *Does not include a small percentage of generic masters and generic doctorate graduates*

Obtaining employment as an RN during 2011-2012 may have also been dependent upon degree type. In a similar survey of 501 deans conducted by the American Association of Colleges of Nursing (AACN), 57 percent of 2011 BSN graduates and 73 percent of entry-level Master of Science in nursing (MSN) graduates had job offers at the time of graduation. Four to six months after graduation, 88 percent of BSN graduates and 92 percent of entry-level MSN graduates had job offers. The survey found that the school and characteristics of the program did not have any affect as to whether new graduates found employment as RNs. AACN also reported that 77.4 percent of employers specify a preference for BSN graduates (AACN, 2012).

BONs have reported associate degree in nursing (ADN) program graduates having difficulty finding jobs in the past year. The District of Columbia Board of Nursing reports that hospitals in its jurisdiction are exclusively hiring BSN graduates. This was affirmed by Sharon Tanner, executive director, NLNAC, speaking at the 2012 National Organization for Associate Degree Nurses (N-OADN) Annual Meeting, who stated that some ADN programs are closing because their students are having difficulty finding jobs after graduation.

The Future of the RN Workforce

Despite reports of new graduates having difficulty finding jobs and some evidence that employers are moving towards hiring baccalaureate prepared nurses, the U.S. Bureau of Labor Statistics Employment Projections 2010-2020 maintains its prediction that 1.2 million additional RNs will be needed by 2020 to meet job growth and replace RNs leaving the field (U.S. Bureau of Labor Statistics, 2012). The 26 percent increase in nursing jobs between 2010 and 2020 predicted by the Bureau of Labor Statistics far exceeds the average for all occupations, which is 14 percent. Aging of the nursing workforce continues to cause concern with the average age of RNs projected to be 44.5 years by 2012, with nurses in their 50s expected to make up the largest portion of the workforce (U.S. Bureau of Labor Statistics, 2012).

LPN/VNs

In 2012 there are approximately more than 731,000[3] LPN/VNs in the U.S. The number of LPNs/VNs per 100,000 capita is not available from the Dept of Labor.

In 2012, it was reported that hospitals are decreasing their use of LPN/VNs (Malone, 2012), though LPN/VNs are still the mainstay of long-term care and continue to be employed in these settings. However, this statistic varies by state. The District of Columbia Board of Nursing reports LPNs in its jurisdiction are having difficulty finding positions because of a recently enacted law requiring more RNs to be employed in nursing homes. The Delaware Board of Nursing reported that major acute care facilities are not hiring LPNs due to their applications for Magnet status. Overall, there are reports of an increase in the usage of LPN/VNs in wound care, behavioral health, schools, prisons, home care and ambulatory care (Malone, 2012).

[3] Does not include states that do not participate in Nursys (as of November 2012).

The Future of the LPN/VN Workforce

Recent predictions from the Bureau of Labor Statistics anticipate there to be a growing need for LPN/VNs in the future and the job market to grow 22 percent from 2010 to 2020 (Bureau of Labor Statistics, 2012).

Advanced Practice Registered Nurses (APRNs)

There are currently no accurate counts of APRNs in the U.S. These data will not be available until every jurisdiction recognizes all four APRN roles and have loaded their APRN data into Nursys®, NCSBN's licensure and discipline databank. Currently, Phillips (2012) annually reports the numbers of APRNs in the country. However, these data are acquired by state self-reports and may be incomplete. Ten states and one U.S. territory do not recognize all four roles and therefore have no accurate method of counting the numbers of nurses practicing in these roles.

Table 4: Number of APRNs: 2009 – 2012

	2009	**2010**	**2011**
Certified Nurse Practitioner	114,815	144,605	156,882
Clinical Nurse Specialist	12,227	12,543	14,157
Certified Nurse Midwife	7,158	6,809	7,102
Certified Registered Nurse Anesthetist	37,460	40,795	41,209
Totals	**171,660**	**204,752**	**219,350**

(Philips, 2012)

It is uncertain what impact the Patient Protection and Affordable Care Act (PPACA) will have on health care; however, the prediction of 30 million more insured individuals seeking health care has many looking to APRNs for assistance in expanding the primary care workforce. Several government agencies have been actively involved in APRN issues during the past year. In 2012, the Federal Trade Commission (FTC) became actively involved in the issue of APRN independent practice by addressing restraint of trade issues in letters to four different state legislatures (West Virginia, Louisiana, Missouri and Kentucky). These letters, written in response to the American Medical Association's (AMA's) opposition to the independent practice of APRNs, supported removing barriers to APRN practice and allowing APRNs to practice to the full extent of their education (FTC, 2012).

In an effort to put more APRNs in primary care, the PPACA has allocated $200 million to a demonstration project designed to reimburse hospitals for the clinical training of APRNs. Five hospitals, Hospital of the University of Pennsylvania (Philadelphia, Pa.), Duke University Hospital (Durham, N.C.), Scottsdale Healthcare Medical Center (Scottsdale, Ariz.), Rush

University Medical Center (Chicago, Ill.) and Memorial Hermann-Texas Medical Center Hospital (Houston, TX) were selected by the Centers for Medicare and Medicaid Services (CMS) to participate (CMS Graduate Education Project, 2012). CMS is also encouraging physicians and hospitals to include APRNs in the work of overseeing patient care by describing the interdisciplinary approach as the best model for patients. CMS also broadened its concept of medical staff to include APRNs in the Final Rule on Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation (CMS, May 2012).

During 2012, the Veterans Health Administration (VHA) expanded the roles of APRNs working in its facilities. Based on the laws/rules of federal supremacy, APRNs working in the VHA are now recognized as independent practitioners regardless of state practice act requirements for supervision or collaborative practice agreements (Rick, 2012).

Studies released this year indicate that APRNs can improve a state's economy (Perryman, 2012), and do not impact on the wages of a physician (Pittman & Williams, 2012). A widely referenced study by Skillman, et al. (2012) implied that there was a trend in the migration of APRNs, particularly to rural areas in states with less restrictive practice regulations; however, findings did not achieve statistical significance.

Other Workforce Issues

As of 2010 (the most recent statistics available) there are 22,568,578 veterans in the U.S. Many of which have been employed in military careers involving health care, such as Army medics and Navy corpsman. As they retire from the military and shift to civilian life, questions are arising as to how they can be expediently transitioned into careers in the nursing workforce. As part of this initiative, the Health Resources and Services Administration (HRSA) is collaborating with the U.S. Armed Forces to determine how to best use allocated resources to determine how the education and experience received in the military may be substituted for academic credit that would allow them to fast track through a nursing program. While the entry of these individuals will be an asset to the profession and add to the numbers of nurses that may be needed in the near future, concern has centered on ensuring that veterans receive the proper nursing education so they are safe to practice in civilian health care facilities where nursing problems and process are different from those encountered in battlefield or military facilities (for more information, see Nursing Education).

NCSBN's Workforce Database

There are currently nine BONs providing data into NCSBN's nursing workforce database: Arizona, Arkansas, Maine, Minnesota, New Hampshire, Texas, Nevada, New Jersey and Ohio. Six more BONs are actively being set up to begin entering data into the system: Connecticut, Washington D.C., Georgia, North Carolina, South Dakota, and Wyoming.

In support of ongoing efforts to collect and analyze state specific nursing workforce data, the Idaho Board of Nursing amended its nurse practice act to allow the BON to support efforts to develop the education, distribution and availability of nurses. The new law also allows the BON to enter into contracts or agreements with others to fulfill these purposes.

NURSING EDUCATION

Faculty

Annually, the NCSBN Environmental Scan reports on the findings of Fang and Li's *Special Survey on the Vacant Faculty Positions for Academic Year* (2012). This survey describes the current status and trends related to nursing faculty in baccalaureate or higher nursing education. The 2011-2012 survey had a response rate of 662 deans. Table 6 provides the 2012 data, as well as faculty trends from 2009 to the present.

Table 6: Nursing Program Faculty: Recent Trends (2009-2012)

	2009	2010	2011	2012
Total full-time budgeted positions	12,184	12,783	14,166	15,574
Total number of full-time vacancies (national vacancy rate)	803 (6.6%)	880 (6.9)%	1,088 (7.7%)	1,181 (7.5%)
Total number of filled positions	11,385 (93.4%)	11,909 (92.3%)	13,078 (92.3%)	14,393 (92.4%)
Mean number of vacancies per school	1.4	1.6	1.8	1.8
Range of vacancies	1-13	1-16	1-16	1-20
The number of schools with no faculty vacancies, but that need additional faculty	117	112 (20.1%)	104 (17%)	103 (17%)
The number of schools with no faculty vacancies, and that do not need additional faculty	127	141 (25.4%)	145 (24%)	182 (30%)

(Fang & Li, 2012)

Reasons for programs not hiring new faculty
(n=103; schools that don't have vacant positions but need more faculty)

- Insufficient funds: 64.1 percent
- Unwillingness of administration to commit to additional full-time positions: 51.5 percent
- Inability to recruit qualified faculty because of competition for jobs with other markets: 35.9 percent
- Qualified applicants for faculty positions are unavailable in the geographic area: 26.2 percent

Most critical issues faced by schools related to faculty recruitment and retention

- Limited pool of doctorally prepared faculty: 32.9 percent
- Noncompetitive salaries: 27.6%
- Finding faculty with right specialty mix: 19 percent
- Finding faculty willing/able to teach clinical courses: 4.9%
- Finding faculty willing/able to conduct research: 5.8 percent
- High faculty load: 3.2 percent

Nursing program accreditation

- 10 percent of LPN/VN programs are currently accredited by NLNAC
- 52 percent of ADN programs are accredited by NLNAC
- 80 percent of diploma programs are accredited by NLNAC
- 96 percent of BSN programs are accredited by either NLNAC or CCNE (16 BSN programs are accredited by both NLNAC and CCNE)

The Indiana State Board of Nursing is currently in the process of requiring NLNAC or CCNE accreditation for all of its nursing programs.

Table 7 depicts the pass rates of first time U.S.-educated students taking the NCLEX-RN® and NCLEX-PN®. Note the increase in the number of first-time RN test takers from 2010 to 2011 and the slight decrease in the number of first-time PN test takers. Pass rates for RNs remained essentially the same, but decreased for LPN/VNs.

Table 7: Graduates from U.S. Nursing Programs: 2000-2010

	January-December 2010	**January-December 2011**
Number of first time U.S. educated students taking the NCLEX-RN	140,889	144,583
Number of first time U.S. educated students taking the NCLEX-PN	66,831	65,334
NCLEX pass-rates first time RN test takers	87.41%	87.89%
NCLEX pass-rates first time PN test takers	87.05%	84.83%

See Table 8 for a breakdown of the number of NCLEX® test takers according to program type. As expected, ADN graduates still comprise the largest number of nursing program graduates. The number of baccalaureate graduates, however, increased at a higher rate than ADN graduates from 2010-2011.

Table 8: Number of U.S. First-time Test Takers Taking NCLEX According to Type of Educational Program

	2010	**2011**
Diploma	3,753	3,476
Associate Degree	81,618	82,764

Baccalaureate	55,414	58,246
Unclassified or special codes	104	97
Total	**140,889**	**144,583**

In 2012, BONs were surveyed by NCSBN to assess whether educational programs were adopting or piloting innovations in nursing education. The survey data were compared with a similar study conducted in 2010. As illustrated in Table 9, for the most part, nursing education programs are using innovative methods to teach students and deal with faculty shortages. The second part indicates that there are fewer nursing education programs using innovative methods to deal with faculty shortages. This may be explained by data in Table 6, which indicate that in 2012, fewer programs need additional faculty.

Table 9: Innovations in Nursing Education: 2010 and 2012

	2010 (n=26 BONs)	**2012 (n=39 BONs)**
Percentage of BONs reporting that nursing programs in their state are developing innovations that have the potential to transform nursing education	48%	57%
Percentage of BONs reporting that their schools are using innovative methods to deal with faculty shortages	76%	60%
Percentage of BONs reporting practice/partner innovations	52%	69%

(Spector & Odom, 2012).

Advancing Education in Nursing

Much emphasis has been placed on baccalaureate-prepared nurses during the past year. New evidence supporting improved outcomes with BSN prepared nurses was released at the end of 2011. Aiken, et al. (2011) published the results of a study that indicated a 10 percent increase in the number of baccalaureate prepared nurses on a hospital unit decreases the odds of a 30-day inpatient mortality and failure to rescue by 4 percent.

As outlined under the Workforce section of this report, some employers are indicating a preference for BSN graduates. NSNA found that 61 percent of ADN graduates had jobs versus 68 percent of BSN graduates (Mancino, 2012) and AACN, in a survey of 501 deans, found 57 percent of 2011 BSN graduates and 73 percent of entry-level MSN graduates had job offers at the time of graduation (AACN, 2012).

The NSNA survey also asked about educational advancement. Respondents (n= 3,733) were asked to answer questions pertaining to the highest level of education they had hoped to acquire. Overall, 78 percent answered that they "intended to return to school for another degree." Only 4 percent said "no" and 18 percent were "unsure." Twenty-three percent (n=292) of ADN

graduates stated they planned to immediately continue their education and enroll in the fall 2011 semester. When asked to predict the highest degree that they plan on receiving, 12 percent (n=422) of new graduates stated a baccalaureate degree in nursing; 57 percent (n=1,922) intend to pursue a master's degree in nursing; 24 percent (n=804) are aiming to acquire a doctorate in nursing practice; and 6 percent (n=215) indicate their goal is to acquire a PhD (Mancino, 2012).

A statement supporting the advancement of nursing education was released this year and endorsed by five educational organizations. *The Joint Statement on Academic Progression for Nursing Students and Graduates* maintains that nursing students and practicing nurses should be supported in their efforts to pursue higher levels of education and encourages "seamless transition into associate, baccalaureate, master's, and doctoral programs." The five organizations that have endorsed the statement include: AACN, the American Association of Community Colleges (AACC), the Association of Community Colleges Trustees (ACCT), the National League for Nursing (NLN), and N-OADN (AACN, 2012).

Academic progression for advancing nurses' education is a major topic of discussion in many states and is related to the recommendations of the IOM report. 25 states reported there are BSN in Ten discussions or initiatives (ADN graduates must complete BSN requirements within 10 years after completing the associate degree) in their state. The board of nursing is actively involved in these discussions or initiatives in approximately 50% of these states. Two states, New York and New Jersey, have legislation pending in committee for amending the state nurse practice act to include the BSN in Ten requirement.

Federal Legislation Related to Education

Program Integrity Regulations for State Authorization of Distance Learning Education

In 2010, the U.S. Department of Education published the final Program Integrity Regulations, amending the eligibility requirements for institutions receiving funding under Title IV of the Higher Education Act (HEA) of 1965. Under the new regulations, a student enrolled in an education program cannot use Title IV funds if the state in which the student is located while receiving instruction has not authorized the offering institution to provide instruction in that state. In response to the regulation, the Association of Private Sector Colleges and Universities filed suit against Department of Education Secretary Arne Duncan. On June 5, 2012, U.S. Court of Appeals for the District of Columbia Circuit affirmed that the regulation related to state authorization of distance learning violated the Administrative Procedure Act because the Department of Education failed to provide adequate notice of the rule to regulated parties.

State Legislation Related to Education

- Utah: A bill goes into effect January 2013 where the Utah State Board of Nursing will lose its oversight role over nursing programs. The BON has expressed concerns about Utah programs that are not meeting current standards and how this new law will affect them.

- Florida: A new law is in effect that will prevent the Florida Board of Nursing from approving an application for a new prelicensure nursing education program if it is submitted by an institution with an existing program currently on probation.
- Virginia- The Virginia Board of Nursing must implement and follow notice and due process before placing a nursing education program on conditional approval with terms that restrict student enrollment.

Other BON Issues Related to Education

- District of Columbia: Decreased enrollment in LPN programs has caused one program to close.
- Nine BONs report increasing numbers of new nursing programs in their state: Alabama, California, Florida, Georgia, Kentucky, Ohio, Oregon, Tennessee and Texas.
- Eight BONs report receiving increased numbers of questions related to distance learning programs: Hawaii, Indiana, Louisiana, Massachusetts, Oklahoma, Pennsylvania, Washington and West Virginia.
- Six BONs report sanctioning nursing education programs in the past year for not meeting standards: Florida, Montana, Oklahoma, Ohio, Texas and Virginia.

Other Nursing Education Issues

In the upcoming year, the Obama administration will be offering financial incentives for nursing programs that assist veterans into a nursing career. Nursing programs that apply for HRSA grants will receive funding priority if the school can demonstrate that it offers a pro-veteran learning environment and provides academic credit for health care training acquired in the military.

One school, the College of Nursing and Health Sciences at Texas A&M University-Corpus Christi is piloting a partnership with Medical Education and Training Command in San Antonio, TX. This facility provides all health care related education and training for three branches of the military: Army, Navy and Air Force. Texas A&M is assisting with identifying barriers and strategies for transitioning military training into academic credit. It is also looking at how to recruit veterans and support them while enrolled in a nursing program (HRSA, 2012).

ECONOMIC INFLUENCES POTENTIALLY IMPACTING NURSING AND NURSING REGULATION

The Federal Budget

Impact of the Fiscal Cliff

Throughout 2012, the country's economic issues continued to dominate the attention of state and federal lawmakers. One of the most significant federal economic issues that arose in 2012 and must be resolved by Congress prior to 2013 is the federal budget. Currently, under the Budget Control Act of 2011 [P.L. 112-25], there will be mandatory, automatic 8.2 percent across-the-board cuts to federal discretionary spending in 2013. This will have a major impact on all federal programs that are nonexempt, nondefense discretionary (NDD) programs. For example, in 2012, 50,000 research projects and training awards were funded by The National Institutes of Health

NIH. An 8.2 percent cut to NIH's fiscal year 2012 $30.711 billion budget would total $2.518 billion and significantly impact the agency's capacity to conduct research (U.S. House of Representatives, 2012).

Impact on States

The impact on the states will vary depending on the state tax structures and how much federal grant money it receives. For example, more than 10 percent of the State of South Dakota's revenue is subject to the influence of the federal budget compared to less than 5 percent of Delaware's income.

The fiscal cliff may be of some benefit to states. Lower federal reductions (increasing the income taxed by the state), the reduction of federal tax credits, higher corporate taxable incomes for the state and changes in the state tax would mean higher revenues for states. Six states, however, allow taxpayers to deduct federal income tax from state income taxes. Higher federal income would mean lower state revenue.

States will lose however. Grants to states from the federal government comprise one-third of the states' total revenue. Eighteen percent of the money from the federal revenue allocated to the states would be included in the across-the-board cuts. This would have a major impact on state social programs, including education, nutrition programs for low-income women and children, public housing, etc.

The exact impact on each state will vary and remains largely unknown. Is difficult to predict how state agencies such as the BONs will be affected. Umbrella boards may feel a greater impact than independent boards. States may enact their own changes in response to the federal government, such as amend their tax codes to compensate for the federal tax changes. Overall, the effect of the tax increases and spending cuts will differ by state and states will have to make difficult decisions in tackling these challenges (Pew Center on the States, 2012).

Impact on Nursing

Title VIII programs that support nursing education would be significantly affected. In 2012, HRSA disseminated Nursing Workforce Development grants totaling $71,950,000 (HRSA, 2012). Cutting 8.2 percent of this funding would have the following impact:

- Nursing Workforce Development Programs: 4,129 nurses and nursing students will be eliminated from the program
- Advanced Education Nursing and Nurse Anesthetist Traineeship programs: 1,011 fewer recipients. This would decrease access to care provided by APRNs. There would also be 645 fewer training opportunities for nurses pursuing graduate-level education.
- Comprehensive Geriatric Education program: 978 fewer nurses, nursing students, faculty and other health professionals will be available to deliver care to the elderly, disabled and chronically ill.
- Nursing Workforce Diversity Program: 872 fewer underrepresented and disadvantaged nursing students enrolled

- Nurse Education, Practice, Quality, and Retention program (which helps schools of nursing, academic health centers, nurse-managed health clinics and health care facilities strengthen programs that provide training opportunities and innovative models for nursing practice): 399 fewer participants
- Nurse Faculty Loan Program: 127 fewer faculty
- Nursing Education Loan Repayment: 96 fewer participants (AACN, 2012)

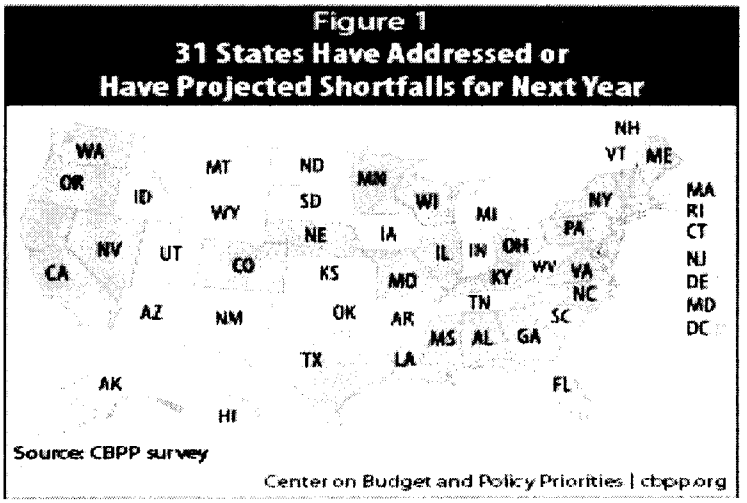
State Budgets

The "Great Recession" that began in 2007 created the most significant collapse in state revenues in history and states continue to suffer from deficits, although there are signs of a slow recovery. Many BONs have been impacted by the state budget crises. BONs have been limited in travel and hiring, and staff were required to take furlough days and had limitations in developing and taking on new projects, in addition to a host of other effects.

July 1, 2012 marked the start of the new state fiscal year[4] and 31 states are attempting to close budget gaps that total $55 billion (Center for Budget and Policy, 2012). Last year, 42 states had projected shortfalls.

Budget shortfalls have forced 46 states into decreasing services for state residents and those impacted the most are the economically disadvantaged. If revenues continue at low rates as is forecasted, additional spending cuts through fiscal year 2013 are predicted.

Figure 1:



On the bright side, some reports are cautiously optimistic. The National Council of State Legislatures (NCSL) conducted an annual survey of state legislative fiscal officers in spring of

[4] For most states, the fiscal year runs from July 1 through June 30 of the following year. Four states have exceptions to this: New York (April 1), Texas (September 1), and Michigan and Alabama (October 1) (Center on Budget and Policy Priorities, 2010)

2012. Data show that "revenue performance remains positive and expenditures in most states are stable." Despite this encouraging news, high unemployment levels, potential federal deficit reduction actions, spending pressures and global economic events are reasons that states remained concerned about the future economic status (NCSL, 2012).

Impact of the State Economy on BONs

BONs continue to suffer from staff shortages and other issues related to poor state economies. The Kentucky Board of Nursing (KY BON) has budgetary restrictions due to the state's fiscal problems. Many boards are losing their own revenue as monies get swept to the general fund. This year the KYBON lost funds of $384,300 which were transferred to the general fund. Other boards sacrificed revenue to the general fund as well.

The Social Milieu: Healthcare in the U.S.

ACCESS TO CARE

The population of the U.S. accounts for 4.52 percent of the world's total population. To put this in a more global perspective, one in every 22 people on earth lives in U.S. (U.S. Dept of Labor). Eighty-four percent of the U.S. population lives in metropolitan regions and the remaining16 percent live in rural areas. Sixteen percent of the population is uninsured. Massachusetts has the lowest number of uninsured (4 percent) and Texas leads the nation in the highest number of uninsured in the country (24 percent).

Among the many services states struggled to provide during 2012 is health care. With unemployment remaining high and employers rescinding health insurance benefits, it is estimated that 4.8 million more people were eligible for subsidized health insurance through Medicaid in 2012 compared to four years ago.

Since 2010, the U.S. has experienced some improvement in access to health care. As illustrated in Table 10, the percentage and number of uninsured decreased in 2011, and for the first time in 10 years, the rate and number of those covered by private insurance coverage did not decrease (DeNavas-Walt, Proctor, & Smith, 2012). Early 2012 reports (most recent available), however, show that rates of uninsured were beginning to fluctuate. The rate of uninsured Americans decreased from 2010-2011, but first quarter reports from the Centers for Disease Control (CDC) based on data from the National Health Interview Survey for January to March 2012 show that rates of the uninsured had already risen 1.7 percent (CDC, 2012 Wayne, 2012).

Table 10: Uninsured Americans: 2010-2011

	2010	**2011**
Number of Americans uninsured	50.7 million	48.6 million

Percentage of Americans uninsured	16.7%	15.7%

(U.S. Census Bureau, 2011)

Health care disparities still exist for racial and ethnic minorities and people of low socioeconomic status (U.S. Department of Health and Human Services, 2012a). Racial and ethnic minorities make up one-third of the U.S. population and more than half of the uninsured population (U.S. Department of Health and Human Services, 2011b). Out of the 250 measures of health care quality and access tracked in the *National Healthcare Disparities Report,* Blacks had worse care than Whites for 41 percent of the measures, Asian Americans, American Indians and Alaska Natives for 30 percent of the measures, and Hispanics for 39 percent of the measures. Lastly, low-income individuals had worse care than high-income individuals for 47 percent of the measures (U.S. Department of Health and Human Services, 2012c).

Many Americans continue to not seek health care due to living in a Health Professional Shortage Area (HPSA). In primary care alone, there are 5,767 HPSAs with 55 million people living in them as of October 2012. It would take 15,297 practitioners to meet the need for primary care providers (U.S. Department of Health and Human Services, 2012d). HPSAs for primary care ranges differ significantly by state. States with the highest percentage of populations underserved by primary care providers include Alaska (69 percent), Washington (65 percent) and Idaho (59 percent); the states with the lowest percentage of populations underserved include New Jersey (2 percent), Vermont (3 percent) and Hawaii (3 percent) (U.S. Department of Health and Human Services, 2012c).

There are five different sources for health insurance coverage: Medicare, Medicaid, military, employer-based or private. Highlights of health care coverage during 2011 include:

- For the first time in 10 years, the rate of people covered by private insurance did not decrease.
- The percentage and number of people with employment based health insurance was not statistically different than 2010.
- The percentage and number of people covered by Medicaid increased by 0.7 percent and 2.3 million.
- The percentage and number of people covered by Medicare increased by 0.6 percent and 2 million people.

(DeNavas-Walt, et al., 2012)

Quality of Care

The Institute of Medicine (IOM) report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (2012), has called for a health care delivery system that continuously learns and evolves by avoiding past mistakes, adopting newfound successes, involving patients in their own health care, and basing rewards and payments on outcomes, thereby moving toward providing the best care at lower cost (IOM, 2012; Weinstock, 2012). Weinstock (2012), in reporting on the new IOM publication in *Hospitals & Health Networks* notes that the IOM report committees chair Mark D. Smith explained that the U.S. health care

system has the knowledge and technology to substantially improve costs and quality. This report also states that licensing boards and accreditation organizations should include concepts and applications of continuous learning and improvement into the education of health care professionals, as well as licensing, certification and accreditation requirements.

The Agency for Healthcare Research and Quality (AHRQ) is mandated to provide Congress with an annual update on the quality of health care delivery in the U.S. The following are key findings from the report:

- Health care quality and access in the U.S. is suboptimal, especially in minority and low-income groups.
- Quality is improving slowly; however, access and disparities are not.

Necessary improvements in quality and reductions in disparities have been identified for certain services, geographic areas and populations, including diabetes care and adverse events; disparities in cancer screening and access to care; and states in the south (U.S. Department of Health and Human Services, 2012c).

- After the passage of the PPACA, the Department of Health and Human Services (HHS) identified the following national priorities: making care safe; ensuring person- and family-centered care; promoting effective communication and care coordination; promoting effective prevention and treatment of leading causes of mortality; starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable (U.S. Department of Health and Human Services, 2012c).

- In reference to these priorities, HHS concluded the following:
  - Quality is improving for ensuring person-and family-centered care and promoting effective prevention and treatment of cardiovascular disease.
  - Improvements need to be made for patient safety, promoting healthy living and increasing data on racial and ethnic minority populations.
  - More data are required to assess care coordination and affordability of care.
  - Disparities persist in health care quality and access.

  (U.S. Department of Health and Human Services, 2012c)

Improvements to health care quality are also being addressed from a technology standpoint. In 2009, the Health Information Technology for Economic and Clinical Health Act was passed as part of the American Recovery and Reinvestment Act (McBride, Delaney, & Tietze, 2012). The act aims to implement a standardized health information technology (HIT) system that demonstrates meaningful use, thereby allowing the reliable exchange of information among different providers and health care locations, and creating a national electronic health information database to prevent duplication of tests, improve cost-effectiveness of interventions and produce a thorough patient history (McBride, et al., 2012). In 2011, CMS launched incentive programs requiring CMS providers and hospitals to implement standardized HIT systems and demonstrate meaningful use of the electronic medical records (McBride, et al., 2012).

Cost of Care

While health care spending has increased as a percentage of gross domestic product (GDP) over time in almost all developed countries, the U.S. has one of the highest growth rates (Kaiser Family Foundation, 2012a). In 2010, health care costs in the U.S. were almost $2.6 trillion, 10 times the amount spent in 1980; total health care spending accounted for 17.9 percent of the GDP (Kaiser Family Foundation, 2012b). The average annual health care expenditures for all consumer units (families, individuals or two or more persons living together who share expenses) increased by 1 percent from 2009 – 2010 and by 4.9 percent from 2010 – 2011 (Bureau of Labor Statistics, 2012).

In 2011, Medicare spending accounted for 15 percent of the federal budget and 21 percent of total health care spending (Kaiser Foundation, 2012). Of the health care spending, it accounted for 29 percent of total spending on hospitals and 23 percent of total spending on physician services (Kaiser Family Foundation, 2011c). A large percentage of Medicare spending on hospitals is represented by a small percentage of beneficiaries who use these services at both a higher volume and higher frequency (Stone and Hoffman, 2010). One of the provisions of the PPACA aims to decrease the number of hospital readmissions within a 30-day period from the discharge date by reducing Medicare payment to hospitals that have high rates of preventable readmissions (Stone and Hoffman, 2010).

Patient Safety

The year 2012 once again had a tragic number of deaths and patient harm attributed to medical error. Despite millions of dollars being spent annually on technology and staff education, and a multitude of patient safety programs being developed, thousands of people continue to die or suffer from errors made by health care providers. The statistics are mindboggling. Recent studies indicate that at least 200,000 Americans die from preventable medical errors and millions suffer harm (Andel, et al., 2012). In January 2012, the Office of the Inspector General (OIG) of HHS released a report of adverse events among Medicare Beneficiaries. The study revealed more than 130,000 Medicare beneficiaries experienced one or more adverse events in hospitals in a single month (HHS, 2012).

Errors continue to drive up health care costs. In a newly published article by Andel, et al. (2012) it is estimated that medical errors cost close to $1 trillion a year when quality life adjusted years (QALYs) are applied to patients that die. The investigators used the 1998 IOM report that estimated preventable medical errors cause 98,000 deaths a year. Based on those data and an estimate that medical errors cost an average of 10 lost years of life at $75,000-$100,000 per year, the study found that medical errors cost the health care system $73.5 billion to $98 billion in QALYs. This may be a significant underestimation. More recent statistics cite medical errors as being responsible for more than 200,000 deaths each year. In fact, the article quotes an estimate that states preventable death from medical error is 10 times greater than the IOM estimate. This brings the cost into the range of $735 billion to $980 billion annually (Andel, et al., 2012).

The Patient Protection and Affordable Care Act (PPACA): An Update

It has been two years since the passage of the PPACA and it will take more than two years to evaluate the influence of the new law. As it unfolds in the years ahead, its true impact on the health care system and the health of the nation will be watched and measured. At this time, the PPACA aims to provide coverage to 94 percent of Americans in the next 10 years (Democratic Policy and Communications Center, 2012). By 2014, the goal is to expand the number of insured Americans by 30 million (Wayne, 2012).

In late 2011, the Supreme Court began hearing arguments related to the constitutionality of the PPACA. The Supreme Court released a much anticipated ruling on June 28, 2011, upholding most of the PPACA, including the controversial provision requiring "shared responsibility" to purchase health insurance, otherwise known as the "individual mandate." The Supreme Court overturned a provision of the law requiring states to expand Medicaid eligibility to everyone earning below 133 percent of the federal poverty level by 2014 or lose all federal Medicaid matching funds. The PPACA provides states a 100 percent subsidy to cover this expanded population, decreasing slowly to a 90 percent subsidy by 2020. As a result of the Supreme Court's ruling, states may now opt-out of the Medicaid expansion without jeopardizing current federal funding levels.

Starting in fiscal year 2013, Medicare payments to hospitals will be linked to quality performance on common reasons for hospitalization, such as cardiac, surgical and pneumonia care. Long-term care sites, inpatient rehabilitation facilities and hospital providers will also participate in this value-based purchasing program starting in fiscal year 2014. Aligned with the demand for better community-based care, there will be funding provided to support increased access to community-based coordinated care, research centers on health delivery system improvement and community-based medication management for patients with chronic diseases.

Health care coverage beginning in 2014:

- Health Insurance Market Reform: This provision will prohibit private insurance companies from denying coverage or deciding on rates based on pre-existing conditions.
- Shared Responsibility: With a few exceptions, individuals will be required to purchase coverage or pay a penalty. Employers will also be subject to provide mandatory insurance to their employees. This requirement will differ depending on the number of employees.
- Medicaid Expansion: Medicaid eligibility will be expanded to include children, parents and childless adults who are not entitled to Medicare and have family incomes 133 percent of the federal poverty level (Democratic Policy and Communications Center, 2012).

To date, less than 20 states have agreed to create their own health exchanges, a premise the PPACA is based upon. A major aspect of this is concern over the state cost of operating the exchanges. The states have until mid-December 2012 to notify the federal government as to

whether they will be implementing a state exchange. Governors that refuse to set up the state exchange will be required to enact one set up by the federal government (Galewitz, 2012).

Political Issues

President Obama was re-elected on Nov. 6, 2012. Both Democrat and Republican campaign platforms emphasized the economy and jobs. During one of the presidential debates, President Obama announced that transitioning veterans for civilian careers especially assisting military medics to transition to careers in nursing was a priority on his second term agenda.

The following section depicts the political composition of the lawmakers and legislative bodies in 2013.This political composition and the ideology of the lawmakers can potentially impact nursing regulation, BONs, and the legislation that is proposed over at least the next two years.

THE .U.S. CONGRESS

Beginning in 2013, the U.S. Senate will be composed of 54 Democrats, 45 Republicans and one Independent. The U.S. House of Representatives will consist of 199 Democrats and 234 Republicans. The November 2012 elections did not change the Congressional picture for 2013 (National Conference of State Legislatures, 2012; National Governors Association, 2012).

GOVERNORS

2013 Governors – 50 States	2013 Governors – 5 U.S. Territories
Republicans: 30 Democrats: 19 Independent: 1	Republicans: 2 Democrats: 2 Independent: 1

STATE LEGISLATORS

Beginning in 2013, there will be 26 Republican Legislatures, 19 Democrat and four split. Nebraska has a nonpartisan, unicameral legislature (NCSL, 2012). The year 2012 was the first state legislative election since redistricting took place. Voters cast ballots in 44 states for candidates running for 6,034 state legislative seats. As a result of the 2012 elections, 25 states will have a veto-proof majority in the state legislature beginning in January 2013. This is the highest number of veto-proof legislatures in more than 10 years. Seven states, Arkansas, Alabama, Indiana, Kentucky, Pennsylvania, Tennessee and West Virginia, will need only a simple majority vote to overturn a gubernatorial veto.

TELEHEALTH

While telehealth's influence in health care has been increasing over the last two decades, it has taken on new political influence that could impact the state licensure system as the American Telehealth Association defines the issues of licensure and regulation as being potentially burdensome to the progression of telehealth services. Although the initial focus is on physicians,

the issues have broad implications for BONs since the number of telehealth nurses grows annually. The exact number of telehealth nurses practicing in the U.S. is unknown.

Major telehealth activities related to regulation and licensure this year include:

1. A Congressional Briefing held on Jan. 31, 2012 to identify issues related to licensing and regulation. The audience included staff from key Congressional leaders (AATA, 2012).

2. Release of the 2012 *American Association of Telehealth Agenda,* whose number one priority is to "Fix the outdated licensure and regulatory system for health professionals" (AATA, 2012).

3. Establishment of fixlicensure.org, a website that is currently requesting "Congress to fix medical licensing for 21st century America" and asking for signatories to support this cause. The website has collected signatories from more than 75 organizations to date (see Appendix B) (Fixlicensure.org, 2012).

The Federation of State Medical Boards has documented the status of state medical boards regarding telehealth regulatory issues. The state medical boards have the following requirements:

- Ten state boards of medicine issue a special purpose license, telehealth license or certificate, or license to practice medicine across state lines to allow for the practice of telehealth.
- Fifty-seven state boards of medicine plus the District of Columbia Board of Medicine require that physicians engaging in telemedicine are licensed in the state in which the patient is located.
- Minnesota allows physicians to practice telemedicine if they are registered to practice telemedicine or are registered to practice across state lines (FSMB, 2012).

Telehealth Legislation

H3859 and S1680 have been introduced in the House and Senate. A section of these bills require the Secretary of HHS to consult with representatives of states, physicians, health care practitioners, and patient advocates to encourage and facilitate the adoption of provisions allowing for multistate practitioner practice across state lines. This bill remains in committee.

Currently, Senator Tom Udall, a proponent of telehealth, is seeking bipartisan sponsors for a bill that would call for a tandem license for those providing telehealth services. The tandem license would allow practice across state lines. Congressman Mike Thompson may also put forward a telehealth bill that would focus on Medicare and Medicaid programs, potentially redefining licensure requirements based on patient location, rather than the practitioner location.

BONs

The following section summarizes the changes and innovations in BONs that have taken place throughout the last year.

Discipline

Over the past several years, there has been an increase in the number of nurses and consequently, an increase in the volume of complaints against nurses. At least 10 states note a 7-10 percent rise in the number of complaints to the BON and two states report almost a 50 percent increase. Criminal background checks (CBCs) and attestation of criminal activity upon renewal, as well as substance use disorder and social media cases, contribute to the increased number of disciplinary investigations and actions by BONs in 2012.

Almost 20 percent of BONs report a 10-50 percent increase in substance use disorder cases. A great majority (85 percent) of BONs refer particular nurses with substance use disorders to alternative to discipline programs. Those states that oversee the actual monitoring of nurses participating in alternative programs often face large workload and fiscal costs for that monitoring, which result in challenges to BONs.

Society now relies on instant communication and photography via handheld devices. The now common and frequent sharing of photos has blurred the lines of privacy and is often the foundation of complaints related to social media and boundary crossings. An NCSBN Web survey conducted this year revealed that 25 percent of BONs have experienced an increase in complaints related to social media and boundary crossings. This elusive and ever-changing means of communication and photography create challenges to the chain of custody of documentation and to investigators.

Several BONs have revised their philosophy of discipline to match core beliefs and practices and others to include principles of Just Culture. There is also interest in streamlining the investigation and discipline processing, especially with respect to low priority or low risk offenses. Tracking systems, BON policies regarding dismissals and consent orders, as well as increased staffing have contributed to decrease the time from complaint to resolution for some BONs.

Practice

See Appendix A for position statements, clinical practice advisories, advisory rulings/opinions and interpretive guidelines issued or revised by BONs in 2012.

The following are nurse practice trends or issues:

- Colorado and Florida are seeing an increase in issues related to nurses in cosmetic practices. In Florida, only ANPs (APRNs) with proper education, training and experience may perform these procedures under protocol with a supervising physician. RNs and LPNs may not perform these procedures as they are considered to be medical acts and not the administration of medication.
- Massachusetts identified unintentional consequences of electronic medical records and electronic communication, such as documentation by proxy, medication reordering and other scope of nursing practice issues.
- Mississippi is experiencing a push for medication assistants/technicians and a push for non-nurses to perform functions once solely performed by LPNs. Additionally, there

have been an increasing number of requests to expand the RN scope of practice, such as in radiology procedures.

Licensing

- Georgia passed a new law that requires everyone seeking to renew a professional license to provide proof of citizenship or legal residency regardless of where they were born. Georgia is also receiving increased numbers of reinstatement applicants. Many of these applicants are re-entering the workforce after lengthy absences and are required to complete BON approved re-entry programs.
- Georgia revised the definition for approved nursing education programs to facilitate licensure of military-trained nurses, clarifying a previous law that inadvertently excluded some military-trained nurses from licensure
- Three additional states (Delaware, Hawaii and Washington) simplified or expedited the licensing process for military spouses.
- Hawaii passed legislation requiring all licensing authorities to consider relevant military training, education or service as part of the evaluation process toward the qualification requirements to receive a license.
- Wisconsin now waives fees for certain professional and occupational licenses issued to veterans, including all licenses, permits, certificates of certification or registrations issued under the nurse practice act.
- Arkansas is issuing a one-time plastic license card without license status. Employers are required to verify license status on an agency registry search.
- Indiana implemented CBCs for new applicants for nurse licensure.
- New Hampshire and Virginia are reporting an increase in license applications with positive CBCs.

Legislative Efforts by BONs

CBCs

Fourteen states are still waiting to enact CBCs. Reasons for not passing legislation range from indifference on the part of the administration of the umbrella board, the governor not being supportive, the need to collaborate with other professional boards, the desire to not place anymore costs on licensees and a lack of staff to handle the information.

NSCBN's CBC Call to Action is part of the organization's ongoing initiative to raise awareness and assist BONs with the adoption and implementation of CBCs. Part of this initiative involves a redesign of the website, new resources to assist BONs, and offering a CBC team that is dedicated to answering inquiries and meeting the needs of BONs.

This past summer NCSBN released new information to assist states in interpreting CBCs. this consists of guidelines, as well as psychologic tests, to help BONs determine the risk of licensing certain individuals.

At the time of the writing of this report, approximately three states are looking to introduce CBC legislation in 2013 and four are preparing for 2014.

On Dec. 4, 2012, the Council of State Governments passed NCSBN's resolution supporting CBCs in nursing.

APRNs

Eight states successfully passed legislation that aligns the state nurse practice act with the APRN Consensus Model:

- Idaho changed title to APRN.
- West Virginia requires graduate level education as a minimum standard.
- Maryland requires national certification for CNS role (newly recognized).
- West Virginia requires national title, license and certification for all roles.
- Massachusetts and Ohio expanded independent prescriptive authority.
- Massachusetts, Vermont, Arizona and Louisiana expanded independent practice authority.

Additionally, several states made advancements in expanding APRN scope of practice:

- Kentucky joined 16 other states in "opting out" of the requirement for physician supervision in the administration of anesthesia care in medically underserved areas.
- In Virginia, a new law changes the practice and prescriptive authority of nurse practitioners to that of a required patient care team collaboration, maintaining a written collaborative agreement with a patient care team physician. However, CRNAs remain under supervised practice.
- West Virginia expanded prescriptive authority for APRNs working under a collaborative agreement.
- Washington now allows pharmacies to fill controlled substance prescriptions written by APRNs in other states.
- California removed a requirement that NPs and CNMs have six months of supervised experience in furnishing and ordering drugs or devices.
- Montana recently limited APRN scope of practice by only allowing physicians to inject into the spine for fluoroscopy, CAT scan, MRI, or ultrasounds.

Six states have pending APRN legislation (Illinois, Massachusetts, Michigan, New Jersey, New York and Pennsylvania). Approximately 22 states and jurisdictions plan to introduce legislation or rule changes that further align with the APRN Consensus Model in 2013.

Emerging Issues, Threats, Opportunities and Policy Implications for the Future

There will be increased demand for the services of APRNs in the coming year and there are numerous opportunities to extend their sphere of influence. It is anticipated that the federal government will continue to lend support to APRNs and regulators should consider how to use the government as well as other untapped resources for assistance in promoting the APRN Consensus Model. As the stages of the PPACA go into effect, it may have more impact on regulation than any other law in history. As larger numbers of nurses are needed to accommodate

the predicted 30 million more Americans that will be insured, the number of nursing programs will continue to rise and approval of programs will continue to present challenges as possible pressure mounts to reduce regulations.

Distance education programs continue to proliferate. BONs will be expected to meet these new challenges. The request for innovation in nursing education will continue to expand the horizons of nursing and the debate regarding whether all nursing programs should be accredited will continue.

With discussions regarding academic progression for nursing education occurring in many states, the question arises as to whether there is a need for a regulatory model and statutory language. How will this concept work and what will be the statutory requirements? This is an opportunity for regulation to develop uniform regulations from the start before every state implements the initiative in a different way.

Veterans transitioning to health care careers will present an opportunity to work with the military to resolve issues related to the education of Army medics and Navy corpsman, and workforce issues will continue to be of concern intensifying the need for licensure statistics and workforce data.

Patient safety remains a significant problem in the U.S. health care system. One possible contribution from regulation is the implementation of better remediation programs that will help nurses learn how to avoid committing errors. As BONs begin to adopt new models, such as Just Culture, and think differently about discipline, collaboration is needed with health care institutions. The future focus must be on remediation and prevention of error, as well as identification of it.

The challenges of licensure will continue throughout 2013. Telehealth will continue to pursue changing the U.S. regulatory and licensure system and BONs should be prepared to respond.

In conclusion, while this report ends with a look at the year ahead, many of the challenges of 2013 and beyond are unforeseen. There is one thing for certain—there will be more economic challenges, social issues and political forces that will influence the work of regulators and the outcomes of health care.

Appendix A

Number of Registered Nurses per 100,000 Population

United States	874
Alabama	945
Alaska	755
Arizona	690
Arkansas	802
California	664
Colorado	831
Connecticut	1,014
Delaware	1,159
District of Columbia	1,728
Florida	865
Georgia	665
Hawaii	743
Idaho	736
Illinois	962
Indiana	938
Iowa	1,085
Kansas	981
Kentucky	1,026
Louisiana	893
Maine	1,115
Maryland	851
Massachusetts	1,321
Michigan	908
Minnesota	1,060
Mississippi	995
Missouri	1,125
Montana	872
Nebraska	1,040
Nevada	605
New Hampshire	1,051
New Jersey	886
New Mexico	740
New York	905
North Carolina	945
North Dakota	1,310
Ohio	1,081
Oklahoma	746
Oregon	800
Pennsylvania	1,026
Rhode Island	1,174
South Carolina	911
South Dakota	1,349
Tennessee	946
Texas	720
Utah	678
Vermont	1,017
Virginia	768
Washington	798
West Virginia	985
Wisconsin	988
Wyoming	845
Guam	Not available
Puerto Rico	493

Virgin Islands	Not available

Data from Appendix A includes all four categories of APRNs.

Source: Bureau of Labor Statistics, State Occupational and Wage estimates, May 2011 available at www.bls.gov/data and U.S. and Census Bureau 2011 population estimates, available at

www.census.gov/population/data/state/totals/2011/index.html

Appendix B

Organizational Signatories Signing Fixlicensure.org Petition as of January 2013

Organization Name	City	State
Carena, Inc.	Seattle	WA
Healthcare Consultants	Marietta	GA
Apollo Telemedicine, LLC	Sheridan	WY
Sisters of Mercy Health System	Chesterfield	MO
Avera Health	Sioux Falls	SD
Children's Hospital Colorado	Aurora	CO
24/7 Family Doctor	McKinney	TX
Alphasante Medical Group, PA	Sunrise	FL
MDLiveCare	Sunrise	FL
Online Therapy Institute	Highlands	NJ
Khmer Health Advocates, Inc.	West Hartford	CT
Torch Health Solutions	San Diego	CA
FONEMED, LLC	Colorado Springs	CO
IntraNerve	Colorado Springs	CO
C30 Telemedicine	Ojai	CA
InSight Telepsychiatry, LLC	Marlton	NJ
ALN Solutions, Inc.	Fort Lee	NJ
EdithForge Consulting	Vancouver	WA
AnestaWeb, Inc.	Cooper City	FL
Alphamed Solutions, Inc.	Chandler	AZ
Healthcare Associates of Bucks Country, PC	Langhorne	PA
Georgia Partnership for TeleHealth	Waycross	GA
1-800MD	Charlotte	NC
CliniciansTelemed Medical Group	Bakersfield	CA
Northwest Stroke Solutions, PLLC	Billings	MT
Health Resources, Ltd.	Tampa	FL
Clinical Fellows Inc.	Boston	MA
CellTrak Technologies	Schaumburg	IL
Breakthrough.com	Palo Alto	CA
Brighter Day Health	Stafford	TX
RediMD	Stafford	TX
XstremeMD	Lafayette	LA
My Psychiatric Partner, LLC	Lima	OH
Pulaski Memorial Hospital	Winamac	IN
Consult-a-Nurse	Fort Myers	FL

TeamHealth Medical Call Center	Knoxville	TN
Nulton Diagnostic and Treatment Center	Johnstown	PA
TeleMed2U	Roseville	CA
Avera Creighton Hospital	Creighton	NE
HealthNation	Scottsdale	AZ
Ultralinq Healthcare Solutions, Inc.	New York	NY
Instant Advice Network - lanchat.com Corporation	Tarzana	CA
eTherapi.com	Mountain	CA
TeleMental Health Institute, Inc.	Carson City	NV
Behavioral Health Care Associates	Shaumburg	IL
Zipnosis	St. Paul	MN
IAGNOSIS, Inc.	McMurray	PA
Hands On Telehealth, LLC	Marietta	GA
ERDocNOW	Knoxville	TN
Utah Telehealth Network	Salt Lake City	UT
Aligne Health Resources	Conshohocken	PA
HealthLinkNow	Sacramento	CA
Behavioral Health Connect	Alameda	CA
GuardMi Inc.	Cincinnati	OH
US Telehealth	Kyle	TX
EHRscribe, Inc	Pittsburgh	PA
Kanopi Health	Reston	VA
Next Gen Counseling and Coaching	Love Park	IL
Psychologial Consulting and Therapy	Waldwick	NJ
Nalari Health	Barrington	RI
E Mental Health Center	Los Angeles	CA
Life Counseling, LLC	Bellingham	WA
MPB Group, Inc.	Columbia	MD
Advanced ICU Care	St. Louis	MO
Behavioral Health Connect	Almeda	CA
Safe Harbor Behavioral Health	Erie	PA
Neurostatus, LLC	Boise	ID
MD Urgent Care	Albuquerque	NM
Vohra Wound Physicians	Miramar	FL
The National Ophthalmology Center	Raleigh	NC
Counselink, PA	Tampa	FL
My Psychiatric Partner, LLC	Lima	OH
CorpCare Associates, Inc.	Atlanta	GA
NuPhysicia Incorporated	Houston	TX
Avery Telehealth	Scottsdale	AZ

Nulton Diagnostic and Treatment Center	Johnstown	PA
Commwell Medical	Evanston	IL
Reiland / Law	Pleasanton	CA
Offsite Care, Inc.	Sebastopol	CA
Tehachapi Valley Healthcare District	Tehachapi	CA

(Fixlicensure.org, 2012).

APPENDIX C

The following position statements, clinical practice advisories, advisory rulings/opinions and interpretive guidelines were issued or revised by boards of nursing (BONs) in 2012:

Alaska

- Adopted "Medication Administration in the School Setting" delegation decision tree as an advisory opinion.
- Registered nurses (RNs) are allowed to perform clinical breast exams according to the Clinical Breast Examination Training and Certification from Mammacare.
- Adopted NCSBN White Paper, *A Nurse's Guide to the Use of Social Media.*
- Administration of propofol for uses other than those documented in the "Advisory Opinion on RN Administration of Sedating and Anesthetic Agents" is outside scope of practice for RNs.
- Administration of nitrous oxide is only within the scope of practice for certified registered nurse anesthetists (CRNAs) and not RNs.

Arizona

- RN role in removal of pleural and/or mediastinal chest tubes given certain criteria
- RN role in injection of contrast media into coronary arteries, in the presence of a physician, given certain criteria
- RN and LPN roles in foot care
- RN role in the informed consent process
- LPN role in intravenous infusion therapy and venipuncture
- RN role in the administration of therapeutic agents via temporary intracranial devices
- RN role in the use of conscious sedation for diagnostic and therapeutic procedures
- RN role in peripherally inserted central catheter (PICC) insertion, suturing, maintenance, removal and verification of tip placement
- RN role in the administration of pharmacological agents used in cardiac stress testing
- Nurse practitioner (NP) role in the prescribing of controlled substances for the treatment of chronic pain
- Dual profession and dual health care licensure/certification

Arkansas

- Scope of practice of ANP with prescriptive authority to use EPT

Kentucky

- Scope of RN practice in the deactivation of internal defibrillator
- Revised the following advisory opinions: Roles of Nurses and Technicians in Dialysis; Roles of Nurses in the Delivery of Prehospital Emergency Medical Care Via Ambulance Services; Roles of Nurses in the Supervision and Delegation of Nursing Acts to Unlicensed Personnel; Roles of Registered Nurses in Invasive Cardiac Procedures; Roles of Nurses in the Delegation of Tasks to Paramedics in a Hospital Emergency Department; Roles of Nurses in the Administration of Medication per Intraspinal Routes; Role of the Registered Nurse First Assistant; Application and Removal of a Cast by Nurses; and Closed Reduction of a Fracture by APRNs.

Louisiana

- Scope of practice of licensed psychiatric mental health NPs in utilizing telemental health technology to deliver mental health services to rural clients in a school setting
- Scope of practice of school RNs to delegate administration of nutrition via a gastrojejunostomy tube connected to an infusion pump to trained, unlicensed school personnel (in the school setting)
- It is not within scope of practice for RN to de-clot PICC line in home health setting
- Scope of practice of certified pediatric NP to provide services to patients over the age of 21 who are survivors of childhood cancers for the purposes of transition to adult care and screening for late effects of cancer treatments

Mississippi

- The LPN and Assessment Functions
- The APN in the Emergency Room Setting
- Revised the following advisory opinion: Management of Pain Relief by Catheter Techniques (Epidural, Intrathecal, Intrapleural, Peripheral Nerve Catheter or Other Pain Relief Devices)

New Hampshire

- Scope of practice of RN in extracting cerebral spinal fluid from indwelling catheter, placement of laryngeal mask airway (LMA) in newborn, assisting with PEG insertion, performing amniotomy specific to emergent situations in absence of primary doctor or midwife, administration of nitrous oxide, assisting with endoscopic procedures, use of lasers, inserting cervical vaginal insert for cervical ripening or induction of labor, telehealth nursing, performing bone marrow biopsy, digital reinsertion of prolapsed rectum, and use of C-arm fluoroscopy
- Scope of practice of LPN in inserting manometry catheter and performing TB (Mantoux) testing
- Scope of practice of licensed nurse assistant (LNA) in use of GS Vibracare, presurgical patient teaching, assisting in sweat test procedures, accepting and signing for medications delivered to the facility by the pharmacy, and performing lavage of nasal passages with saline
- Scope of practice of RN and LPN in changing Coude catheter, working as histologic technician and administration of vaccinations based on indication of protocol
- Scope of practice of RN and LPN/LNA in performing Therabath treatments with paraffin wax

North Carolina

- Revised the following position statement: RN and LPN practice during the process dying and death

North Dakota

- Revised the following practice statements: Role of the RN in the Management of Analgesia by Catheter Techniques for Obstetrical Patients and Temporary Reassignment

Ohio

- Revised the following interpretive guideline: RN performance of a patient health history and physical examination for purposes of providing nursing care
- RN utilization of the Sapiens TCS or other comparable device to confirm PICC tip placement in adults

Oklahoma

- Revised the following position statements and guidelines: CRNA Inclusionary Formulary; School Nurse Position Statement; Policy on Names; Patient Assessment Guidelines; Monitoring of Moderate Conscious Sedation Patient by LPN Guidelines; Licensure Verification and Photocopying of Nursing Licenses; and IV Medication Administration by LPNs Guidelines

Vermont

- APRN Prohibition on Prescribing Oral Buprenorphine
- Role of RN, LPN and LNA in Initiating and Withholding CPR
- Revised the following position statements: Role of LPN in IV Therapy, Role of the RN and APRN as First Assistant and LNA Scope of Practice with Decision Tree

Virginia

- Adopted the following guidance documents: Nursing Employment Practice under Orders of Probation; Guidance on the Use of Social Media; and Disposition of Cases Against CNAs, RMAs, and CMTs for Practice with Expired Registrations or Certificates
- Revised the following guidance documents: Guidelines for Agency Use Regarding Transmittal of Third-party Orders (accepted by the boards of nursing and medicine); guidance statement by BON regarding PICC lines; BON opinion on delegation of collection of specimens for gonorrhea and Chlamydia; Delegation of Authority to Board of Nursing RN Education and Discipline Staff; BON interpretative statement on blousing epidural anesthesia by RNs; Decision-making Model for Determining RN/LPN Scope of Practice; Whether a nurse may administer a medication that has been transmitted orally or in writing by a pharmacist acting as the prescriber's agent; Authority of NPs to write DNR orders; guidelines for the training of public school employees in the administration of insulin and glucagon; BON motion on disposition of cases against nurses practicing with expired licenses; surveillance activities required by the Occupational Safety and Health Administration (OSHA) Respiratory Standards; BON motion adopting article on patient abandonment; BON opinion on delegation of the removal of venous and arterial sheaths to unlicensed personnel; Treatment by Women's Health NPs of Male Clients for STDs; Virginia Board of Nursing Code of Conduct; and Information on Prescriptive Authority

References

AACN. (2012a). Employment of new nurse graduates and employer preferences for baccalaureate-prepared nurse. Retrieved from http://www.aacn.nche.edu/leading_initiatives_news/news/2012/employment12

AACN. (2012b). Impending sequestration: Estimating the impact on America's nursing workforce and healthcare discoveries. Retrieved from http://www.aacn.nche.edu/government-affairs/AACN-Sequestration-Factsheet.pdf

AACN. (2012c). Joint statement on academic progression for nursing students and graduates. Retrieved from https://www.aacn.nche.edu/aacn-publications/position/joint-statement-academic-progression

AARP. (2012). State action coalitions. Retrieved from http://campaignforaction.org/state-action-coalitions

Aiken, L. H., Cimiotti, J. P., Sloane, D. M., Smith, H. L., Flynn, L., & Neff, D. F. (2011). Effects of nurse staffing and nurse education on patient deaths in hospitals with different nurse work environments. *Medical Care, 49*(12), 1047-1053.

Andel, C., Davidow, S. L., Hollander, M., & Moreno, D. A. (2012). The economics of health care quality and medical errors. *Journal of Health Care Finance, 39*(1), 39-50.

ATA. (2012). 2012 Telemedicine policy priorities. Retrieved from http://www.americantelemed.org/files/public/policy/2012%20Policy%20Priorities.pdf

ATA. (2012). ATA holds briefing on State Medical Licensing. Retrieved from http://www.americantelemed.org/files/public/policy/MedicalLicensing_1_31_2012.pdf

Bureau of Labor Statistics. (2012a). Occupational health statistics. Retrieved from http://bls.gov/oes/current/largest_occs.htm

Bureau of Labor Statistics. (2012b). Occupational outlook handbook, licensed practical and licensed vocational nurses. Retrieved from http://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm

Bureau of Labor Statistics. (2012c). Occupational outlook handbook, registered nurses. Retrieved from http://www.bls.gov/ooh/healthcare/registered-nurses.htm

Burress, J. (2012, November 12). Doctors' and nurses' licenses snagged by new immigration law in Georgia. *Kaiser Health News.* Retrieved from http://www.kaiserhealthnews.org/Stories/2012/November/12/Georgia-immigration.aspx

Calvan, B. C. (2012, October 12). Representative Edward Markey seeks action to regulate compounding pharmacies. *The Boston Globe.* Retrieved from

http://www.bostonglobe.com/news/nation/2012/10/12/representative-edward-markey-calls-for-action-regulate-compounding-pharmacies/rltOEQvvpHrNuiywBxwucM/story.html

Change.gov. (2012). Retrieved from http://change.gov/agenda/

Choo, C. W. (2001). Environmental scanning as infomration seeking and organizational learning. *Information research, 7*(1). Page number?

CMS. (2012). Graduate nurse education demonstration. Retrieved from http://innovations.cms.gov/initiatives/gne/

CMS. (2012). Medicare and Medicaid programs; Reform of hospital and critical access hospital conditions of participation. Retrieved from http://www.gpo.gov/fdsys/pkg/FR-2012-05-16/html/2012-11548.htm

Department of Health and Human Services. (2012). Hospital inpatient systems do not capture patient harm. Retrieved from https://oig.hhs.gov/oei/reports/oei-06-09-00091.pdf

Djukic, M., Kovner, C. T., Brewer, C. S., Fatehi, F. K., & Cline, D. (2011). Work environment factors other than staffing associated with nurses' ratings of patient care quality. Retrieved from http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/09/the-rn-work-project/work-environment-factors-other-than-staffing-associated-with-nur.html

Fang, D. & Li, Y. (2012). Special survey on vacant faculty positions for academic year 2012-2013. Retrieved from http://www.aacn.nche.edu/leading-initiatives/research-data/vacancy12.pdf

Federation of State Medical Boards. (2012). Telemedicine overview: Board-by-board approach. Retrieved from http://www.fsmb.org/pdf/grpol_telemedicine_licensure.pdf

FTC. (April 2012). FTC staff comment before the Louisiana House of Representatives on the likely competitive impact of Louisiana House Bill 951 concerning advanced practice registered nurses ("APRNs"). Retrieved from http://www.ftc.gov/opp/advocacy_date.shtm

FTC. (March 2012a). FTC staff letter to the Honorable Paul Hornback, Senator, Commonwealth of Kentucky State Senate concerning Kentucky Senate Bill 187 and the regulation of advanced practice registered nurses. Retrieved from http://www.ftc.gov/opp/advocacy_date.shtm

FTC. (March 2012b). FTC staff letter to the Honorable Representative Jeanne Kirkton, Missouri House of Representatives, concerning Missouri House Bill 1399 and the regulation of certified registered nurse anesthetists. Retrieved from http://www.ftc.gov/opp/advocacy_date.shtm

FTC. (September 2012). FTC staff testimony before Subcommittee A of the Joint Committee on Health of the State of West Virginia Legislature on the review of West Virginia laws governing the scope of practice for advanced practice registered nurses and consideration of possible revisions to remove practice restrictions. Retrieved from http://www.ftc.gov/opp/advocacy_date.shtm

Galewitz, P. (2012, December 1). Insurance surcharges will fund most online exchanges created under health law. *Kaiser Health News.* Retrieved from http://www.kaiserhealthnews.org/Stories/2012/December/01/health-insurance-exchanges-states-fees.aspx

Gallup. (2012). Honesty/Ethics in professions. Retrieved from http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx

Griswold, A. (2012, June 18). Has nursing been overhyped as a career choice? *Forbes.* Retrieved from http://www.forbes.com/sites/alisongriswold/2012/06/18/has-nursing-been-overhyped-as-a-career-choice/2/

Health Affairs. (2012). Health policy brief: The Supreme Court and health reform. Retrieved from http://www.healthaffairs.org/press/2012_09_27.php

Health Reform.gov. (2012). Fact sheet: Creating jobs and increasing the number of primary care providers. Retrieved from http://www.healthreform.gov/newsroom/primarycareworkforce.html/

HRSA. (2012). Helping veterans become nurses. Retrieved from http://bhpr.hrsa.gov/veterans/nurses.html

IOM. (July 2012). *Geographic adjustment in medicare payment - phase II: Implications for access, quality, and efficiency.* Washington, DC: Author.

Jones, A. (2012, June 28). Supreme Court upholds Affordable Care Act. T*he Wall Street Journal.* Retrieved from http://blogs.wsj.com/law/2012/06/28/supreme-court-upholds-affordable-care-act/

Kaiser Foundation. (2012). Health insurance coverage of the total population, states (2010-2011), U.S. (2011). Retrieved from http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3

Kaiser Foundation. (2011c, September). Medicare Spending and Financing. Retrieved September 21, 2012 from kff.org/medicare/upload/7731-03.pdf

Mancino, D. (2011). Inactivity is not an option. *Dean's Notes, 33*(2). Retrieved from http://www.ajj.com/services/publishing/deansnotes/nov11.pdf

National Conference of State Legislatures. (2012). State legislatures: 2012 state and legislative partisan composition. Retrieved from http://www.ncsl.org/documents/statevote/2012_Legis_and_State.pdf

National Council of State Legisltatures. (2012). State budget updates: Spring 2012. Retrieved from http://www.ncsl.org/portals/1/documents/fiscal/sbu_spring2012_freeversion.pdf

National Governors Association Governors. (2012). Governors roster 2012. Retrieved from http://www.nga.org/files/live/sites/NGA/files/pdf/GOVLIST.PDF

NCSBN. (2012a). NCLEX® statistics from NCSBN. Retrieved from https://www.ncsbn.org/Table_of_Pass_Rates_2012.pdf

NCSBN. (2012b). A preferred future for prelicensure program approval:Part I: Recommendations. Retrieved from https://www.ncsbn.org/2919.htm

NCSBN. (2012c). A preferred future for prelicensure program approval: Part II: Strategies for moving forward. Retrieved from, https://www.ncsbn.org/2919.htm

NCSL. (November 7, 2012). History holds true in 2012 legislative elections. Retrieved from http://www.ncsl.org/press-room/history-holds-true-in-2012-legislative-races.aspx

NPSF. (2012). Lucian Leape Institute forum & gala. Retrieved from http://www.npsf.org/about-us/lucian-leape-institute-at-npsf/lucian-leape-institute-annual-forum-gala/

Oliff, P., Mai, C., & Palacios, V. (2012). States continue to feel recession's impact. Retrieved from, http://www.cbpp.org/cms/index.cfm?fa=view&id=711

PEW Center on the States. (November 2012). The impact of the fiscal cliff on the states. Retrieved from http://www.pewstates.org/uploadedFiles/PCS_Assets/2012/Pew_fiscal_cliff_report.pdf

Phillips, S. J. (2012). APRN consensus model implementation and planning. *Nurse Practice, 37*(1), 22-45.

Pittman, P., & Williams, B. (2012). Physician wages in states with expanded APRN scope of practice. *Nursing Research and Practice.* Retreived from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3306917/

Rick, C. (2011). Office of nursing services annual report 2011. Retrieved from http://www.va.gov/NURSING/docs/2011onsAnnualRptweb.pdf

Rosenbaum, S. (2011). The patient protection and Affordable Care Act: Implications for public health policy and practice. *Public Health Reports, 126*(1), 130–135.

Shaffer, S. (2012). Colorado Appellate Court upholds opt out from federal anesthesia rule Retreived from http://www.aana.com/newsandjournal/News/Pages/071912-Colorado-Appellate-Court-Upholds-Opt-Out-from-Federal-Anesthesia-Rule.aspx

Shanton, K. (2012). Half the states will have veto-proof majorities. Retrieved from http://ncsl.typepad.com/the_thicket/

Sherwood, G., & Barnsteiner, J. (Eds). (2012). *Quality and safety in nursing: A competency approach to improving outcomes*. UK: Wiley-Blackwell.

Skillman, S. M., Kaplan, L., Fordyce, M. A., McMenamin, P. D., & Doescher, M. P. (2012). Understanding advanced practice registered nurse distribution in urban and rural areas of the United States using national provider identifier data. Retrieved from http://depts.washington.edu/uwrhrc/uploads/RHRC_FR137_Skillman.pdf

Spector, N. & Odom, S. (2012). The initiative to advance innovations in nursing education: Three years later. *Journal of Nursing Regulation, 3*(2), 40-44.

Stone, J. and Hoffman, G, (2010). Medicare Hospitals Readmissions: Issues, Policy Options and the PPACA. Penny Hill Press, Damascus, MD.

The Joint Commission. (2012a). National patient safety goals. Retrieved from http://www.jointcommission.org/standards_information/npsgs.aspx

The Joint Commission. (2012b). Standards, national and international patient safety goals. Retrieved from http://www.jointcommission.org/topics/hai_standards_and_npsgs.aspx

The Perryman Group. (May 2012). The economic benefits of more fully utilizing advanced practice registered nurses in the provision of health care in Texas: An analysis of local and statewide effects on business activity. Retrieved from http://www.texasnurses.org/associations/8080/files/PerrymanAPRN_UltilizationEconomicImpactReport.pdf

U.S. Department of Health and Human Services. (2012). Testimony before the Health Subcommittee of the Energy and Commerce Committee, U.S. House of Representatives. Statement of Francis S. Collins, M.D., Ph.D. Retrieved from http://democrats.energycommerce.house.gov/sites/default/files/image_uploads/Testimony_Collins_HE_06.20.12.pdf

U.S. Department of Labor Statistics. (2012). United States population. Retrieved from http://www.tradingeconomics.com/united-states/population

Unruh, L. Y. & Zhang, N. J. (2012). Nurse staffing and patient safety in hospitals: New variable and longitudinal approaches. *Nursing Research, 61*(1), 3-12.

Wakefield, M. (2012). Joining forces. Taking action to serve America's military families. Retrieved from http://www.whitehouse.gov/joiningforces

WCET. (2012). Court deals second blow to federal state authorization regulation. Retrieved from http://wcetblog.wordpress.com/2012/06/05/state-authorization-appeal/

v. Respondent shall not contact by telephone or other manner, any pharmacy or drug supplier for the purposes of filling a prescription order. This applies both while Respondent in working in the capacity of Respondent's employment or not.

NCSBN
National Council of State Boards of Nursing

Letter from the President

POST-BOARD MEETING UPDATE

July 18, 2013

Your 2012-2013 Board of Directors (BOD) met for the last time July 10–12, 2013.

Highlights of the meeting included:
A report from the Center for Creative Leadership (CCL) regarding the outcomes for the executive officer (EO) coaching program in which 17 EOs participated was reviewed. Outcomes indicated positive differences in the leadership development of the participants. The BOD is pleased to continue the opportunity for EOs and BOD members who are not EOs. Kathy Apple, CEO, will solicit interest via email in the near future.

From the environmental scan discussion, it was confirmed that interest in facilitating telehealth remains a high priority. Licensure issues and reimbursement are perceived as obstacles to effective telehealth practice that must be overcome. Representative Mike Thompson (CA) will reintroduce his bill to state that where the physician is located and licensed is sufficient and appropriate for telehealth practice. This is consistent with the position that the American Nurses Association (ANA) espouses that practice occurs where the nurse is located rather than where the patient is located.

An article in the July 2013 issue of *Health Affairs* reported that nurse practitioners (NPs) are influenced to practice in those jurisdictions that allow independent practice. This has implications for legislative change in many jurisdictions without that provision.

Apple reported that Robert Wood Johnson (RWJ) Foundation noted that states where boards of nursing (BONs) are actively engaged in the Action Coalitions (ACs) are advancing at a more rapid pace and in fact, would prefer that BONs be leading, if at all possible. We want to hear from you about what ACs are doing in your jurisdictions and what are potential regulatory implications exist as a result of the work of ACs.

FEPI (the European initiative similar to NCSBN) reports that a shortage of 1 million nurses is expected in Europe by 2020. FEPI has also actively promoted NCSBN's research brief *Report of Findings from the 2012 LPN/VN Nursing Knowledge Survey (Vol. 59).*

Kudos to Dawn Kappel, director, Marketing & Communications and her team for the NCSBN 2011 Annual Report winning the top award (Best in Division) at the 2013 Graphic Excellence Awards. Congratulations for a job well done!

The Distance Education Learning (DEL) Committee (for PRELICENSURE programs only) reviewed feedback to its recommendations that were to be presented to the Delegate Assembly in August 2013. The BOD determined to withdraw the recommendations that were going to Delegate Assembly and asked the DEL to look deeper into the issues raised.

The TERCAP® "think tank" reviewed results of 2,000 cases collected and analyzed through the TERCAP instrument for the purpose of determining how TERCAP data could be disseminated and used. The group believes that data should be disseminated with caution since TERCAP contains specific data strictly from BONs and is limited in its ability to identify

systems errors either because these types of errors were not reported to BONs or because BONs did not choose to enter them in TERCAP. The group advocated for adding questions to the TERCAP tool to capture outcomes in order to be able to apply for a Patient-Centered Outcomes Research (PCOR) grant. Furthermore, the group recommended revision to the tool to make it more user friendly (asking the users in order to capture appropriate changes). TERCAP is an ongoing project.

The proposed research agenda for 2014-2017 was reviewed and approved. Thank you to all the BONs that responded to the survey to garner input for this important work. Among the topics are: continued competence, discipline/substance use/misuse, advanced practice registered nurses and transition to practice for international nurses.

The application to American National Standards Institute (ANSI) for approval as a standards development organization (SDO) was submitted and we are awaiting a decision.

As always if you have questions and/or comments never hesitate to contact me or other BOD members. It remains a pleasure to serve you. Thank you to NCSBN staff who work hard every day to support member boards and to all our committee volunteers who give of their time and expertise to help us in achieving evidence- based regulation in so many arenas.

We look forward to seeing you in Providence, R.I. for Delegate Assembly Aug. 14-16, 2013, as we commemorate and celebrate NCSBN's 35th anniversary.

Myra Broadway, JD, MS, RN
President
207.287.1148
myra.a.broadway@maine.gov