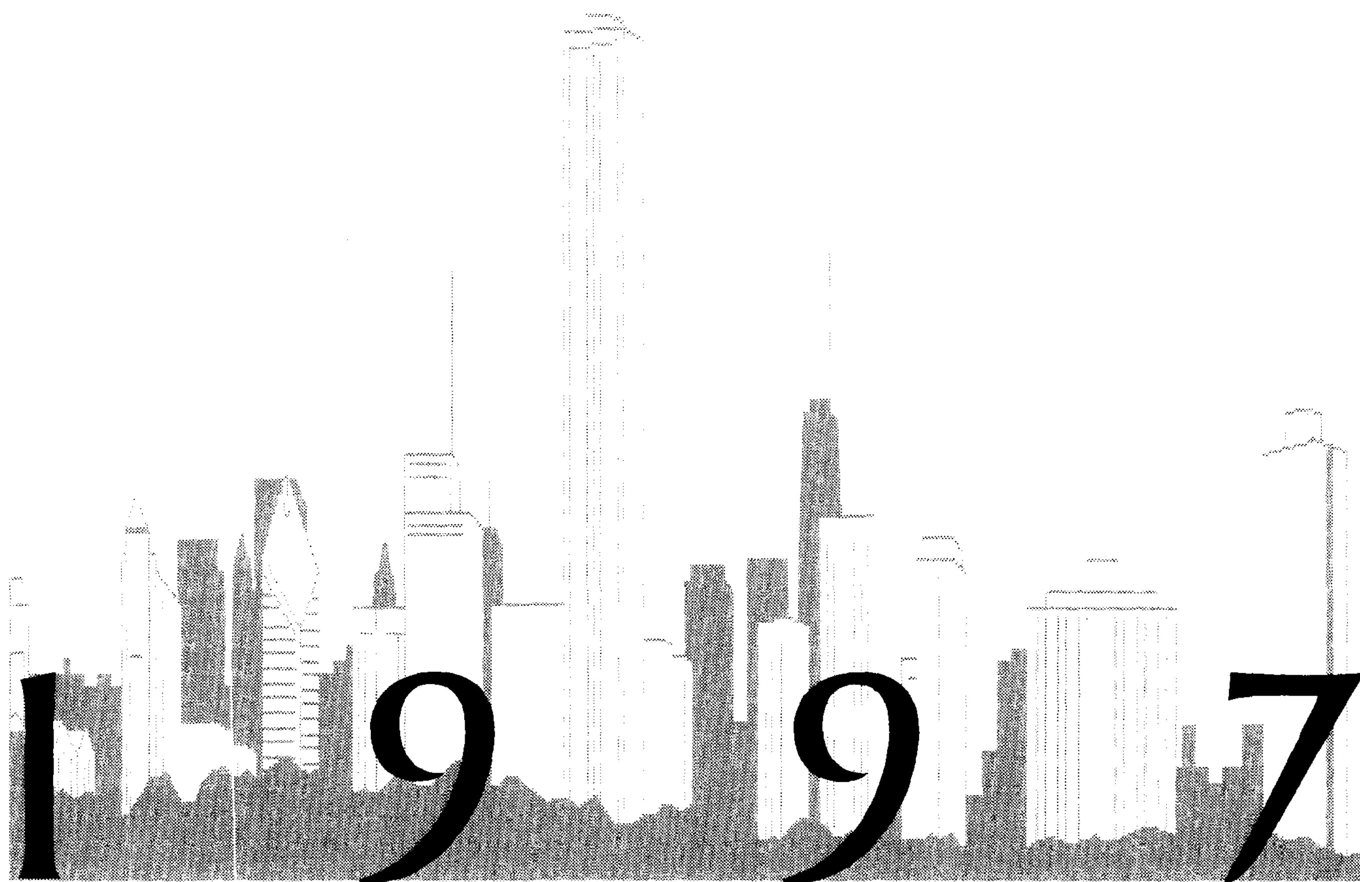
National Council's Book of Reports



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Annual Meeting Schedule

Incidental meeting rooms are available throughout the week and may be reserved by calling Sue Davids at the National Council prior to the meeting or via sign-up sheets located at the registration desk on-site. Incidental meeting rooms will be allocated on a first-come, first-served basis.

Monday, August 18

8:00 a.m. - 8:30 a.m.
Registration for Dialogue on Discipline
Salon G/H

8:30 a.m. - 5:00 p.m.
Dialogue on Discipline
Salon G/H

Tuesday, August 19

8:00 a.m. - 9:00 a.m.
11:30 a.m. - 5:00 p.m.
Registration
Fifth Floor

8:30 a.m. - 11:30 a.m.
Executive Officers Networking Session
Chicago Ballroom AB

1:00 p.m. - 2:30 p.m.
Concurrent Educational/Research Sessions
- Developing Regulations for UAP: Model for Process and Product
- A Universal Approach to APN Certification and Licensure
- Rural Distance Learning: Collaboration Effort Between Nursing Practice and Education
- Naturopathic Physicians as an Authorized Provider - Working With Nurses

Chicago Ballrooms AB; C; FG; H

2:30 p.m. - 3:00 p.m.
Poster Session and Exhibits
Refreshment Break
Fifth Floor Foyer

3:00 p.m. - 4:30 p.m.
Concurrent Educational/Research Sessions
- Utilization of Unlicensed Assistive Personnel in the Work Place
- Enhancing Licensees' Ownership of Practice: Rule Development for Advanced Practice Nurses
- Implications of a Health Care Integrated Educational System for Nursing and Allied Health Students
- Characteristics of Chemically Dependent Nurses Who are Successful in Their Recovery Programs

Chicago Ballrooms AB; C; FG; H

4:30 p.m. - 5:00 p.m.
Poster Session and Exhibits
Fifth Floor Foyer

5:00 p.m. - 6:30 p.m.
Early Bird Social *(cash bar)*
Chicago Ballroom D

Wednesday, August 20

7:30 a.m. - 2:00 p.m.
Registration
Fifth Floor

8:00 a.m. - 9:00 a.m.
Orientation
Chicago Ballroom AB

9:00 a.m. - 10:30 a.m.
Networking Groups

- Executive Directors
- Board Members
- Board Staff - Education
- Board Staff - Practice/Discipline

Chicago Ballrooms AB; C; FG; H

10:30 a.m. - 11:00 a.m.
Coffee Break
Fifth Floor Foyer

11:00 a.m. - 12:00 p.m.
Special Interest Groups (SIGs)

- Chemically Impaired Nurse Issues
- LPN/VN Issues
- Member Board Presidents
- Nursing Education Approval/Accreditation
- Public Policy Issues

Chicago Ballrooms AB; C; FG; H; LA/Miami

12:00 p.m. - 1:30 p.m.
Lunch Break

1:30 p.m. - 2:30 p.m.
Delegate Assembly
Grand Ballroom III

Delegate Assembly Note: Business conducted during the Delegate Assembly will be continuous, advancing through the agenda as time and discussion permits.

2:30 p.m. - 2:45 p.m.
Refreshment Break
Grand Ballroom III Foyer

2:45 p.m. - 5:00 p.m.
Candidates' Forum
Grand Ballroom III

5:00 p.m. - 6:30 p.m.
NCLEX® Examination Dialogue
LA/Miami

Session Note: Representatives from Chauncey Group International/Sylvan will be available to answer questions.

Thursday, August 21

8:00 a.m. - 2:00 p.m.
Registration
Fifth Floor

8:00 a.m. - 9:00 a.m.
Breakfast with the Chauncey Group/ Sylvan Prometric
Grand Ballroom II

9:00 a.m. - 10:30 a.m.
Two Curve Change: The Choice for the National Council
Guest Speaker: Dr. Jamie Orlikoff, Orlikoff and Associates
Grand Ballroom III

10:30 a.m. - 11:00 a.m.
Coffee Break
Grand Ballroom III Foyer

11:00 a.m. - 12:00 p.m.
Forum Presentations

- Regulation of Nursing Education: Debate/Panel
- Position on Terminology Related to *Approval* and *Accreditation*

Grand Ballroom III

12:00 p.m. - 1:30 p.m.
Area Luncheons
Chicago Ballrooms FG; H; LA/Miami; Scottsdale

1:30 p.m. - 3:00 p.m.
Forum Presentations

- Revision of the Model Nursing Practice Act
- Assessing Continued Competence: Personal Accountability Profile
- Discipline Data Bank: Present and Future
- UAPs: Issues and Resources
- Revision of the *NCLEX-RN® Test Plan*

Grand Ballroom III

3:00 p.m. - 3:30 p.m.
Refreshment Break
Grand Ballroom III Foyer

3:30 p.m. - 5:00 p.m.
Forum Presentations

- NCLEX Examination Contractor and Candidate Fee: 1999-2002
- Revision of the Bylaws and Organization Plan
- Electronic Licensure Verification Information System (ELVIS)
- Open Forum

Grand Ballroom III

Open Forum Note: The purpose of scheduled forums is to provide information valuable to decisions to be made by the Delegate Assembly. To promote dialogue and discussion on the issues by all attendees, an Open Forum will be conducted. President Tom Neumann will serve as facilitator, and attendees are encouraged to bring forward any question or comment on any topic or issue related to the activities of the National Council. Attendee participation is key and will determine the topics discussed during the Open Forum.

Friday, August 22

8:00 a.m. - 10:00 a.m.
Registration
Fifth Floor

8:00 a.m. - 9:00 a.m.
Breakfast With Assessment Systems, Inc.
(A subsidiary of The Psychological Corporation)
Grand Ballroom II

9:00 a.m. - 10:30 a.m.
Forum Presentation
- Multistate Regulation

Grand Ballroom III

10:30 a.m. - 11:00 a.m.
Coffee Break
Grand Ballroom III Foyer

11:00 a.m. - 12:30 p.m.
Delegate Assembly
Grand Ballroom III

12:30 p.m. - 2:15 p.m.
Awards Luncheon
Grand Ballroom II

2:30 p.m. - 4:00 p.m.
Delegate Assembly
Grand Ballroom III

4:00 p.m. - Evening
Resolutions Committee Meeting
Illinois

Meeting Note: This meeting is only for attendees who wish to propose new business for consideration by the Delegate Assembly.

Saturday, August 23

7:30 a.m. - 9:00 a.m.
Registration
Fifth Floor

7:30 a.m. - 8:30 a.m.
Elections
Lincolnshire

Elections Note: Elections will be conducted electronically. To promote familiarity with electronic voting, a practice program will be made available on-site prior to the scheduled elections. Delegates are strongly encouraged to practice electronic voting prior to election day.

9:00 a.m. - 9:15 a.m.
Delegate Assembly Election Results
Grand Ballroom III

9:15 a.m. - 9:45 a.m.
Resolutions/New Business Forum
Grand Ballroom III

9:45 a.m. - 10:45 a.m.
Delegate Assembly
Grand Ballroom III

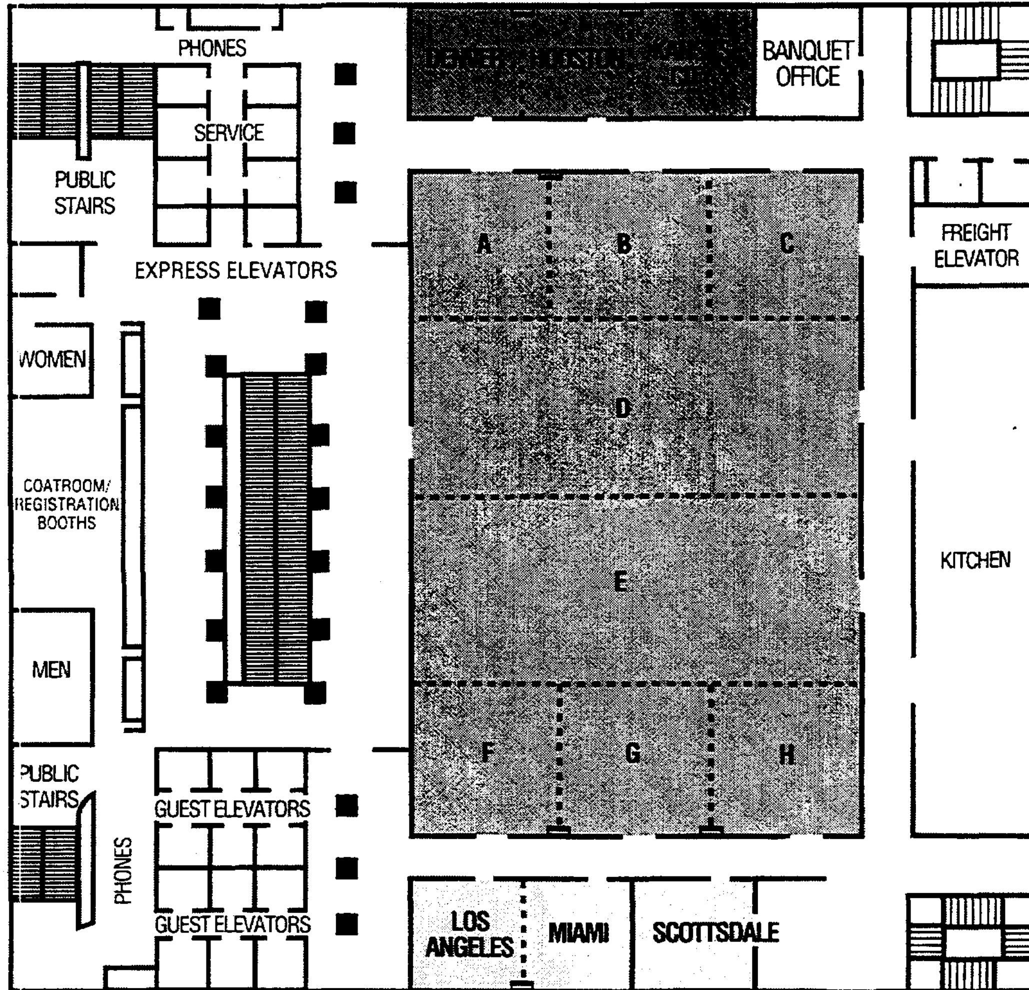
10:45 a.m. - 11:00 a.m.
Coffee Break
Grand Ballroom III Foyer

11:00 a.m. - 12:30 p.m.
Delegate Assembly
Grand Ballroom III

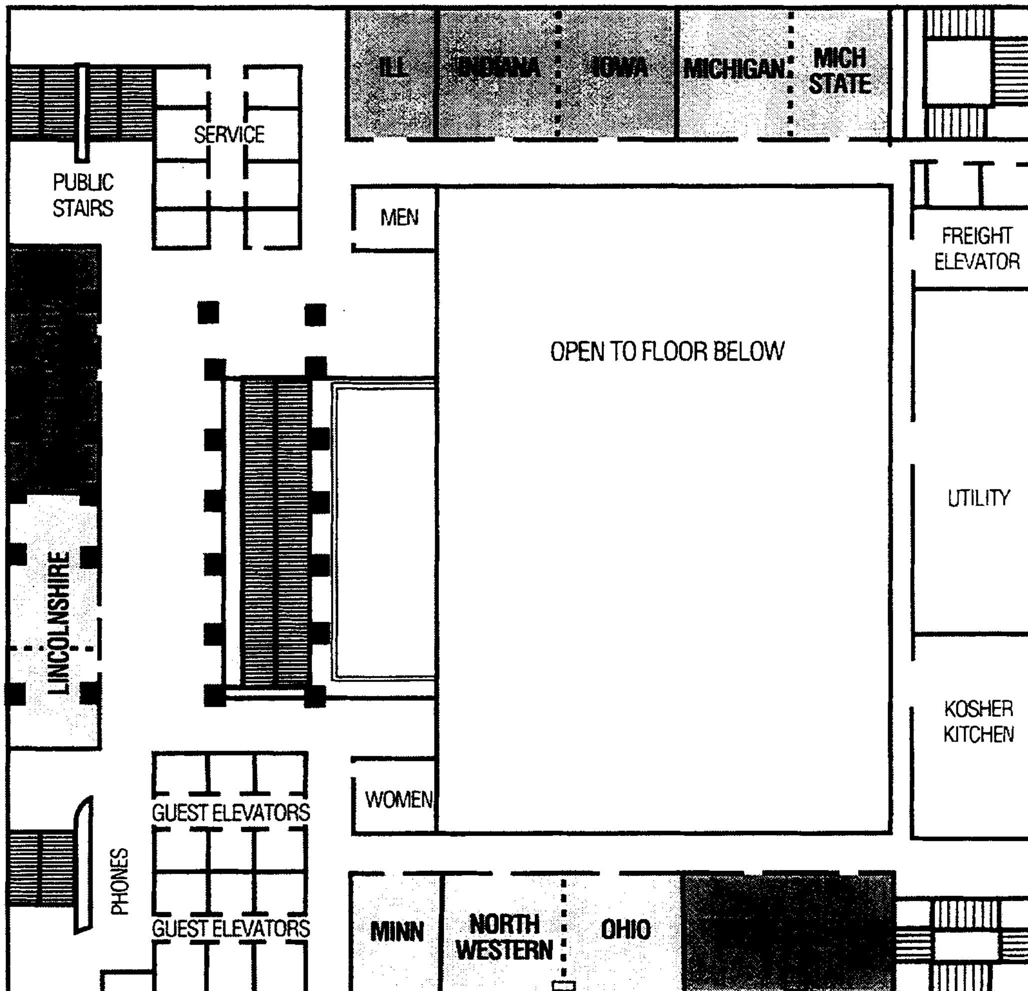
12:30 p.m. - 2:00 p.m.
Lunch Break

2:00 p.m. - 5:00 p.m.
Delegate Assembly
Grand Ballroom III

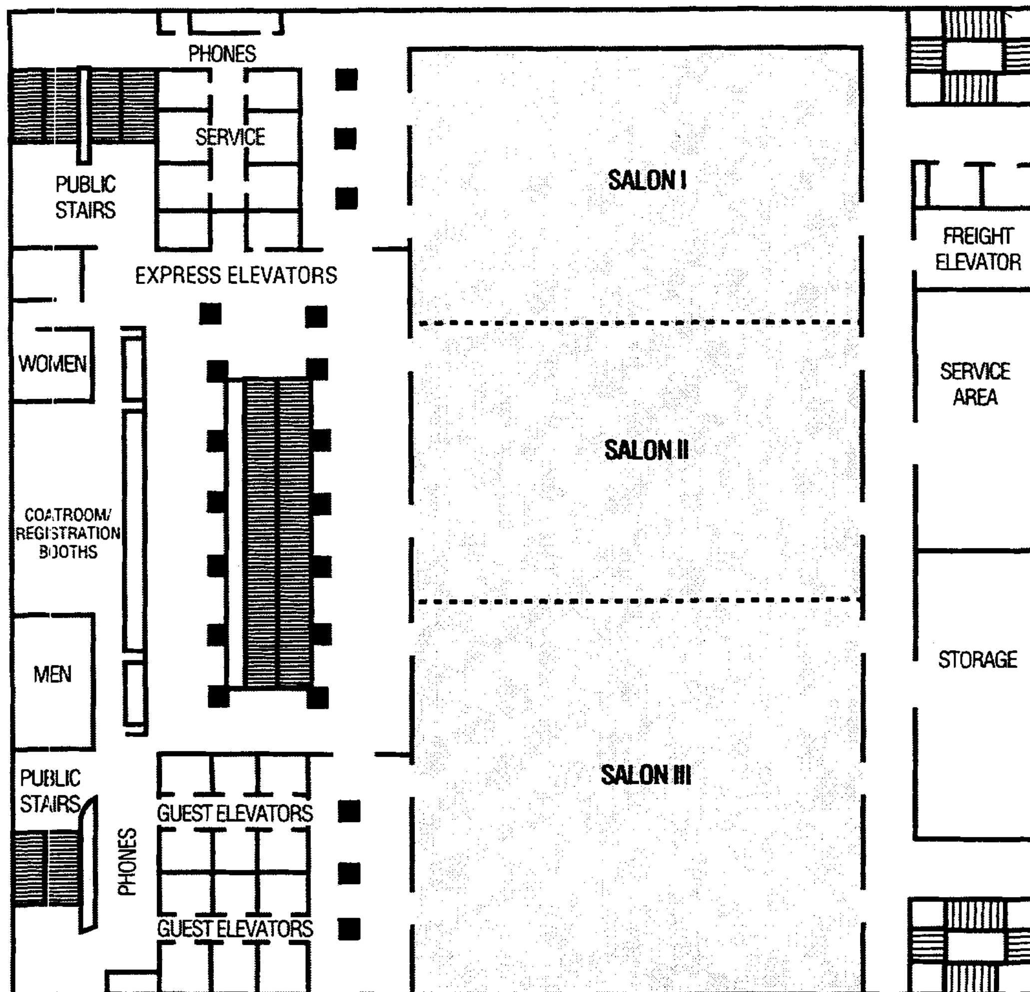
Floor Plan of the Chicago Marriott Downtown



6TH FLOOR BREAKOUTS



7TH FLOOR
GRAND BALLROOM



Business Agenda of the 1997 Delegate Assembly

Special Note
Business conducted during the Delegate Assembly will be continuous, advancing through the agenda as time and discussion permits.

Wednesday, August 20
1:30 p.m. - 2:30 p.m.

Opening Ceremonies
- Introductions
- Announcements

Opening Reports
- Credentials Committee
- Rules Committee

Adoption of Agenda

Bylaws Amendments

Report of the Committee on Nominations
- Slate of Candidates
- Nominations from Floor

President's Address

Friday, August 22
11:00 a.m. - 4:00 p.m.

Officers' Reports
- Treasurer's Report-Audit

Report of Staff
- National Council Administrative Staff and Organizational Charts

Examination Committee Report

Report of Test Services
- The Chauncey Group International and Sylvan Prometric
- Assessment Systems, Inc.
- National Board of Medical Examiners

Nursing Practice & Education Committee Report and Subcommittees
- Nursing Program Accreditation/Approval Subcommittee
- Subcommittee to Revise Model Act and Rules

Saturday, August 25
9:45 a.m. - 5:00 p.m.

Election of Officers and Committee on Nominations

Finance Committee Report

Board of Directors' Report
(Including reports of task forces and focus groups)

- **Related to Goal V – Organization**
  Bylaws Task Force
  Long Range Planning Task Force
  Multistate Regulation Task Force
  Special Services Division

- **Related to Goal IV – Information**
  Communications Evaluation Task Force
  Institute for the Promotion of Regulatory Excellence Task Force
  Research Advisory Panel

- **Related to Goal II – Nursing Practice**
  Disciplinary Data Bank Task Force
  Discipline Modules Task Force

- **Related to Goal I – Licensure and Credentialing**
  Advanced Practice Registered Nurse Task Force
  Computerized Clinical Simulation Testing Task Force
  Licensure Examination Comparison Task Force
  Licensure Verification Task Force
  NCLEX® Negotiation Team
  Unlicensed Assistive Personnel Task Force

New Business
- Resolutions Committee and New Business

Adjournment

Standing Rules of the Delegate Assembly

1. Procedures

A. The Credentials Committee, directly after the opening ceremonies of the first business meeting, shall report the number of delegates and alternates registered as present with proper credentials, and the number of delegate votes present. The committee shall make a supplementary report after the opening exercises at the beginning of each day that business continues.

B. Upon registration:
   1. Each delegate and alternate shall receive a badge which must be worn at all meetings.
   2. Each delegate shall receive the appropriate number of voting cards. Delegates authorized to cast one vote shall receive one voting card. Delegates authorized to cast two votes shall receive two voting cards. Any transfer of voting cards must be made through the Credentials Committee.

C. A member registered as an alternate may, upon proper clearance of the Credentials Committee, be transferred from alternate to delegate. The initial delegate may resume delegate status upon clearance by the Credentials Committee.

D. Members shall be in their seats at least five minutes before the scheduled meeting time. Delegates shall sit in the section reserved for them.

E. There shall be no smoking in the meeting rooms.

F. The Board of Directors may place reports on the consent agenda that do not contain recommendations and can be considered received without discussion. An item will be removed from the consent agenda at the request of any delegate. All items remaining on the consent agenda will be considered received without a vote.

2. Motions

A. The Board of Directors, National Council committees and delegates representing Member Boards shall be entitled to make motions. Motions proposed by the Board of Directors or National Council committees shall be presented by the Board or committee directly to the Delegate Assembly.

B. Motions and resolutions submitted prior to Friday, August 22, 1997, at 2:00 p.m., shall be reviewed by the Resolutions Committee according to its Operating Policies and Procedures. Motions and resolutions submitted after the deadline shall be submitted directly to the Delegate Assembly during New Business. All motions and resolutions so submitted will be presented with written analysis of consistency with National Council mission, goals and objectives; assessment of fiscal impact; and potential legal implications. The Resolutions Committee will meet on Friday, August 22, 1997, at 4:00 p.m., with the motion maker(s).

C. The Resolutions Committee shall prepare suitable motions to carry into effect resolutions referred to it, and shall submit to the Delegate Assembly, with a fiscal impact statement, these and all other motions referred to the committee.

D. All motions and amendments shall be in writing on triplicate motion paper signed by the maker and a second and shall be sent to the chair prior to being placed before the Delegate Assembly.

3. Debate

A. Any representative of a Member Board wishing to speak shall go to a microphone.

B. Upon recognition by the chair, the speaker shall state his/her name and Member Board.

C. Members and employees of Member Boards may speak only after all delegates who wish to speak on the motion have spoken. Guests may be recognized by the chair to speak after all delegates, members and employees of Member Boards wishing to speak, have spoken.

D. No person may speak in debate more than twice on the same question on the same day, or longer than four minutes per speech, without permission of the Delegate Assembly, granted by a majority vote without debate.

E. A red card raised at the microphone interrupts business for the purpose of a point of order, a question of privilege, orders of the day, a parliamentary inquiry or an appeal.

F. A timekeeper will signal with a red card when the speaker has one minute remaining, and a buzzer will sound when the allotted time has expired.

4. Nominations and Elections

A. A delegate making a nomination from the floor shall be permitted two minutes to give the qualifications of the nominee and to indicate that written consent of the nominee and a written statement of qualifications have been forwarded to the Committee on Nominations. Seconding speeches shall not be permitted.

B. Electioneering for candidates is prohibited in the vicinity of the polling place.

C. The voting strength for the election is determined by those registered by 8:30 a.m. on the day of the election.

D. Election for officers and members of the Committee on Nominations shall be held Saturday, August 23, 1997, 7:30 a.m.- 8:30 a.m.

E. If no candidate receives the required vote for an office and repeated balloting is required, the president shall announce the time for repeated balloting immediately after the original vote is announced.

Recommendations to the 1997 Delegate Assembly With Rationale

To help Member Boards and delegates in their deliberations on recommendations made to the Delegate Assembly prior to attendance at the 1997 Annual Meeting, following are the recommendations, with rationale, received as of July 1, 1997. Additional recommendations may be brought forward during the 1997 Annual Meeting.

Committee on Nominations

1. **That the Delegate Assembly adopts the 1997 Slate of Candidates.**

   Rationale

   The Committee on Nominations has prepared the 1997 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of the National Council.

Treasurer

1. **That the auditor's report for October 1, 1995, through September 30, 1996, be approved as presented.**

   Rationale

   The audit was completed in December 1996. The auditors found no irregularities in the financial statements and expressed an unqualified opinion in their management letter to the organization. The National Council of State Boards of Nursing remains financially strong.

Examination Committee

1. **That the Delegate Assembly adopts the proposed revisions of the *NCLEX-RN® Test Plan* (Attachment A).**

   Rationale

   Empirical evidence provided by the research department from job incumbents, the professional judgment of the committee members in collaboration with the National Council and the Chauncey Group International (Chauncey) staff, legal counsel and feedback from Member Boards garnered through survey and Area Meeting dialogue supports revision in the *NCLEX-RN® Test Plan.*

Nursing Practice & Education (NP&E) Committee

1. **That the Delegate Assembly approves the position paper developed by the Nursing Program Accreditation/Approval Subcommittee related to the terms *approval* and *accreditation* (see report of the subcommittee).**

   Rationale

   The terms *approval* and *accreditation* are used in different ways by boards of nursing. The position paper, developed by the Nursing Program Accreditation/Approval Subcommittee, provides guidance to Member Boards in defining these terms in nursing practice acts and rules/regulations related to nursing education. The paper clarifies for the public the meanings of these terms and moves toward greater consistency in the use of regulatory language.

2. **That the Delegate Assembly provides feedback to the Subcommittee to Revise Model Act and Rules at the Annual Meeting forum regarding the process for developing proposed content, format and overall direction for the revised models.**

   Rationale

   The subcommittee agrees that the models provide an opportunity to synthesize much of the work of the National Council in the past few years into a congruent view of regulation, encompassing all the major elements that comprise nursing regulation. The subcommittee recognizes the need to collaborate with other

committees, Board of Directors and other National Council groups to assure that the models reflect a comprehensive, accurate and timely approach to nursing regulation.

3. **That the Delegate Assembly provides feedback to the Nursing Practice & Education Committee at the Annual Meeting forum regarding the use of the Personal Accountability Profile as an approach toward promoting continued competence among licensed nurses.**

Rationale

The Personal Accountability Profile (PAP) is a means for Member Boards to promote professional development and audit the activities of nurses related to continued competence. The PAP is proposed as a mechanism for working with nurses who meet certain criteria that trigger a focused interaction with the board regarding competence. In essence, the PAP requires that the licensed nurse apply the nursing process to her/his professional development, to plan and implement what is needed by the individual nurse to be competent within the role and setting for current practice. The PAP is intended to be comprehensive, flexible and useful to the nurse, as well as the board of nursing. In addition to tracking a record of professional development to meet board of nursing continued competence requirements, the PAP can be used by nurses in collaboration with employers to meet the employer's expectations related to continued competence. Additionally, the individual nurse can promote self-marketability and assure adaptability to a changing health care environment.

Board of Directors

1. **That the Delegate Assembly adopts the amendment to Article V, Section 2 of the Bylaws, Election of Officers.**

Rationale

This amendment was proposed by the Elections Committee. The committee's rationale follows: During the 1996 elections, combining both a large number of potential candidates and the need to elect two Directors-at-Large resulted in the need for not only a second ballot, but also election by lot. While procedures were in place to accommodate this situation, questions were raised by delegates, Election Committee members and staff regarding the process and the fairness of the current process to elect Directors-at-Large.

The Board of Directors supports the recommendation which clarifies the process and provides an opportunity for the delegates to express their preference.

2. **That the Delegate Assembly adopts the amendment to Article V, Section 1.c. of the Bylaws, Elections.**

Rationale

This amendment was proposed to the Board of Directors by the Committee on Nominations as a preferred means of identifying a chairperson for the committee. The committee's rationale follows: The current system has three disadvantages that do not exist in the proposed change. The current system:

- penalizes the Areas that nominate multiple candidates (Because the committee chair is the candidate who receives the highest number of votes, if one Area has three candidates for the Committee on Nominations, and another Area has only one candidate, it is almost impossible for the Area with three candidates to have one of those candidates become the committee chair.);
- conducts the same election for membership on the Committee on Nominations as it does for committee chair; and
- allows for the election of an individual to chair even though that person may not be interested or willing to function as chair of the committee.

This proposed change eliminates the previously mentioned disadvantages, as well as provides the committee members with the opportunity to meet members of the Board of Directors and observe the Board in action so as to better understand the function of the Board.

The Board supports this recommendation.

3. **That the Delegate Assembly adopts the amendment to Article X, Section 1.a. of the Bylaws, Examination Committee.**

Rationale

This amendment, to restructure the Examination Committee, was proposed to the Board by the Examination Committee as a means of expediting the work of the committee and relieving some of the excessive workload experienced in recent years. The Board supports this recommendation.

4. **That the mission of the National Council be revised to read: "The mission of the National Council of State Boards of Nursing is to lead in nursing regulation by assisting Member Boards, collectively and individually, to promote safe and effective nursing practice in the interest of protecting public health and welfare."**

Rationale

The proposed mission makes clear what the organization does, who it serves and what are its underlying beliefs. It is congruent with the purpose statements found in the bylaws and articles of incorporation, which emphasize boards of nursing acting together on matters of common concern affecting public health, safety and welfare.

5. **That the wording of Organization Plan objectives be modified to read as follows:**
I.H. Provide a comprehensive approach to assessing continued competence.
II.A. Analyze the environment for trends and issues affecting the regulation of nursing practice.
III.A. Analyze the environment for trends and issues affecting the regulation of nursing education.

Rationale

Objective I.H. currently states, "Identify the role of a board of nursing related to continued competence." The Board believes that the organization has, in adopting the 1996 position statement, moved beyond identification of role and progressed to a stage more aptly described by the proposed wording. Objectives II.A. and III.A. currently include the modifier "health care" before "environment." The Board believes that there are other aspects of the environment (e.g., the regulatory community, technological developments) which may also affect the regulation of nursing practice and education, and thus suggests deleting the limiting modifier in these two objectives.

6. **That the Chauncey Group International be selected as the NCLEX® examination test service for the period October 1, 1999, through September 30, 2002, according to the terms and conditions negotiated by the Negotiating Team.**

Rationale

The Board of Directors believes that the terms and conditions negotiated with Chauncey are responsive to the evaluation of Chauncey's services carried out last year. The continuation of the same services which have proven very satisfactory for the past three-plus years, with the addition of clear performance standards in key areas, will provide the quality examination program which Member Boards and candidates expect.

7. **That the NCLEX examination candidate fee be set at $120, from October 1, 1999, to September 30, 2002.**

Rationale

The proposed candidate fee incorporates the price negotiated with the Chauncey Group International and a portion for the National Council. (Please refer to confidential report found behind Tab 10-N provided to Member Boards only.) The fee would be reflected in the standard Member Board contract for the next renewal following this fall's, i.e., to take effect October 1, 1999.

8. **That the Member Board contract include the following language to facilitate the provision of an electronic licensure verification information system (ELVIS) for Member Board use:**

Paragraph 10 (new language in italics): <u>Council Use of Candidate Data</u>: [Member] Board hereby authorizes Council to use any and all candidate data collected for the *purposes of (1) administering the nurse licensure examinations, including but not limited to*, identifying candidates approved for the examination, determining their status as first-time, repeat and/or multiple application candidates, *preparing the examination results related to the validity and psychometric integrity of the nurse licensure examinations, and (2) developing and maintaining a comprehensive national data bank of information on nurse licensees for use by Member Boards of the Council in evaluating applicants for endorsement, in monitoring disciplinary actions and in any other licensing-related actions authorized by applicable state and federal law. Candidate data collected hereunder shall not be disseminated to parties other than the Member Boards or used for other purposes without prior approval by the Member Board.*

Rationale

The Licensure Verification Task Force has worked to carry out the charge from the 1996 Delegate Assembly to move toward full development of an electronic licensure verification information system, including a fee payment mechanism. The proposed contract amendment makes provision for data to be infused into the database from NCLEX examination applicant files. If adopted by the Delegate Assembly, the language will be part of the standard contract offered to each jurisdiction this fall, extending through September 30, 1999.

9. **That the National Council endorses a mutual recognition (i.e., driver's license) model of nursing regulation and authorizes the Board of Directors to develop strategies and services, including an interstate compact and information system, needed to assist boards of nursing with implementation.**

Rationale

The Multistate Regulation (MSR) Task Force presented its work at the Member Board MSR Workshop in Arlington, Virginia, June 4, 1997. The Board supports the recommendation proposed by the task force on the basis of the outcomes of that meeting. It is responsive to the input received from Member Boards and it acknowledges the primary components that would be required to bring this concept to fruition, i.e., an interstate compact and an information system.

The adoption of this motion has fiscal implications for Member Boards and the National Council. Fiscal information, in addition to that which was presented at the June MSR Workshop, is being gathered and will be presented at the Annual Meeting.

Report of the Committee on Nominations

Committee Members
Billie Rozell, AL, Area III, *Chair*
Louise Dean, AK, Area I
Deborah Feldman, MD, Area IV
Margaret Kotek, MN, Area II

Staff
Christopher T. Handzlik, *Integrated Media Manager/Webmaster*

Relationship to Organization Plan
Goal V................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective C.........Maintain a system of governance for the National Council that facilitates leadership and decision-making.

Recommendations to the Delegate Assembly
1. **That the Delegate Assembly adopts the 1997 Slate of Candidates.**

Highlights of Activities
■ **Preparation of slate**

By the February 21, 1997, nomination deadline, 14 individuals had submitted completed nomination forms for consideration for the 1997 Slate of Candidates. The committee extended the deadline to allow for submission of additional nominations. The committee finalized the slate on April 28, 1997. The list of slated candidates was published in the May 2, 1997, *Newsletter*, sent to Member Boards. Full biographical information for each candidate was published in the May 30, 1997, *Newsletter* in addition to being included within this report.

■ **Bylaws change recommendation**

The committee initiated a bylaws change recommendation. The proposed change would specify that the chair of the Committee on Nominations be selected by the committee at its first meeting, and that the committee hold its first yearly meeting concurrent with the first Board of Directors' meeting of the upcoming fiscal year. Please see the Report of the Bylaws Task Force, Tab 10-A, in the *Book of Reports* or Tab 15, Bylaws, for proposed language and rationale.

■ **Committee observation of Board of Directors' meeting**

On February 12, 1997, the committee observed the Board of Directors' meeting. As part of this activity, the committee dialogued with the Board on topics related to the nomination process at the National Council, including: criteria for selection of candidates; difficulty in generating interest in elected office and potential opportunities for recruiting; expansion of the letter sent to nominees not placed on the slate to include generalities of selection criteria; ways to determine the extent of a nominee's regulatory background; promoting online methods of submitting nominations; means of encouraging each year's Committee on Nominations to observe part of a Board meeting; and strategies for ensuring that each year's committee is well-grounded in the history and procedures of prior years' committees. The committee discussed the Board's input during its own, subsequent meeting.

■ **New committee communication efforts**

The committee discussed options for promoting nominations to National Council office and decided to print a brochure to serve as a companion piece to the National Council orientation video, which the committee believes is a valuable tool for Member Boards. The brochure focuses on getting involved in the National Council and highlights both elected office and volunteering for task forces/committees. The brochure will be distributed at the 1997 Annual Meeting. The committee also sent a letter to Member Board executive officers in early December 1996 to enlist their help as partners in the effort to gain nominations. This letter supplemented the reminder letter traditionally sent

to Member Board executive officers in January of each year, reminding them of the approaching nomination deadline. In addition, the committee sent a letter to members of the 1996-97 National Council volunteer pool, composed of persons who expressed a desire to be appointed to a committee or task force. The letter encouraged these volunteers to consider expanding their interest in serving the National Council to encompass elected positions, as well.

Meeting Dates

- October 28, 1996 *(telephone conference call)*
- February 12-13, 1997
- April 7, 1997

Recommendations to the Delegate Assembly

1. That the Delegate Assembly adopts the 1997 Slate of Candidates.

Attachments

A .... 1997 Slate of Candidates, *page 3*

Attachment A

1997 Slate of Candidates

The following is an overview of the slate developed and adopted by the Committee on Nominations. More-detailed information on each candidate is provided in the subsequent pages of this report. This detailed information is taken directly from candidates' nomination forms. Each candidate will have an opportunity to expand on this information during the Candidates' Forum, scheduled to be held Wednesday, August 20, 1997, from 2:45 p.m. to 5:00 p.m.

AREA I DIRECTOR

Laura Poe.. Utah
Jo Elizabeth Ridenour..................... Arizona

AREA II DIRECTOR

Lorinda Inman .... Iowa
Linda Peterson Seppanen................ Minnesota

AREA III DIRECTOR

Nathan Goldman............................. Kentucky
Julia Gould.. .... Georgia-RN

AREA IV DIRECTOR

Milene Sower.................................. New York
Anna Yoder..................................... Massachusetts

DIRECTOR-AT-LARGE (two positions)

Dorothy Fiorino .... Ohio .... Area II
Dorothy Fulton .... Alaska .... Area I
Gregory Howard .... Alabama............................ Area III
Melba Lee-Hosey............................ Texas-LVN .... Area III
Janice McCoy .... Wyoming .... Area I

COMMITTEE ON NOMINATIONS

Area I

Louise Dean.................................... Alaska
Helen Zsohar.................................. Utah

Area II

Deb Haagenson............................... North Dakota
Margaret Kotek............................... Minnesota

Area III

Patricia Block.................................. Alabama
Bobbie Johnson............................... Georgia-PN

Area IV

Monica Collins................................ Maine
Jean Fergusson................................ Pennsylvania

DETAILED INFORMATION, as taken directly from nomination forms and organized as follows:

1. Name, Jurisdiction, Area
2. Present board position, board name
3. Present employer
4. Educational preparation
5. Offices held or committee membership, including National Council activity
6. Professional organizations
7. Date of term expirations and eligibility for reappointment
8. Personal statement

Area I Director

1. **Laura Poe, Utah, Area I**

2. Executive Administrator, Utah State Board of Nursing

3. Utah State Board of Nursing

4. Brigham Young University, Nursing Education and Administration, MS, 1988
   Brigham Young University, Nursing, BS, 1986

5. National Council
   - Director-at-Large, 1996-present
   - Information Services Evaluation Task Force, 1995-1996
   - Executive Officer Orientation Task Force, 1994-1995

   Utah Nurses Association
   - Board of Nursing Nurse Practice Act Task Force, 1996-1997; 1991-1992
   - Government Relations Committee, 1984-1995

   Utah Board of Nursing
   - Entry into Practice Task Force, 1985-1986

6. Nursing Leadership Forum
   Phi Kappa Phi
   Sigma Theta Tau

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. These next few years are going to be critical in the regulatory arena, and the National Council will be there taking the lead regarding public policy as it relates to licensure and public protection. I want to be there, actively participating in and debating the issues which will usher in the new century. Priority issues include multistate licensure, telehealthcare, advanced practice, delegation and scope of practice.

   I bring to the National Council Board of Directors a keen mind and sense of humor. I enjoy lively discussions but feel that humor can make almost any situation tolerable. I have the critical thinking skills necessary to provide meaningful dialogue. I don't hesitate to ask why or to think outside of the box. I also recognize the rich experience available from those who have been involved in regulation for a number of years and respect their input.

Area I Director

1. **Jo Elizabeth Ridenour, Arizona, Area I**

2. Executive Director, Arizona State Board of Nursing

3. Arizona State Board of Nursing

4. University of Phoenix, Nursing, MS, 1993
   Arizona State University, Nursing, BSN, 1969

5. National Council
   - Area I Director, 1995-1997
   - Long Range Planning Committee, 1996-1997
   - Finance Committee, 1994-1995

   Arizona State Board of Nursing
   - President/Board Member, 1992-1995; 1984-1989
   - Scope of Practice, Chair, 1993-1995

   Arizona State University
   - Adjunct Faculty/Committee to Revise Graduate Curriculum, 1996-1997

   RWJ Colleagues in Caring
   - Consortium Member, 1996-1997

6. American Organization of Nurse Executives
   Arizona Nurses Association
   Arizona Organization of Nurse Executives
   Sigma Theta Tau

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. Having been both a board member and executive director of a board of nursing over the past ten years, I bring a diversity of perspectives and experience to Area I leadership. Commitment to National Council's mission and goals has been demonstrated through the Finance Committee, and currently, as liaison to Long Range Planning and the Board of Directors. Three critical challenges are: 1) identifying new strategies to lead the way in regulatory effectiveness as the health care environment and consumer needs change; 2) leveraging the Board's time differently by spending 80 percent on what is desired to happen in the future and only 20 percent on monitoring the past; and 3) improving the match of volunteers to Board and committee positions to increase effectiveness of decisions on critical activities. I offer a deep and genuine interest to be your "servant leader" as the Area I Director. The last two years have been a gift – thank you.

Area II Director

1. **Lorinda Inman, Iowa, Area II**

2. Executive Director, Iowa Board of Nursing

3. Iowa Board of Nursing

4. Loyola University, Nursing, MS, 1976
   University of Iowa, Nursing, BSN, 1971

5. National Council
    Finance Committee, 1995-1997
    Resolutions Committee, 1995-1996
    Executive Officer's Orientation Task Force, 1995
    Long Range Planning Task Force, 1989-1995
   County Extension Council
    Member, 1997

6. American Nurses Association
   Iowa Organization of Nurse Executives
   National League for Nursing
   Sigma Theta Tau International

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. During my 14 years of involvement in the National Council, I have served as delegate and committee member. This has provided me with strong knowledge of, and commitment to, the National Council as it supports Member Boards in their public protection mission. My background in nursing education, testing, long range planning and financial planning has prepared me to be an effective leader within the National Council.

   As an organization of regulatory boards, we need to be focused on providing assistance to Member Boards in responding to the changing dynamics in the health care field. These responses must include: relevant and innovative approaches to assessing entry-level competency, continued competency, delegation, advanced nursing practice, complex disciplinary matters, changing practice parameters and the multitude of external demands placed on nursing regulation. We must use the knowledge gained from the past as, collectively, we work toward the best approaches to today's issues.

Area II Director

1. **Linda Peterson Seppanen, Minnesota, Area II**

2. Board Member, Minnesota Board of Nursing

3. Winona State University, Winona, Minnesota

4. University of Alabama, Administration of Higher Education, PhD, 1981
   Catholic University of America, Maternal-Infant Health Nursing, MSN, 1969
   St. Olaf College, Nursing, BSN, 1966

5. National Council
    Board of Directors, 1994-present
    Job Analysis Monitoring Panel, 1996
   Kappa Mu, Sigma Theta Tau
    Treasurer, Faculty Counselor, 1992-present
   Minnesota Board of Nursing
    Advanced Practice Committee, Education Committee, 1994-present
   Minnesota League for Nursing
    Board of Directors, 1986-1993
   National League for Nursing Council of Baccalaureate and Higher Degree Programs
    Accreditation Site Visitor, 1991-present; 1984-1988

Winona Arms, Inc.
President, Board, 1987-1995
Winona State University
Inter-Faculty Organization, Faculty Senate, 1992-1994
Long Range Planning Committee, 1995-present

6. Association of Women's Health, Obstetric and Neonatal Nurses
Minnesota Inter-Faculty Organization
National League for Nursing
Sigma Theta Tau International
Winona Registered Nurse Association

7. Date of expiration of term: January 2001
Eligible for reappointment: No

8. I bring to this position a combination of regulatory experience with the National Council and the Minnesota Board of Nursing, along with the educator's orientation to both current and future nursing practice. I can contribute a logical mind, a work ethic, willingness to question "conventional wisdom," consensus building and continuity to the work of the National Council. Priorities that I see for the National Council include: 1) maintaining our national and international presence for reasoned, effective change in the policy arena; 2) assisting Member Boards in our major problem areas such as discipline, overlapping scopes of practice, delegation and nurse mobility; 3) refining our mechanisms and exams that assure entry-level and continued competence; 4) providing open dynamic networking opportunities; and 5) ensuring wise fiscal management when we have so many opportunities and needs as the health care system, technology and state governments are changing.

Area III Director

1. **Nathan Goldman, Kentucky, Area III**

2. General Counsel, Kentucky Board of Nursing

3. Kentucky Board of Nursing

4. University of Louisville, Law, JD, 1979
University of Louisville, Theatre Arts and Speech, BA, 1975

5. National Council
Task Force to Analyze Advisory Opinions/Rulings, 1996
Disciplinary Case Analysis Focus Group, 1994
Council of Licensure, Enforcement and Regulation (CLEAR)
Regulatory Issues Task Force, 1993-1997

6. Kentucky Bar Association

7. Date of expiration of term: (NA)
Eligible for reappointment: (NA)

8. As a full-time attorney for the Kentucky Board of Nursing for the last seven years, I believe I bring a unique perspective to the National Council. I have been involved in every major issue affecting the regulation of nursing during these tumultuous times. My experience with the Kentucky Board of Nursing, my experience with the National Council and my interaction with other states will allow me to contribute

both my legal background and my regulatory experience to further the goals of the National Council. I believe the next several years will be crucial ones for the nursing regulatory community. As a director of the National Council, I will devote my time and energy to meeting the challenges.

Area III Director

1. **Julia E. Gould, Georgia, Area III**

2. Nursing Education Consultant, Georgia Board of Nursing

3. Georgia Board of Nursing

4. University of Michigan, Nursing, MS, 1970
   University of British Columbia, Nursing, BSN, 1964

5. National Council
   - Licensure Examination Comparison Task Force, Chair, 1996-present
   - Task Force to Implement Education Programs for Nursing Education Program Surveyors, 1995
   - Task Force to Develop Educational Programs for Nursing Education Program Surveyors, 1994
   - Nursing Practice and Education Committee, Member, 1989-1993; Chair, 1992-1993
   - Delegate, 1988-1993
   - Resolutions Committee, 1988

   Commission on Graduates of Foreign Nursing Schools
   - Trilateral Initiative - Workforce on Approval and Accreditation, Member, 1995-1997
   - Board of Trustees, National Council Representative, 1996-2000

   Georgia League for Nursing
   - Executive Board, Member, 1993-1997

6. National League for Nursing
   Sigma Theta Tau

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. As the Nursing Education Consultant for 18 years, my responsibilities include communicating with, regulating and consulting with Georgia's 40 nursing programs for registered nurses. Since 1990, the board has adopted education rules and processes which have departed from the prescriptive behaviorist paradigm for ones which enable user-friendly flexibility while maintaining quality. My qualifications include a profound commitment to nursing, credibility, polished communication skills and organization.

   For many years, I have participated in the National Council's Area Meetings, Delegate Assemblies and committees. In the last four years, I have learned board member skills on the boards of the Georgia League for Nursing and the Commission on Graduates of Foreign Nursing Schools.

   Over the next two years, the National Council's issues will concern burgeoning changes in health care and their impact on consumers, education, practice and regulation. All of us will have to make very careful. informed decisions in the interest of public safety.

Area IV Director

1. **Milene A. Sower, New York, Area IV**

2. Executive Secretary, New York State Board for Nursing

3. New York State Board for Nursing

4. University of Iowa, Education, PhD, 1980
University of Iowa, Medical-Surgical Nursing, MA, 1972
College of Saint Scholastica, Nursing, BSN, 1961

5. National Council
    Examination Committee-Alternate, 1996-present
    Examination Committee, 1988-1996
American Business Women's Association
    Chapter President, 1985-1986
National League for Nursing
    Nursing Education Site Visitor for Diploma and A.D. Schools of Nursing, 1985-1987; 1977-1979

6. American Nurses Association
Sigma Theta Tau

7. Date of expiration of term: (NA)
Eligible for reappointment: (NA)

8. I have 25 years of experience as a dean of nursing for diploma, associate, baccalaureate and master's degree nursing programs. I have been the executive secretary of the New York Board for Nursing for 10 years and the executive secretary of the Respiratory Therapy Board for three years.

    I am an avid public speaker and address many groups of nurses and RTs in New York State. I have eight years' experience as a member of the Examination Committee and participated in the implementation of CAT (computerized adaptive testing).

    Maintaining our leadership role in testing, the National Council will need to keep abreast of the health care changes being advanced by groups who work for the "public good" and the most cost-effective care. It is important that the National Council focus on being a clearinghouse for information that will assist states to stay a step ahead of issues and be a knowledgeable force in state regulation.

Area IV Director

1. **Anna F. Yoder, Massachusetts, Area IV**

2. Chairperson, Massachusetts Board of Registration in Nursing

3. Beth Israel Deaconess Medical Center, Boston, Massachusetts

4. Boston University, Rehabilitation Nursing, MS, 1972
Elizabethtown College, Post-Nursing Degree Program, BS, 1961
Harrisburg Hospital, Nursing, Diploma, 1959

5. National Council
    Director-at-Large, Area IV Director, 1996-1997
    Area IV Meeting Planning Committee, 1996, 1997
    NACEP Task Force, 1993-1996

    American Nurses Association
    Delegate-Massachusetts, 1993-1995; 1980-1988

    Massachusetts Nurses Association
    Council on Professional Nursing Practice, Member, 1976-1983; Chair, 1979-1983

    Massachusetts Nurses Association, District 5
    President, 1987-1991
    Board of Directors, 1976-1979

    Massachusetts Organization of Nurse Executives
    Committee on Government Affairs, Member, 1988-1996; Chair, 1991-1993

6. American Organization of Nurse Executives
    Massachusetts Public Health Association
    Sigma Theta Tau, Theta Chapter-at-Large

7. Date of expiration of term: February 1998
    Eligible for reappointment: No (Governor has consistently delayed replacement of board members from one to five years; will serve until replaced.)

8. Throughout the year, I have made significant contributions to the work of the National Council as director-at-large and Area IV director following appointment to that position in December 1996. My previous knowledge of health care policy and the regulatory environment has been strengthened through this work, and I am committed to increasing effectiveness as a board member on your behalf. I am able to analyze and synthesize large amounts of information affecting the regulation of nurses and nursing education, and have skills in negotiation, consensus building and networking. I am challenged and stimulated by the complex issues facing us. Priorities that are most relevant include: 1) regulatory challenges inherent in the increasing use of technology and changes in the health care environment which affect public safety; and 2) the challenge to remain a stable, pioneering and visionary organization which is, when necessary, flexible and rapidly responsive in fine-tuning its priorities.

Director-at-Large

1. **Dorothy Fiorino, Ohio, Area II**

2. Executive Director, Ohio Board of Nursing

3. Ohio Board of Nursing

4. Wright State University, Nursing, MS, 1980
    Alverno College, Nursing, BSN, 1963

5. National Council
    Computerized Clinical Simulation Testing Task Force, Member, 1990-present; Chair, 1994
    Planning Committee, Area II Day of Dialogue, Chair, 1996
    Task Force to Study Advanced Nursing Practice Mobility, 1994-1995

    Village at Deercreek Condo Association
    President, Board Member, 1989-1993

    Ohio Pediatric Nurse Associates Practitioners
    Treasurer, 1976-1978

6. American Nurses Association
   Ohio Nurses Association
   Sigma Theta Tau

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. At this time of revolutionary change in all aspects of both health care and regulation, National Council's leaders need to be able to respond rapidly, flexibly and proactively to a wide variety of challenges. I believe that my varied nursing, management, leadership and regulatory experiences qualify me to be a part of that leadership. I am able to view the challenges that face us from a regulatory perspective but have the ability to see the larger picture in which regulation is only one frame.

   Major issues for the coming year are: determining competency measures for all levels of nursing caregivers; solving the licensure dilemmas evoked by technology while retaining the credentialing mechanisms which assure consumer safety; dealing with the issues concerning unlicensed caregivers; and assuring that the National Council's organizational structure allows for proactive responses to these issues.

   I would welcome being part of these challenging and exciting decisions.

Director-at-Large

1. **Dorothy P. Fulton, Alaska, Area I**

2. Executive Administrator, Alaska Board of Nursing

3. Alaska Board of Nursing

4. Alaska Pacific University, Education, MA, 1985
   Alaska Pacific University, Human Resource Development, BA, 1984
   University of Alaska, Nursing, ADN, 1978

5. National Council
   - Disciplinary Data Bank Task Force, Chair, 1996-1997
   - Nurse Aide Competency Evaluation Program Committee, 1991-1995

   Alaska Nurses Association
   - Member, 1989-present
   - Membership Committee, 1995-1996

   National Association of Orthopedic Nurses, Alaska Chapter
   - Member, 1984-present
   - President, 1994-1995

6. Sigma Theta Tau

7. Date of expiration of term: (NA)
   Eligible for reappointment: (NA)

8. I have served on several boards and committees and would bring leadership qualities to this position. I have worked in nursing, nursing education, state government and the private sector. Having worked in all areas of nursing, clinical practice, management and administration has afforded me the opportunity to completely understand all aspects of the nursing profession. This background has provided me with an

informed and objective perception of nursing practice and the challenges faced by nurses in providing quality nursing care.

One of my greatest assets is my ability to communicate to diverse audiences. Working in Alaska gives me the opportunity to understand both rural and multicultural populations, and the ability to be more proactive with health care issues.

I believe the National Council should address the issues of multistate licensure, chemical dependency in nursing, unlicensed assistive personnel (UAP) and study the feasibility of developing a disciplinary data bank for UAPs.

Director-at-Large

1. **Gregory Howard, Alabama, Area III**

2. Vice-President, Alabama Board of Nursing

3. Tuscaloosa V.A. Medical Center, Tuscaloosa, Alabama

4. Shelton State Technical College, LPN, 1982
   Stillman College, 1965-1967

5. National Council
   - Director-at-Large, 1997-present
   - Committee on Nominations, 1992

   Alabama Board of Nursing
   - Continuing Education, 1992-present
   - Education Committee, 1992

   AFLPN, Inc., Division 10
   - Treasurer, Vice-President, President, 1997, 1990-1994

   Tuscaloosa VA Medical Center
   - LPN Performance Standards Board, 1993-1996

6. Alabama Federation of Licensed Practical Nurses, Inc.
   National Federation of Licensed Practical Nurses, Inc.

7. Date of expiration of term: November 1999
   Eligible for reappointment: Yes

8. I support the mission of National Council and would like to continue to participate in the National Council's vision for the future of nursing. I feel I will bring the National Council a clearinghouse of trends and issues that address all levels of nursing. Having served on committees in my professional organization, Alabama Board of Nursing and National Council, this will confirm my commitment to support the methodology of the National Council. I can best serve the National Council by actively participating in the process that evaluates the goals and objectives, strategies and structure of this agency.

   With the impact of CAT (computerized adaptive testing), nursing has taken a different twist, and the possibilities for the future of nursing are moving rapidly. And we will have to address the issues of home care, multistate practice and telemedicine.

Director-at-Large

1. **Melba Lee-Hosey, Texas, Area III**

2. President, Texas Board of Vocational Nurse Examiners

3. Pedi Special Care, Bellaire, Texas

4. Alvin Community College, Mental Health/Substance Abuse, 1996
   Houston Community College, Nursing, LVN, 1973

5. National Council
   - Examination Committee, 1997
   - Job Analysis Monitoring Panel, 1996

   Texas Board of Vocational Nurse Examiners
   - President

   National Black Nurses Association
   - Co-Chair, Nominating Committee, 1991-present
   - Past Board Member

   Nurses on the Move
   - Chair, Banquet/Luncheon, current

6. Executive Women in Texas Government
   National Association of Nurse Executives
   National Association for Practical Nurse Education and Service

7. Date of expiration of term: September 1997
   Eligible for reappointment: No (Governor has frequently delayed replacement of board members.)

8. I bring to this committee my leadership skills, as well as my ability to deal with a diverse society. I have worked with patients from birth until death, the old as well as the young, the rich as well as the poor. I have networked with students as well as CEOs in the corporate world. I believe the National Council should address stress, downsizing and substance abuse both in nurses and in students who are entering the nursing profession. I think the National Council should set forth a mentorship program for all of the Areas (I, II, III, IV) and put members in those positions (no matter what their titles are) who *want* to work with students and those who have an interest in the profession.

Director-at-Large

1. **Janice McCoy, Wyoming, Area I**

2. President, Wyoming State Board of Nursing

3. Central Wyoming College, Riverton, Wyoming

4. Walden University, Education, PhD, 1993
   University of Portland, Nursing, MS, 1986
   Winona State University, Nursing, BSN, 1969

5. Wyoming State Board of Nursing
   - Vice-President, President, Disciplinary Committee, 1995-1997

Wyoming Nurses Association
District President, Board Member, current
Central Wyoming College
Coordinator, Institutional Effectiveness, 1995
Nurse Educators of Wyoming
Past Chair, Secretary
Wyoming Commission for Nursing and Nursing Education
Subcommittee Master Plan Nursing Education
Wyoming League for Nursing
Past Board Member

6. American Nurses Association
National League for Nursing
Sigma Theta Tau

7. Date of expiration of term: February 2000
Eligible for reappointment: No

8. For the past 14 years, I have been employed in an associate degree nursing program and have extensive experience in curriculum development, implementation and evaluation. I have skills in computer applications, adult education, nursing and UAP education, and electronic delivery of nursing courses. I authored the Institutional Effectiveness Plan for Central Wyoming College, demonstrating my ability to apply systems theory and outcome-based assessment. I also have experience with rural health care and Native American populations. Based on my past experiences, I believe I have much to contribute toward the achievement of the National Council's Goal III on nursing education by providing input regarding the provision of nursing education and care to rural and at-risk populations. I believe the biggest issue facing nursing education is how to structure programs that will prepare a safe, competent graduate and meet the health care needs of diverse populations in an ever-changing delivery system.

Committee on Nominations: Area I

1. **Louise M. Dean, Alaska, Area I**

2. Chair, Alaska Board of Nursing

3. University of Alaska Center for Economic Development, Anchorage, Alaska

4. Alaska Pacific University, Business Administration, MBA, 1996
Alaska Pacific University, Management, BA, 1990
University of Alaska-Fairbanks, Business Supervision Accounting, AAS, 1982

5. National Council
Committee on Nominations, 1996-1997; 1995-1996
Alaska Board of Nursing
Chair, 1992-present
Board Member, 1990-present
CNA Task Force, 1996-1997

6. None

7. Date of expiration of term: March 1998
Eligible for reappointment: No (Board members serve until replaced.)

8. If re-elected to the Committee on Nominations, I would bring a working knowledge of that committee and the process involved in preparing a slate of candidates. This will be important for the next committee members because of the challenge in presenting candidates for offices such as president and vice-president. I work well as a team member and am committed to the purpose of the committee.

   As a public member, I bring a different perspective to the organization. This has been valuable to previous committees, working groups, task forces, the Alaska Board of Nursing and the National Council.

   I believe the National Council should address the issues of multistate licensure and the licensing and/or certification of unlicensed assistive personnel. This could begin with the possibility of including these individuals in the disciplinary data bank.

Committee on Nominations: Area I

1. **Helen Zsohar, Utah, Area I**

2. Board Member, Utah State Board of Nursing

3. University of Utah College of Nursing, Salt Lake City, Utah

4. Arizona State University, Education, PhD, 1982
University of Texas, Nursing, MSN, 1971
University of Texas, Nursing, BSN, 1967

5. National Council
Nursing Program Accreditation/Approval Subcommittee, 1996-1997

Utah State Board of Nursing
    Probation Peer Review, 1994-present
    Education Peer Review, 1994-present; 1987-1991
    Chair, 1990-1991

6. American Nurses Association
   Sigma Theta Tau
   Utah Nurses Association

7. Date of expiration of term: June 1999
   Eligible for reappointment: Yes

8. I have been active in regulatory issues in Utah since 1987, when I was first appointed to the board of nursing. My continuing work with the board reflects a personal and professional committee to advance the nursing profession in a manner that is truly accountable for public health, welfare and safety. I co-chaired the task force that revised the Utah Nurse Practice Act in 1992, where significant gains were made for advanced practice nursing in Utah. I have attended two National Council Delegate Assemblies as a voting delegate and have participated in two Area I meetings. I am currently serving on the National Council Nursing Program Accreditation/Approval Subcommittee, which is looking at issues of boards of nursing roles in accreditation/approval processes. In addition to the current accreditation/approval issues, I am interested in National Council taking a proactive stance on entry-level preparation for advanced practice nursing.

Committee on Nominations: Area II

1. **Deb Haagenson, North Dakota, Area II**

2. President, North Dakota Board of Nursing

3. MeritCare Health System, Fargo, North Dakota

4. University of Wisconsin-Madison, Nursing, BSN, 1978

5. North Dakota Board of Nursing
    President, current
    Long Range Planning Committee, current
    Executive Committee, 1995-current; 1992-1994
    Vice-President, 1995-1996
    Treasurer and Finance Committee, 1992-1994

6. American Nurses Association
   Association of Women's Health, Obstetric and Neonatal Nursing
   International Lactation Consultants Association
   North Dakota Healthy Mothers, Healthy Babies Coalition

7. Date of expiration of term: July 1999
   Eligible for reappointment: No

8. I am interested in the opportunity to serve the National Council as a member of the Committee on Nominations. I have had the opportunity to be involved in leadership and decision-making experiences which I feel would serve the work of this committee. I value and try to put into practice communication skills that facilitate understanding and collaboration. The Committee on Nominations, in its role to provide

the Delegate Assembly with qualified candidates for office, contributes to the future leadership and strength of the National Council. Strong leadership is essential to carry out the mission of the National Council and will be needed to achieve the National Council's goals. I feel priorities for the National Council need to revolve around supporting a model for nursing regulation that remains a safeguard for the public but that is not seen as a barrier to practice. Thank you for your consideration.

Committee on Nominations: Area II

1. **Margaret Kotek, Minnesota, Area II**

2. Board Member, Minnesota Board of Nursing

3. College of St. Catherine, St. Paul, Minnesota

4. University of North Dakota, Adult Health Nursing, MS, 1992
   College of St. Catherine, Nursing, BS, 1968

5. National Council
   Committee on Nominations, 1996-1997
   Licensure Examination Comparison Task Force, 1995-1996
   Grand Forks Technical College
   LPN Advisory Committee, 1981-1991

   Minnesota Board of Nursing
   Education Committee, 1995-1997
   Public Policy Committee, 1996-1997
   NLN/MBN Pilot Project: "Transforming Nursing for the 21st Century," 1995-1996
   Minnesota Community College
   Bush Grant Critical Thinking Interview Process, 1992-1997

6. None

7. Date of expiration of term: January 1999
   Eligible for reappointment: Yes

8. As an educator, practitioner, board member and attendee at Area Meetings and Delegate Assemblies, I have developed an awareness of the value of competent leadership. As a manager and leader, I have used a deliberate and thoughtful process to identify and seek out the right person for the right job. The National Council has assumed an affirmative role in regulation and thus requires leaders who are committed to the mission and goals of the organization and responsive to the membership. As a member of the Committee on Nominations, I will be an active participant in the process of selecting and recruiting individuals who will provide vision and wisdom to the organization, leadership in the regulatory arena and motivation to the membership.

Committee on Nominations: Area III

1. **Patricia Block, Alabama, Area III**

2. Board Member, Alabama Board of Nursing

3. East Alabama Medical Center, Opelika, Alabama

4. Troy State University, Adult Health, MSN, 1991
   Troy State University, Nursing, BSN, 1988
   St. Luke's Regional Medical Center, Nursing, Diploma, 1968

5. Alabama Board of Nursing
   - UAP Task Force, Chair, 1995-present
   - Practice Committee, Member, 1995-present
   - Continuing Education Committee, Member, 1995-present
   - Scholarship Committee, Member, 1995-1996

6. Alabama State Nurses Association
   American Nurses Association
   Sigma Theta Tau, Theta Delta Chapter

7. Date of expiration of term: December 1998
   Eligible for reappointment: Yes

8. As we approach the 21st century, many issues face the National Council. These include multistate licensure, advanced practice, utilization of and delegation of unlicensed personnel, and telecommunications technology. As an experienced nurse who has survived 25 years of change, I bring a strong nursing background to the Committee on Nominations. I have been a board member for three years serving as chair of the UAP Task Force and on the Practice Committee, exploring the scope of practice of RNs and LPNs. I have had the opportunity to attend Area meetings and Delegate Assemblies. I have held leadership roles in both professional and private organizations. The Committee on Nominations must strive to achieve the strongest possible slate of candidates. By doing so, the mission of the National Council, promoting public policy related to the safe and effective practice of nursing, will be maintained.

Committee on Nominations: Area III

1. **Bobbie Johnson, Georgia, Area III**

2. President, Georgia State Board of Licensed Practical Nurses

3. Athens Dialysis, Athens, Georgia

4. M.D.T.A. School of Practical Nursing, 1984

5. National Council
   - Committee on Nominations, 1995-1996
   - Area III Meeting, Attendee, 1995, 1996
   - Delegate, 1995

   Georgia State Board of Licensed Practical Nurses
   - President, 1997
   - Vice-President, 1996

   Georgia Licensed Practical Nurses Association
   - Chair, Nominating Committee, 1996

6. American Nephrology Nurses Association
   Board of Nephrology Examiner Nurses and Technology
   National Association for Practical Nurse Education and Service

7. Date of expiration of term: April 1997
   Eligible for reappointment: Yes

8. I feel with all the health care changes and reform, we must address all issues with a focus on what's best for the customers. That's what I will offer the National Council: a clear focus.

Committee on Nominations: Area IV

1. **Monica M. Collins, Maine, Area IV**

2. Board Member, Maine State Board of Nursing

3. School of Health Professions, Husson College, Bangor, Maine

4. University of Maine-Orono, Educational Administration, PhD, 1996
   Boston University, Maternal Child Health Nursing, MS, 1975
   Boston College, Nursing, BS, 1967
   Boston City Hospital, Graduate Nurse, Diploma, 1960

5. National Council
   Computerized Clinical Simulation Testing Task Force, 1997
   Job Analysis Monitoring Panel, 1996

   Maine State Board of Nursing
   Member, 1992-present
   Chair, 1995-1996

6. Gerontological Society
   Katahdin Area Health Education Center
   Maine League for Nursing
   Maine Nursing Honor Society
   National League for Nursing
   Northeast Organization for Nursing Executives
   Sigma Theta Tau, Kappa Zeta Chapter
   Who's Who in the East
   Who's Who in American Nursing

7. Date of expiration of term: August 1997
   Eligible for reappointment: Yes

8. It is imperative that a slate of candidates be presented to the Delegate Assembly of the National Council that have the leadership qualities to continue facilitation of policy development related to safe and effective nursing practice and education in the interest of public protection. I believe my interactions as a member of the Computerized Clinical Simulation Testing Task Force, as a delegate to the National Council's Delegate Assembly and as a participant in Area IV meetings have contributed to my ability to assess the qualifications of candidates who will meet the mission and goals of the organization. Also contributing to my abilities is my experience as a past chairperson of the Maine State Board of Nursing and, presently, as a member. Additionally, I have served on national committees as a member and leader. I believe my experiences will enable me to be a most effective member of the Committee on Nominations.

Committee on Nominations: Area IV

1. **Jean H. Fergusson, Pennsylvania, Area IV**

2. Board Member, Pennsylvania State Board of Nursing

3. University of Pennsylvania, School of Nursing, Philadelphia, Pennsylvania

4. Columbia University, Education, EdD, 1991
   University of Pennsylvania, Nursing, MSN, 1979
   Villanova University, Education, MA, 1973
   Villanova University, Nursing, BSN, 1970
   Children's Hospital, Boston, MA, Nursing, Diploma, 1948

5. Pennsylvania State Board of Nursing
   - Advanced Practice Committee, Co-Chair, 1991-present
   - Committee on I.V. Conscious Sedation, 1991-1992

   Association of Pediatric Oncology Nurses
   - Board member, 1990-1992; 1982-1985
   - Nominations, Chair, 1985-1986

6. American Nurses Association
   Eastern Nursing Research Society
   Pennsylvania Nurses Association
   Sigma Theta Tau

7. Date of expiration of term: February 2003
   Eligible for reappointment: Yes

8. I would consider it an honor to serve on the Committee on Nominations for the National Council of State Boards of Nursing.

   I would bring the following qualities and skills to this committee: 1) experience as a member of nomination committees, 2) experience as a reviewer of resumes of candidates for faculty positions in advanced practice nursing programs, 3) experience interviewing applications for graduate nursing programs and for pediatric nurse practitioner programs in oncology, and 4) experience as co-chair of the Committee for Advanced Practice Nursing for joint regulations with the Pennsylvania Board of Medicine for prescriptive privileges for advanced practice nurses.

   I believe the major focus for the National Council should be achieving national agreement on the following issues: 1) delegation, 2) unlicensed assistive personnel, 3) advanced practice prescriptive privileges, 4) national licensure, and 5) the role of nursing in a managed health care system.

Report of the President

Tom Neumann, MSN, RN, President
Administrative Officer, Wisconsin Board of Nursing

I am pleased and honored to welcome you to the 19th Annual Meeting of the National Council of State Boards of Nursing. As always, the Board of Directors looks forward to networking with you and fulfilling the National Council's purpose of providing an organization "through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare."

I want to sincerely thank the many volunteers who participated on committees, task forces, focus groups, panels and in other capacities during the past year. Similarly, I owe a debt of gratitude to the staff of the National Council, who also spent countless hours addressing regulatory issues and providing expert guidance to Member Boards. And, of course, I am deeply grateful to the Board of Directors who have been supportive of me and indispensable to me in my role as president. They were always well-prepared for Board meetings, having done their reading, and were ready to discuss and take action on the many agenda items. I also extend special thanks to Marcia Rachel, past president, who graciously volunteered to continue negotiations on behalf of the National Council with the nurse practitioner certifying bodies regarding the regulatory sufficiency of their certification exams.

A major thrust of my term is the promotion of "synergism" among all parts of the National Council, including Member Boards, Board of Directors, volunteers, staff and others. Synergism is defined as "cooperative action of discrete parts such that the total effect is greater than the sum of the effects taken independently." I believe that it is truly our strong synergism that enables us to carry out our mission and achieve our vision as an organization.

Collectively, we have addressed myriad issues since the past Annual Meeting in Baltimore, including telenursing and the multistate licensure models; nurse practitioner certification exams; proposed revisions in the *NCLEX-RN® Test Plan*; ongoing negotiations with The Chauncey Group International regarding the NCLEX® contract and item pool needs; use of Computerized Clinical Simulation Testing, Nurse Information System and Electronic Licensure Verification Information System; nursing education approval/accreditation; and organizational/ long-range planning. The proverbial plate is not only very full; it is running over.

The Board of Directors and National Council staff, along with the chairs of the Examination Committee, Multistate Regulation Task Force, and Nursing Practice & Education Committee, met with the Long Range Planning Task Force as part of the Board retreat in November 1996 to focus on strategic planning for the future of the National Council. Oliver Wendell Holmes once stated: "The great thing in this world is not so much where we stand, as in what direction we are moving." Keeping that in mind, the participants at the meeting reconsidered the wording of the National Council mission statement; discussed the structure of the organization in relation to its past and future; addressed the role of the Board of Directors in relation to leadership and representation; and considered change models for strategic, successful movement ahead as a learning, knowledge-based organization.

Along with Executive Director Jennifer Bosma, I have participated in executive liaison meetings with the following organizations: American Nurses Association, American Association of Colleges of Nursing, National Federation of Licensed Practical Nurses, Commission on Graduates of Foreign Nursing Schools, American Organization of Nurse Executives, National Organization for Associate Degree Nursing, National Association for Practical Nurse Education and Service, and Joint Commission on Accreditation of Healthcare Organizations. At the time of preparation of this report, additional meetings are planned with the Division of Nursing of the U.S. Department of Health and Human Services and National League for Nursing. In all meetings we discussed issues of mutual interest, but we consistently addressed the National Council's goals, objectives and tactics for all matters related to nursing regulation. It is essential that we continue to collaborate with other organizations in achieving our mission of public protection and that we continue to serve as a leader in nursing regulation.

I also represented the National Council at other meetings such as the National Clearinghouse on Licensure, Enforcement and Regulation Annual Meeting; the symposium sponsored by the National Council on the Aging, "Autonomy or Abandonment: Changing Perspectives on Delegation;" and the International Conference on the Regulation of Nursing and Midwifery.

It was my pleasure to meet with all of you who attended the 1997 Area Meetings and to listen to your dialogue about regional and national regulatory interests. I also wish to express my sincere thanks to the Area Directors, host jurisdictions, National Council staff and others who contributed to planning and conducting the Area Meetings.

It has been most evident to me that synergistic efforts have permeated the National Council this past year and have contributed to the highly respected image of the organization, thanks to the collaborative interest of all of the "parts."

Thank you for the opportunity to serve you during the past year as president of the National Council. It is always a pleasure to confer with my colleagues in regulation about the challenging, changing issues facing us.

Report of the Vice-President

Margaret C. Howard, MSN, RN, Vice-President
Field Representative, New Jersey Board of Nursing

As Vice-President of the National Council of State Boards of Nursing, I participated in all of the Board of Directors' meetings and conference calls. I represented the National Council at the American Association of Colleges of Nursing Spring meeting in Washington, DC; the Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration; the National Advisory Council on Nursing Education and Practice meeting in Silver Spring, Maryland; the Division of Nursing 50th Anniversary Celebration and Symposium in Washington, DC; and the National Practitioner Data Bank meeting in Arlington, Virginia.

I also served on a Board subcommittee to review the job descriptions of the members of the Board of Directors based on competencies adopted by the Board.

Serving on the Board this year has been challenging, educational and rewarding. It has given me an opportunity to interact with many individuals both professionally and in regard to regulatory issues.

I would like to express my thanks to all of the National Council volunteers who served on various committees, as well as the staff of the National Council, who truly facilitate the work of the Board of Directors.

Report of the Treasurer

Charlene Kelly, PhD, RN, Treasurer, and Chair, Finance Committee
Executive Secretary, Nebraska Board of Nursing

Relationship to Organization Plan

Goal V................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

Objective B.........Maintain a sound resource management system for the National Council.

Recommendations

1. **That the auditor's report for October 1, 1995, through September 30, 1996, be approved as presented.**

Rationale

The audit was completed in December 1996. The auditors found no irregularities in the financial statements and expressed an unqualified opinion in their management letter to the organization.

The National Council of State Boards of Nursing remains financially strong. Revenues exceeded expenditures in the past fiscal year. The financial forecast, based on a projected decline in the number of candidates over the next five years, anticipates the need to draw from the fund balance to meet expenses.

The National Council continues to take actions to protect the financial position of the organization. The organization has already begun to see gains from investments made in collaboration with its investment adviser. All groups associated with National Council have demonstrated careful and wise use of their budget dollars, frequently staying under budget. The Board remains ever cognizant of the long-term fiscal effects of its decisions. The Special Services Division appears to be on track to begin to reduce National Council's dependence on candidate fees in the near future.

During the past year, I attended all meetings of the Board of Directors and chaired the Finance Committee. I would like to thank Tom Vicek and Jennifer Bosma for their financial diligence on behalf of the organization and for their support to me as Treasurer.

National Council of State Boards of Nursing, Inc.
Report of Independent Auditors

Board of Directors
National Council of State Boards of Nursing, Inc.

We have audited the accompanying statement of financial position of National Council of State Boards of Nursing, Inc., as of September 30, 1996, and the related statements of activities and cash flows for the year then ended. These financial statements are the responsibility of management of National Council of State Boards of Nursing, Inc. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of National Council of State Boards of Nursing, Inc., at September 30, 1996, the changes in its net assets and its cash flows for the year then ended in conformity with generally accepted accounting principles.

As discussed in Note 2 to the financial statements, National Council of State Boards of Nursing, Inc., adopted Statement of Financial Accounting Standards No. 116, *Accounting for Contributions Received and Contributions Made*; No. 117, *Financial Statements of Not-for-Profit Organizations*; and No. 124, *Accounting for Certain Investments Held by Not-for-Profit Organizations.*

Ernst & Young LLP
December 12, 1996

National Council of State Boards of Nursing, Inc.
Statement of Financial Position

September 30, 1996

Assets	
Current assets:	
Cash and cash equivalents	$1,015,041
Accounts receivable	680,315
Examination fees due from Member Boards	240,030
Accrued interest, prepaid expenses and others	406,371
Total current assets	2,341,757
Investments, at fair value	12,154,648
Cash held for others	557,553
Property and equipment:	
Furniture, fixtures and leasehold improvements	206,416
Equipment and computer software	1,276,456
	1,482,872
Less: Accumulated depreciation	(1,049,690)
	433,182
Total assets	$15,487,140
Liabilities and Net Assets	
Current liabilities:	
Accounts payable	$2,057,376
Accrued salaries and payroll taxes	337,515
Total current liabilities	2,394,891
Deferred revenue – Examination fees collected in advance (net of prepaid processing fees of $2,532,142)	1,061,866
Liability for cash held for others	557,553
Unrestricted net assets:	
Board-designated	2,720,376
Other	8,752,454
	11,472,830
Total liability and net assets	$15,487,140

See notes to financial statements.

National Council of State Boards of Nursing, Inc.
Statement of Activities

September 30, 1996

Revenues	
Examination fees	$15,658,079
Grant revenue	286,288
Net investment income	847,922
Membership fees	183,000
Royalty revenue	429,685
Other income	440,599
	17,845,573
Expenses	
Program services:	
Licensure and credentialing	13,173,881
Nursing practice	449,738
Nursing education	35,248
Information	1,411,689
Special services division	393,360
Organizational	353,278
Total program services	15,817,194
Supporting services:	
Management and general	1,109,105
Total supporting services	1,109,105
Total expenses	16,926,299
Increase in unrestricted net assets before cumulative effect	919,274
Cumulative effect of change in accounting principle *(Note 2)*	(67,204)
Increase in unrestricted net assets	852,070
Net assets, beginning of year	10,620,760
Net assets, end of year	$11,472,830

See notes to financial statements.

National Council of State Boards of Nursing, Inc.
Statement of Cash Flows

September 30, 1996

Operating Activities	
Increase in net assets	$852,070
Adjustments to reconcile revenue increase in net assets to net cash provided by operating activities:	
Cumulative effect of accounting change	67,204
Depreciation	228,263
Changes in operating assets and liabilities:	
Accounts receivable and examination fees due from Member Boards	(245,100)
Accrued interest, prepaid expenses, inventories and other	(565,604)
Accounts payable	1,194,420
Accrued salaries and payroll taxes	65,218
Deferred revenue, net	213,834
Net cash provided by operating activities	1,810,305
Investing Activities	
Net additions to property and equipment	(167,252)
Increase in investments, net	(711,013)
Net cash used in investing activities	(878,265)
Increase in cash and cash equivalents	932,040
Cash and cash equivalents at beginning of year	83,001
Cash and cash equivalents at end of year	$1,015,041

See notes to financial statements.

National Council of State Boards of Nursing, Inc.
Notes to Financial Statements

September 30, 1996

1. Organization and Operation

National Council of State Boards of Nursing, Inc., (National Council) is a not-for-profit corporation organized under the statutes of the Commonwealth of Pennsylvania. The primary purpose of the National Council is to serve as a charitable and educational organization through which state boards of nursing act on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing. The National Council is a tax-exempt organization under Internal Revenue Code Section 501(c)(3).

The goals of the National Council are as follows:

- *Licensure and credentialing* — provide member boards with examinations and standards for licensure and credentialing.
- *Nursing practice* — provide information, analyses and standards regarding the regulation of nursing practice.
- *Nursing education* — provide information, analyses and standards regarding the regulation of nursing education.
- *Information* — promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
- *Organization* — foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
- *Special services division* — maintain a sound basis to support the mission and programs of the National Council by providing services or products.

2. Summary of Significant Accounting Policies

Accounting Changes

National Council adopted Statements of Financial Accounting Standards (Statement) No. 116, *Accounting for Contributions Received and Contributions Made;* No. 117, *Financial Statements of Not-for-Profit Organizations;* and No. 124, *Accounting for Certain Investments Held by Not-for-Profit Organizations.* Statement No. 116 establishes standards of financial accounting and reporting for contributions and requires not-for-profit organizations to distinguish between contributions received that increase permanently restricted net assets, temporarily restricted net assets and unrestricted net assets. It also requires recognition of the expiration of donor-imposed restrictions in the period in which the restrictions expire. Temporarily restricted net assets are those whose use has been limited by donors to a specific purpose or time period. Permanently restricted net assets are those for which donors require the principal of the gift to be maintained in perpetuity. The adoption of Statement No. 116 had no impact on the previously reported net assets or on the change in net assets of National Council. Statement No. 117 requires that resources be classified for reporting purposes into three net asset categories as temporarily restricted, permanently restricted, and unrestricted net assets according to the existence or absence of donor-imposed restrictions. The adoption of Statement No. 117 resulted in various changes to the format and classifications of the 1996 financial statements. Statement No. 124 requires that all investments in equity securities with readily determinable fair values and all investments in debt securities be recorded at fair value in the statement of financial position and investment gains, losses and income are recorded in the statement of activities.

The cumulative effect as of October 1, 1995, of the change in the accounting for investments was to decrease unrestricted net assets by $67,204. The effect on the change in net assets for the year ended September 30, 1996, is an increase in unrestricted net assets of $92,684.

Use of Estimates
The preparation of financial statements in conformity with generally accepted accounting principles requires the use of estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Examination Fees
Examination fees collected in advance, net of processing costs incurred, are deferred and recognized as revenue at the date of the examination.

Grant Revenue
Grant funds are recognized as revenue at the time they are incurred.

In 1993, the National Council was awarded a grant from the Robert Wood Johnson Foundation to support the establishment of a national nurse information system.

In 1995, the National Council was awarded an additional $499,995 from the Robert Wood Johnson Foundation which will be fully received by January 31, 1997. Of this amount, the National Council has received $155,674 in fiscal year 1996 and $100,726 in fiscal year 1995.

Cash Equivalents
Cash equivalents consist of money market funds.

Pension Plan
The National Council maintains a defined-contribution pension plan covering all employees who complete six months of employment. Contributions are based on employee compensation. The National Council's policy is to fund pension costs accrued. Pension expense was $198,245 for the year ended September 30, 1996.

Property and Equipment
Property and equipment are stated on the basis of cost. Provisions for depreciation are computed using the straight-line method over the estimated useful lives of the assets.

Board-Designated Funds
The Board of Directors has designated certain funds to be used for specific projects. These projects include the development of computerized clinical simulation testing (CST®), nurse information system (NIS), special services division and chemical dependency study. These funds are reflected as Board-designated unrestricted net assets.

3. Investments
Investments are carried at fair value. Investments consist of the following at September 30, 1996:

	Cost	Market Value
U.S. government and government-backed obligations	$9,676,915	$9,883,911
Corporate securities	2,183,209	1,991,552
Other	269,044	279,185
	$12,129,168	$12,154,648

Net investment income consists of the following for the year ended September 30, 1996:

	Unrestricted
Dividends and interest	$755,238
Net realized and unrealized gains	92,684
Total net investment income	$847,922

4. Commitments

The National Council leases office space under an operating lease arrangement. Future noncancelable rental commitments as of September 30, 1996, are as follows:

1997	$247,721
1998	252,674
1999	257,730
2000	262,882
2001 and thereafter	985,229

Rent expense for 1996 under the lease was $242,862.

Report of the Area I Director

Joey Ridenour, MN, RN, Area I Director
Executive Director, Arizona State Board of Nursing

During the past year, the Board of Directors enthusiastically committed increased time and attention on strategic issues that will affect Member Boards' and National Council's future. As Area I Director, I have had an opportunity to represent you and actively engage in planning and governance issues during the 13 days of the quarterly meetings. I have also represented the Board of Directors at the Long Range Planning Task Force meetings, where the recommendation was made and adopted that the Board spend increased time on "making sure future directions are explored and that our headlights reach farther down the road."

Board representation and educational opportunities were plentiful as I developed new relationships and knowledge at five national meetings for 17 days: American Organization of Nurse Executives, Phoenix, Arizona; Second Annual Health Information Infrastructure Highway Conference, Washington, DC; National Student Nurses Association, Phoenix; Nursing Futures and Regulation, Miami, Florida; and American Nurses Association, Washington, DC.

The Area I Meeting in San Francisco, California, was attended by 78 registrants, who gave the meeting outstanding ratings in content as well as location. Special acknowledgment goes to Ruth Ann Terry, CA-RN, and Theresa Bello-Jones, CA-VN, as well as Kathy Apple, NV; Dorothy Fulton, AK; and Dianne Wickham, MT, for their successful planning achievement. The Utah State Board of Nursing is looking forward to hosting the Area I Meeting, March 12-13, 1998.

I further developed my knowledge about Area I boards by visiting the California-RN board in March and the Oregon board in May. The boards' staff and executive directors were impressive in their sharing of how their operations work.

During the past year, Area I volunteers have been appointed to more than 25 committees representing 14 states: nine board members, 10 executive directors and six staff.

Finally, Area I welcomes and congratulates two new executive directors since the last report: Kathy Apple, NV; and Sandy Evans, ID. I also need to recognize the executive directors who are the senior leaders and mentors: 13 years, Nan Twigg and Karen Brumley; nine years, Joan Bouchard and Toma Nisbet; seven years, Dianne Wickham; five years, Laura Poe; four years, Marie Ma'o, Ruth Terry and Teresa Bello-Jones; three years, Dorothy Fulton; and two years, Patty Hayes.

The commitment to make a difference is evident throughout the Area I Member Boards, and I continue to be honored by this opportunity. Thank you.

Report of the Area II Director

Linda Peterson Seppanen, PhD, RN, Area II Director
Board Member, Minnesota Board of Nursing

As Area II Director of the National Council of State Boards of Nursing, I was an active participant in Board of Directors' meetings and conference calls. During the past year, I represented the National Council at the National Organization for Associate Degree Nursing (NOADN) meeting in Colorado and the State and Territorial Directors of Nursing meeting in Mississippi.

The Regulatory Day of Dialogue and Area II Meeting were held in Charleston, West Virginia, April 11-12, 1997. The West Virginia boards were gracious hosts, including a reception at the West Virginia Museum on the capitol grounds.

The Regulatory Day of Dialogue focused on board governance and the goal-planning process. Through the facilitator, Phil Devendorf of Professional Development Services, board members and board staff had the opportunity to discuss the process of differentiating roles and setting action plans. The members and staff of the Ohio Board of Nursing were valuable resources after going through the process recently. During the Area II Meeting, reports were presented on organizational planning, progress in work with certifying bodies, unlicensed personnel, NCLEX-RN® examination fees plan, multistate regulation and licensure verification, which generated extensive discussion. Area-selected topics reflected those of primary concern, which were identified during introductions in the morning. The most often cited issue was unlicensed assistive personnel, with advanced practice, non-nurse midwives, multistate regulation, discipline, impaired nurses and basic entry following. Written reports from each Member Board were shared.

The 1998 Area II Meeting will be hosted by the South Dakota Board of Nursing in either Sioux Falls or Rapid City, South Dakota, with the Ohio Board of Nursing hosting in 1999.

I want to thank all the Area II board members and staff who participated in National Council activities this past year. Your efforts make this organization a dynamic and responsive voice in regulatory matters as we wrestle with significant changes.

Thank you for the opportunity to serve as Area II Director. I appreciate your willingness to share ideas and opinions with me and your ability to get things done. It continues to be a challenging, stimulating and rewarding experience as we deal with the possibilities of multistate licensure and doing more things electronically.

Report of the Area III Director

Nancy K. Durrett, MSN, RN, Area III Director
Executive Director, Virginia Board of Nursing

It has been a privilege to serve as the Area III Director of the National Council of State Boards of Nursing for the past four years. I have attempted to bring your ideas and concerns to the Board's discussions about the issues and then participate in making decisions that are the best for the entire organization. Sometimes this has been quite a challenge.

During the past year, I participated in all of the Board of Directors' meetings and telephone conference calls. Additionally, I participated in the Public Policy Conference in June and represented the National Council at the National League for Nursing Convention in Portland, Oregon.

The Area III Meeting and Regulatory Day of Dialogue, hosted by the Alabama Board of Nursing, was held on April 3-4, 1997, in Orange Beach, Alabama. Thanks are extended to the members and staff of the Alabama Board of Nursing for their most gracious hospitality.

The Regulatory Day of Dialogue featured the topics of continued competence and criminal background checks, interspersed with wellness exercises designed to keep the audience alert and involved. Thanks to the Planning Committee chaired by Polly Johnson, NC, and including Marjorie Bronk, TX-VN; Thania Elliott, LA-RN; Sandy Johanson, KY; Carol McGuire, KY; Teresa Mullin, VA; and Mary Shenk, OK.

As always, Area III board members and staff continue to make significant contributions to the National Council through their participation in committees, task forces, focus groups and other activities. Our Area always has more volunteers than there are positions to fill, so do not be discouraged if you are not selected right away. An ongoing database is being maintained so that volunteers can be chosen as the need arises for a particular expertise.

Thank you for the opportunity to serve as the Area III Director. It has certainly been one of the highlights of my professional career and an experience I will always treasure.

Report of the Area IV Director

Anna F. Yoder, MS, RN, CNAA, Area IV Director
Chairperson, Massachusetts Board of Registration in Nursing

After a few short months of serving on the Board of Directors of the National Council as Director-at-Large, I was appointed by the Board to the vacated position of Area IV Director. It has been a busy but gratifying year, as I have attempted to provide leadership as a Board member and to represent the diverse but common interests of the membership of Area IV. During this time, I represented the National Council at meetings of regional licensed practical nursing associations in Area IV, as well as the National Federation of Specialty Nursing Organizations.

Area IV was fortunate to have its Area Meeting and Regulatory Day of Dialogue hosted by the Board of Nurse Examiners of the Commonwealth of Puerto Rico on April 17-18, 1997, in beautiful San Juan. The Regulatory Day, planned by a committee that included Iva Boardman, DE; Mary Kinson, NH; and me, focused on the multiple challenges facing boards of nursing as they seek to protect the public in a rapidly changing health care environment. The impact of the corporatization of health care, telehealth, telemedicine and telenursing were discussed, along with the implications that all of these changes hold for state-based licensure of health professionals. The National Council is fortunate to have assumed a leadership role in this area, specifically as it relates to the licensing of nurses, through the work of the Multistate Regulation Task Force, along with other individuals and groups within the organization.

The 1997 Area Meeting generated lively discussion about these and multiple other topics of concern to Area members. The 1998 meeting will be hosted by the Massachusetts Board of Registration in Nursing.

During the year, I was an active participant in all meetings and conference calls of the Board of Directors and was stimulated and challenged by the volume of reading and the number and complexity of the issues which face us. Your input continues to be critical as we analyze and work through these issues, and your work on committees and task forces, along with your input to me as your Area IV Director, is important in shaping our outcomes.

I am grateful for the opportunity to serve you in these ever-changing and challenging times and for the even greater opportunity to work on behalf of the public whom we exist to protect.

Report of the Director-at-Large

Gregory Howard, LPN, Director-at-Large
Board Member, Alabama Board of Nursing

It has been a challenging and learning experience to serve as Director-at-Large. I would like to take this opportunity to thank Tom Neumann, president, and Jennifer Bosma, executive director, for the in-depth orientation. It certainly added to my comfort level as a new Board member. Also, my thanks go to my fellow Board members and my colleagues at the Alabama Board of Nursing.

During my tenure on the Board, I:

- engaged in careful review of all materials received in preparation for Board meetings and conference calls;
- participated in a conference call concerning the testing service;
- attended the February Board meeting in Chicago, Illinois;
- participated in a conference call as a follow-up to the February Board meeting;
- attended the Area III Meeting at Perdido Beach, Alabama; and
- attended the May Board meeting in Chicago.

It has become increasingly clear that the National Council is an organization composed of people with diverse talents and creative energy. I am extremely grateful for the opportunity to cultivate my talents and energy and assist in accomplishing our mission. In the months to come, I look forward to additional opportunities to contribute to the National Council.

Again, thanks to each of you.

Report of the Director-at-Large

Laura Poe, MS, RN, Director-at-Large
Executive Administrator, Utah State Board of Nursing

As a Director-at-Large for the National Council of State Boards of Nursing, I participated in Board of Directors' meetings and conference calls. I served as a Board liaison to the Multistate Regulation Task Force and Advanced Practice Task Force.

I represented the National Council at the 21st Annual Federation of Associations of Regulatory Boards Meeting in Philadelphia in January. During May, I represented the National Council at the Nursing Futures and Regulation Conference in Miami, Florida, and the APRN Roundtable in Chicago, Illinois.

During Board meetings, I actively participated in discussions regarding several regulatory issues such as advanced practice, delegation, use of unlicensed assistive personnel, changes to the *NCLEX-RN® Test Plan*, Computerized Clinical Simulation Testing and the Electronic Licensure Verification Information System. I also participated in ad hoc committees of the Board that addressed issues such as the mission statement, Board member competencies and functions, and evaluation of the Delegate Assembly standing rules.

The National Council continues to be a leader in the regulatory arena. It has been an honor to be actively involved with the National Council and Member Boards as a Director-at-Large. I thank you for the opportunity I have had to serve on the Board.

Report of Staff Activities

Jennifer Bosma, PhD, CAE, Executive Director

In its oversight of the affairs of the organization, the Board of Directors identifies tactics that will lead to accomplishment of the mission, goals and objectives of the National Council of State Boards of Nursing. This report is an accounting of staff work focusing on Board-assigned tactics for this past year. For ease of reading, it is organized by program area.

A staff organization chart (Attachment A) accompanies this report. Descriptions of staff responsibilities are found behind Tab 14, Orientation Manual, in the *Book of Reports*.

Testing Programs

National Council Licensure Examinations (NCLEX® examination)

Purpose: To provide legally defensible, psychometrically sound and progressive entry-level licensure examinations with timely and appropriate information flow; to anticipate Member Board support needs and provide appropriate levels of support.

Supporting activities:

- Monitored the third year's implementation of computerized adaptive testing (CAT) for the NCLEX examination to approximately 185,000 candidates.
- Recruited, screened and confirmed the attendance of 252 item writers and 110 item reviewers to fill 40 item development sessions through August 1997.
- Worked with The Chauncey Group to continue publication of the *NCLEX® Program Reports* to more than 760 subscribers.
- Worked with the Examination Committee to revise the *NCLEX-RN® Test Plan.*
- Worked with the Negotiating Team to negotiate a new test service contract proposal for action by the 1997 Delegate Assembly.
- Provided staff support to the Examination Committee.

Nurse Aide Competency Evaluation Program (NACEP™)

Purpose: To provide a legally defensible, psychometrically sound nurse aide competency evaluation in a competitive environment.

Supporting activities:

- Completed working with The Psychological Corporation (TPC) and Assessment Systems International (ASI) to transition the operational NACEP program testing services to ASI.
- Continued working with ASI to create a nurse aide assessment that blends the strengths of ASI's previous product and NACEP.
- Worked with TPC and ASI to provide the NACEP to 22 states and territories for the testing of more than 50,000 nurse aide candidates, primarily in long-term care.
- Sponsored the Eighth Nurse Aide/UAP Conference in Chicago, Illinois, which was attended by more than 100 state and federal regulators, educators and others interested in nurse aide/assistant issues.

Nursing Practice-Related Programs

Unlicensed Assistive Personnel

Purpose: To provide resources for Member Boards with varying degrees of responsibilities for regulating unlicensed assistive personnel.

Supporting activities:
- Provided staff support to Unlicensed Assistive Personnel Task Force.
- Participated in a delegation workshop sponsored by the Washington Nursing Quality Assurance Commission.

Advanced Nursing Practice

Purpose: To identify actual and potential regulatory needs of Member Boards related to advanced nursing practice and coordinate strategies for addressing the issues.

Supporting activities:
- Monitored issues related to advanced nursing practice and education.
- Provided staff support to APRN Task Force.
- Ensured continued inclusion of advanced practice nursing in ongoing analysis of multistate practice.
- Represented regulatory perspective at several national APRN meetings.
- Monitored modifications of Certified Nurse Midwife testing standards for impact on Member Boards.
- Responded to numerous inquiries about advanced practice nursing regulation.

Consistency in the Licensing and Credentialing Process

Purpose: To support the promotion of nurse mobility while maintaining the standards needed to assure public safety.

Supporting activities:
- Devised a systematic approach for monitoring issues and trends related to the work of the boards of nursing.
- Monitored topics such as legal issues, telenursing, temporary permits, and other licensing and credentialing issues through a variety of means (networking, reading, updates from committee members, conferences, etc.).
- Provided staff support to the Subcommittee to Revise Model Act and Rules.

Continued Competence

Purpose: To develop strategies, resources and processes for use in assuring continued competence.

Supporting activities:
- Provided staff support to the Nursing Practice & Education Committee.
- Made presentations on continued competence at two national meetings.
- Represented National Council's work and perspective on continued competence to the Interprofessional Workgroup on Health Professions Regulation.
- Provided staff support to the Nursing Practice & Education Committee in its coordination role and its work related to continued competence and professional accountability.

Discipline-related Resources

Purpose: To progressively build and upgrade disciplinary resources to create a collection of which will provide useful and defensible information and tools to support the disciplinary process and discipline decisions by boards of nursing.

Supporting activities:
- Managed Disciplinary Data Bank (DDB) services and provided staff support to the DDB Task Force.
- Served as member of the National Practitioner Data Bank (NPDB) Executive Committee.
- Explored options for adding informational services to DDB (e.g., access to criminal data).
- Participated in two federal workshops focused on developing data systems to support federal credentialing (intergovernmental, military, VA, etc.) efforts.
- Participated in three Health Resources and Services Administration (HRSA) focus groups related to mandatory reporting to the NPDB and federal fraud and abuse reporting.
- Directed data collection and analysis activities designed to identify relationships between grounds for discipline, the disciplinary process, disciplinary actions (remedies), mitigating or extenuating circumstances and

nurse compliance with board orders; prepared report of findings for Quality Assurance Division, Health Resources and Services Administration, U.S. Department of Health and Human Services.

- Provided staff support for the Discipline Resource Modules Task Force.
- Provided staff support for the Second Annual Conference for Directors of Alternative Programs for Chemically Dependent Nurses.
- Provided staff support for the 1997 Dialogue on Discipline.
- Presented a workshop on professional boundary issues for a coalition of Maine nursing organizations and the Maine State Board of Nursing.

Monitoring the Education Environment

Purpose: To track changes in the health care environment as they drive changes in practice, roles and education.

Supporting activities:

- Monitored nursing education issues and trends related to nursing regulation.
- Reviewed and analyzed activities of the U.S. Department of Education with respect to recognition status of the National League for Nursing as an accrediting agency.
- Reviewed and analyzed information related to the Commission on Collegiate Nursing Education and the National League for Nursing Accrediting Commission.
- Reviewed and analyzed current literature and readings related to approval/accreditation of nursing education programs.
- Presented information to various organizations and publics with respect to issues in approval/accreditation and education technology.
- Collaborated with organizations related to the regulatory implications of nursing education issues and development of potential partnerships to address issues.
- Initiated a Nursing Education Advisory Council to analyze nursing education issues.

Education-related Resources

Purpose: To provide documents and other resources which provide assistance, support and guidance regarding the regulation of nursing education.

Supporting Activities:

- Provided staff support for the Subcommittee on Nursing Program Approval/Accreditation.
- Developed *The Education Connection* to facilitate the exchange of information regarding nursing education issues.
- Planned sessions at the Delegate Assembly related to nursing education issues, including a panel presentation on the regulation of nursing education, special interest group with respect to approval/accreditation issues and a board staff education consultant meeting.
- Developed and published *Emerging Issues* article related to approval and accreditation of nursing education programs.

Policy and Regulation-related Services

Multistate Regulation

Purpose: To continue to develop the concept of a regulatory model which incorporates the characteristics of a multistate license.

Supporting activities:

- Provided staff support to the Multistate Regulation Task Force.
- Coordinated the collection of data from health care delivery system executives, licensed nurses, Member Boards and other interested parties.
- Prepared communications for external dissemination of task force work via *MSR Task Force Communiqué.*

- Facilitated the development of draft uniform licensure requirements for licensed practical/vocational nurses (LPN/VNs) and registered nurses (RNs) and the preparation and validation of a comparison of current board requirements to the draft uniform requirements.
- Prepared calculations of the impact of various multistate regulatory models on board revenues and costs of a central database.
- Conducted telephone survey of attorneys advising boards of nursing regarding legal issues of multistate practice.
- Reviewed jurisdictional statutes and rules and analyzed for potential impact on multistate practice.
- Provided resources and consultation for exploring mechanisms for effective cross-state disciplinary process.
- Organized, participated in and reported on recommendations of an expert legal panel regarding multistate practice legal issues.
- Analyzed telecommunications technology developments for potential impact on nursing regulation.
- Participated in numerous conferences about new telecommunications technology, response of the regulatory system and opportunities to enhance consumer access to nursing care.
- Prepared a proposal to the States Initiative Program, funded by Pew, to support a Member Board conference addressing multistate licensure issues; received a $20,000 grant.

Policy Analysis

Purpose: To promote the mission of the National Council by providing ongoing analysis of the health care delivery system, environment and regulatory issues, with primary focus being the impact on Member Boards.

Supporting activities:

- Systematically reviewed state and federal legislation to identify potential impact on the regulatory system.
- Developed a systematic mechanism to review relevant literature about events and changes in the health care delivery system.
- Developed a system to monitor health care literature to determine the policy impact of changes in the health care and technology environments.
- Published *Policy Currents* to provide Member Boards with state legislative information.
- Facilitated consideration of external environmental issues with internal organizational activities.
- Responded to numerous inquiries about National Council activities and regulatory policy surrounding nursing practice.
- Coordinated the program for a national public policy conference featuring local to international perspectives.

Nursing Regulation

Purpose: To develop strategies and resources to support Member Boards in their roles of regulating nursing and to systematically ensure consideration of the nursing regulatory perspective in external policy and health care delivery arenas.

Supporting activities:

- Ensured organizational networking with essential regulatory policy-makers.
- Initiated development of a systematic approach to shaping health policy related to nursing regulation.
- Conducted numerous presentations about nursing regulation within nursing, health care and political arenas (e.g., Nursing Management Congress, Council of State Governments, American College of Nurse Practitioners, American Telemedicine Association, Joint Working Group on Telemedicine (federal)), and Center for Public Service Communication.
- Participated in governmental work groups developing strategies for implementation of new health care modalities to ensure inclusion of regulatory perspective.
- Submitted the National Council's response to the Pew Taskforce on Health Care Workforce Regulation.
- Facilitated the Interprofessional Workgroup on Health Professions Regulation, including its joint response to the Pew Taskforce on Health Care Workforce Regulation.

- Participated in joint planning sessions with the American Academy of Nursing for the May invitational meeting, "Forging the Future Health Care Work Force: Regulation, Education and Practice" held in Miami, Florida, and made presentations on delegation/accountability and regulatory models.

International Issues

Purpose: To ensure mutual understanding of the impact of international developments on nursing regulation.

Supporting activities:

- Facilitated completion of a chapter on regulation of nursing in each of the NAFTA countries for inclusion in Trilateral Initiative for Nursing monograph.
- Participated in development of trilateral recommendations for future collaborative nursing activities among the NAFTA participants and their unveiling at Colegio de Enferma annual meeting in Mexico.
- Met with the staff of the U.S. Trade Representative's Office and continued to monitor trade agreements.
- Served on the organizing committee for the Third International Standing Conference on the Regulation of Nursing and Midwifery.

Research Programs

Job Analysis Research

Purpose: To support validity arguments for NCLEX-RN examination, NCLEX-PN® examination and NACEP.

Supporting activities:

- Completed 1996 job analysis study of newly licensed RNs and provided support to the Examination Committee during its use of the study to evaluate the current *NCLEX-RN® Test Plan* and identify proposed revisions.
- Initiated job analysis study of newly licensed LPN/VNs in May 1997.
- Initiated a longitudinal study of newly licensed RNs and LPN/VNs to identify trends in employment and work environment characteristics.

Family Nurse Practitioner Pharmacotherapeutics and Prescriptive Privileges Project

Purpose: To develop pharmacotherapeutic curriculum guidelines to promote curricular standardization; to develop criteria that Member Boards can use to evaluate competence of family nurse practitioners applying for prescriptive privileges.

Supporting activities:

- Based on review of input provided by Member Boards and representatives of external groups with interests in the education/practice of family nurse practitioners, prepared revised curriculum guidelines and regulatory evaluation criteria. The final versions were approved by the Board of Directors.
- Prepared and presented oral and written project report, in March 1997, to the Agency for Health Care Policy and Research (Health Resources and Services Administration, U.S. Department of Health and Human Services) and the Division of Nursing (Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services), who awarded the contract for the project.
- Obtained no-cost extension of the contract to allow use of unexpended funds to: 1) facilitate preparation and publication of a report containing the curriculum guidelines, regulatory evaluation criteria and a summary of project activities; and 2) to support dissemination of project outcomes to key nurse practitioner groups.

Computerized Clinical Simulation Testing (CST®) Project

Purpose: To provide an authentic assessment of registered nurse competence in clinical decision-making.

Supporting activities:

- Continued collaboration with the National Board of Medical Examiners (NBME) to complete development of the new CST user interface, case development, scoring software, CST orientation and practice software.

- Continued development of the Nursing Information Retrieval System (NIRS©), the database which underlies and supports CST cases, including case-end feedback for six orientation cases.
- Provided staff support to the CST Task Force.
- Following recruitment and orientation of nurses to serve on the Case Development Committee (CDC) and on Scoring Key Development Committee (SKDC), reinitiated development of cases and scoring keys in preparation for FY98 pilot activities.
- Contracted with five nursing education programs in the Philadelphia, Pennsylvania, metropolitan area to facilitate field testing of newly developed CST cases; gathered participant evaluations via an on-line survey following completion of each field test.
- Recruited 95 RN nursing education programs, in ten jurisdictions, for the FY98 pilot study and arranged to place CST software and orientation cases in these schools in fall 1997.
- Solicited Member Board participation to explore the use of CST for RN education and continued competence evaluation, and initiated contract and licensing agreement activities with those selected to participate.
- Initiated discussions with Sylvan Prometric regarding its assistance in administering the FY98 pilot study.
- Published articles and exhibited CST capabilities at a variety of conferences.
- Developed a three-year communications plan for the CST program.

Nurse Information System (NIS)

Purpose: To establish an unduplicated master list of all nurse licensees as a basis to support services such as the Electronic Licensure Verification Information System (ELVIS).

Supporting activities:

- Continued technical development of ELVIS software.
- Sent 225,000 scan forms to seven of nine Member Boards that agreed to use these forms.
- Received and scanned/hand-entered 98,676 scan forms during the period May 1996 through April 1997.
- Continued verification of scan form data's integrity; hand edited more than 103,351 records.
- Requested/collected licensee data from several Member Boards for use in ELVIS prototype and pilot testing.
- Implemented use of Matchware software to standardize and match licensee records.
- Initiated development of quality-assurance procedures.
- Met with NIS Technical Advisory Panel to evaluate the methodology for and progress in development.
- Provided staff support to Licensure Verification Task Force, including detailed analysis of projected database operational/maintenance costs.
- Obtained no-cost extension of grant from Robert Wood Johnson Foundation to allow continued expenditure of unused grant funds to support development of NIS.

Other Research Services

Purpose: Through the maintenance of statistical and other databases and the performance of controlled research studies, provide information to Member Boards and the National Council to assist with and inform policy decisions.

Supporting activities:

- Provided consultative services to committees, task forces, and staff regarding survey development and data analysis; and staff support to the Research Advisory Panel.
- Performed electronic literature searches for Member Boards and consultation regarding research projects.
- Completed data analysis and prepared report for the Organization Plan Objective Effectiveness Study.
- Performed data analysis for study to identify competencies for individuals serving on the Board of Directors.
- Represented the National Council at the National Nursing Research Roundtable and the Interagency Conference on Nursing Statistics (ICONS); had leadership role in the development of an ICONS resource document identifying nurse supply and demand data sources and gaps.
- Presented information about job analysis study results and National Council activities at the National League for Nursing's Convention.

- Prepared new editions of the documents: *Profiles of Member Boards* (1996) and *1995-96 Licensure and Examination Statistics* based on information collected from Member Boards and the test service.
- Developed database of information about surveys performed by Member Boards regarding regulatory issues.
- Conducted studies to use as basis for determining NCLEX examination candidate projections for FY97 through FY2000.

Communications Programs

Publications and Interorganizational Communications

Purpose: To gain national-level government, private sector and media connections and influence that work to enhance the image and public perception of the value of nursing regulation.

Supporting activities:

- Designed and disseminated multiple editions of a new publication tailored for two audiences (i.e., boards of nursing and the public) to provide information on the activities of the Multistate Regulation Task Force, titled *MSR Task Force Communiqué*.
- Produced a new monthly publication, *The Education Connection*, for distribution to boards of nursing.
- Published four editions of *Issues*, three editions of *Insight: Newsletter on Nurse Aides and Assistive Personnel.*
- Published, and made available for sale, a number of publications including a series of educational booklets and brochures on the topic of professional sexual misconduct, *Guidelines for NCLEX-RN® Item Writers, Profiles of Member Boards, RN Job Analysis, Licensure and Examination Statistics, Nurse Practitioner Job Analysis* and *Functional Abilities Study.*
- Developed and implemented a promotional program (including brochure, ad slicks, poster, postcards, certificates, pins and letters) to recruit item development panel volunteers.
- Published a variety of informational materials for the NCLEX examination and CST programs.
- Conducted a readership survey on the *Book of Reports*, resulting in the new publication of a *Business Book* for Annual Meeting attendees.
- Developed and disseminated various materials to promote the public World Wide Web site (http://www.ncsbn.org) and the *NACEP Review Book.*
- Developed draft community outreach materials for presentation at the 1997 Annual Meeting.
- Provided staff support to the Communications Evaluation Task Force.

Meetings

Purpose: To provide opportunities for Member Boards to act and counsel together on matters of common interest regarding the role of nursing regulation in public protection.

Supporting activities:

- Planned and implemented the meeting logistics for the Annual Meeting, four Regulatory Days of Dialogue, four Area Meetings, Advanced Practice Roundtable and a national nurse aide conference, including the submission of continuing education units where requested.
- Provided staff support for the Institute for the Promotion of Regulatory Excellence and its selected educational offering, a joint public policy conference and multistate regulation workshop.
- Coordinated eight educational sessions and a poster session for the 1996 Annual Meeting; published and distributed the 1997 Call for Papers to all 1996 meeting attendees and educators nationwide.
- Coordinated communications among National Council volunteers, travel agency, corporate hotel and office staff regarding committee meetings.
- Negotiated and secured hotel contracts for National Council meetings.
- Approved continuing education units for 15 National Council educational programs (including, but not limited to, NCLEX item writer meetings and test construction workshops).

Information Resources

Purpose: To build an information access highway to Member Boards and others who could use the information for promotion of safe and effective nursing practice and the protection of the public.

Supporting activities:

- Maintained three Web sites for use by Member Boards, National Council staff and the general public, respectively, realizing a current average of 125 hits per day on the public Web site.
- Transitioned Member Boards to unlimited access dial-up accounts for NCNET; determined and implemented new NCNET logins and passwords that simplified access by Member Boards.
- Upgraded the hardware of all Member Board NCNET computers to extend the life of the computer by a projected three years and enable Internet access.
- Upgraded software on all Member Board NCNET computers to install Windows 95 and Web interfaces for NCNET services (e.g., disciplinary data bank and electronic irregularity reports).
- Installed software to enable remote diagnosis and troubleshooting services on NCNET computers by National Council staff.
- Produced and disseminated NCNET training program, including an instructional videotape with accompanying manual and books for NCNET users.
- Launched the electronic, interactive NCLEX® Diagnostic Profile program on the public Web site.
- Continued to electronically scan National Council documents for inclusion in a comprehensive electronic text search database available via NCNET (the name of the service is EDWARD).
- Completed programming for SAHVI (Storehouse of Administrative, Historical and Volunteer Information), a comprehensive mail list of volunteers, board members, board staff and Member Boards.
- Designed and delivered electronic voting for officer elections beginning with the 1996 Annual Meeting and electronic forms for officer and awards nominations via NCNET.
- Installed ISDN lines for telecomputing and implemented videoconferencing services.

Other Services

- Responded to requests from four Member Boards for Resource Network services.
- Exhibited National Council services at nine meetings of nursing and regulatory groups.

Leadership and Management Programs

Governance

Purpose: To ensure that boards of nursings' common interests are well-served through able leadership of the organization.

Supporting activities:

- Participated in liaison activities with multiple organizations: American Associations of Colleges of Nursing; American Nurses Association: American Organization of Nurse Executives; Citizen Advocacy Center; Commission on Graduates of Foreign Nursing Schools; Council on Licensure, Enforcement and Regulation; Division of Nursing; Federation of Associations of Regulatory Boards; Federation of State Medical Boards; Joint Commission on Accreditation of Healthcare Organizations; National Association for Practical Nurse Education and Service; National Association of Boards of Pharmacy; National Council on the Aging; National Federation of Licensed Practical Nurses; National League for Nursing; National Organization for Associate Degree Nursing; National Organization of Nurse Practitioner Faculties; and National Organization for Competency Assurance.
- Conducted two orientation programs for new executive officers.
- Provided staff support to the Board of Directors, Committee on Nominations, and the Long Range Planning, Bylaws and Resolutions task forces.
- Revised new Board of Directors' orientation program, including Board of Directors' *Orientation Manual.*

Executive and Administrative Services

Purpose: To support the governance of the National Council in identification and accomplishment of significant ends related to public protection through nursing regulation.

Supporting activities:

- Maintained a cumulative organizational assessment in four major areas: outcomes evaluation, performance appraisal, structure/documents assessment and future needs assessment.
- Provided a record of progress toward accomplishment of all FY97 tactics in the Organization Plan for each meeting of the Board of Directors.
- Coordinated efforts toward a more efficient and effective long-range organizational planning process.
- Revised short-term planning process with the aim of maximizing congruence among the Organization Plan, mission, vision and projected availability of resources.

Resource Management

Purpose: To maintain sound financial and human resource management systems for the National Council.

Supporting activities:

- Retained professional management for investments.
- Directed planning and construction of additional office space.
- Updated staff position descriptions, market priced staff positions and updated the compensation framework.
- Re-bid medical, dental, life and long-term disability insurance benefit plans to realize significant cost savings.
- Provided staff support to the Finance Committee.

Special Services Division (SSD)

Purpose: To maintain a sound basis to support the mission and program of the National Council by providing services or products through the SSD.

Supporting activities:

- Submitted business plans for the development of NIRS software products and production of plastic nursing licenses; following approval by the director of administrative services and the executive officer, implemented the plans.
- Contracted with Lippincott-Raven publishers for the development of NIRS software products.
- Contracted with Cardpro Services, Inc., to fulfill Member Board plastic license orders; contracted with North Carolina, Nevada and California-RN boards of nursing for plastic licenses.
- Offered seven nursing educator workshops on assessment strategies.
- Implemented credentialing on-site for CEPN-LTC certification candidates.
- Complied fully with SSD Administrative Guidelines.

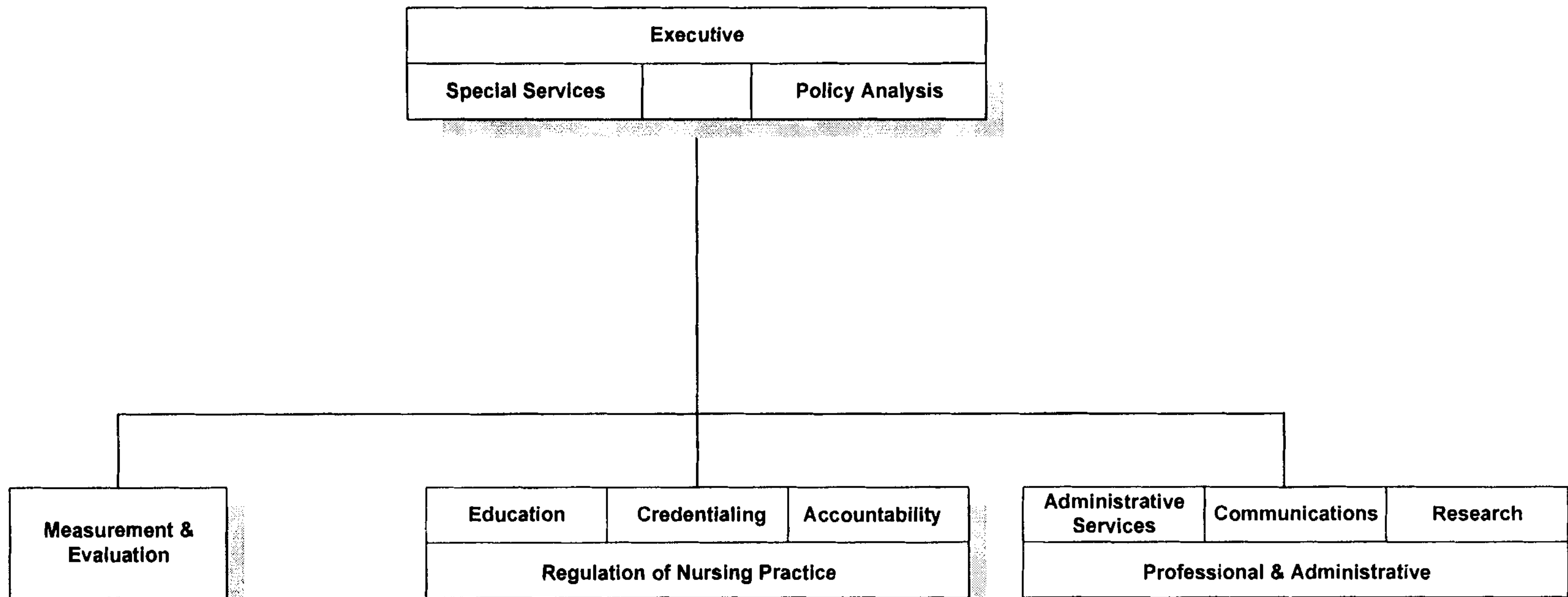
Attachment A

National Council Administrative Staff

The staff of the National Council count it a privilege to work with an organization so committed to the goal of safe and effective nursing care for all citizens. We thank you for allowing us to work in partnership with you.

Jennifer Bosma, PhD, CAE	Executive Director
Doris Nay, MA, RN	Associate Executive Director
Sean Barden	Programmer/Analyst *(beginning November 1996)*
Anna Bersky, PhD, RN	CST® Project Director
Jodi Borger	NCLEX® Administrative Assistant *(through April 1997)*
Sandra Brooks	Administrative Assistant, Executive Office
Valerie Brown, BSN, RN	Research Database Coordinator
Ladon Brumfield	Administrative Assistant, Practice and Accountability *(beginning March 1997)*
Delores Caruso	Staff Accountant
Nancy Chornick, PhD, RN	NCLEX®/SSD Coordinator
Darcy Colby	SSD Project Manager
Diane Creal, MS, RN	Practice & Policy Associate *(through October 1996)*
Susan Davids, CMP	Meetings Manager
John Ditzel, MBA	Software Trainer/Help Desk Coordinator
Ruth Elliott, EdD, RN	Director for Education and Practice *(beginning November 1996)*
Heather Freise	Communications Manager
Ellen Gleason, MSIR, MSOD	NCLEX® Volunteer Coordinator
Barbara Halsey, MBA	NCLEX® Administration Manager
Christopher T. Handzlik	Integrated Media Manager/Webmaster
Carol Hartigan, MA	NCLEX® Contract Manager
Laura Hoeckner	Administrative Assistant, Education and Practice *(beginning May 1997)*
Carolyn Hutcherson, MS, RN	Senior Policy Advisor
Peggy Iverson	NIS Administrative Assistant
Ellen Julian, PhD	Psychometrician
Lorraine E. Kenny, RN	CST® Research Study Coordinator *(beginning March 1997)*
June Krawczak, EdD, RN	CST® Project Associate
Tara Kumar, MSN, RN	CST® Content Coordinator *(beginning September 1996)*
Amy Langen	NIS Administrative Assistant *(beginning September 1996)*
Philip J. LaForge, MBA	Marketing Director
Margaret McGrath	Administrative Assistant, Public Policy *(beginning August 1996)*
Craig S. Moore, MSTS	Network Administrator
Melanie Neal, MA	NIS Project Manager
Bryan M. Newson	Software Engineer/Database Manager *(through May 1997)*
Lea R. Newson	Communications Administrative Assistant
Vickie Sheets, JD, RN	Director for Practice and Accountability
Ruth Spiro, MBA	Testing Administrative Coordinator
Thomas Vicek, MBA, CPA	Director of Administrative Services
Ann Watkins	Executive Secretary
Anne Wendt, PhD, RN	NCLEX® Content Manager
Susan Williamson, MPH, RN	Director of Practice and Credentialing *(beginning February 1997)*
Susan Woodward	Director of Communications
Carolyn J. Yocom, PhD, RN, FAAN	Director of Research Services
Anthony R. Zara, PhD	Director of Testing Services

National Council of State Boards of Nursing
Organizational Chart
Areas



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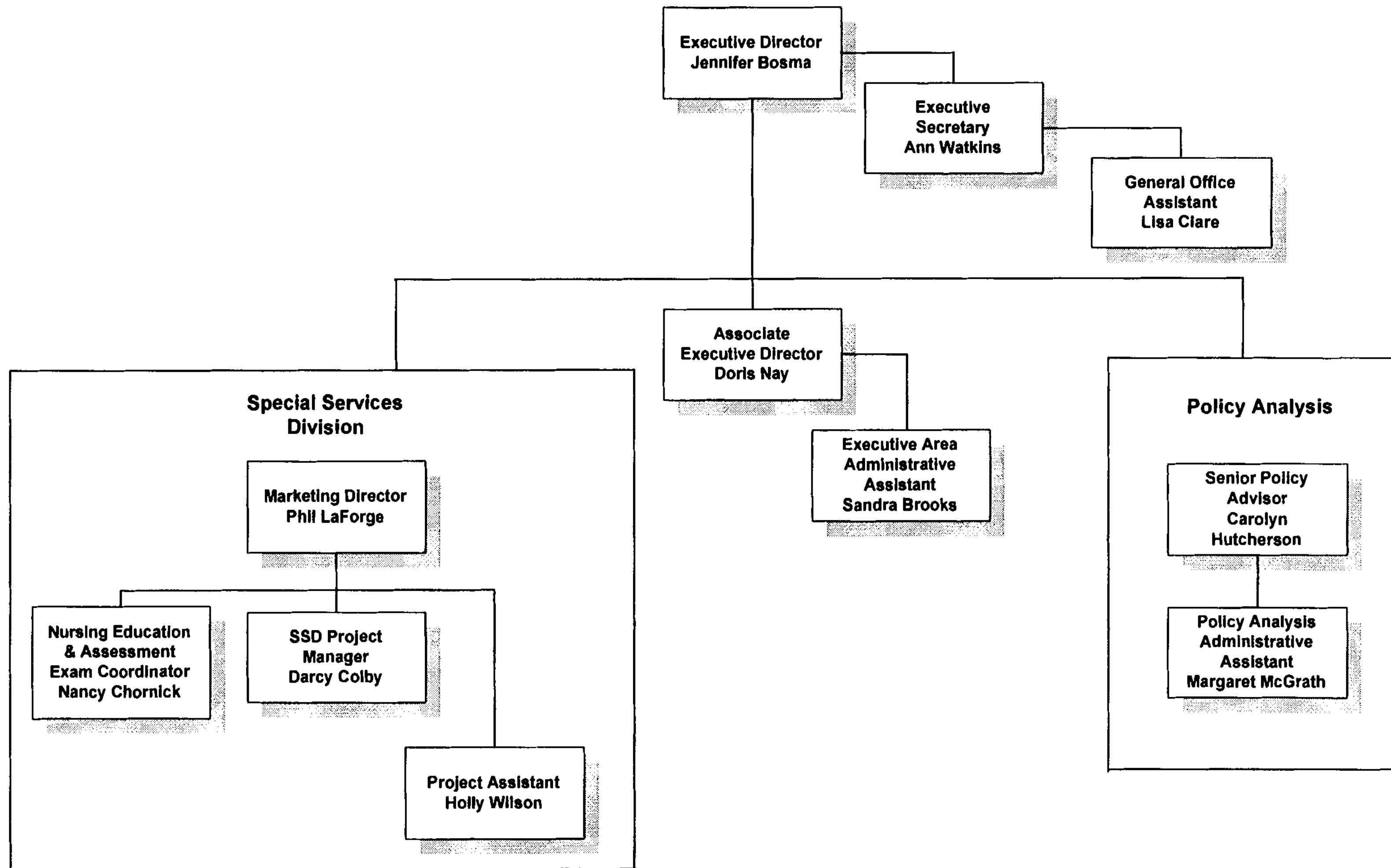
National Council of State Boards of Nursing
Organizational Chart
Executive Area



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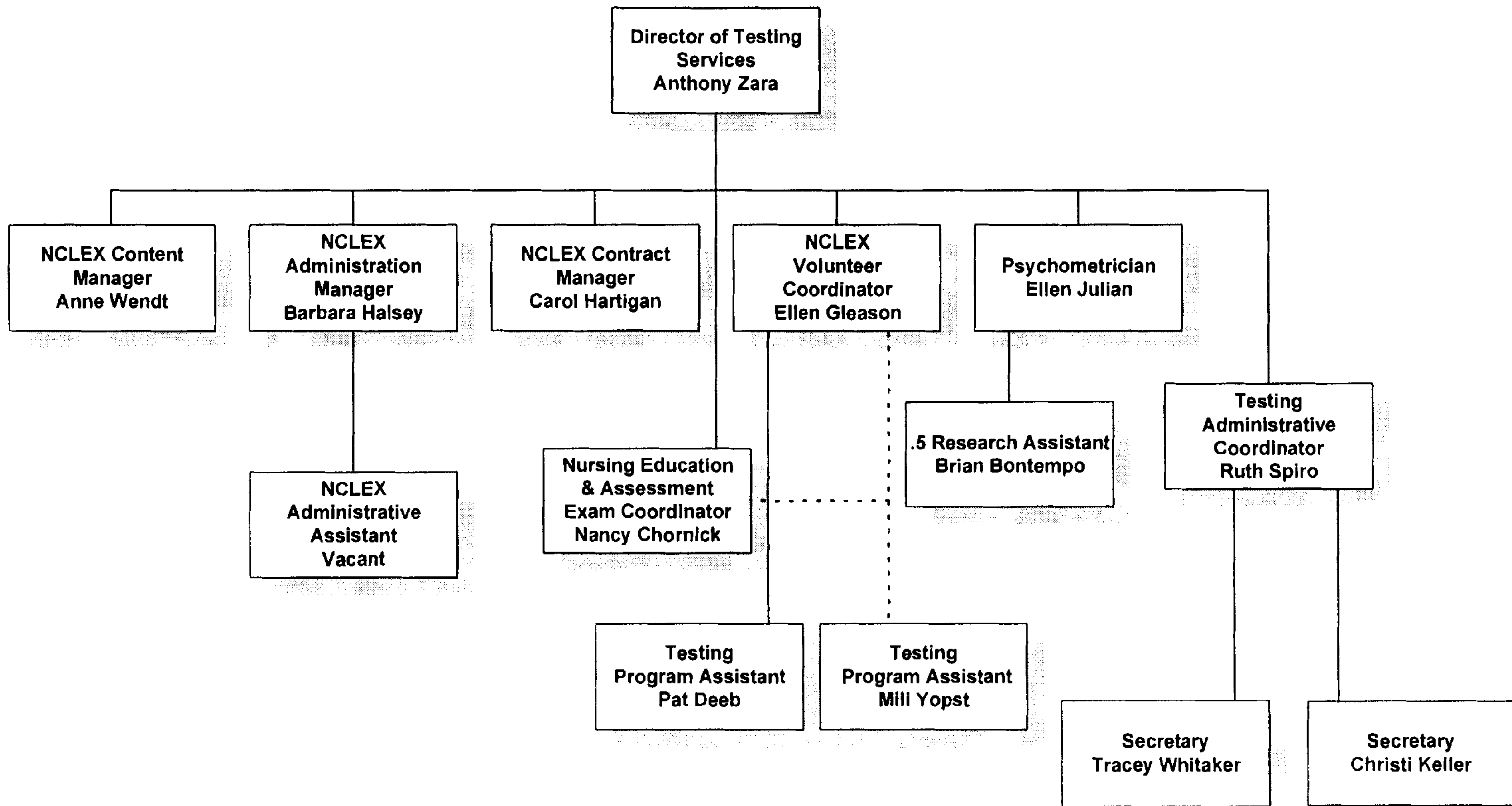
National Council of State Boards of Nursing
Organizational Chart
Measurement & Evaluation



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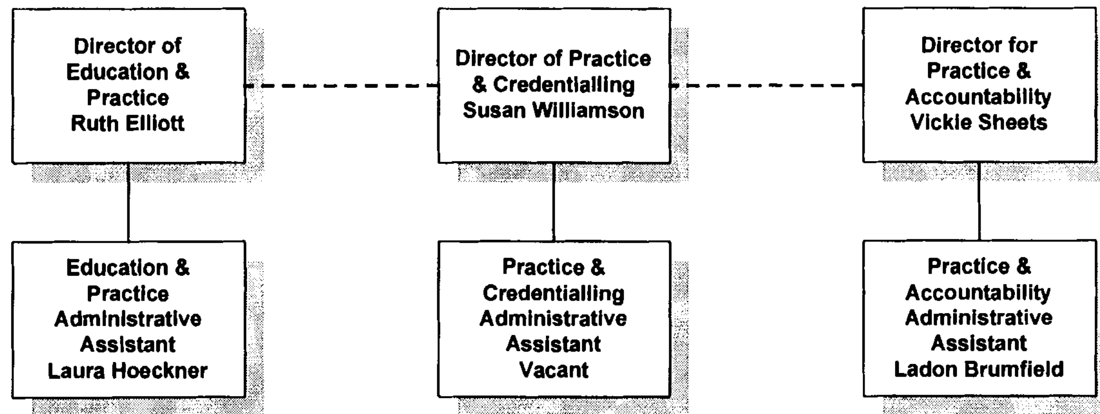
National Council of State Boards of Nursing
Organizational Chart
Regulation of Nursing Practice Area



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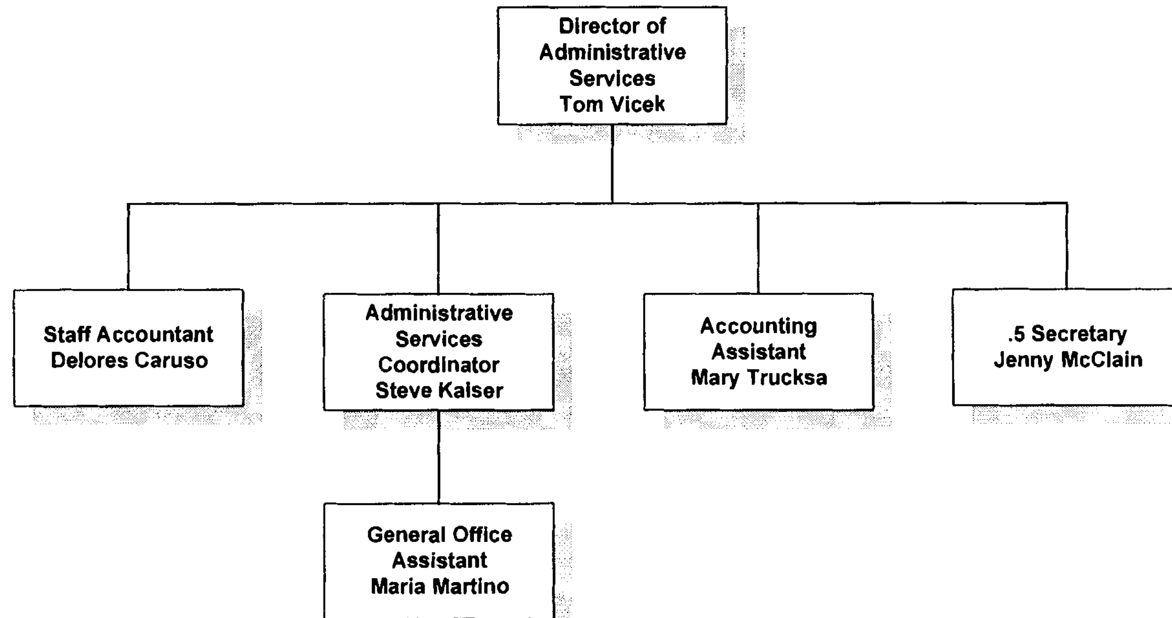
National Council of State Boards of Nursing
Organizational Chart
Administrative Services



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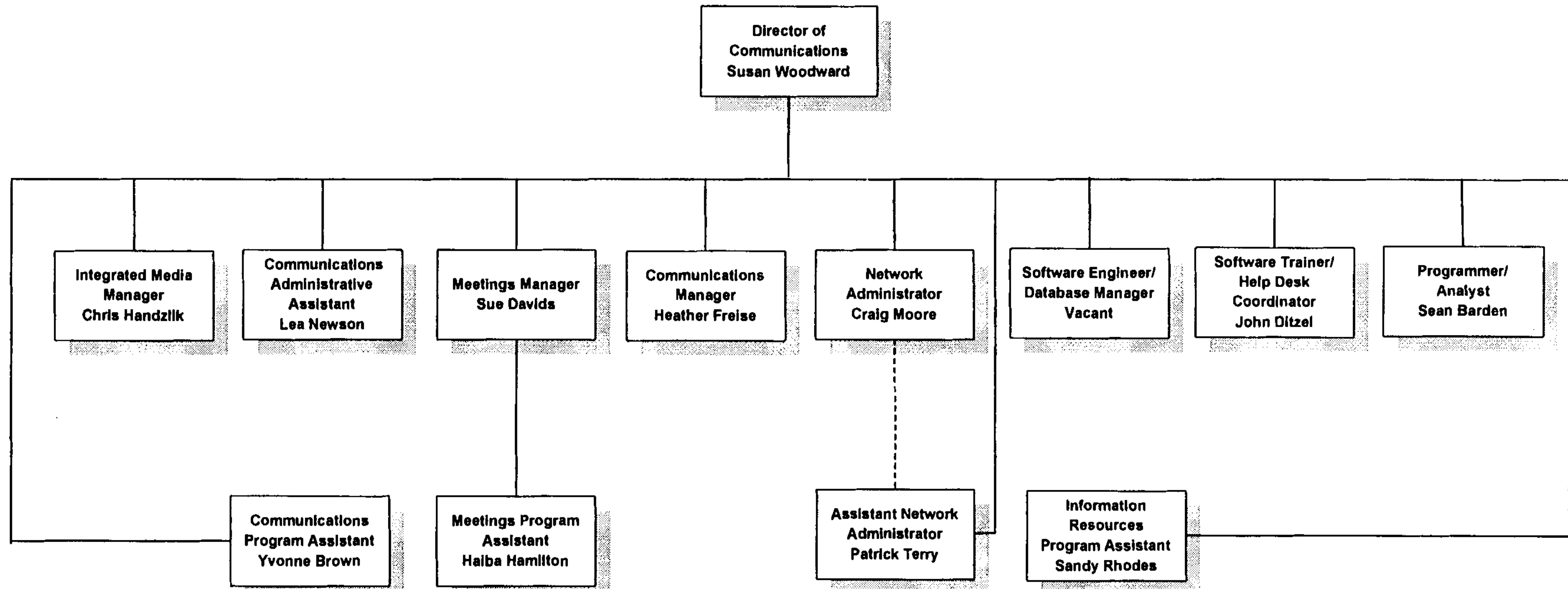
National Council of State Boards of Nursing
Organizational Chart
Communications



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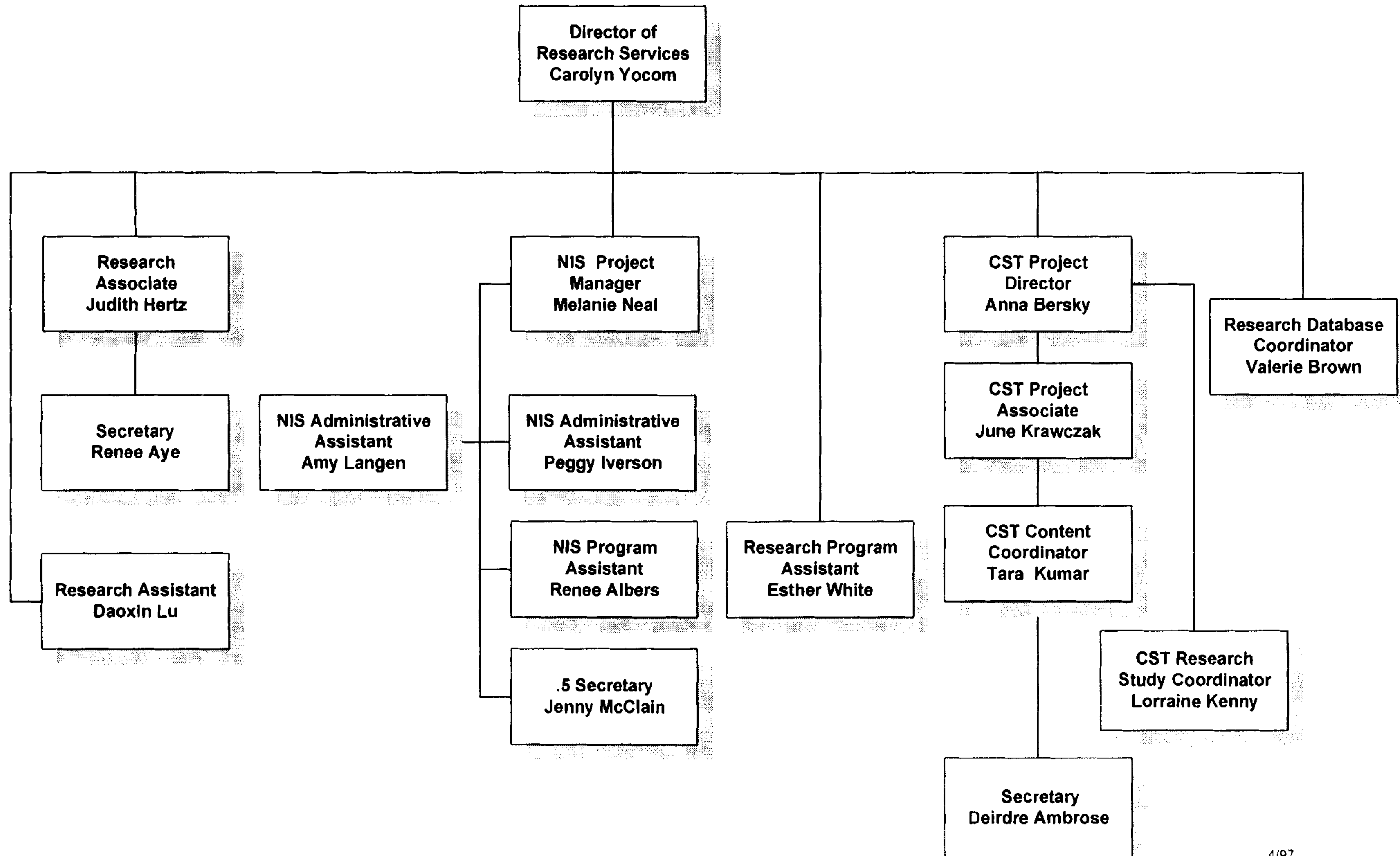
National Council of State Boards of Nursing
Organizational Chart
Research



Attachment B

Current Research Addressing the Impact of Using Licensed vs. Unlicensed Nursing Personnel on the Quality of Client Care

Concern regarding the impact of substituting unlicensed personnel for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) was raised during the 1994 Annual Meeting and again at the 1996 Annual Meeting. Both times, this concern was formalized via the adoption of a motion directing the monitoring and reporting of external groups/individuals' research activities addressing this issue.

At the time both motions were being prepared for introduction to the Delegate Assembly, much discussion ensued regarding whether or not the National Council should implement its own research project. The primary factor arguing against such an approach was the nonstandardization of patient outcome indicators and the resulting lack of uniformity in data collection and storage across nursing care delivery systems and agencies/organizations. Until progress has been made in these two areas, the ability to conduct the desired research in an acceptable manner is severely compromised.

As a result of the 1994 Delegate Assembly action, staff identified, collected and analyzed research studies addressing the impact of staff mix on patient outcomes and the cost of care. This report, published in the *1995 Book of Reports*, included the following passage:

> *This study demonstrates the sparseness of research literature which addresses how changes in the mix of licensed and unlicensed nursing personnel impact the quality and cost of nursing care. From a research perspective, redesign of the health care delivery environment is still relatively new since the current focus on designing and implementing change, and the pace of these changes, does not lend itself to doing the type of in-depth, longitudinal research necessary to address these types of questions. Consequently, the available literature focuses, primarily, on single-site implementation studies. As described [in the report] ... the results are equivocal for both dependent variables. Therefore, it is difficult to draw strong conclusions about the impact of changes in skill mix until additional studies are completed.*

More recently, the Institute of Medicine's (IOM) 1996 report, *Nursing staff in hospitals and nursing homes – Is it adequate?*, was released. That report also notes a paucity of objective research on the relationships among restructuring, nurse staffing and quality in hospitals. One of the recommendations of the report was that the National Institute of Nursing Research (NINR) and other appropriate agencies fund scientifically sound research on the relationships between quality of care and nurse staffing levels and staff mix, taking into account organizational variables. In an Agency for Health Care Policy and Research (AHCPR) announcement (published in the November 13, 1996, *Federal Register)* requesting comments on a proposed research agenda to address the issue of staff mix and quality of care, the following statement was made:

> *Based on the expert discussions, the IOM Report and a review of the published literature, the overarching questions to be addressed by research related to nurse staffing and quality of care in hospitals are: What is the contribution of nursing to the quality of care in hospitals, and what are the cost implications of this contribution? Within this area,* ***a high research priority continues to be identifying patient outcomes that are sensitive to nursing care*** *[emphasis added].*

Current Status of Research Activities Addressing Staff Mix and Quality of Care

As a result of the 1996 Delegate Assembly action, staff has identified a number of research initiatives that address the issue of the relationship between staff mix and quality of care. Broad-based, periodic searches of published literature, contacts with governmental and nongovernmental funding agencies and national nursing organizations were used to identify information about projects/studies that represent multi-site (i.e., regional,

national) studies. As described later, many of the initiatives that were identified are works in progress. Therefore, final outcomes cannot be communicated at this time.

- The *Federal Register* for November 13, 1996, contained a request for comments and suggestions of priority research topics related to the impact of nurse staffing on the quality of care in hospitals. Responses to the request, would be considered by the AHCPR, the NINR and the Division of Nursing (DN) of the Health Resources and Services Administration (HRSA) in planning for future research initiatives to benefit health care for the public and the health of the nation. Following consultation with the Nursing Practice & Education Committee, the chair of the Unlicensed Assistive Personnel (UAP) Task Force and other National Council staff, a response to the request for comments was prepared and submitted. A copy of the document was disseminated to Member Boards with the January 10, 1997, *Newsletter* and is available upon request. The outcomes of the review of all submitted documents (i.e., identification of a research agenda) by the three federal agencies (AHCPR, NINR and DN) has not been released. When it is available, it will be shared with Member Boards.
- The American Nurses Association (ANA) is continuing its efforts in the development of quality indicators and exploration of the impact of staff mix on quality of care. These efforts are outlined below:
  - The ANA has provided funding for the performance of a pilot study exploring the impact of staff mix on quality of care indicators. Data from institutions in California, Massachusetts and New York were used to perform the study. The report of the study's findings has recently been published; following receipt and review of this document, significant findings will be reported to Member Boards.
  - In 1996, the ANA funded planning grants to the state nurses' associations in Arizona, California, Minnesota, North Dakota, Texas and Virginia in an effort to move nursing's quality indicators into broader use. A brief synopsis of the focus of each state association's initiative was published in the November/December 1996 issue of *The American Nurse*. These initiatives, designed to assist in the development of research teams and proposal development for further research, are scheduled for completion during the spring and fall of 1997. Copies of the final reports have been requested from the six state nurses associations.
    - ***ANA/California***: Is undertaking a consensus-building and nurse education project prior to establishing the California Nursing Outcomes Coalition (CALNOC) database and incorporating nursing's quality indicators into state regulatory health databases.
    - ***Arizona Nurses Association***: Is creating a public/private consortium critical to the nursing policy-making process; establishing mechanisms for identifying and describing current data collection processes in urban and rural hospitals; standardizing data collection mechanisms, across acute care institutions, for the seven quality indicators; and establishing a formal mechanism for maintaining and funding the nursing report card project.
    - ***Minnesota Nurses Association:*** Is initiating a consumer- and nurse-information campaign regarding the linkages between nursing care and quality patient outcomes, identifying which ANA quality indicators are in use in 20 acute care hospitals, conducting a feasibility study for collecting indicator data and integrating the nursing quality indicators into the Minnesota Health Data Institute activities.
    - ***North Dakota Nurses Association***: Is designing a methodology to obtain consistent, reliable and valid data across the health care system in the state to facilitate analyses of quality care indicators, including cost data, for long-term and acute care.
    - ***Texas Nurses Association***: Is determining the feasibility of collecting data on input, process and outcome variables across all types of units in selected health care agencies; identifying which quality indicators and outcome, process and structure variables can be operationalized best by type of agency unit; developing the infrastructure for the planning and implementation phases of the project and for encouraging collaboration among agencies and nurses; and refining the definitions and measurement of the variables and quality indicators for use in future implementation activities.
    - ***Virginia Nurses Association***: Is conducting a pilot study to identify the feasibility of collecting specific types of outcome data in rural Virginia hospitals.
  - As a follow-up to the planning grants, the ANA plans to issue a request for proposals for implementation projects. Two proposals will be funded.
- The NINR has awarded $1.6 million to Margaret Sovie, PhD, RN, (University of Pennsylvania) and an interdisciplinary team for a three-year study on the impact of hospital restructuring on costs and patient

outcomes and satisfaction. Thirty-four university teaching hospitals are involved in the study. Structural and process variables, such as worked nursing care hours, staff mix, nurse-physician collaboration, technological supports, role of nurses in decision-making and staff satisfaction, will be examined in relation to their impact on patient care outcomes (pressure ulcers, falls and injury rates, urinary tract infections, pain management and patient satisfaction).

The projects described previously demonstrate that a number of initiatives, either under way or in the planning stages, address the need for standardization of patient outcome indicators and uniformity in data collection and storage across nursing care delivery systems and agencies/organizations. These systems must be in place to evaluate the impact of skill mix on the quality of client care. Staff will continue to: 1) monitor the previously mentioned initiatives; 2) summarize the outcomes of completed studies, as the reports become available; and 3) continue searching for information about additional initiatives.

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1. Rowell, P. (1996). ANA quality initiative reaches out to states. *The American Nurse, 28*(8), 8.
2. Wonderlich, G.S. & Davis, C.K. (1996). Nursing staff in hospitals and nursing homes – Is it adequate? Washington, D.C.: National Academy Press.
3. Penn Nursing awarded $1.6 million for hospital restructuring study. *University of Pennsylvania Alumni Newsletter*, Spring 1997.

Report of the Examination Committee

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Cora Clay, TX-VN, Area III
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Sheila Exstrom, NE, Area II
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Relationship to Organization Plan
Goal I ....Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B ....Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendations to the Delegate Assembly
1. **That the Delegate Assembly adopts the proposed revisions of the *NCLEX-RN® Test Plan* (Attachment A).**

Rationale
The Examination Committee (EC) reviewed and accepted the *1996 Job Analysis Study of Newly Licensed, Entry-Level Registered Nurses* (Yocom, 1997) as the basis for consideration of changes in structure and content distribution for the *NCLEX-RN® Test Plan*. Empirical evidence provided by the research department from job incumbents, the professional judgment of the committee members in collaboration with National Council and The Chauncey Group International, Ltd., (Chauncey) staff, legal counsel and feedback from Member Boards garnered through survey and Area Meeting dialogue support revision in the *NCLEX-RN® Test Plan*.

Background

A subcommittee of members of the EC researched the work of nursing theorists Benner and Watson and reviewed other licensure examination blueprints to investigate alternative frameworks as part of the overall evaluation of the *NCLEX-RN® Test Plan*, other than the existing "Client Needs" and "Nursing Process" dimensions.

The EC determined that the retention of "Client Needs" as the structure for the *NCLEX-RN® Test Plan* is indicated because this structure is supported by empirical data from the job analysis and expert opinion. The "Client Needs" structure provides a common framework that describes the domain of nursing practice in a way that is easily understood by candidates and other interested parties, allows for periodic inclusion of new content without a major test plan change and facilitates reliable item coding.

Integration of "Nursing Process" is recommended to emphasize its importance in all areas of the *NCLEX-RN® Test Plan*, reduce the potential for redundant content, allow for flexible terminology in a rapidly changing health care environment and clarify the content dimensions of the *NCLEX-RN® Test Plan*. "Nursing Process" remains as a key organizing concept, only in an integrated fashion rather than as a specific content dimension. Reorganization and resequencing of the "Client Needs" categories and subcategories are recommended to provide conceptual clarity and improve item coding. The sequencing of the "Client Needs" categories were changed to reflect a transition from overriding nursing concepts such as environment and management in "Safe, Effective Care Environment," to health and wellness concepts in "Health Promotion and Maintenance," and finally to illness concepts in "Physiological Integrity."

Examination items will continue to be written to all "Phases of the Nursing Process" and the NCLEX-RN item pools will be configured so that all item pools contain equivalent proportions of items from the "Phases of the Nursing Process." However, "Nursing Process" will not be used in the item selection algorithm that controls the assembly of each candidate's examination.

The draft revised *NCLEX-RN® Test Plan* was sent to all Member Boards in October 1996 for first comment on the proposed changes. This input was considered by the EC at its February 1997 meeting, and the subsequent draft revised *NCLEX-RN® Test Plan* was again sent to all Member Boards for comment and discussion at Area Meetings. The final draft of the proposed revised *NCLEX-RN® Test Plan* was developed by the EC at its April 1997 meeting.

After consulting with Chauncey and legal counsel, the committee determined that the new *NCLEX-RN® Test Plan* could be implemented no sooner than April 1998, in conjunction with the regularly scheduled item pool rotation. This proposed timeline enables the National Council, Member Boards and Chauncey to effectively plan for and communicate the *NCLEX-RN® Test Plan* changes to all appropriate individuals and agencies, and allows a panel of judges to use the newly approved *NCLEX-RN® Test Plan* in its criterion-referenced, standard-setting process scheduled for October 1997. Any changes in the registered nurse (RN) passing standard would be implemented with the *NCLEX-RN® Test Plan* change. Finally, this timeline is consistent with the National Council's goal to decrease the length of time from Delegate Assembly approval to new *NCLEX-RN® Test Plan* implementation, thus enhancing the fidelity between the examination and current nursing practice as depicted in the most recent incumbent job analysis.

Highlights of Activities

- **Developed and monitored NCLEX® examination policies and procedures**

The committee reviewed and evaluated the effectiveness of all Board of Directors-approved, examination-related policies and procedures and selected policies and procedures from the *NCLEX® Manual* for Member Boards. Revisions were made in pertinent procedures to reflect processes changed and refined during the third year of NCLEX examination administered via computerized adaptive testing (CAT).

- **Conducted committee item review sessions**

In the interest of preserving consistency in the manner in which NCLEX examination items are reviewed before becoming operational, the committee continued to review new items only after they were tried out and had accompanying statistics. All nurse members of the committee reviewed the items in a single group and all decisions regarding coding or operational definitions were made by the entire group. Each new item and at least 25 percent of the base pool are reviewed annually, over the course of five meetings. The use of EC alternates to assist in the item review process was significantly diminished. This item review process continues to enhance the consistency of decisions, but contributes to a heavy item review workload, given the rapid item development rate dictated by the test service contract.

- **Monitored item production**

Chauncey's item development plan to meet the contractual goal of three optimal item pools has continued to be a chief concern of the EC. In analyzing the rate of new item production and survival, as well as the attrition rate of items from the base pool, primarily due to currency, the net gain in total NCLEX examination items has been carefully scrutinized by the committee, the six-member NCLEX Strike Force (key test development staff from National Council and Chauncey) and the Board of Directors on a frequent basis. In addition to increasing the number of traditional item writing sessions held each year and making changes in the structure of the item writing workshops to increase the time available for writing, last year, the EC approved the pilot testing of several supplemental strategies for item development. The implementation of these supplemental strategies, which included initiating item development at home by experienced item writers, development of a fast-track item writer variation, rewriting of EC-flagged items by test service staff, cloning of items and development of graphic items, has been monitored and outcomes evaluated on an ongoing basis by the committee. In considering actual increase in volume of items produced, the effectiveness of the supplemental items was primarily in the area of staff revision of items. The committee has encouraged the NCLEX Strike Force to develop a method of coding clones that would allow long-term coupling of the cloned item with the parent item through identification coding. At this time, no cloned items are in the active item development process. The NCLEX Strike Force also guided the development and implementation of a new item database, the NCLEX Item Coding and Tracking (NICT) database, which allows for an even finer analysis of the content, coding, difficulty, history, statistical performance, validations and other variables for each item within the entire master pool.

- **Evaluated item development process and progress**

The committee evaluated Chauncey item writing and item review sessions for process and productivity. Committee representatives attended and monitored the item development sessions whenever possible to provide feedback to Chauncey.

To facilitate the item development process, the committee reviewed and approved revised *Guidelines for NCLEX-RN® Item Writers* and *Guidelines for NCLEX-PN® Item Writers* and approved additions to the Operational Definitions during the item review portion of each committee meeting.

As part of its activities, the committee responded to Member Boards' questions and concerns regarding NCLEX items and examinations; particularly review of RN and LPN/VN items that were designated by Member Boards as inconsistent with jurisdiction statutes and/or not reflective of entry-level practice.

The EC met with the research department at each of its regularly scheduled meetings to provide input into the *NCLEX-RN® Test Plan* development process. The committee considered the calculation of importance weight data for the *1996 RN Job Analysis Study*, reviewed the timing definition for entry-level practice, received periodic updates on pending job analyses and offered ideas for enhancements to the job analysis questionnaire. The EC requested the research department to initiate a study to obtain information from nurses currently in entry-level practice positions regarding their use of handheld calculators for dosage calculations in the clinical setting. This request has been implemented and data are being gathered for consideration by the EC at its spring 1998 meeting.

- **Monitored examination analysis**

The committee periodically evaluated the NCLEX examination by reviewing reports on item and candidate performance, including item exposure rates, overlap among the items seen by different candidates, non-test-plan content coverage, questioned or challenged items, precision of competence estimates and pass/fail decisions, and passing rates and examination-completion rates for many subgroups of candidates. These reports support that the NCLEX examination meets National Council and industrywide quality standards.

- **Monitored the development of two parallel operational item pools**

The committee continued to monitor the ongoing process for the annual configuring and implementing of two parallel RN and LPN/VN item pools. The committee reviewed a report from Chauncey on a plan for configuring the item pools and approved the plan which incorporates the use of the NICT database item codes for splitting the pools. Because the number of items coded for each variable to be used for pool configuration continues to change, the committee provided direction as to how to use the NICT codes for identifying the variables to be used to split the pools. The EC will review these variables prior to each pool configuration. After the pools are configured, the EC will be able to review the pool configuration reports and face validity reports that will enable the EC to monitor

the pool configuration process. In addition, criteria that could be used for sculpting the item pools were identified and weighted for pool sculpting.

The committee determined that the RN and LPN/VN pools should continue to be rotated semiannually for the period of April 1997 through March 1998, as they were during the first two years of CAT administration of the NCLEX examination.

- **Directed Member Board Office System (MBOS) fixes and enhancements**

Based on Member Board input regarding the desirability of certain MBOS enhancements, as well as consideration of the availability of budgeted National Council funds, the committee prioritized and authorized program changes for future versions of the software at its May 1996 meeting. The new software version incorporating these changes was introduced into Member Board offices in April 1997.

- **Monitored procedures for candidate tracking; candidate matching algorithm**

Because of the importance of candidate tracking, the status and effectiveness of the candidate matching algorithm continues to be a standing agenda item for the EC. Chauncey continues to investigate state-of-the-art enhancements to prevent duplicate candidate registrations.

- **Monitored electronic irregularity reports and site compliance**

The committee received reports on electronic irregularity report (EIR) summaries and reports on item content EIRs. The committee has continued to review site compliance reports filed by Member Boards and National Council staff and written and telephone complaints from candidates, Member Boards, schools of nursing, legislators and other stakeholders to determine that the Sylvan Technology Center (STC) sites and Educational Testing Service (ETS) corporate sites are in compliance with existing procedures and security requirements. The committee has also carefully monitored any reported incidence of hardware, software or customer service problems in an attempt to discern any evidence of trending.

In December 1996, the EC determined that five ETS corporate sites were out of compliance with security requirements according to contractual guidelines. The EC determined that two of the sites, Stevens Point, Wisconsin, and Hilo, Hawaii, must cease NCLEX examination testing immediately until compliance with security measures could be met. The EC further determined the other three sites, located in Marquette, Michigan; Roswell, New Mexico; and Kearney, Nebraska, be prohibited from allowing any future testing appointments, and to cease testing completely if not compliant with security measures by January 15, 1997. None of the three centers reached compliance by the January 15 deadline and NCLEX examination testing ceased. Successful, secure removal of the NCLEX examination item pools from the affected centers was accomplished. The National Council authorized the reopening of the Kearney site to NCLEX examination testing on March 21, 1997, and the Stevens Point center on April 26, 1997. The EC is working closely with the ETS Office of Test Security to assist the remaining three closed centers to achieve compliance as quickly as possible.

The EC monitored the investigation of a possible security breach at a Sylvan center, which was conducted by the ETS Office of Test Security. Based on information provided by the ETS Office of Test Security, the EC determined that the security of the NCLEX item pool *was not* breached as a result of the incident.

- **Monitored testing compliance according to the Americans with Disabilities Act (ADA)**

All approved requests for ADA modifications continue to be routed to a single individual at the Sylvan Candidate Services Call Center (CSCC) so that these candidates can be carefully monitored to prevent scheduling noncompliance or legal complaints. This process has continued to provide consistency in the scheduling of candidates and the provision of modifications as requested.

- **Computerized Clinical Simulation Testing (CST®)**

Three members of the EC joined with three members of the Computerized Clinical Simulation Testing (CST) Task Force to form a workgroup to set guidelines for the development of CST cases, examinations, scoring mechanisms and standard-setting procedures that will be used during preparation for the 1998 CST pilot study. For additional details, please refer to the Report of the CST Task Force (Tab 10-K).

- **Revised committee structure**

After a two-year analysis of current and projected workload associated with the development of three optimal item pools, the EC developed a proposed new structure to facilitate its work. The proposed structure change is detailed in the suggested amendments to the bylaws (see Tab 15).

Future Activities

Large-scale item development will continue throughout FY98, including the supplemental strategies, to move toward the creation of three optimal NCLEX-RN® and NCLEX-PN® item pools. Issues associated with examination administration will continue to be of the highest priority for the committee, and regularly scheduled assessments of the efficacy of administration and the quality of customer service will be conducted. Working with the CST Task Force, enhanced item coding, further enhancements to MBOS, results-reporting procedures and the continued accuracy of the candidate database and matching algorithm remain high priority items for the committee in the coming year.

Meeting Dates

- July 8-12, 1996
- October 14-19, 1996
- December 11-16, 1996
- February 3-8, 1997
- March 19, 1997 *(EC Administration Subgroup telephone conference call)*
- April 10, 1997 *(EC Item Pool Configuration and Sculpting Work Group telephone conference call)*
- April 16, 1997 *(EC Administration Subgroup telephone conference call)*
- April 21-26, 1997
- May 15, 1997 *(EC Administration Subgroup telephone conference call)*
- May 19, 1997 *(EC Item Pool Configuration and Sculpting Work Group telephone conference call)*
- May 20, 1997 *(EC Administration Subgroup telephone conference call)*
- May 28-31, 1997 *(Item Review Only)*
- May 29, 1997 *(EC Administration Subgroup telephone conference call)*
- June 20, 1997 *(EC telephone conference call)*

Recommendations to the Delegate Assembly

1. That the Delegate Assembly adopts the proposed revisions of the *NCLEX-RN® Test Plan* (Attachment A).

Attachments

A .... Proposed *NCLEX-RN® Test Plan, page 7*

Attachment A

NCLEX-RN® Test Plan

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TEST PLAN FOR THE NATIONAL COUNCIL LICENSURE EXAMINATION FOR REGISTERED NURSES (NCLEX-RN)

INTRODUCTION

Entry into the practice of nursing in the United States and its territories is regulated by the licensing authorities within each jurisdiction. To ensure public protection, each jurisdiction requires a candidate for licensure to pass an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level registered nurse. The National Council of State Boards of Nursing, Inc., develops a licensure examination, the National Council Licensure Examination for Registered Nurses (NCLEX-RN), which is used by state and territorial boards of nursing to assist in making licensure decisions.

The initial step in developing the NCLEX-RN examination is the preparation of a test plan to guide the selection of content and behaviors to be tested. In this plan, provision is made for an examination reflecting entry-level nursing practice as identified in the *1996 Job Analysis Study of Newly Licensed, Entry-Level Registered Nurses* (Yocom, 1997). The activities identified in this study were analyzed in relation to the frequency of their performance, their impact on maintaining client safety and the settings where performed. This analysis guided the development of a framework for entry-level nurse performance that incorporates specific client needs. The *NCLEX-RN® Test Plan* derived from this framework provides a concise summary of the content and scope of the examination. The plan also serves as a guide for both examination development and candidate preparation. Based on the *NCLEX-RN® Test Plan*, each unique NCLEX-RN examination reflects the knowledge, skills and abilities essential for the nurse to meet the needs of clients requiring the promotion, maintenance and restoration of health. The following sections describe beliefs about nursing and people which are integral to the examination, the cognitive abilities which will be tested in the examination and the specific components of the *NCLEX-RN® Test Plan*.

BELIEFS

Beliefs about people and nursing underlie the *NCLEX-RN® Test Plan*. People are viewed as finite beings with varying capacities to function in society. They are unique individuals defining their own systems of daily living which reflect values, motives and lifestyles. Additionally, they are viewed as having the right to make decisions regarding their health care needs and participate in meeting those needs. The profession of nursing makes a unique contribution in helping clients (individuals or group of individuals) in any setting to achieve an optimal state of health.

Nursing is both an art and a science which integrates concepts from the liberal arts and the biological, psychological and social sciences. The nature of nursing is dynamic and evolving. The goal of nursing in any setting is to promote health and to assist individuals throughout the life span to attain an optimal level of functioning by responding to the needs, conditions or events that result from actual or potential health problems (American Nurses Association, 1995). The registered nurse uses the Nursing Process to assess and analyze the health needs and/or problems of clients, plan and implement appropriate actions based upon nursing diagnoses or identified client needs, and

evaluate the extent to which expected outcomes are achieved. Nursing actions include such activities as promoting health, maintaining life, coping with health problems, adapting to or recovering from the effects of disease or injury, and supporting dying with dignity.

LEVELS OF COGNITIVE ABILITY

The NCLEX-RN examination consists of multiple-choice questions at the cognitive levels of knowledge, comprehension, application and analysis (Bloom, et al. 1956). Because the practice of nursing requires application of knowledge, skills and abilities, the majority of the questions in the examination are written at the application and/or analysis level of cognitive ability.

TEST PLAN STRUCTURE

The framework of *Client Needs* was selected for the NCLEX-RN examination because it provides a universal structure for defining nursing actions and competencies across all settings for all clients.

CLIENT NEEDS

Four major categories of *Client Needs* organize the content of the *NCLEX-RN®* *Test Plan.* These client needs are further divided into subcategories that define the content contained within each of the four major *Client Needs* categories. These categories and subcategories are:

A. Safe, Effective Care Environment

1. Management of Care
2. Safety and Infection Control

B. Health Promotion and Maintenance

3. Growth and Development Through the Life Span
4. Prevention and Early Detection of Disease

C. Psychosocial Integrity

5. Coping and Adaptation
6. Psychosocial Adaptation

D. Physiological Integrity

7. Basic Care and Comfort
8. Pharmacological and Parenteral Therapies
9. Reduction of Risk Potential
10. Physiological Adaptation

INTEGRATED CONCEPTS AND PROCESSES

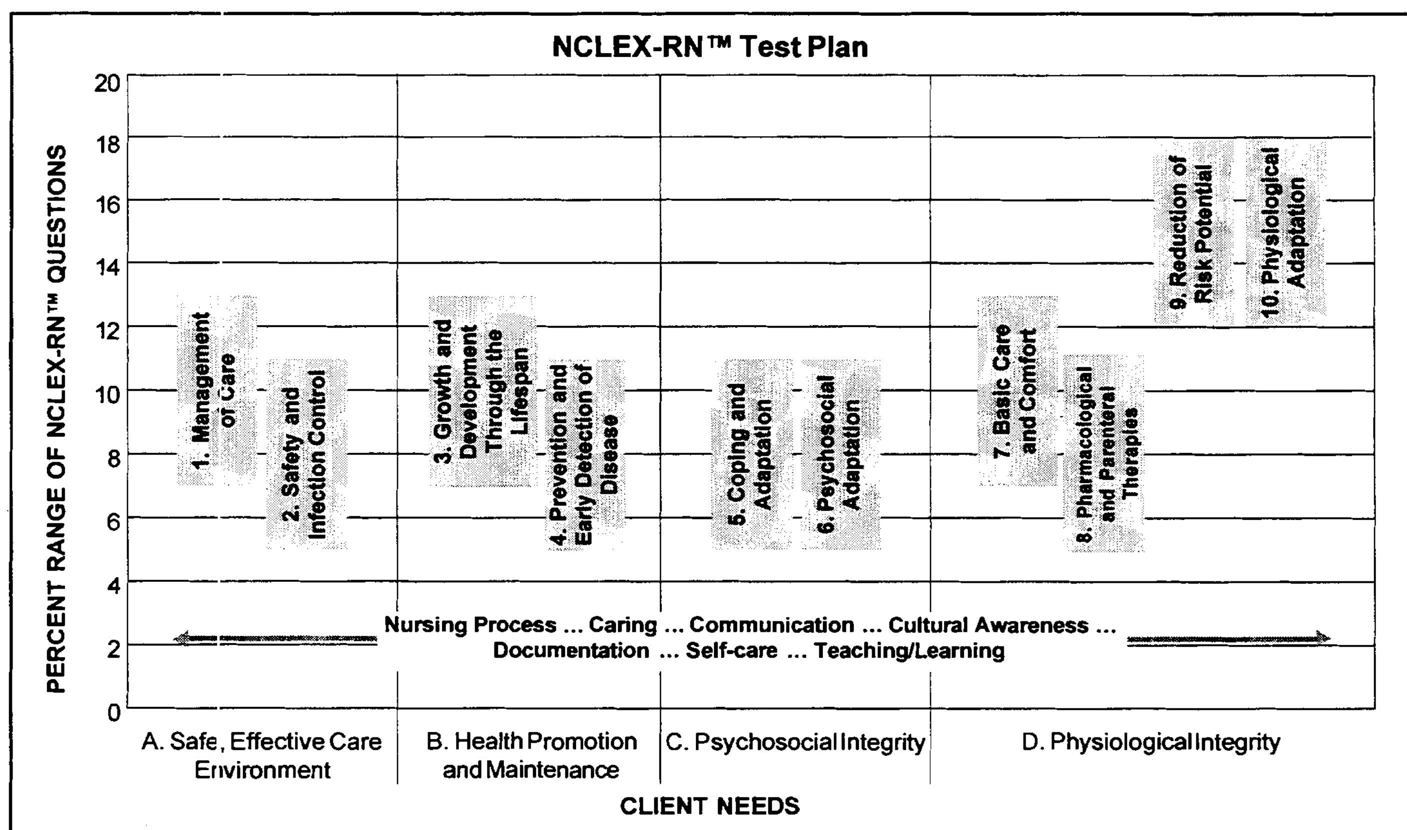
The following concepts and processes fundamental to the practice of nursing are integrated throughout the four major categories of *Client Needs*:

- Nursing Process
- Caring
- Communication
- Cultural Awareness
- Documentation
- Self-care
- Teaching/Learning

DISTRIBUTION OF CONTENT

The percentage of test questions assigned to each *Client Needs* subcategory in the *NCLEX-RN® Test Plan* is based on the results of the *1996 Job Analysis Study of Newly Licensed, Entry-Level Registered Nurses* (Yocom, 1997) and expert judgment provided by members of the National Council's Examination Committee and the 1996 Job Analysis Panel of Experts:

CATEGORIES	PERCENTAGE OF TEST QUESTIONS
A. Safe, Effective Care Environment	
1. Management of Care	7-13%
2. Safety and Infection Control	5-11%
B. Health Promotion and Maintenance	
3. Growth and Development Through the Life Span	7-13%
4. Prevention and Early Detection of Disease	5-11%
C. Psychosocial Integrity	
5. Coping and Adaptation	5-11%
6. Psychosocial Adaptation	5-11%
D. Physiological Integrity	
7. Basic Care and Comfort	7-13%
8. Pharmacological and Parenteral Therapies	5-11%
9. Reduction of Risk Potential	12-18%
10. Physiological Adaptation	12-18%



OVERVIEW OF CONTENT

All content categories reflect client needs across the life span in a variety of settings.

A. Safe, Effective Care Environment

1. *Management of Care* - providing integrated, cost-effective care to clients by coordinating, supervising and/or collaborating with members of the multi-disciplinary health care team.

   Related content includes but is **not limited** to:

   - Advance Directives
   - Advocacy
   - Case Management
   - Client Rights
   - Concepts of Management
   - Confidentiality
   - Continuity of Care
   - Continuous Quality Improvement
   - Delegation
   - Ethical Practice
   - Incident/Irregular Occurrence/Variance Reports
   - Informed Consent
   - Legal Responsibilities
   - Organ Donation
   - Consultation and Referrals
   - Resource Management
   - Supervision

2. *Safety and Infection Control* - protecting clients and health care personnel from environmental hazards.

   Related content includes but is **not limited** to:

   - Accident Prevention
   - Disaster Planning
   - Error Prevention
   - Handling Hazardous and Infectious Materials
   - Medical and Surgical Asepsis
   - Standard (Universal) and Other Precautions
   - Use of Restraints

B. Health Promotion and Maintenance

3. *Growth and Development Through the Life Span* - assisting the client and significant others through the normal expected stages of growth and development from conception through advanced old age.

   Related content includes but is **not limited** to:

   - Aging Process
   - Ante/Intra/Postpartum and Newborn
   - Developmental Stages and Transitions
   - Expected Body Image Changes
   - Family Planning
   - Family Systems
   - Human Sexuality

4. *Prevention and Early Detection of Disease* - managing and providing care for clients in need of prevention and early detection of health problems.

Related content includes but is **not limited** to:

- Disease Prevention
- Health and Wellness
- Health Promotion Programs
- Health Screening
- Immunizations
- Lifestyle Choices
- Techniques of Physical Assessment

C. Psychosocial Integrity

5. *Coping and Adaptation* - promoting client's ability to cope, adapt and/or problem solve situations related to illnesses or stressful events.

Related content includes but is **not limited** to:

- Coping Mechanisms
- Counseling Techniques
- Grief and Loss
- Mental Health Concepts
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Situational Role Changes
- Stress Management
- Support Systems
- Unexpected Body Image Changes

6. *Psychosocial Adaptation* - managing and providing care for clients with acute or chronic mental illnesses.

Related content includes but is **not limited** to:

- Behavioral Interventions
- Chemical Dependency
- Child Abuse/Neglect
- Crisis Intervention
- Domestic Violence
- Elder Abuse/Neglect
- Psychopathology
- Sexual Abuse
- Therapeutic Milieu

D. Physiological Integrity

7. *Basic Care and Comfort* - providing comfort and assistance in the performance of activities of daily living.

Related content includes but is **not limited** to:

- Assistive Devices
- Elimination
- Mobility/Immobility
- Non-Pharmacological Comfort Interventions
- Nutrition and Oral Hydration
- Personal Hygiene
- Rest and Sleep

8. *Pharmacological and Parenteral Therapies* - managing and providing care related to the administration of medications and parenteral therapies.

   Related content includes but is **not limited** to:

   - Administration of Blood and Blood Products
   - Central Venous Access Devices
   - Chemotherapy
   - Expected Effects
   - Intravenous Therapy
   - Medication Administration
   - Parenteral Fluids
   - Pharmacological Actions
   - Pharmacological Agents
   - Side Effects
   - Total Parenteral Nutrition
   - Untoward Effects

9. *Reduction of Risk Potential* - reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatments or procedures.

   Related content includes but is **not limited** to:

   - Alterations in Body Systems
   - Diagnostic Tests
   - Lab Values
   - Pathophysiology
   - Potential Complications of Diagnostic Tests, Procedures, Surgery and Health Alterations
   - Therapeutic Procedures

10. *Physiological Adaptation* - managing and providing care to clients with acute, chronic or life-threatening physical health conditions.

    Related content includes but is **not limited** to:

    - Alterations in Body Systems
    - Fluid and Electrolyte Imbalances
    - Hemodynamics
    - Infectious Diseases
    - Medical Emergencies
    - Pathophysiology
    - Radiation Therapy
    - Respiratory Care
    - Unexpected Response to Therapies

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Annual Report of The Chauncey Group International and Sylvan Prometric

Highlights of Activities

■ **Telephone activity in NCLEX® examination operations**

For the quarter ending March 1997, NCLEX examination customer service staff at The Chauncey Group International answered 29,314 phone calls, which is a 4 percent increase from the same quarter last year. Telephone registrations accounted for 5,073 calls during that time, which is a 3 percent decrease from the same period last year. The number of calls received in NCLEX examination operations in the latest 12 months showed a slight increase (+5 percent) in comparison to April 1995 through March 1996. Overall, activity on the candidate 800-number inquiry line has remained steady and predictable. From the time the inquiry line was opened in February 1994, NCLEX examination customer service staff have answered more than 430,000 candidate calls.

Registration and Testing Activities by Calendar Year

Registration Type	1994	1995	1996	Total
Scanned Registrations	122,493	122,814	116,575	361,882
Telephone Registrations	22,745	26,136	26,281	62
Electronic Registrations	38,435	42,531	41,549	122,515
Other Registrations	3,017	3,322	3,541	9,880
Total Registrations	186,690	194,803	187,946	569,439
Test Sessions	155,111	189,057	181,726	525,894

■ **Staff and workload in NCLEX examination operations**

As we enter our fourth year of production, the incoming workload for NCLEX examination operations is stable and predictable. By using agency staff, our operations group expands and shrinks to accommodate the changing requirements of our workload. As of April 1, 1997, more than 558,000 test sessions have been delivered to NCLEX examination candidates since the start of computerized adaptive testing (CAT) in 1994. The operations group has processed 385,000 scannable registration forms, 80,000 telephone registrations and 131,000 electronic registration records in the same period. To prepare for our period of peak activity when we can expect more than 40 percent of the years' registrations to be processed between April and June, additional customer service and clerical staff are hired and trained. During this time, we expect that 12 full-time agency workers will be answering calls and performing the required daily clerical support functions.

Four Chauncey staff people also work to ensure a smooth daily operation, which includes monitoring the routine computer activity as well as working with Sylvan and the National Council to research and resolve candidate and board issues. In addition, operations staff process requests to deliver tests to candidates with special needs, prepare and mail program reports and quarterly reports, respond to candidate correspondence and collect customer satisfaction survey data.

■ **Customer satisfaction survey**

Each quarter, to measure the effectiveness of our customer service, a random sample of NCLEX examination candidates using the NCLEX examination 800-registration/inquiry phone number is sent a customer satisfaction survey. The intention of this survey is to measure the perceptions of our services, identify areas of weakness based on respondents' written comments and address any concerns with individual customer service representatives. Results continue to be very positive about the convenience of telephone registration and the level of service provided by our customer service representatives. For the quarter ending March 1997, each survey question has received 98 percent to 100 percent positive answer from respondents. All free-form comments express satisfaction with the convenience of telephone registration and the professionalism of the staff.

- *NCLEX® Program Reports*

Three annual cycles of the *NCLEX® Program Reports* have been produced and distributed to educational program subscribers. (The *NCLEX® Program Reports* replaced the *CTB Summary Profiles* in providing information to nursing programs about performance of their candidates on the NCLEX examination.) Each annual cycle covers two cumulative testing periods: April through September and October through March. Subscribers generally receive two reports each year unless all graduates test within one reporting cycle. Included in each report is information about a program's passing rate for the testing cycle, as well as historical passing rate information, candidate performance on the *NCLEX® Test Plan* dimensions, a program's national and state rank, candidate performance on Categories of Human Functioning; Categories of Health Alterations; A Wellness/Illness Continuum; Stages of Maturity; and a Stress, Adaptation and Coping model.

The *NCLEX® Program Reports* are based on candidate data that are retained in the NCLEX Data Center at the Chauncey Group and, as such, must rely on accurate gridding by candidates who complete the NCLEX examination registration. Included in each edition of the *NCLEX® Program Reports* is a 13-item, Likert-type evaluation form that subscribers are asked to complete and return. Space is also provided for narrative comments to be added. While we have received only a small response rate from subscribers, the responses and comments received have been positive and are being used to direct enhancements of the reports for future editions.

The following table provides a summary of subscription volumes:

	1994-1995	1995-1996	1996-1997
RN Educational Programs	572	657	587
PN Educational Programs	176	209	175

Test Development Activities

- **Item writing workshops**

For the NCLEX-RN® examination, there were 10 item writing workshops held between April 1996 and March 1997. A total of 134 item writers, representing all four major practice areas (medical/surgical, obstetrics/gynecology, psychiatric, pediatrics), developed 3,815 items, more than double the number of items developed during the previous year. For the NCLEX-PN® examination, eight general (all specialty areas) sessions were held with a total of 92 item writers producing 2,503 items, reflecting a 60 percent increase over the previous year.

The sessions were conducted by members of the Princeton, New Jersey-based, and Atlanta, Georgia-based, Chauncey test development staff. Item writers represented all four National Council geographic areas at each workshop. Members of the National Council Examination Committee and staff also audited the workshops whenever possible.

For the next year, nine NCLEX-RN item writing workshops and seven NCLEX-PN item writing workshops are scheduled.

- **Item review meetings**

The 11 NCLEX-RN examination item review panels that met between May 1996 and March 1997 approved 2,952 (91.5 percent) of the 3,225 items reviewed, while eight NCLEX-PN examination item review panels that met between April 1996 and March 1997 approved 2,001 (82.7 percent) of the 2,417 items reviewed. All of the meetings were held either at the Princeton or Atlanta site. Each item review panel consisted of participants who represented each of the four National Council geographic areas. Examination Committee members and National Council staff also audited these meetings.

- **Item review at the Examination Committee meetings**

Between May 1996 and December 1996, the Examination Committee approved 1,043 (92.2 percent) of the 1,131 NCLEX-RN examination items and 878 (91 percent) of the 967 NCLEX-PN examination items pretested for inclusion in a future operational pool. At the May 1996, July 1996 and February 1997 meetings, the Examination Committee reviewed base pool items for currency. The committee approved a total of 823 (85.5 percent) of the 962 NCLEX-RN examination items and 582 (84.8 percent) of the 686 NCLEX-PN examination items for continued use in the operational pools.

■ **Targeting item difficulty**

The Chauncey NCLEX examination test development team continues to intensify efforts in targeting item difficulty for the NCLEX examination pools. Several complementary approaches have been initiated. These include the following: expanding discussion of item difficulty during the didactic portion of item writing workshops and item review meetings; discussing numerous exemplars of difficult items; rewriting items that are based on appropriate content, but which have not met item statistical criteria; and providing National Council staff with recommendations for extending invitations to experienced item writers to return to subsequent workshops.

The mean item difficulty during the first three quarters of the 1996-97 testing year show a steady increase in difficulty of the items in the tryout pools as compared to the average difficulty of all quarters in the 1995-96 testing year.

■ **Monitoring**

The Chauncey NCLEX examination test development team recognizes the importance of maintaining the currency of items over time. Ongoing monitoring of the operational NCLEX-RN examination item pools and NCLEX-PN examination item pools for content accuracy, currency and appropriateness is done prior to release of the pools in October and April. Items that are flagged for content and sensitivity concerns are presented to the Examination Committee for disposition and removed from the master operational pool.

Chauncey and the National Council have jointly developed an extensive coding system and all items in the RN and PN master pools have been coded according to several detailed content codes. This will enable us to query the database for content that may be outdated or inaccurate.

Test development staff are reviewing the base pool items on a rotational basis to revalidate. Items that are flagged for accuracy or currency concerns during this review process are presented to the Examination Committee for disposition. Many of the flagged items are revised and then included in a future tryout pool, thus updating their content.

■ **NCLEX Item Coding and Tracking (NICT) database**

In 1996, Chauncey developed a new coding and tracking database to facilitate management of the large item database, such as those involved with the RN and PN master pools. This database enables Chauncey to code items for numerous variables over and above those involved with the test plan. Items within the NCLEX Item Coding and Tracking (NICT) component of the Chauncey item banking system are coded for test plans codes, content codes (such as medical diagnoses, drugs), validation source, event codes, author codes and program report codes, in addition to the large number of statistical data fields.

The NICT will provide detailed information necessary in developing new test items, evaluating old test items, tracking the history of the item, pretesting new items and formulating operational pools.

■ **Construction of 1997 operational pools**

Prior to configuring the April 1997 operational pools, a master pool of available items was evaluated. For the NCLEX-RN examination, the master pool consists of approximately 5,460 items, an increase of more than 1,000 items from the previous year. For the NCLEX-PN examination, the master pool consists of approximately 4,150 total items, an increase of 600 items from the previous year.

■ **Progress of pools**

At the February 1997 meeting of the Examination Committee, Chauncey staff presented an item pool status report on the NCLEX-RN examination and the NCLEX-PN examination master pools and progress towards enhancing the item pools. National Council and Chauncey staffs have been working together as part of the NCLEX Strike Force to evaluate the entire test development process and propose modifications to the current procedures. An update on the progress of the strike force is presented to the Examination Committee at each of its meetings.

■ **Face validity reviews**

The Chauncey test development staff routinely review actual and simulated NCLEX examinations based on criteria established by the Examination Committee. The criteria include non-test plan content areas, such as maternal/child, infection control, medications, pediatrics and geriatrics, that are not controlled by the NCLEX

examination item selection algorithm. The review also includes the identification of items based on similar content within an NCLEX examination.

The actual and simulated NCLEX examinations are reviewed for face validity at five competence levels: low competence, moderately low competence, borderline (pass/fail) competence, moderately high competence and high competence.

Face validity reviews of simulated and actual examinations from the April 1996 and October 1996 RN and PN operational pools indicated that some content overlap occurs, but is most apparent in the longer examinations. These results are consistent with previous face validity reviews of operational pools.

■ **Sensitivity reviews**

In-house sensitivity reviews are required for all tests generated at Chauncey. The reviews are based on item-level and test-level concerns and are conducted by trained individuals drawn from non-NCLEX examination Chauncey staff. Using guidelines reviewed by the Examination Committee, the new items for the NCLEX examination pools undergo a sensitivity review as they are processed with the item review panels.

To address test-level concerns, such as gender balance and juxtaposition of items, sensitivity reviews are done on the simulated NCLEX examinations generated as part of developing the operational NCLEX examination item pools. The review of the October 1996 and the April 1997 operational pools indicated that the pools are generally in accordance with ETS sensitivity guidelines, which Chauncey uses. As the Examination Committee proceeds with its planned systematic review of the existing pool, any identified sensitivity issue can be easily resolved as editorial changes are made to address the concerns.

■ **NCLEX examination differential item functioning (DIF) review panel meetings**

The NCLEX-DIF Review Panel consists of five members, of which there is at least one male, one representative of three of the ethnic focal groups of NCLEX examination takers, one individual with a general linguistic background and one individual who is currently licensed as an RN.

DIF statistics are computed comparing the performance of males with females and of whites with other ethnic/focal groups: blacks, hispanics, Asian-Indians, Asian-others, Native Americans and Pacific Islanders. Items containing moderate to large DIF are reviewed at a DIF Review Panel meeting.

The source of the items for DIF review at the July 1996 meeting was the October 1995 operational pools. The panel reviewed a total of 76 RN and 79 PN items from the operational pools. The panel recommended the referral of seven RN examination and six PN examination items from the operational pools to the Examination Committee for review and disposition.

The source of the items for review at the January 1997 meeting was the April 1996 operational pools and the October 1995, January 1996, April 1996 and July 1996 pretest pools. The panel reviewed 104 RN and 78 PN items from the April 1995 operational pools and 59 RN and 81 PN items from the tryout pools. The panel recommended the referral of five RN and two PN items from the operational pools and one RN item from the pretest pools to the Examination Committee for review and disposition.

The reasons for referral included idiomatic use of language, assumptions regarding the nuclear family and dominant culture, and judgments related to role-playing by the nurse in hypothetical situations. The Examination Committee reviewed the items from the July 1996 DIF Review Panel meeting at the October 1996 meeting and the items from the January 1997 DIF Review Panel meeting at its February 1997 meeting. Items were either approved for reuse in the operational pools, put on hold for revising or removed from the pool.

■ **Readability levels of NCLEX examination pools**

The Fry method of determining readability levels (Fry, 1972) was used to calculate the reading levels of the NCLEX-RN examination and NCLEX-PN examination operational pools for October 1996 and April 1996. This method calculates readability based on non-medical terminology. According to the Fry index, the estimated reading levels of the October 1995 and April 1996 RN operational pools are grades 7.2 and 6.4, respectively, and the estimated reading levels of the October 1996 and April 1997 PN operational pools are grades 7.1 and 6.7. respectively. These levels are within the guidelines of the National Council policy for a maximum reading level of 10th grade for the NCLEX-RN examination and of eighth grade for the NCLEX-PN examination.

■ **Member Board reviews**

Each spring and fall, Member Boards have the opportunity to conduct item reviews at Sylvan Technology Centers. Member Boards can review online newly developed items that are in the pretest pools and/or simulated examinations for high, medium and low achievers for the NCLEX-RN examination and NCLEX-PN examination.

In the fall 1996 period, 10 Member Boards scheduled review sessions, while in the spring 1997 period, 16 Member Boards have scheduled reviews.

All comments received from the Member Boards are forwarded from the National Council to Chauncey test development staff for review. All items referred are re-evaluated for accuracy and currency and brought to the Examination Committee for disposition.

Sylvan Prometric Update

■ **Status of Sylvan Technology Centers**

The number of sites in the network has remained fairly stable while seating capacity continues to increase in our centers. NCLEX examinations are currently administered in 210 testing labs with 1,820 workstations vs. 210 labs with 1,796 workstations in 1996. Network seating capacity will continue to grow over the next year as Sylvan expands existing sites and adds new ones to provide for the continued growth of computer-based testing.

Sylvan has completed upgrading all Technology Center fileservers. The upgrades represent triple the computing speed, eight times the RAM and 10 times the storage capacity of the fileservers installed prior to 1996. Standard keyboards at candidate workstations have been replaced by quiet keyboards. This has reduced the number of typing noise comments we receive from candidates. Additionally, Sylvan is in the process of upgrading all candidate workstations. These upgrades, expected to be completed by the end of the third quarter of 1997, will triple the computing speed of the current workstations and will enhance the level of service we are able to provide to clients and candidates.

■ **Corporate relocation**

Sylvan Learning Systems' corporate offices moved to Baltimore, Maryland, in late November 1996. The NRC (National Registration Center) remained in Columbia, Maryland, relocating to another building in the office complex formerly occupied by Sylvan's corporate offices. Sylvan's Candidate Services Call Center (CSCC), previously known as the NRC, will be moving in late May 1997 to a new 18,000-square-foot facility just outside of Baltimore. This will triple the number of customer service representatives who are available at peak times to make candidate appointments. Joining the expanded CSCC staff will be Sylvan's expanding technical support and client inquiry staffs – allowing these three departments to be housed under the same roof and use the same systems.

■ **Capacity issues with spring/summer volumes**

Sylvan maintained sufficient capacity on a site-by-site basis to adequately provide compliant seating to candidates during the 1996 peak NCLEX examination testing season. As in previous years, Sylvan continues to analyze center utilization levels based on the testing needs of all clients. Analysis of projected volumes show we still maintain sufficient capacity on a site-by-site basis to provide compliant seating to candidates during the 1997 peak NCLEX examination testing season.

We continue to monitor center capacity on a daily basis. Any centers with greater than 70 percent utilization during the upcoming 30 days are contacted by Sylvan's channel support department to open additional hours and days beyond the contracted operating hours. Center staff continue to be responsive to these requests and are currently staffing up for the peak season.

■ **30/45-day compliance**

During the last year, all NCLEX examination candidates, except two special-needs candidates approved for extra time and a separate room, were offered seats within the 30/45-day compliant period. Candidates who are not seated within the compliant period are sent a refund of their registration fee.

■ **NCLEX examination appointment overlap**

In June 1995, the National Council approved a pilot program designed to increase testing availability for NCLEX examination candidates through overlapping NCLEX examination appointments by 45 minutes. Overall, the program has been highly successful. Nine candidates have been delayed due to an overlapped appointment since

the program began in 1995. Three other cases are currently being investigated to determine whether or not the delay in seating was exacerbated by an overlapped appointment.

- **Quality assurance update**

Sylvan Prometric's quality assurance department became fully operational in July 1996. The quality assurance department is responsible for monitoring and analyzing the quality assurance trigger points generated from statistical data from NCLEX examinee exit evaluation summaries (EEEs) and electronic irregularity reports (EIRs) to ensure candidates are delivered a level of service consistent with Sylvan's quality standards. Sylvan's client inquiry department continues to provide real-time support to center staff, as well as review and follow-up on EIRs and candidate complaints for all Sylvan clients.

The quality assurance department began providing a quarterly report to the Examination Committee at the October 1996 meeting. Updated reports are provided to the committee at each business meeting. Centers that appear to be performing at a lower statistical average than national norms are placed on a phased Quality Performance Improvement Plan.

- **Update on natural disaster policy**

Since the last report in May 1996, 11 Member Boards have declared natural disasters for candidates scheduled to test in 22 different centers on 15 different days. The policy was implemented in five cases and not needed in the other cases because the center was closed due to inclement weather.

- **Automated scheduling system**

Sylvan began beta testing an automated scheduling system during late summer of 1995. Numerous modifications have been made since that time based on candidate suggestions on how to make the system more user-friendly. Sylvan has recently doubled the number of lines available to this system, thus doubling the number of NCLEX examination candidates who can take advantage of automated scheduling at one time. A more sophisticated and user-friendly application is expected to be released in the near future. Some planned enhancements include the ability to perform more than one transaction per call, confirming each entry as the candidate makes it and reconfirming the date, time and location of the scheduled appointment. The automated system has been available to candidates only during normal business hours so that calls could be monitored by Sylvan's communications staff. Hours of service will be extended to approximately 22 hours per day once all quality assurance processes are complete and the system is fully functional.

Future Service Enhancements

- **Ombudsman program**

In Sylvan's ongoing efforts to enhance customer satisfaction, a new service is being piloted. This ombudsman service provides a group of customer service representatives specifically trained to handle customer satisfaction calls. These agents have the systems and skills necessary to quickly and completely take care of the needs of candidates who have been unable to test for any reason. This service will be available during the same hours of service as the CSCC. Part of this program includes a Sylvan Cares Kit for Test Center Administrators to use in dealing with candidates at the sites. Contents include food vouchers, video training materials and cards with the dedicated ombudsman 800-number.

- **Hotline support expansion**

Sylvan's hotline support has expanded in two critical areas. The number of hotline support representatives has been doubled and the hotline support group are being cross-trained to provide those portions of client inquiry, CSCC and Data Center functions required to quickly resolve technical issues related to test delivery. The expanded services offered will speed problem resolution by eliminating the number of groups that need to be involved in the solution.

- **Problem management system**

All points of test center contact are being linked to one central problem management system to coordinate all reports from sites and site operators as well as candidate input regarding their experiences at testing sites. This will

allow for earlier detection of trends or problems and is managed by a dedicated problem analyst whose sole task is to extract and identify new or recurring problems so that they can be addressed in a timely fashion.

NCLEX Examination Operations

■ Candidate matching

Matching candidate records is essential to ensure an accurate, consistent database. Starting last year, we implemented a weekly scan of candidates registered during the prior week to detect the possibility that the registration record should have been matched to an existing record in the database. Any cases that are found to have slipped through the matching algorithm are corrected and matched to the prior record. The advantage of the weekly scan (as opposed to the prior practice of scanning the entire database two or three times per year) is that the correction takes place before the candidate schedules an appointment and tests. We believe this process is effective because, in the past year, no Member Board has brought to our attention cases in which a repeater's record has failed to combine with that candidate's prior test record.

Our ability to match candidate records is dependent on the accuracy and consistency of the identifying information provided by the candidate at the time of registration. In recognition of this fact, Chauncey has proposed and the Examination Committee has approved a scan of the entire database to search for pairs of records that might represent the same person. This scan will use matching criteria other than those used in the weekly scan so that it will serve as an audit of the effectiveness of the weekly scan. The results of this supplementary scan will be reported to the Examination Committee quarterly.

■ MBOS (Member Board Office Software)

The Examination Committee approved a suite of changes to MBOS that substantially enhance the reporting capabilities of the MBOS system. These changes have been implemented and released to the Member Boards. The enhancements included the ability to: 1) view a report on screen as well as printing on paper; 2) select the preparation of complete reports or only the summary totals; 3) use additional fields in selecting candidates to be included in reports (selecting candidates as first time or repeater, educated in a Member Board jurisdiction or in a foreign country, and selecting candidates using a range of graduation dates); and 4) add the first-time or repeater code to the main candidate screen, as well as to the test session screen. These enhancements have been well-received by the Member Boards.

■ Quality assurance

In a system as complex as the NCLEX examination system (that tests more than 180,000 candidates at more than 200 test centers with operational pools and pretest pools each rotating twice a year, and with daily transmissions of data among the Member Boards, National Council, Chauncey, ETS and Sylvan) inevitably there are instances where events do not proceed as intended. All parties to the process are vigilant about identifying and reporting aberrant events as soon as they occur so that appropriate resources are brought to bear on correcting the situation. We attempt to address these events promptly and, fortunately, they have only affected a small fraction of NCLEX examination candidates.

This past year, after consultation with National Council staff, we have tightened the quality assurance procedures associated with the processing of NCLEX examination results. More cases are now inspected by Chauncey staff prior to the release of the results to the Member Boards.

■ Quarterly Reports

The Quarterly Reports (informally referred to as the Green Sheets) have been produced and sent to the Member Boards during the month after the close of the quarter throughout this year.

■ Summary of NCLEX examination results for the January through December 1996 testing period

Tables 1 and 3 provide a technical summary of the NCLEX examination results from January through December 1996. In addition, summaries for the January through December 1995 testing interval are provided. Tables 1 and 2 present results for the NCLEX-RN examination, and Tables 3 and 4 present results for the NCLEX-PN examination. Summary statistics for the total group of candidates and the reference group of candidates (that is, first-time, U.S.-educated candidates) for 1996 are presented in Table 1 for the NCLEX-RN examination and in Table 3 for the NCLEX-PN examination. It should be noted that the data provided here are intended only to serve as a general

summary. For more comprehensive information about the statistical characteristics of the NCLEX-RN examination and NCLEX-PN examination, the reader is referred to the NCLEX examination technical reports.

The following bullet points are **candidate** highlights of the 1996 testing year for the **NCLEX-RN examination**.

- Overall, 127,481 RN candidates tested during 1996, compared to 130,370 during the 1995 testing year. This represents a decrease of 2.2 percent.
- 94,278 first-time, U.S.-educated candidates tested, compared to 96,714 for the 1995 testing year, representing a decrease of 2.5 percent.
- The 1996 average passing rates were lower, in part, because of the increase in the RN passing standard that went into effect on October 1, 1995. The overall passing rate was 76.5 percent compared to 79.8 percent in 1995. The first-time, U.S.-educated passing rate was 88.0 percent compared to 90.3 percent in 1995.
- 52.6 percent of the total group and 57.1 percent of the reference group ended their tests after a minimum of 75 items were administered. This is slightly lower than the 1995 testing year in which 53.3 percent of the total group and 57.6 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 13.0 percent for the total group and 10.8 percent for the reference group. This is slightly higher than last year's percentages (12.5 percent for the total group and 10.7 percent for the reference group).
- The average time needed to take the NCLEX-RN examination during the 1996 testing period was 2.19 hours (or two hours, 11 minutes) for the overall group, and 2.02 hours (or two hours, one minute) for the reference group.
- 35.2 percent of the candidates took the mandatory break that occurs after two hours of testing, and approximately 3.5 percent of the candidates chose to take the optional break.
- Overall, 3.1 percent of the total group, and 2.0 percent of the reference group, ran out of time before completing the test. These percentages of candidates timing out were slightly higher but comparable to the overall cumulative percentages for candidates during the 1995 testing year.
- In general, the NCLEX-RN examination summary statistics for the 1996 testing period indicated patterns that were similar to those observed for the 1995 testing period. These results provide continued evidence that the administration of the NCLEX-RN examination is psychometrically sound.

The following bullet points are **item-level** highlights of the 1996 testing year for the **NCLEX-RN examination**.

- The operational item statistics were consistent across the year and with the 1995 testing year. Point biserials correlations were generally in the range of 0.21-0.22 and model-data fit statistics were 0.09 to 0.27. Average item times were 60.9 to 62.9 seconds, indicating that candidates took slightly more than one minute, on average, to answer each question.
- Tryout item statistics indicated that 1,854 items were pretested during 1996, an increase of 381 items compared to 1995. The number of tryout items flagged (36.6 percent) was slightly higher than last year (34.5 percent), but was well within the expected range of percentage of tryout items flagged.
- The mean B-Value of the RN tryout items for the 1996 year was -0.58, compared to -0.74 for the 1995 testing year. This continues the positive trend toward developing items of higher difficulty.

The following bullet points are **candidate** highlights of the 1996 testing year for the **NCLEX-PN examination**.

- Overall, 54,245 PN candidates tested during 1996, compared to 58,687 during the 1995 testing year. This represents a decrease of 7.6 percent.
- 43,689 first-time, U.S.-educated candidates tested, compared to 46,432 for the 1995 testing year, representing a decrease of 5.9 percent.
- The 1996 average passing rate for the total group was slightly higher than in 1995. The overall passing rate was 82.6 percent in 1996 compared to 82.1 percent in 1995, while the reference group passing rate was slightly lower in 1996 than in 1995 (90.5 percent in 1996 compared to 90.7 percent in 1995).

- 58.7 percent of the total group and 62.6 percent of the reference group ended their tests after a minimum of 85 items were administered. This is slightly lower than the 1995 testing year in which 59.7 percent of the total group and 64.0 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 15.6 percent for the total group and 13.0 percent for the reference group. This is slightly higher than last year's percentages (15.4 percent for the total group and 12.5 percent for the reference group).
- The average time needed to take the NCLEX-PN examination during the 1996 testing period was 1.98 hours (or one hour, 59 minutes) for the overall group, and 1.85 hours (or one hour, 51 minutes) for the reference group.
- 31.3 percent of the candidates took the mandatory break that occurs after two hours of testing, and approximately 1.6 percent of the candidates chose to take the optional break.
- Overall, 0.7 percent of the total group, and 0.4 percent of the reference group, ran out of time before completing the test. These percentages of candidates timing out were the same as the overall cumulative percentages for candidates during the 1995 testing year.
- In general, the NCLEX-PN examination summary statistics for the 1996 testing period indicated patterns that were similar to those observed for the 1995 testing period. These results provide continued evidence that the administration of the NCLEX-PN examination is psychometrically sound.

The following bullet points are **item-level** highlights of the 1996 testing year for the **NCLEX-PN examination**.

- The operational item statistics were consistent across the year and with the 1995 testing year. Point biserials correlations were 0.22 and model-data fit statistics were 0.11 to 0.25. Average item times were 55.4 to 57.3 seconds, indicating that candidates took slightly less than one minute, on average, to answer each question.
- Tryout item statistics indicated that 1,562 items were pretested during 1996, a decrease of 26 items compared to 1995. The number of tryout items flagged (33.0 percent) was slightly higher than last year (32.2 percent), but was well within the expected range of percentage of tryout items flagged.
- The mean B-Value of the PN tryout items for the 1996 year was -0.46, compared to -0.49 for the 1995 testing year. This continues the positive trend towards developing items of higher difficulty.

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Table 1
Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for 1996 Testing Year

	Jan 96 - Mar 96		Apr 96 - Jun 96		Jul 96 - Sep 96		Oct 96 - Dec 96		Cumulative 1996	
	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S. Ed
Number Testing	25,794	18,110	36,968	29,048	49,049	41,223	15,670	5,897	127,481	94,278
Percent Passing	74.9	88.5	81.0	91.0	80.3	87.2	56.8	77.0	76.5	88.0
Ave. # Items Taken	119.4	111.7	114.4	107.9	118.6	115.1	138.1	127.7	119.9	113.0
% Taking Min. # Items	53.0	58.3	56.5	60.7	53.3	55.6	40.5	46.8	52.6	57.1
% Taking Max. # Items	12.7	10.4	11.1	9.1	12.7	11.6	18.9	15.3	13.0	10.8
Ave. Test. Time (Hrs)	2.19	2.00	2.09	1.92	2.15	2.06	2.57	2.33	2.19	2.02
% Taking Mand. Break	34.9	28.2	31.6	26.2	34.0	30.8	48.0	39.9	35.2	29.5
% Taking Opt. Break	3.4	2.2	3.0	1.9	3.1	2.3	5.8	3.8	3.5	2.3
% Timing Out	3.0	1.9	2.6	1.5	2.8	2.1	5.7	4.2	3.1	2.0

Table 2
Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for 1995 Testing Year

	Jan 95 - Mar 95		Apr 95 - Jun 95		Jul 95 - Sep 95		Oct 95 - Dec 95		Cumulative 1995	
	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.
Number Testing	25,778	18,232	40,836	32,673	48,683	40,268	15,073	5,541	130,370	96,714
Percent Passing	78.5	90.1	84.7	93.1	83.4	89.6	57.4	78.7	79.8	90.3
Ave. # Items Taken	117.7	111.0	113.3	107.5	117.7	114.4	133.9	124.9	118.2	112.0
% Taking Min. # Items	53.4	58.0	57.1	61.3	53.4	55.6	42.5	48.2	53.3	57.6
% Taking Max. # Items	11.6	9.8	11.2	9.5	12.5	11.5	17.6	14.8	12.5	10.7
Ave. Test. Time (Hrs)	2.19	2.00	1.98	1.82	2.06	1.97	2.46	2.22	2.11	1.94
% Taking Mand. Break	34.1	27.8	27.8	22.4	30.5	27.4	44.2	36.1	32.0	26.3
% Taking Opt. Break	2.7	1.8	1.9	1.1	2.0	1.5	4.6	2.8	2.4	1.5
% Timing Out	3.6	2.4	1.8	1.1	2.1	1.6	4.6	3.6	2.6	1.7

Table 3
Longitudinal Technical Summary for the NCLEX-PN® Examination
Group Statistics for 1996 Testing Year

	Jan 96 - Mar 96		Apr 96 - Jun 96		Jul 96 - Sep 96		Oct 96 - Dec 96		Cumulative 1996	
	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.
Number Testing	10,866	8,157	11,319	8,613	19,555	16,877	12,505	10,042	54,245	43,689
Percent Passing	81.5	91.4	79.6	89.3	86.5	92.2	80.0	88.0	82.6	90.5
Ave. # Items Taken	114.7	108.5	114.0	109.3	109.6	106.8	116.2	113.0	113.1	109.0
% Taking Min. # Items	57.2	63.5	57.9	62.9	62.3	65.1	54.9	57.6	58.7	62.6
% Taking Max. # Items	16.5	12.5	16.5	13.5	13.1	11.3	17.8	15.7	15.6	13.0
Ave. Test. Time (Hrs)	2.01	1.84	2.04	1.88	1.89	1.80	2.04	1.93	1.98	1.85
% Taking Mand. Break	32.7	25.4	33.7	26.8	27.6	23.5	33.8	28.8	31.3	25.7
% Taking Opt. Break	1.8	0.8	1.9	0.9	1.2	0.8	1.7	0.8	1.6	0.8
% Timing Out	0.8	0.3	0.9	0.4	0.5	0.3	0.9	0.5	0.7	0.4

Table 4
Longitudinal Technical Summary for the NCLEX-PN® Examination
Group Statistics for 1995 Testing Year

	Jan 95 - Mar 95		Apr 95 - Jun 95		Jul 95 - Sep 95		Oct 95 - Dec 95		Cumulative 1995	
	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.	Overall	First-time U.S.-Edu.
Number Testing	11,754	8,474	11,815	8,733	21,720	18,584	13,398	10,641	58,687	46,432
Percent Passing	76.9	88.3	79.9	90.8	86.5	92.3	81.4	89.7	82.1	90.7
Ave. # Items Taken	116.0	110.6	113.2	107.7	109.0	105.8	114.0	109.9	112.4	108.0
% Taking Min. # Items	57.1	62.0	59.0	64.8	63.2	66.2	57.0	61.2	59.7	64.0
% Taking Max. # Items	17.9	14.3	16.0	12.6	13.1	11.1	16.3	13.6	15.4	12.5
Ave. Test. Time (Hrs)	2.06	1.89	1.95	1.77	1.81	1.71	1.97	1.83	1.92	1.78
% Taking Mand. Break	33.5	26.7	29.5	22.1	23.5	19.4	30.1	24.5	28.2	22.4
% Taking Opt. Break	1.9	1.0	1.3	0.6	1.0	0.5	1.4	0.8	1.3	0.7
% Timing Out	1.2	0.7	0.8	0.4	0.4	0.2	0.8	0.5	0.7	0.4

Annual Report of The Psychological Corporation/ Assessment Systems, Inc.

Program Overview

1. About ASI

Founded in 1981, Assessment Systems, Inc., (ASI) is the leading provider of credentialing services to state regulatory agencies and national associations. These clients license and certify a variety of professions and occupations such as nurse aides, insurance, real estate and appraisal, cosmetology, allied health, construction and environmental restoration. With more than 300 employees, ASI supplies testing and processing support for more than 160 of these customers in all 50 states. As a result, the company today administers more than 600,000 examinations annually at up to 500 test centers. A pioneer in computer-based testing, ASI continues to expand its network of electronic testing centers, now at 175 sites nationwide.

ASI, a subsidiary of The Psychological Corporation, also handles routine administrative work for more than a dozen state agencies – freeing their staff to concentrate on key regulatory functions. ASI provides the high-volume processing capabilities with the advanced computer technologies state regulators need to improve the constituent services that typically consume their resources. These include phone and mail inquiries, applications processing and credentials issuance.

2. ASI Nurse Aide Credentialing

ASI has been a leading provider in the nurse aide credentialing arena since 1986. During that period, the company administered tests for eight of the largest states and managed three nurse aide registry programs. When The Psychological Corporation acquired ASI in 1995, it transferred the administration of the Nurse Aide Competency Evaluation Program (NACEP) to its new subsidiary. Moving to ASI were the nurse aide testing programs of 23 states, three of them with nurse aide registries. ASI geared up by hiring and training more than two dozen new client-services specialists, expanding its computing power and telecommunications systems, and completing extensive systems programming to meet the unique needs of each client.

Completed by March 1997, the transfer of these 23 accounts expands the ASI nurse aide program to six registries and 31* testing states. Overall, the combined administration program gives clients a wider range of service options from which to choose. Programs can be full-service or ship-and-score; testing can be paper-and-pencil or electronic. With electronic testing, clients gain the options of photo-bearing certificates, application screening and on-site renewal processing. The registries, which previously had no direct access to their registry status or complaint information, also saw expanded service. Today, clients have local access via a personal computer in their office, and potential employers can use their touch-tone phone to obtain registry information 24 hours a day, seven days a week via an automated interactive voice response (IVR) system.

* *Note: In 1997, ASI will add the registries of South Carolina and Mississippi and will add Mississippi for testing.*

3. The New NNAAP Exams

Also in 1996, ASI began work on a new series of examinations combining test questions from the item pools of ASI and the National Council of State Boards of Nursing, Inc. (NCSBN). These new, expanded examinations are the result of a cooperative agreement that combines the assessment resources of both organizations, backed up by nationally recognized committees of subject matter experts (SMEs). The tests will be based on the job analysis conducted by the NCSBN in 1995 (to be updated in 1997-98) and the new, significantly larger item pool.

The National Nurse Aide Assessment Program (NNAAP) test development committees have won significant participation from both prior client families. Their first assignment has been to review the NCSBN job analysis and develop a formal content outline. Next, they will review each item for approval and link it to the right knowledge statement in the content outline. Finally, they will perform a cut-score study for the exam itself. The skills test will undergo a similar process; beginning with defining the skills list and then conducting a cut-score study. The new NNAAP exams are targeted for their first administrations in 1998.

Program Highlights

1. **NCSBN/ASI Contract**
   - Actions: Long-term agreement signed between NCSBN and ASI to develop and administer new examination.
   - Results: Pools ASI test development and administration expertise with NCSBN test development and subject matter expertise.
   - Benefits: Provides nurse aide regulators with unparalleled examination program.
   - Next Step: ASI to use NCSBN 1995 job analysis as foundation for 1997 meetings of SMEs to develop NNAAP exam.

2. **NACEP Program Administration Transferred to ASI**
   - Actions: Transitioned 15 NACEP states' administration to ASI; revised candidate handbooks, rater manuals, program manuals to better meet needs of client states; streamlined application processing; provided weekly client reports, re-engineered testing process in full-service states.
   - Results: Completed transfer of 15 NACEP accounts to ASI; candidates tested with passing rates indicated on attached charts:

June 1996	ND, SD
July 1996	AK, AZ, LA, NV, RI, VI, WY
August 1996	SC
September 1996	UT
October 1996	MD, CO
November 1996	DC
December 1996	DE
January 1997	CA, FL, WA
March 1997	AL, NH, ME, VA

   - Benefits: Enhanced service delivery to these accounts.
   - Next Step: None anticipated.

3. **Marketing Activities Successful**
   - Actions: ASI submitted eight proposals in response to requests for proposals from Arizona, Delaware, Florida, New Jersey, New Mexico, New York, Texas and Virginia.
   - Results: All contracts were awarded to ASI.
   - Benefits: Growth of client family, nationwide standards, reciprocity and program revenue.
   - Next Step: ASI will continue business development activities in this marketplace.

Nationwide Program Enhancements

1. **Application Processing Streamlined**
   - Actions: Enhanced applications processing procedures using automated ASI systems.
   - Results: Reduced time required to process applications by 50 percent.
   - Benefits: Accelerated turnaround time for nurse aides.
   - Next Step: Further process enhancements for continuous improvement.

2. **System Generated Billing Reports**
   - Actions: Produced systems-generated billing reports for clients to replace previous manual billing process using ASI automated systems.
   - Results: Automatically produce reports.
   - Benefits: Accelerated client billing reports, increased accuracy to 100 percent.
   - Next Step: None anticipated.

3. **Weekly Client Score Reports**
   - Actions: Modified ASI systems to change reporting of results from monthly to weekly cycle. Improved reports to client states by providing weekly score report rosters.
   - Results: Provided weekly rosters to all NACEP states.
   - Benefits: Kept clients reports on test results more up-to-date.
   - Next Step: None anticipated.

4. **Registry States Gain Online Access**
   - Actions: Transferred DE, MD and DC registries to management by ASI.
   - Results: These clients now have online access to their registries.
   - Benefits: Provided clients with access to more up-to-date registry data.
   - Next Step: None anticipated.

5. **Registry States Gain 24-hour Interactive Voice Response (IVR) Verification With Fax-Back Confirmation**
   - Actions: Automated DE, MD and DC registries with IVR system for registry status verification.
   - Results: Facilities call 800 number and receive information on nurse aides via telephone and fax.
   - Benefits: Increased accessibility of registry data.
   - Next Step: None anticipated.

State Program Enhancements

1. **Colorado**
   - Actions: Moved written tests to electronic administration at six weekly sites, four quarterly sites, four ad-hoc sites; provided on-site scoring of written tests via EXPro; conducted daily electronic upload to registry; and created monthly training program reports.
   - Results: Implemented enhancements successfully.
   - Benefits: Expanded availability of testing, reduced waiting time for written test results from weeks to minutes and kept registry data more up-to-date.
   - Next Step: Work with client for continuous process improvement.

2. **Delaware**
   - Actions: Administering both skills and written exams on same day on monthly basis with flexibility for additional administrations. Transferring data electronically to registry and IVR system one day after scoring.
   - Results: Implemented all enhancements successfully.
   - Benefits: Increased frequency of testing; kept registry data more up-to-date.
   - Next Step: Work with client for continuous process improvement.

3. **Florida**
   - Actions: Began providing in-facility testing, weekly testing at 22 test sites, issuance of certificates and wallet cards for passing nurse aides.
   - Results: Implemented all enhancements successfully.
   - Benefits: Enhanced standards and frequency of testing.
   - Next Step: Work with client for continuous process improvement.

4. **South Carolina**
   - Actions: Revised candidate handbooks, rater manuals and program manuals; screened applicants for testing eligibility; managed application processing; and provided state-wide standards for testing.
   - Results: Implemented all enhancements successfully.
   - Benefits: Standardized and enhanced application and testing processes.
   - Next Step: Work with client for continuous process improvement.

TESTED BY ASSESSMENT SYSTEMS, INC.

1. January to December, 1996

State	Written/Oral # Tested	Written/Oral % Pass	Skills # Tested	Skills % Pass
Alaska	159	81.8	142	97.2
Arizona	2374	90.2	2222	95.9
Colorado	270	88.5	864	97.0
Connecticut	2940	94.5	3302	81.5
Delaware	48	93.6	47	100.0
District of Columbia	111	79.3	81	90.1
Florida	21	95.2	18	100.0
Idaho	337	92.0	390	92.3
Louisiana	450	73.8	0	0.0
Maryland	644	84.5	761	96.1
Minnesota	5372	97.4	5575	93.2
Nevada	516	98.7	503	95.2
New Jersey	4944	88.5	5211	89.5
New Mexico	1790	89.4	0	0.0
New York	21104	87.0	21088	91.3
North Dakota	973	93.5	957	97.3
Ohio	12198	98.1	12698	93.1
Pennsylvania	11377	97.3	11778	92.5
Rhode Island	1004	87.7	0	0.0
South Carolina	1563	76.3	1597	93.2
South Dakota	681	92.7	884	92.6
Texas	23725	87.3	0	0.0
Utah	496	90.1	0	0.0
Virgin Islands	13	84.6	5	100.0
Washington	17	88.2	55	100.0
Wyoming	547	96.9	558	93.7
TOTAL	93674	90.8	68736	91.9

TESTED BY THE PSYCHOLOGICAL CORPORATION

2. January to December, 1996

State	Written/Oral # Tested	Written/Oral % Pass	Skills # Tested	Skills % Pass
Alabama	3453	82.3	2936	96.5
Alaska	104	90.4	98	96.9
Arizona	776	89.2	843	99.1
California	21	95.2	23	87.0
Colorado	1921	89.4	1899	98.2
Delaware	731	81.2	657	97.1
District of Columbia	389	79.4	425	93.6
Florida	13662	80.1	11930	93.3
Idaho	1684	94.9	0	0.0
Louisiana	243	77.0	196	95.4
Maine	213	98.1	198	91.4
Maryland	2377	83.0	2053	96.8
Nevada	353	89.2	340	95.6
New Hampshire	419	99.8	417	96.4
North Dakota	973	93.5	957	97.3
Rhode Island	613	88.9	0	0.0
South Carolina	2339	75.9	1985	90.8
South Dakota	220	91.8	265	94.0
Virgin Islands	52	71.2	49	95.9
Virginia	6892	84.5	5736	95.6
Washington	5221	86.0	4836	96.0
Wyoming	311	96.5	329	94.2
TOTAL	42379	83.6	35589	94.9

Annual Report of the National Board of Medical Examiners

The following report summarizes the Computerized Clinical Simulation Testing (CST®) activities completed by the National Board of Medical Examiners (NBME) from May 1996 to May 1997 as part of Phases II and III.

Phase II

Phase II involved the translation of the 1994 User Specification Document (developed as a guide and reference during Phase I) into the new Windows-based CST system. Phase II began in August 1995 and was completed in January 1997. Tasks in this phase involved work on the user interface, case and key authoring systems, and support databases.

NBME debugged the new case and key authoring tools by entering four cases and keys. Both NBME and the National Council debugged the user interface, simulation engine and support database content during this time. Following written feedback from the National Council, NBME corrected identified problems. On January 14, 1997, the National Council provided written verification of satisfactory completion of Phase II (some activities, documented under Deferred Phase II activities, were not completed during Phase II and were written into the First Amendment to the Phase III Agreement).

Phase III

Phase III started on January 15, 1997, following execution of the First Amendment to the Phase III Agreement. The project tasks to date have focused on the resumption of case and key development activities, maintenance of databases, completion of deferred Phase II activities, modifications of the search algorithm and field test preparation.

Case Development

In preparation for case development, National Council staff was oriented to the NBME's computer-based examination (CBX) case development process and the logistics of a CBX case development meeting. NBME provided CBX case development materials and consulted on their modification for use with CST.

To date, two Case Development Committee (CDC) meetings have taken place at the NBME facilities. In preparation for the December 9-10, 1996, meeting, two new cases were programmed and revisions were completed for the four cases programmed during Phase II. In preparation for the March 12-14, 1997, CDC meeting, eight new flowcharts were developed from the CST case authors' original materials; 12 CST cases were programmed. NBME provided case printouts for National Council review; case materials, i.e., flowcharts and history and physical examination information, were also prepared for inclusion in committee members' meeting materials.

During both meetings, NBME staff consulted on case programming and requested clarification from committee members on case content and revisions. Following the CDC meeting, NBME mailed the CDC members' documented case revisions to the National Council. At the time of this report, NBME has completed changes, as requested by the National Council, to six cases.

Scoring Key Development

The first Scoring Key Development Committee (SKDC) meeting took place April 14-16, 1997. In preparation for this meeting, a number of tasks were completed: National Council staff was oriented to the CBX scoring key development process and the logistics of a CBX SKDC meeting; revisions were made to six cases approved at the March CDC meeting; six orientation cases were reviewed and updated by NBME staff; NBME provided cases printouts for review by the National Council; NBME provided National Council staff with a slide presentation on the scoring key development process to assist in their preparation for orientation of SKDC members; and case flowcharts and history and physical examination information were developed.

At the meeting, NBME staff requested clarification from committee members on classification (i.e., benefit, neutral) of items defined during case discussion, consulted on item structure (type, timing or sequence), acted as a resource for the case content and programming, consulted with National Council staff on the meeting process and recorded items defined by the committee.

Following the meeting, NBME provided the National Council with paper copies of the scoring keys defined by the SKDC, in addition to case revisions the committee recommended be made prior to the May 1997 field test. NBME is presently completing changes to CST field test cases as requested by the SKDC members.

Database Maintenance

Work continues on data verification following the second data reformation. Also, additional activities are being added to the CST database.

Deferred Phase II Activites

In keeping with the First Amendment to the Phase III Agreement, the following were delivered on March 31, 1997: score reports (unanticipated actions, raw data files and unmatched orders), paper copies for the Phase II scoring keys and transaction lists. Also, the classification attributes for the case authoring system and the update function were demonstrated to National Council staff on March 26, 1997, and April 15, 1997. Transaction lists were provided to the National Council based on National Council and NBME staff running CST cases.

The National Council has requested the transaction list generation program so that a transaction log could be generated at National Council's office in Chicago. NBME provided this CD on May 3, 1997; the transaction log printing function is being installed, tested and debugged at the time of this writing.

Modification of Search Algorithm

The CST search algorithm was modified from an exact match to a partial match on a first-tier term.

Field Test Preparation

The first field test is scheduled for May 7-9, 1997. The field test will be administered at the NBME test center. Preparation includes: the completion of revisions to cases to be used in the field test, completion of database additions, development of interface screens to present surveys to candidates and development of test administration program (this program will administer CST cases and surveys and will collect candidate data).

In the first field test, 15 CST cases will be administered to candidates. NBME will provide examinee survey data and transaction lists. Beginning July 1, 1997, the National Council will receive score reports (i.e., raw data files) in addition to unrecognized and unanticipated examinee action data.

Report of the Nursing Practice & Education Committee

Committee Members
Jan Zubieni, CO, Area I, *Chair*
Marjorie Bronk, TX-VN, Area III
Patricia Dixon, MO, Area II
Kenneth Lowrance, TX-RN, Area III
Cynthia Van Wingerden, VI, Area IV

Staff
Ruth Elliott, *Director for Education and Practice*
Vickie Sheets, *Director for Practice and Accountability*

Relationship to Organization Plan
Goal I ....Provide Member Boards with examinations and standards for licensure and credentialing.
Objective H.........Identify the role of a board of nursing related to continued competence.

Goal II.................Provide information, analyses, and standards regarding the regulation of nursing practice.
Objective B ....Provide resources regarding health care issues which affect the regulation of nursing practice.

Recommendations to the Delegate Assembly
1. **That the Delegate Assembly approves the position paper developed by the Nursing Program Accreditation/Approval Subcommittee related to the terms *approval* and *accreditation* (see report of the subcommittee).**

   #### *Rationale*
   The terms *approval* and *accreditation* are used in different ways by state boards of nursing. The position paper, developed by the Nursing Program Accreditation/Approval Subcommittee, provides guidance to Member Boards in defining these terms in nursing practice acts and rules/regulations related to nursing education. The paper clarifies for the public the meanings of these terms and moves toward greater consistency in the use of regulatory language. The Nursing Practice & Education (NP&E) Committee supports the adoption of this position paper by the Delegate Assembly.

2. **That the Delegate Assembly provides feedback to the Subcommittee to Revise Model Act and Rules at the Annual Meeting forum regarding the process for developing proposed content, format and overall direction for the revised models (see report of the subcommittee).**

   #### *Rationale*
   The subcommittee recognized that the models provide an opportunity to synthesize much of the work of the National Council in the past few years into a congruent view of regulation, encompassing all the major elements that comprise nursing regulation. The subcommittee recognizes the need to collaborate with other committees, Board of Directors and other National Council groups to assure that the models reflect a comprehensive, accurate and timely approach to nursing regulation. The framework developed by the subcommittee provides a means to assure that certain basic considerations form the foundation for each topical area of the models. The subcommittee's plan includes information about how things are currently approached by boards, as well as suggests desired elements for future regulation. The framework was piloted by the subcommittee, focusing on nursing education program approval and identifying the future direction for their work with the intent of developing actual proposed language next year. The proposed electronic format will provide a rich source of regulatory information that will support Member Board regulatory activities. The NP&E Committee supports the work of the Subcommittee to Revise Model Act and Rules.

3. **That the Delegate Assembly provides feedback to the Nursing Practice & Education Committee at the Annual Meeting forum regarding the use of the Personal Accountability Profile as an approach toward promoting continued competence among licensed nurses (Attachment A).**

Rationale

The Personal Accountability Profile (PAP) has been developed as a means for Member Boards to promote professional development and audit the activities of nurses related to continued competence. The PAP is proposed as a mechanism for working with nurses who meet certain criteria that trigger a focused interaction with the board regarding competence. In essence, the PAP requires that the licensed nurse apply the nursing process to her/his professional development, to plan and implement what is needed by the individual nurse to be competent within the role and setting for current practice. The PAP is intended to be comprehensive, flexible and useful to the nurse, as well as the board of nursing. In addition to tracking a record of professional development to meet board of nursing continued competence requirements, the PAP can be used by nurses in collaboration with employers to meet the employer's expectations related to continued competence. Additionally, the individual nurse can promote self-marketability and assure adaptability to a changing health care environment.

Background

Continued competence continues to be a critical topic for health care and regulation, and the work of the committee is responsive to concerns identified by the Citizen Advocacy Center (CAC) and the Pew Health Professions Commission's Task Force on Health Care Workforce Regulation.

National Council efforts to develop a regulatory approach to continued competence date back to the 1980s when the Nursing Practice and Standards Committee struggled with this topic. In 1991, the NP&E Committee made a significant contribution to the work in this area with its *Conceptual Framework for Continued Competence*. This paper identified the need for competency assessment, as well as strategies to attain or maintain competence. In 1993, the NP&E Committee discussed a paradigm shift, where it recognized the need to define *competence* before continued competence could be articulated. Subsequently, a subcommittee of the NP&E Committee worked for two years on the topic and presented a paper to the 1996 Delegate Assembly titled, *Assuring Competence: A Regulatory Responsibility*. The subcommittee's work included a definition of competence that incorporated application of knowledge and skills, standards for competence to compare and evaluate the practice of individual practitioners, and identification of behaviors that demonstrate competence. Critical regulatory points for review of competence were identified as at entry, at renewal, at reinstatement and after discipline. In addition, the paper discussed the debate centering on the question, *to what standard is the licensee held for continuing competence?* The FY96 Continued Competence Subcommittee identified three possibilities: 1) a standard based upon current entry-level competency for the profession, 2) a standard based on a generalist core competency for the profession, and 3) a standard based on competence needed for safe and effective practice in the focused area of practice. The subcommittee determined that, to best benefit the consumer, it made sense to focus on assuring that a practitioner's knowledge and skills in the current area of practice are such that safe and competent care is delivered and recommended that the third standard be used for determining continued competence.

This year, the NP&E Committee, building upon the subcommittee's work, developed a "how to" – a practical approach for implementation of the regulatory role in continued competence. The NP&E Committee used the subcommittee's definition and standards for competence (applicable to every nurse in every practice role and addressing the continuum of practitioner experience), licensure competence requirements and the need for collaboration in competence accountability. The NP&E Committee, while concerned about safe and effective practice in the nurse's focused area of practice, believes that there are certain core elements applicable to every role and every setting. This interest in the core elements triggered a reconsideration of the role of the board of nursing in continued competence. The committee believes that collaboration between the individual nurse, educator, employer and board of nursing is needed to assure continued competence.

Highlights of Activities

- **Coordination role**

The NP&E Committee worked with two subcommittees this year: Subcommittee to Revise Model Act and Rules and Nursing Program Accreditation/Approval Subcommittee. The NP&E Committee supported continued

work related to alternative models for approval of nursing education programs. In addition, the NP&E Committee communicated and provided feedback to other task forces working on nursing practice and education-related topics.

- **Developed recommendations for uniform licensure requirements for renewal and re-entry**

The NP&E Committee developed recommendations for uniform licensure requirements, consistent with the work to date on continued competence, and shared these with the Multistate Regulation (MSR) Task Force.

- **Reviewed additional literature and resources**

The NP&E Committee reviewed books, articles, Internet materials, feedback from meetings and conferences, and other resources addressing continued competence.

- **Developed Guidelines for the Functional Abilities Study**

The NP&E Committee developed guidelines to assist Member Boards in the use of the *1996 Functional Abilities Study*. Publication of these guidelines is expected in late summer (Attachment B).

- **Developed the concept of the Personal Accountability Profile (PAP) as an approach to promote the continued competence of licensed nurses (Attachment A)**

The PAP provides a framework for nurses to track and document a synthesis of professional growth activities across a nurse's career. In essence, the PAP requires the nurse to apply the nursing process to her/his professional development. This involves assessing strengths, weaknesses and identification of learning needs; planning strategies to maintain/attain/regain competence; implementing strategies needed by the individual nurse to assure competence within the nurse's role and current practice setting; and conducting an evaluation to determine if learning objectives have been met.

- **Explored assessment options for continued competence**

The NP&E Committee explored formal assessment options for evaluating core requirements of nursing that cross all roles and settings. The committee reviewed Dorothy del Bueno's work, including her description of three core topical areas: critical thinking, interpersonal relations and technical applications (with the content of these core topics differing in context by setting and role). The committee thought that four abilities identified by del Bueno – the ability to recognize significant findings, the ability to act on those findings, the ability to prioritize different significant findings and the ability to defend (or articulate the principles supporting) the chosen actions – summarized the essential abilities needed for nursing practice. The committee believes that Computerized Clinical Simulated Testing (CST®) has potential for use in assessing continued competence, as it provides a means of evaluating critical thinking. However, CST currently is applicable for registered nurses only. The committee also explored other options: self-assessment tests, development of a core requirements assessment (based on a job analysis of experienced nurses), NCLEX-RN® examination and NCLEX-PN® examination, and other existing examinations that might be adaptable for use in this type of assessment.

Future Activities

The NP&E Committee plans to pilot the use of the PAP with at least one state (more if interest is expressed). The committee also plans to explore possible collaboration with other organizations regarding efforts to develop continued competence resources. The committee will develop a plan for piloting other tools for possible use in assessing continued competence. The committee is also interested in exploring opportunities to promote learning modules related to regulation and jurisprudence that might be used as PAP strategies.

Meeting Dates

- October 28-30, 1996
- December 11-13, 1996
- February 20-22, 1997
- May 5-7, 1997

Recommendations to the Delegate Assembly

1. That the Delegate Assembly approves the position paper developed by the Nursing Program Accreditation/Approval Subcommittee related to the terms *approval* and *accreditation* (see report of the subcommittee).

2. That the Delegate Assembly provides feedback to the Subcommittee to Revise Model Act and Rules at the Annual Meeting forum regarding the process for developing proposed content, format and overall direction for the revised models (see report of the subcommittee).

3. That the Delegate Assembly provides feedback to the Nursing Practice & Education Committee at the Annual Meeting forum regarding the use of the Personal Accountability Profile as an approach toward promoting continued competence among licensed nurses (Attachment A).

Attachments

A .... Continued Competence and the Personal Accountability Profile, *page 5*
B .... Outline for *Functional Abilities Guidelines, page 13*

Attachment A

Continued Competence and the Personal Accountability Profile

The NP&E Committee devoted significant effort in FY97 in developing a practical how-to approach for the implementation of the regulatory role in continued competence. The committee built upon the foundation provided by the work of the 1995-96 Subcommittee on Continued Competence – the definition of competence, standards for competence and supporting paper, *Assuring Competence: A Regulatory Responsibility*. The NP&E Committee studied a variety of articles, resources and approaches by other health-related organizations to inform its discussions. Through this study, the committee identified the following assumptions regarding continued competence.

Assumptions

1. Regulatory activities in the area of continued competence can be considered an indicator for demonstrating responsibility and accountability for practice and decisions (in other words, *regulatory activities should be considered positive and proactive efforts, not punishment*).
2. Every licensed nurse has a foundation base of knowledge and every licensed nurse needs to be a lifelong learner.
3. The half-life of knowledge is approximately two years. The half-life of technology is even shorter.
4. Every licensed nurse has control of her/his professional development (self-initiated, self-directed), thus control of own future growth.
5. Adult learning needs, styles and effective learning strategies vary; therefore, flexibility and an acceptable range of opportunities should be provided for nurses.
6. Professional accountability begins with students laying a foundation of values and self-expectations and includes the determination of personal limitations. Personal limitations may involve knowledge, skills, abilities, authority (i.e., licensure or employment status) or functional abilities. Professional accountability also requires nurses to place themselves in settings that maximize their potential and ability to meet client needs and provide reasonable accommodations for nurses with special needs.
7. Assuring continued competence is complicated in a profession with varying scopes, levels and settings of practice.
8. Regulation plays a role in the assurance of competence.
9. Any regulatory approach to continued competence needs to address the question raised by the CAC and Pew, that is, "*Can the public be confident that health care professionals who demonstrated minimum levels of competence when they earned their licenses continue to be competent years and decades after they have been in practice?*"
10. Minimum, essential competence for safe practice includes elements such as critical thinking, interpersonal relations, basic nursing principles and aspects of jurisprudence/ethics.

Guiding Principles

In addition to these assumptions, the committee articulated principles that guided the development of the approach for implementation of the regulatory role.

1. The primary responsibility of boards of nursing is to protect the public.

Rationale. Boards exist to protect the public health, safety and welfare through the regulation of nursing practice. Nursing is a profession that requires the application of substantial knowledge and skills. The unsafe or unethical practice of nursing could cause harm to the public unless there is a high level of accountability.

2. **Boards have a role in assuring the public that licensed nurses meet minimum standards of competence throughout their professional lives.**

   Rationale: Although many boards have devoted efforts primarily to evaluating individuals for licensure and determining the need for removal or modification of the licensure authority, consumers and legislators are looking more to the boards to take an active role in reviewing the ongoing competence of the nurses in between the extremes of "getting them in and getting them out." Consumers are looking to the license as a validation of ongoing competence for those nurses who regularly renew their licenses and are not identified for discipline proceedings.

3. **Attaining, maintaining and advancing competence is a joint responsibility among the individual nurse, employer, licensing board, educator and profession.**

   Rationale: Boards can provide a framework for competence – identification of standards, expectations, a means of tracking activities and evaluations – as well as take disciplinary action when practice is proven unsafe. The employer can determine on an ongoing basis whether or not the nurse can perform in her/his assigned nursing role. Educators, in addition to competence development of nursing students, also need to play a role in continued professional development by enhancing and expanding the knowledge and skills of licensed nurses. The profession as a whole, through its professional organizations, promotes the evolution of nursing practice, identifies standards of excellence and provides opportunities for professional development. The individual nurse must be accountable for practice and implement professional development activities based on assessed learning needs.

4. **Licensure is a privilege, not a right; therefore, each licensed nurse has responsibility to the licensing entity granting the authority to practice and to the public who receives nursing services.**

   Rationale: To be licensed as a nurse, an individual must choose to apply and submit to the jurisdiction of the licensing authority. It is a personal choice to apply for licensure (granted, a choice forced by selection of a professional career). An individual must meet identified requirements before being granted a license and the authority to practice nursing. The burden is upon the individual to provide evidence that the person has met the educational, examination, behavioral and other requirements. In receiving that authority, the nurse is free to practice within the scope of nursing practice identified by a jurisdiction. The forgotten half of that freedom is responsibility. In accepting the authority to practice nursing and the freedom to practice within the given parameters, a nurse also assumes the responsibilities associated with that authority. Once licensed, the nurse continues to be subject to the jurisdiction of the licensing entity and the requirements set by that entity for renewal and continued authority. Beyond this external accountability, a nurse is accountable first of all to oneself (internal accountability).

5. **Every nurse needs to periodically demonstrate minimum, essential competence for safe practice.**

   Rationale: When the NP&E Committee uses the terms *minimum, essential*, it refers to elements of practice that cross all settings and roles, and, thus, the NP&E Committee recognizes that the statement of this principle is a deviation from the recommendation of the 1996 Continued Competence Subcommittee, which was to focus continued competence strategies on the current practice of a nurse. The concern articulated by the subcommittee was that using time and resources to focus on practitioners acquiring knowledge and skills unrelated to daily practice was questionable at best; at worst, a detraction from the advancement of knowledge and skills needed for a particular nursing role. The NP&E Committee struggled with this principle, appreciating the value of professional development. The need for professional development is critical, but the NP&E Committee sees that responsibility belonging primarily to the individual nurse, employer, educator and the profession. A regulatory board, on the other hand, provides a safety net. A board determines the minimum, essential standards for nursing practice. Through disciplinary activity, boards have long attempted to identify the outliers who do not meet these standards. The minimum, essential elements identified by the committee include critical thinking, interpersonal relations and technical understanding (basic nursing principles, i.e., asepsis, universal precautions).

6. **Regulatory approaches to continued competence, in order to be viable, must be:**

- **administratively feasible,**
- **publicly credible,**
- **professionally acceptable,**
- **legally defensible, and**
- **economically feasible.**

Rationale: The NP&E Committee believes that these criteria, adopted from the National Board for Professional Teaching Standards Assessment Criteria, summarize the key elements that are needed for an effective regulatory continued competence approach.

7. **Additional criterion: any model selected for a regulatory review of competence must be applicable to all the regulatory approaches identified by the MSR Task Force.**

Rationale: The NP&E Committee has worked with the MSR Task Force to develop renewal recommendations for licensed nurses in multistate practice. It is important that the work of the two committees is congruent and does not veer off in different directions. The NP&E Committee worked to develop and propose a model for regulatory review of competence that is flexible, creative and forward-thinking, as well as adaptable to changes in the health care and regulatory environments.

Personal Accountability Profile (PAP)

The framework for the individual nurse's tracking of professional development (attaining and maintaining competence) has been titled Personal Accountability Profile (PAP). The following elements are included in the PAP and describe the steps each licensed nurse would be expected to follow on a regular basis:

- assessment,
- analysis/plan,
- implementation, and
- evaluation.

The PAP is proposed as a mechanism for boards of nursing to work with nurses who meet certain criteria that trigger an audit of the PAP. In essence, the PAP requires that the licensed nurse apply the nursing process to her/his professional development to assess strengths, weaknesses and learning needs; identify learning objectives and plan learning strategies; implement what is needed by the individual nurse to be competent within the role and current practice setting; and evaluate whether or not learning objectives have been met.

- **Assessment**

1. Identification of strengths and weaknesses.
2. Identification of learning needs applicable to current nursing practice area (or, in case of re-entry, expected nursing practice area, which could be generalist).

Range of acceptable approaches to include:

- *formal testing,*
- *self-assessment (formal or informal),*
- *peer review,*
- *employer review,*
- *practice audit,*
- *consultation, and*
- *other approaches that meet guideline criteria.*

Product: A diagnostic profile of one's current strengths and weaknesses with corresponding learning needs relative to the core elements and one's own practice area.

- **Analysis/planning**

1. Identification of goals/objectives reflecting learning needs and priorities.
2. Identification of strategies to meet learning needs.
3. Identification of accommodations to support special needs (as needed).
4. Identification of how to evaluate achievement of goals/objectives.

Range of acceptable approaches:

- *formal education,*
- *independent study,*
- *focused continued education,*
- *professional certification,*
- *mentored/preceptored relationship which meets guideline criteria,*

- *authoring (journal article, text, other),*
- *teaching class or developing workshop,*
- *conducting research, and*
- *other approaches that meet guideline criteria.*

Product: A learning plan with measurable objectives individualized to the licensee's learning needs.

- **Implementation**

1. Complete strategies identified in learning plan.
2. Track documentation which validates plan and implemented strategies.

Range of acceptable approaches:

- *Implementation of plan, using strategies identified above.*

Product: Documentation of manner and time that each strategy was implemented, with any pertinent notes regarding effectiveness.

- **Evaluation**

1. Evaluate whether goals/objectives have been attained.
2. Track documents that provide evaluative information.

Range of acceptable approaches:

- *summary of evaluations by employer and/or peer review;*
- *professional certification (or recertification);*
- *copy of article, text chapter, etc.;*
- *validation of skill demonstration by employer or educator;*
- *graduation, degree from formal educational program; and*
- *transcript verifying successful completion of classes.*

Product: A formal attestation that the strategies were implemented and the learning goals/objectives attained. (NOTE: The expectation is that a nurse would maintain the PAP as an ongoing record of professional development. Therefore, one would expect to see new learning reflected in follow-up documentation, i.e., subsequent evaluations, classes selected to build on previous study, etc.)

How PAP Works

All licensed nurses would be expected to maintain a PAP. Each nurse would complete each of the four elements and comply with the quantitative and qualitative requirements as set forth in board rule. Criteria for evaluating each element would be developed, as would guidelines to assist nurses in the development and maintenance of their PAPs. Part of the application for renewal of license would include: 1) affirmation that the PAP was maintained during the renewal period, and 2) responses to a series of questions regarding practice. The elements for the scannable renewal form considered by the committee include:

- worksite/setting;
- role;
- full-time/part-time (hours of practice);
- educational level and any change in educational level during the renewal period;
- past discipline history;
- whether or not physical or mental status has changed in such a manner that affects ability to practice safely;
- years of practice;
- years since completion of last formal education;
- any disciplinary action by employer related to nursing practice, since last renewal;
- list activities undertaken to assess learning needs:
    - self-assessment,
    - employer-required assessment,
    - peer review,
    - formal testing,
    - certification examination,

  - none, and
  - other;
- what strategies have been implemented to meet learning needs;
- identify learning activities related to practice area;
- certification in specialty or advanced practice;
- enrollment in formal nursing program, what type; and
- enrollment in education program other than nursing.

The purpose of asking for additional information on the application would be to support the audit process. The NP&E Committee proposes that groups selected for audit would be made up of part random selection and part identified trigger. The committee suggests that a trigger would be selected from the elements listed previously. The audited trigger would change periodically. The rationale for selecting a trigger and targeting the individuals responding within identified parameters for the audit group would focus on a particular trigger in an identified time frame. In addition to the random and triggered audits, a mandatory audit would be performed on all nurses re-entering practice after a period of a lapsed license. The NP&E Committee suggests that disciplinary orders address competence requirements and might include a mandatory audit of the nurse's PAP.

Audited nurses would be requested to provide documentation of how the various PAP elements have been conducted. If a nurse's PAP documentation meets identified criteria, the nurse would be informed that the submission met board requirements. If a nurse submitted PAP documentation that did not meet requirements, the nurse would work with a Board Review Committee to evaluate and redesign PAP as needed. The nurse would be given a period of time to implement the revised PAP. If a nurse failed to submit PAP documentation, the nurse would be referred for disciplinary review.

This summary provides a broad overview as to how PAP is expected to be implemented. The NP&E Committee will continue to work on developing suggested criteria and guidelines and refine the process as part of pilot development.

Selling Points

In discussions regarding PAP, the committee also considered selling points for different audiences that could be used to promote the concept of PAP, including boards of nursing, educators, employers, nurses and the public. A key audience identified was that of educators, because the NP&E Committee members recognized that faculty would play major roles in presenting the concept to students as part of lifelong learning, as part of professional development and as an expectation of the profession.

- **Selling Points – Boards of Nursing**

PAP promotes the meaning of licensure and the credibility of boards of nursing; complements current board of nursing processes by adding proactive activities (promotion of PAP with random and triggered audit for compliance) to current reactive activities (disciplinary process for complaints); infuses the license with additional meaning; provides the means to address continued competence (Research to validate effectiveness could demonstrate the benefit of regulation to nursing, and validate the regulatory role of boards of nursing. If research would not validate the PAP approach, we would be back to the drawing board to develop different approaches.); meets criteria for administrative feasibility (Because the board will not be receiving documentation from all licensees demonstrating the completion of PAP for the prior licensing/renewal period, the board can devote resources to those selected for PAP audit, thereby focusing effort to providing more in-depth review of some.); and provides a measure for board self-evaluation and accountability to public.

- **Selling Points – Nurses, Employers and Public**

PAP provides flexibility for nurses and aims to be cost-effective, because it uses mechanisms in place, such as performance review and peer review (that would meet specified criteria) and allows a variety of strategies (within specified criteria). PAP literally can be as simple or as complex as the nurse determines is best for her/his needs. PAP promotes self-direction – the nurse chooses from many opportunities to fulfill the requirements; offers a wide range of choices, an a la carte or cafeteria-style approach; provides a meaningful approach – a well-prepared PAP would be useful to an individual nurse for career development and to promote one's marketability; and provides benefit to the employer as well as the nurse.

PAP prepared in collaboration with an employer provides additional information about the licensed nurse. A nurse's shared PAP could be useful in meeting facility competence accreditation requirements. Education regarding triggers (and why criteria are chosen as triggers) could be used to educate employers in their role in the collaboration to assure continued competence.

PAP also promotes quality of care through the development of nurses, thus is useful to the public; does not expect "one size to fit all"; responds to the concerns identified by Pew; addresses, at least in part, the questions raised by the CAC; and tailors to future trends in regulation and can be adaptive for a changing health care environment.

■ **Selling Points – Educators**

PAP provides opportunity/means to instill/promote the value of lifelong learning (LLL) and why LLL is more important than ever in an ever-changing work environment. The message to students and nurses: *It's going to affect what you do, what you earn and what opportunities are available.*

PAP also promotes understanding of nursing process by having students apply the process to themselves; provides the opportunity to stress to students that license is a privilege and brings with it responsibility; and promotes the marketability of nurses as they progress throughout their careers. PAP is anticipated to track development, in any setting, role, state. All activities contributing to professional development could be tracked and would promote current analysis of strengths, challenges and learning needs. The same PAP process would be used for all levels of education (differences would occur in content, depth, etc.). The content will change, the strategies will change, but the process and the value of lifelong learning is constant.

In addition, PAP promotes career laddering and articulation of education.

Anticipated Concerns Regarding PAP

The NP&E Committee recognizes that any type of new process, any type of change, can be threatening. From the board of nursing perspective, the ability of boards to implement the use of PAP will be dependent on whether or not rule change (or, for a few, seeking statutory authority) would be required. In addition, board resources would be another major factor: implementation of a new process means additional staff and resources, as well as work redesign. Some boards would be taking on a new activity, others would require work redesign. Boards that have not previously accepted a role in assuring continued competence would experience a challenge to values. All boards could expect to be held accountable in a different way. PAP could be potentially a hard sell to some educators, who are already dealing with limited time and expanding content for their students. Some nurses may perceive that the work required to implement PAP is burdensome. PAP presents a different role for those entities identified as being part of the collaboration needed to assure continued competence: educators, employers and regulators. PAP may be overwhelming for some, but the intended flexibility could also be troublesome to nurses, educators, employers and regulators prepared in more structured environments. The NP&E Committee believes that nurses need to recognize that it is a whole new world in health care and the society at large. This is but a piece of all the change taking place. It is hoped that, after ascending the "mountain of transition," the need to expend extra effort would level off and PAP would be perceived as a supportive process for boards of nursing doing what they are created to do: protect the public.

Assessment Mechanisms

As the NP&E Committee attempted to refine the process for PAP, difficulty was encountered with the assessment element. A PAP assessment could lead to significant effort and expense by the nurse in implementation of a plan to meet identified learning needs. The committee members, as well as staff psychometricians, voiced concerns that there is no way of assuring that the different forms of assessment (e.g., peer review, client review, etc.) identified for use could be considered equivalent. Two nurses with exactly the same practice strengths and weaknesses could fare very differently depending upon the choice of assessment. One nurse could get a very stringent plan from a group of peers and the other nurse a very lenient plan from an employer or vice versa. This did not seem fair and objective to the committee and raised concerns regarding the legal defensibility of using multiple assessment options. Yet, a basic premise of PAP involves promoting flexibility for the nurse. The committee could see no way, even by setting specific assessment criteria, to resolve the tension between the need to be equitable and the goal of providing flexibility in PAP.

The committee considered using some type of formal assessment to evaluate the core elements (critical thinking, etc.) as well as the possibility of re-testing nurses periodically with the NCLEX® examination (a few states already require NCLEX examination of nurses re-entering practice). The committee also considered the feasibility of formal self-assessment tests (similar to those in use by the dietitians) or an exam developed to address those specific elements of continued competence. The committee will pursue the potential applicability of computerized clinical simulation testing (CST®) for this purpose but is also interested in options that would be available before the 1999 completion of CST (in addition to timing, the committee members were concerned that currently CST focuses only on RN practice). The committee plans to continue exploration of possible assessment options and possible pilots of assessment approaches.

PAP Algorithms

The NP&E Committee discussed the possibility that learning algorithms could be developed to support areas of particular interest. Such learning tools could be developed by a variety of sources – publishers, nursing organizations and institutions/agencies. The committee is particularly interested in developing learning modules for nurses regarding regulation, jurisprudence and ethics. These modules would provide a consistent and objective approach to be used by boards when working with nurses identified as having particular learning needs.

Future Activities

The NP&E Committee plans to work with at least one volunteer state next year to pilot the PAP concept and also plans to explore/pilot other assessment options. The committee plans to share information regarding PAP with a variety of stakeholders for feedback and comment. This includes other National Council committees, members of the previous continued competence subcommittee, National Council staff and other external entities. The NP&E Committee recognizes that research to validate the PAP concept will be critically needed. Research will also be needed to determine whether the committee's hypothesis that promotion of a collaboration of individual, employer, board, educator and profession will prove to have a positive impact on competence, thus improving the quality of care.

Attachment B

Outline for *Functional Abilities Guidelines*

I. Introduction

- Background
- Purpose for each category of potential users (boards, educators, employers)
- Delineate what study means and what it does not mean

II. Guidelines/suggestions for boards of nursing

- Questions, checklist for core competencies
- The *Functional Abilities Study* can be used in combination with other resources (job analysis, scope, experts)
- Documentation of need for accommodations and that accommodation meets the need
- Itemize where (what board activities) these studies could be helpful
- Functional abilities as related to professional accountability and competence
- Education of the public as to need of disabled individuals to have an opportunity to be successful
- Use as a resource, in conjunction with other resources, to guide decisions in licensure, renewal and discipline

III. Guidelines/suggestions for nursing educators

- The *Functional Abilities Study* is a resource to be used in combination with other resources to guide decision for admission and with regard to successful completion of program objectives
- Documentation of need for accommodations and that accommodation meets needs
- Functional abilities as related to professional accountability and competence

IV. Guidelines/suggestions for nursing employers

- The *Functional Abilities Study* can be used as a resource in combination with other resources to guide decisions regarding hiring, accommodations and determining activities needed for particular positions
- Documentation of need for accommodations and that accommodation meets needs
- Functional abilities as related to professional accountability and competence

V. Americans with Disabilities Act (ADA)

- *Emerging Issues* on ADA
- Review of ADA caselaw

VI. Workshop Prototype

VII. Bibliography

Appendix A, Functional Abilities Study

Appendix B, Readability Study

Report of the Nursing Program Accreditation/Approval Subcommittee

Committee Members
Eileen Deges Curl, KS, Area II, *Chair*
Claire Glaviano, LA-PN, Area III
Judith Mayer, MD, Area IV
Helen Zsohar, UT, Area I

Staff
Ruth Elliott, *Director for Education and Practice*

Relationship to Organization Plan
Goal III ....Provide information, analyses, and standards regarding the regulation of nursing education.
Objective B ....Provide resources regarding issues that affect the regulation of nursing education.

Recommendations to the Nursing Practice & Education Committee
1. **That the NP&E Committee approves the position paper related to use of the terms *approval* and *accreditation*.**

   #### *Rationale*
   The terms *approval* and *accreditation* are used in different ways by state boards of nursing. This position paper provides guidance in differentiating between these terms in nurse practice acts and rules and regulations related to Member Board responsibilities in the approval process for nursing education programs. It also clarifies for the public the inherent meanings of the terms *approval* and *accreditation*.

2. **That continued work related to models for approval of nursing education programs be completed.**

   #### *Rationale*
   The report of the Member Board Needs Assessment Regarding Approval/Accreditation (Attachment B) provides data to support continued study related to this area. Member Boards expressed interest in exploring various approaches that might be used in approval of nursing education programs. These analyses and continued work will provide useful information to Member Boards in evaluating various potential approaches that might be utilized in functions and responsibilities related to approval of nursing education programs. Additional opportunities for collaboration between Member Boards, external organizations, the National Council and the accreditation community have been identified by the subcommittee for further exploration.

Background
To carry out its charge related to completion of a needs assessment related to Member Board needs in approval/accreditation, the subcommittee completed several significant tasks. These activities included: review of literature and resources, identification of significant issues in approval of nursing education programs, development of a needs assessment survey instrument, analysis of findings and identification of future directions. Each of these activities will be described under highlights and future directions.

Highlights of Activities
- **Review of literature and organizational activities related to accreditation and approval of nursing education programs**

Review of Literature and Resources. The Nursing Program Accreditation/Approval Subcommittee conducted a comprehensive review of the literature and resources related to approval and accreditation of nursing education programs. Several resources served as a foundation for the Member Board needs assessment. These resources included: environmental scan related to nursing education, *Profiles of Member Boards*, Pew Health Professions Commission report on *Critical Challenges: Revitalizing the Health Professions for the 21st Century*, Nursing

Practice & Education Committee report with a comparison of criteria used by the National League for Nursing (NLN) and by boards of nursing to approve/accredit nursing education programs, American Association of Colleges of Nursing (AACN) agenda for nursing education, AACN proposal related to an alliance model, *Minnesota Board of Nursing Vision Project* and selected journal articles. In addition, an update of national, regional and local issues related to approval/accreditation was discussed at each meeting. Updates included reports related to the NLN status as a recognized accrediting agency by the U.S. Department of Education (DOE), Pew Commission Task Force on Accreditation, AACN initiative to accredit nursing education programs and Member Board issues related to approval/accreditation, analysis of findings and identification of future directions.

Identification of Significant Issues. Based upon this environmental assessment, the subcommittee identified significant issues related to approval/accreditation of nursing education programs as follows:

- lack of consistency in the meaning of the terms *approval* and *accreditation*;
- perceived Member Board unique role and responsibility in the approval/accreditation process;
- diversity of approaches used in approval/accreditation process;
- differences in board standards used in the approval /accreditation process;
- significant unique role of Member Boards in assessing the need for new nursing education programs;
- potential overlap between board of nursing approval process and voluntary accreditation process;
- difference between perceived roles of organizations and groups in establishment of state and national nursing education standards; and
- need for criteria to support innovative approaches in nursing education such as distance learning, Internet courses and virtual universities.

- **Development of a position paper related to terms *approval* and *accreditation***

A position paper related to the terms *approval* and *accreditation* was developed to address the lack of consistency in the terminology (Attachment A).

- **Completion of a Member Board Needs Assessment Related to Approval/Accreditation**

After conducting an environmental analysis, a survey instrument to assess Member Board needs related to approval/accreditation of nursing education programs was completed. The survey explored the effectiveness of various approaches to approval/accreditation, participation in standards for nursing education, desirability of uniform requirements for approval/accreditation, National Council services and future directions. The survey instrument was divided into the following major areas: terminology and fees, basic nursing education programs, advanced practice nursing programs, issues, future directions and demographics. Results of the Member Board needs assessment are found in Attachment B.

Future Activities

Future activities are based upon the findings of the needs assessment as reported by Member Boards. These findings may be found in Attachment C.

- Sponsor a roundtable with Member Boards and representatives of accrediting agencies to discuss and study various models to be considered by state boards of nursing in the initial and/or continuing approval process.
- Explore potential models for approval of advanced practice nursing programs and basic nursing education programs that are accredited by voluntary accreditation agencies and those programs not holding voluntary accreditation. Work with other appropriate National Council committees regarding issues related to approval of nursing education programs.
- Continue work related to approval /accreditation issues. Consider conducting descriptive research by means of survey or interview methodology to analyze approval/accreditation issues from the perspectives of nursing education programs and external organizations.
- Facilitate the development of uniform standards for initial and continuing approval of nursing education programs congruent with states' rights.
- Analyze the need for and implications of the National Council becoming recognized as an "accrediting agency" by the DOE. Various models and approaches would be explored to serve Member Boards and address approval/accreditation issues by considering: protection of the public, evaluation of outcomes, responsiveness

to health care system, responsiveness to innovation and creativity in education, use of state-of-the-art technology and exploration of potential partnerships with accrediting agencies.

- Publish an article in *Issues* or another journal related to the unique functions of state boards of nursing in approval/accreditation of nursing education programs.
- Develop education programs for board staff and board members having direct responsibilities related to approval/accreditation of programs or have interest in the approval/accreditation process. These programs would build upon *Guidelines for Education Program Surveyors* previously developed by the National Council. Explore the development of a certification program for site visitors involved in the approval/accreditation process in states.

Meeting Dates

- January 9-10, 1997
- April 8, 1997 *(telephone conference call)*
- April 24-25, 1997
- May 2, 1997 *(telephone conference call)*
- May 12, 1997 *(telephone conference call)*
- May 19, 1997 *(telephone conference call)*

Recommendations to the Nursing Practice & Education Committee

1. That the NP&E Committee approves the position paper related to use of the terms *approval* and *accreditation.*

2. That continued work related to models for approval of nursing education programs be completed.

Attachments

A .... Position Paper Related to Use of Terms *Approval* and *Accreditation, page 19*
B .... Member Board Needs Assessment Regarding Approval/Accreditation of Nursing Education Programs, *page 21*
C......... Findings of Member Board Needs Assessment, *page 29*

Attachment A

Position Paper Related to Use of Terms *Approval* and *Accreditation*

The right to practice a profession or discipline is protected by the U.S. Constitution. The Constitution also states that a state may regulate a profession or occupation that affects general welfare. Nursing is a profession that makes an impact on general welfare and is, therefore, subject to regulation by the state. Language in state nurse practice acts and rules and regulations, however, has not been consistent in differentiating between mandated, legal processes and voluntary, quality-assurance processes, as related to the regulation of nursing education programs. A review of the nurse practice acts and rules and regulations of the 61 Member Boards of the National Council of State Boards of Nursing (NCSBN) indicates that most state boards of nursing use the term *approval* to describe oversight of nursing education programs. Some boards use the term *accreditation*, and a few boards use both terms interchangeably. The purpose of this position paper is to differentiate between the terms *approval* and *accreditation* as they describe a state regulatory body's role and responsibility in nursing education programs.

The term *approval* is defined as "official or formal consent, confirmation or sanction" (*American Heritage Dictionary*, 1993, p. 122). In the National Council's *Model Nursing Administrative Rules*, *approval* is defined as "official recognition of nursing education programs which meet standards established by the board of nursing" (NCSBN, 1994, p. 2). Implied in approval is permission to carry out an act, in this case, the operation of a nursing education program. In the regulatory arena, approval refers to mandatory and legal recognition of a nursing program to begin and/or continue to operate. Graduation from an approved program is necessary for a student to be eligible to take the NCLEX® examination for registered nurses or licensed practical/vocational nurses.

Approval also requires compliance with essential educational standards to protect both the students who are enrolled in the program and the public who will receive nursing care from the graduates of the program. Participation by regulatory bodies in the approval process is congruent with their legal responsibility.

The term *accreditation* is defined as "recognition of an institution of learning as maintaining prescribed standards requisite for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice" (*American Heritage Dictionary*, 1993, p. 122). In the National Council's *Model Nursing Administrative Rules*, *accreditation* is defined as "the official authorization or status granted by an agency other than a state board of nursing" (NCSBN, 1994, p. 2). Inherent in the accreditation process is evaluation by peers (Bogue & Saunders, 1992).

Whereas approval is a mandatory process related to permission for an education program to begin and continue operating by meeting essential educational standards, accreditation is generally considered a voluntary process that focuses on program excellence. In addition, approval processes (initial and continuing) are generally carried out by governmental agencies while accreditation is conducted by peers.

Both approval and accreditation are important components in the successful operation of nursing education programs designed to protect the public and provide appropriate educational experiences for future nurses. Thus, it is important that boards of nursing review their state Nurse Practice Acts and Rules and Regulations to ensure that terminology is consistent with the inherent differences between the terms *approval* and *accreditation*.

References

1. American Heritage Dictionary. (1993). Houghton Mifflin Co.: Boston.
2. Bogue, E.G. & Saunders, R.L. (1992). The evidence for quality: Strengthening the tests for academic and administrative effectiveness. San Francisco: Jossey-Bass Publications.
3. National Council of State Boards of Nursing. (1994). Model Administrative Rules. Chicago: NCSBN.

Attachment B

Member Board Needs Assessment Regarding Approval/Accreditation of Nursing Education Programs

Introduction

After conducting an environmental analysis, a draft survey instrument to assess Member Board needs related to approval/accreditation of nursing education programs was completed. The survey explored the effectiveness of various approaches to approval/accreditation, participation in standards for nursing education, desirability of uniform requirements for approval/accreditation, National Council services and future directions. The survey instrument was divided into the following major areas: terminology and fees, basic nursing education programs, advanced practice programs, issues, future directions and demographics.

Data Collection

The needs assessment survey instrument was mailed to Member Boards on February 7, 1997. Each Member Board was invited to participate in the needs assessment. Each jurisdiction was requested to complete one copy of the staff survey and one copy of the board member survey.

Survey results were collected until April 25, 1997, and considered in the findings of the needs assessment. Some boards of nursing copied and returned additional copies of the survey and submitted them to the National Council. All responses were reviewed by the subcommittee. Duplicate copies of the survey were randomly eliminated so that a maximum of two responses from each jurisdiction was included in the final analysis.

Demographics of Respondents

The total number of surveys received from Member Boards was 99 (53 staff; 46 board members). Upon deletion of duplicate copies of surveys the final response rate was 78.6 percent (N=48) for board staff and 57.3 percent (N=35) for board members. A total of 50 jurisdictions responded for a response rate of 81.9 percent of the membership. The following pie charts depict the demographics and representation of respondents completing the survey (see Figures 1, 2 and 3).

Figure 1. Response Rate by Member Boards

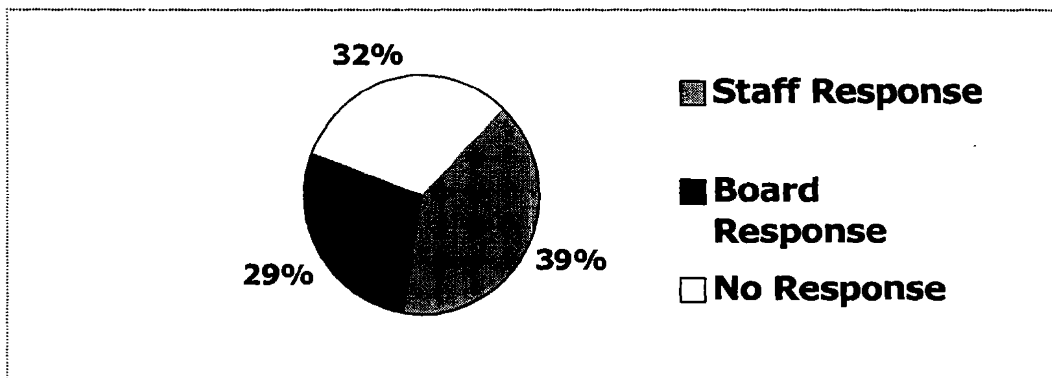


Figure 2. Response Rate by Board Member Category (N=35)

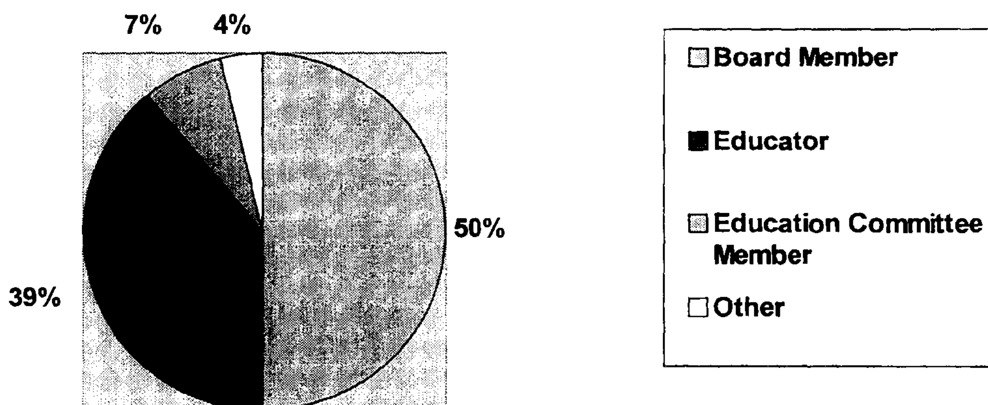
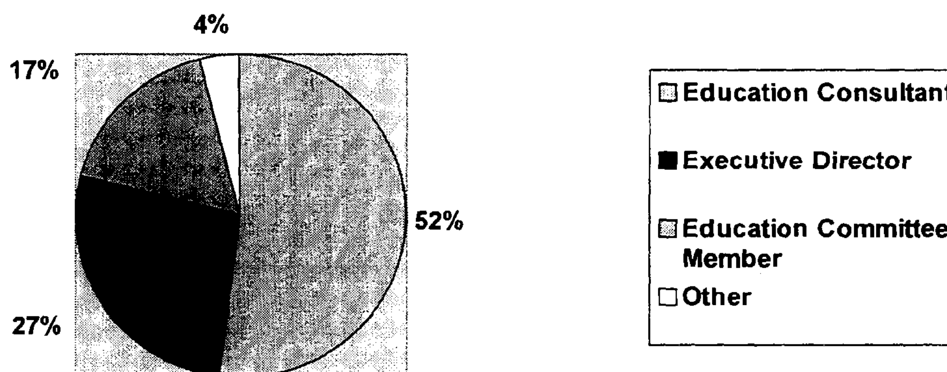


Figure 3. Response Rate by Staff Category (N=48)



Most staff members completing the survey were education consultants. Most board members responding were educators from all types of nursing education programs. The length of time of service between board members and staff were similar with a mean of 2.68 years for board members and 2.70 years for staff. Most boards of nursing identified at least one staff member having primary responsibility for nursing education issues. Five boards stated that a staff member for nursing education was not employed at the board office. The range of staff members in board offices was between zero to five staff.

Data Analysis

The Member Board Needs Assessment Regarding Approval/Accreditation was analyzed with respect to qualitative and quantitative data. Each question of the survey was reviewed relative to findings, implications and future directions. A list of general themes and findings from the study was compiled. Some of the general findings and themes were identified as follows:

- *approval* was the predominant term used to describe board role in nursing education;
- most jurisdictions were satisfied with their approach to approval/accreditation of nursing education programs;
- most boards recognized redundancy in the approval process and believed it was a positive factor in the check-and-balance system;
- most states do not charge a fee for survey visits to nursing education programs;

- the predominant model for approval/accreditation is that of the board of nursing granting initial approval and renewing the approval of a nursing education program;
- the alternative approach to approval/accreditation, that is board involvement in initial approval of programs and collaboration with voluntary accrediting agencies for renewal of approval, showed increased interest for the future;
- boards of nursing were more interested in approval of basic nursing programs than advanced practice programs even though boards desire involvement in approval of standards for advanced practice;
- strong interests were expressed in National Council role related to information sharing, analysis of issues, facilitating core standards in nursing education and collaborating with other organizations; and
- moderate interest was expressed in the National Council becoming a DOE-recognized accrediting agency.

Terminology and Fees

A review of the survey findings revealed significant issues surrounding each of the major categories. The first section addressed terminology and fees. Most jurisdictions (N=60; 72.2 percent) reported use of the term *approval* to describe responsibilities related to nursing education programs. Eight individuals (9.6 percent) responded that the term *accreditation* only was used in the rules and regulations. Two respondents (2.4 percent) indicated that the terms *approval* and *accreditation* were used interchangeably. Seven individuals (8.4 percent) reported that *approval* and *accreditation* were used differently. Other terms were used to describe the approval/accreditation process according to four (4.8 percent) respondents. Similar findings were found with regard to terms used in the statutes.

Most boards do not charge a fee for initial approval or renewal of approval. When a fee is assessed, the range for initial approval is $50 to $250; for renewal of approval, from $30 to $200.

Basic Nursing Education Programs

The second major category of the survey instrument related to basic nursing education programs. The predominant model for approval/accreditation of nursing education programs was that the board of nursing grants initial approval and renews the approval/accreditation of nursing programs (N=66, 79.5 percent). A total of 7.2 percent (N=6) of respondents reported using the approach that the board of nursing grants initial approval and then accepts voluntary accreditation status from a recognized accrediting agency for continuing approval/accreditation. One individual (1.2 percent) reported that the board of nursing was not involved in the approval/accreditation process (1.2 percent). Six respondents (7.2 percent) indicated that another approach was used in approval/ accreditation of nursing education programs.

Jurisdictions were then requested to evaluate their approach to approval/accreditation (on a scale of zero to three with 0=ineffective; 1=somewhat effective; 2=effective; and 3=very effective) based on several indicators. Indicators were identified as public protection, promotion of quality in education, responsiveness to health care changes, responsiveness to innovation in education, cost to schools/jurisdictions, time efficiency for board, board staff time required for education program review and user-friendliness for nursing education programs. The range of responses was from zero to three. Mean values for each of the indicators reported by Member Boards are found in Figure 4.

Figure 4. Mean Average Related to Effectiveness of Approval Approach—Basic Nursing Education

Indicator	Mean
Public protection/accountability	2.49
Promotion of quality in education	2.36
Responsiveness to health care changes	2.09
Responsiveness to innovation in education	2.28
Cost to schools/jurisdictions	2.71
Time efficiency for board	2.27
Board staff time required for education program review	2.17
User-friendliness for nursing education program	2.49

Most state boards of nursing reported satisfaction with the approach used in approval/accreditation of nursing education programs. Eighty-nine percent (N=74) indicated that the approach used at the present time would continue to safeguard the public in the changing health care environment. Four respondents (4 percent) indicated that the present approach would not continue to meet the needs of the changing environment. Most respondents rated each of the indicators as effective to very effective. Boards believed that the approach used in their jurisdiction was very effective in terms of cost to schools and jurisdictions for approval/accreditation.

Responses were analyzed with respect to a jurisdiction's recognition by the DOE as a recognized accrediting agency. Most jurisdictions (N=73; 87.9 percent) reported that they were not recognized by the DOE. Ten respondents (12.1 percent) identified that the state board of nursing was DOE-recognized. Of the respondents affirming DOE recognition, the survey explored whether or not DOE recognition made a difference in the aforementioned indicators. A range of zero to three, from ineffective to very effective, was reported for each of the indicators. The range of means for each of the indicators was from 1.06 to 1.87. A limitation of these findings was the fact that few Member Boards hold DOE recognition and, thus, it is difficult to discern conclusions relative to the impact of this recognition on the indicators.

Information was gathered with regard to approval/accreditation needs of the future related to basic nursing education programs. Most jurisdictions reported that the board of nursing granting initial approval and renewing the approval of nursing education programs would meet the needs of the future (N=60; 72.2 percent). An increase from 7.2 percent (N=6) to 18 percent (N=15) was noted in the number of respondents that indicated that the board of nursing granting initial approval and then accepting nursing accreditation status from a recognized accrediting agency for continuing approval would meet future needs. Boards of nursing perceiving future needs by not being involved in approval/accreditation of nursing education programs was identified by 8 percent (N=4).

Redundancy in Process

Redundancy in the approval/accreditation process was explored as an issue. Most respondents (N=56; 67.4 percent) identified that redundancy existed in the approval/accreditation processes related to basic nursing education programs. Approximately 26 percent (N=22) indicated that redundancy did not exist within the state, region or nation in approval/accreditation. Specific areas of redundancy related to overlap between board and voluntary accreditation agency (N=54; 65 percent), overlap between board and other state agencies (N=1; 1.2 percent) and overlap between board and regional accreditation agencies (N=3; 3 percent). Redundancy related to overlap between board and voluntary accreditation agencies reflected the highest reported area of redundancy (N=54; 65 percent). Most Member Boards (N=55; 66.2 percent) reported that redundancy between the board of nursing and other approval/accrediting agencies was a desirable characteristic in providing a check-and-balance system for the approval accreditation process.

Standards

Standards related to basic nursing education programs were explored. Six percent (N=5) of the respondents felt that national standards only should be used in approval of nursing education programs. State and national standards should be used according to 56 percent (N=47) of respondents. State standards only should be used in approval/accreditation of nursing education programs, according to 31 percent (N=26) of respondents. Therefore, most boards reported that national and state standards were desirable in approval of basic nursing education programs.

The role of the various groups related to core state standards was assessed. Most respondents identified that boards of nursing have a significant role in input, review and approval of core state standards for basic nursing education. Significant input roles were identified for National Council, national nursing organizations, state nursing organizations, nurse educators, employers and consumers. In comparing the input role and the review role of various groups in core state standards, all groups reflected a decreased role in the review of core state standards when compared to input. The role of groups other than boards of nursing in approval of core state standards was perceived as limited (see Figure 5).

Figure 5. Role of Agencies in Core State Standards. N= 83.

	TYPE OF ROLE		
	Input	Review	Approval
☐ Boards of Nursing	64	60	76
☐ Other state regulatory agency please list:________	29	22	11
☐ National Council of State Boards of Nursing	54	30	6
☐ National nursing organizations	42	14	5
☐ State nursing organization	49	26	1
☐ Specialty nursing organizations	33	12	3
☐ Nurse educators	71	57	8
☐ Employers	64	35	4
☐ Consumers	62	31	4
☐ Other please list:________	8	6	3

The roles of groups related to core national standards were analyzed with regard to input, review and approval. Most groups were identified as having a significant input role in establishment of core national standards. Nurse educators, National Council, national nursing organizations, employers, consumers and boards of nursing were perceived as having the most significant role in establishment of core national standards. Review of core national standards was a significant role for state boards of nursing, National Council and nurse educators. Boards of nursing and National Council were perceived as having significant roles related to core national standards for basic nursing education programs (see Figure 6).

Figure 6. Role of Agencies in Core National Standards. N=83.

	TYPE OF ROLE		
	Input	Review	Approval
☐ Boards of Nursing	68	62	67
☐ Other state regulatory agency please list:__________	24	14	4
☐ National Council of State Boards of Nursing	63	55	47
☐ National nursing organizations	59	33	16
☐ State nursing organization	43	17	3
☐ Specialty nursing organizations	40	18	8
☐ Nurse educators	67	49	11
☐ Employers	59	31	3
☐ Consumers	59	27	2
☐ Other please list:__________	8	5	1

Uniform processes and procedures related to approval/accreditation of basic nursing education programs were explored. Of the boards responding, most respondents (N=41; 49.3 percent) supported uniform processes and procedures, while 25.3 percent (N=21) were opposed to uniform processes and procedures. A significant number of individuals did not respond to this question (N=21; 25.3 percent).

The relative importance of board of nursing involvement in approval/accreditation of nursing education programs was investigated. Each respondent was asked to evaluate whether or not board involvement in basic nursing education programs, registered nursing (RN) completion programs, master's degree programs and doctoral programs was essential. Most boards of nursing reported that board involvement in basic nursing education programs was very essential. Boards perceived it was somewhat essential to be involved in RN completion programs. Respondents reported that it was not as essential for boards to be involved in approval/accreditation of master's degree programs and doctoral programs (see Figure 7).

Figure 7. Importance of Board Involvement in Nursing Education Programs. N=83.

	not essential 0	somewhat essential 1	essential 2	very essential 3	*Mean*
Basic nursing education programs (PN, AD, BS, diploma)	2	2	6	63	2.78
RN completion programs	21	16	16	19	1.45
MSN programs	24	21	9	18	1.29
Doctoral programs	43	13	9	6	.69

Advanced Practice Nursing Programs

The third section of the needs assessment related to advanced practice nursing programs. The role of various agencies and organizations in the development of core state standards for advanced practice programs was reviewed. Significant roles were identified for boards of nursing, National Council, national and state nursing organizations, specialty nursing organizations, nurse educators, employers and consumers.

The role of organizations in development of core national standards for advanced practice programs was analyzed. With regard to input, significant organizations were identified as boards of nursing, National Council, national nursing organizations, specialty nursing organizations, nurse educators, employers and consumers. For review of core national standards, major agencies were identified as boards of nursing, National Council, national nursing organizations, specialty nursing organizations and nurse educators. Approval of core national standards was perceived as a significant role for boards of nursing and the National Council.

The future approval/accreditation needs related to advanced practice nursing programs was evaluated. The relative importance of board of nursing involvement in programs preparing nurse anesthetists, nurse midwives, nurse practitioners and clinical nurse specialists was evaluated. Most respondents reported that involvement in all advanced practice nursing programs was essential to very essential to meet the needs of the future (see Figure 8). It is noted that Member Board interest in approval/accreditation of advanced practice programs is less than that reported for basic nursing education programs. The rating scale reflected values of zero=nonessential to three=very essential.

Figure 8. Mean Values for Importance of Approval Related to Advanced Practice Nursing Programs

Advanced Practice Programs	Mean
Nurse Anesthetist	**1.95**
Nurse Midwife	**1.97**
Nurse Practitioner	**2.04**
Clinical Nurse Specialist	**1.81**

Uniform processes and procedures related to advanced practice nursing programs were reviewed. Most respondents reported that the use of uniform processes and procedures for approval/accreditation of advanced practice programs was desirable (N=53; 63.9 percent). Approximately 15 percent (N=13) reported that uniform processes and procedures were not desirable. A significant number of individuals (N=17; 20.4 percent) did not respond to the survey question.

Issues Related to Approval/Accreditation

The final section of the needs assessment related to issues surrounding approval/accreditation. Member Boards assessed the unique role of the board of nursing in approval/accreditation as compared to other groups. A unique role of the board of nursing was identified as public protection because of enforcement of standards without vested

interest. This unique responsibility was perceived as being carried out through establishment of curriculum criteria, evaluation of clinical agencies, accountability of nursing education programs for NCLEX® examination results, consultation on regulatory issues, approval of new nursing education programs, regulatory oversight for programs and monitoring compliance with standards, and renewal of approval.

Future Services by the National Council

Future services provided by National Council were explored with respect to approval/accreditation. Member Boards expressed strong support for National Council's role in sharing information about approval/accreditation issues and analyzing trends. Strong support was also identified for National Council facilitating core standards for use by boards of nursing in initial approval of nursing programs and renewing the approval of nursing education programs. Member Boards supported National Council facilitating core standards for advanced practice programs. Strong interest was identified for National Council development of an electronic format for survey reports as a service to jurisdictions. Moderate support was identified for National Council exploring the feasibility of becoming a recognized accrediting agency by the DOE as a service to boards of nursing. Member Boards also supported collaboration between the National Council with organizations and regional accrediting agencies. Moderate support was also expressed for developing a certification program for site visitors, assisting boards of nursing in survey visits and facilitating core standards for boards of nursing to evaluate voluntary accrediting agencies. Member Boards also were very interested in education programs for board staff or board members. Figure 9 provides a summary of future services.

Figure 9. Future Services of the National Council. N=83.

Types of Services		
Sharing information about approval/accreditation issues	71	85.54
Analyzing trends and issues in nursing education	72	86.74
Providing a service to assist the board of nursing in conducting approval/accreditation visits	21	25.30
Conducting education programs for board staff or board members related to survey visits	45	54.21
Developing a certification program for site visitors	29	34.93
Facilitating core standards for use by boards of nursing in the initial approval of nursing education programs	48	57.83
Facilitating core standards for use by boards of nursing in renewal of approval of nursing education programs	48	57.83
Facilitating core standards for boards of nursing to evaluate voluntary accrediting agencies	24	28.91
Collaborating with organizations in the development of approval/accreditation models	42	50.60
Collaborating with regional accrediting agencies (e.g., North Central Association)	30	36.14
Exploring the feasibility of the National Council becoming a recognized accrediting agency by the U.S. Department of Education as a service to those boards of nursing seeking a mechanism for national accreditation of nursing programs	31	37.34
Providing an electronic format for survey reports as a service to boards of nursing	37	44.57
No role	2	2.40
Other	1	1.20

Issues in Nursing Education

Significant regulatory issues surrounding nursing education were identified by respondents. These issues included: faculty qualifications, community-based care, distance learning, proliferation of practical nursing programs and emerging technologies in education. Additional questions were raised related to national standards for faculty qualifications, home health experiences, core competencies for community-based practice, review of model nurse practice act and rules and regulations in a changing health care environment, and the adequacy of one nursing license to meet the changing needs of health care delivery. These issues will be referred to the Nursing Practice & Education Committee and Nursing Education Planning Group for further review and analysis.

Attachment C

Findings of Member Board Needs Assessment

1. The terms *approval* and *accreditation* are used and interpreted differently among jurisdictions.
2. State boards of nursing indicated a need to continue in *initial* approval of nursing education programs.
3. Some state boards of nursing indicated interest in exploring alternative models for *continuing* approval of nursing education programs to decrease associated costs to state and reduce redundancy. Member Boards identified increased interest in approving basic nursing education programs as compared to advanced practice nursing programs.
4. Data are needed from all types of nursing education programs and external organizations with respect to approval/accreditation issues.
5. Member Boards expressed interest in uniform standards to be used in approval/accreditation of nursing education programs to promote mobility and consistency. State rights were expressed as a significant value in the development of standards.
6. Member Boards expressed moderate support for analyzing the implications of the National Council seeking recognition by the DOE as an approved accrediting agency.
7. Member Boards perceived *unique* functions of state boards of nursing with respect to their responsibilities in approval/accreditation of nursing education programs.
8. Member Boards expressed interest in education programs for board staff and board members who have direct responsibilities in approval/accreditation or serve as survey visitors.
9. Member Boards expressed moderate support for National Council collaborating with other organizations in development of approval/accreditation models.
10. Member Boards expressed strong support for the role of National Council in sharing information regarding approval/accreditation issues and the analysis of trends and issues in nursing education.

Based upon these findings, future activities have been identified by the subcommittee (see page 2 of the subcommittee's report for future activities).

Report of the Subcommittee to Revise Model Act and Rules

Committee Members
Toma Nisbet, WY, Area I, *Chair*
JoAnn Allison, NH, Area IV
Nathan Goldman, KY, Area III
Rita Pobanz, OH, Area II

Staff
Vickie Sheets, *Director for Practice and Accountability*

Relationship to Organization Plan
Goal II.................Provide information, analyses, and standards regarding the regulation of nursing practice.
Objective B.........Provide resources regarding health care issues which affect the regulation of nursing practice.

Recommendations to the Nursing Practice and Education Committee
1. **That the Board provides feedback regarding the framework developed for addressing each topical area for inclusion in the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*, the principles that have guided the subcommittee's work, and the subcommittee's plan for obtaining additional feedback at the 1997 Annual Meeting.**

Rationale
The subcommittee members approached their assignment to begin model revision with the recognition that the models provide an opportunity to synthesize much of the work of the National Council in the past few years into a congruent view of regulation, encompassing all the major elements that comprise nursing regulation. The subcommittee recognized the need to collaborate with other committees, Board of Directors and other National Council groups to assure that the models reflect a comprehensive, accurate and timely approach to nursing regulation. The framework developed by the subcommittee was a means to assure that certain basic considerations provide the foundation for each topical area of the models. The subcommittee also recognized a need to provide information about how things are currently approached by boards as well as suggesting desired elements for future regulation. The framework was piloted by the subcommittee focusing on the nursing education program approval and identifying the future direction for its work, with the intent of developing actual proposed language next year. The subcommittee also considered Member Boards' needs regarding models and devised an electronic format that is expected to address multiple requests and provide a rich source of regulatory information that will support Member Boards as they enforce nursing regulation across the country.

Background
The National Council's *Model Nursing Practice Act* and *Model Nursing Administrative Rules* were one of the first projects undertaken by the new organization in the late 1970s. Under a grant from the Kellogg Foundation, these documents were developed and approved (the model act in 1982 and the model rules in 1983). The first revision of the models occurred in 1988, the models were again scrutinized in 1992 and 1993. There has developed a pattern of revisiting the models every five years to assure that they are current and meet the needs of the Member Boards.

Again in 1997, the traditional five-year review of the models was undertaken. However, it seemed short-sighted to complete a major revision of the models before the Multistate Regulation Task Force completed its work, made recommendations and a position regarding multistate practice was adopted by the Delegate Assembly. Therefore, the Subcommittee to Revise Model Act and Rules was directed to begin the revision project by focusing on the content of nursing education approval.

Highlights of Activities

- **Review of current statutes addressing nursing education program approval**

The subcommittee completed a review of current language in Member Board Nursing Practice Acts as well as review of the current model language.

- **Identification of key topics and groups for collaboration**

The subcommittee members recognized that significant work in a number of topical areas has been completed by National Council committees and Member Boards in the past few years. The subcommittee members see a large part of their work as synthesizing previous National Council content, developing a workable framework for congruency and developing models as resources that meet a variety of Member Board needs. To that end, the subcommittee identified key topics for inclusion and groups for collaboration within the organization. Examples of key topics for inclusion in the models are continued competence, uniform requirements, chemical dependency alternative programs, boundary violations and professional sexual misconduct, delegation, other unlicensed assistive personnel issues and professional accountability.

In addition, the subcommittee conducted an e-mail survey regarding Member Board use and suggestions for the models.

- **Development of framework for model development**

The subcommittee developed a framework for model development to assure that each conceptual area of the models will be based on a foundation of articulated purpose and guiding principles (Attachment A). The subcommittee determined that an exploration of the context within which the models would be used and identification of concepts related to process and outcomes would be informative. The subcommittee wanted to include elements used in current Nursing Practice Acts (to reflect current use of regulatory language), as well as desired elements to provide flexibility and future direction.

- **Identification of content for nursing education program approval**

The subcommittee was specifically directed to focus on nursing education content in FY97. The subcommittee applied the framework for model development to present content for nursing education approval (Attachment B).

- **Identification of new format for revised models**

The Subcommittee to Revise Model Act and Rules received suggestions for the models ranging from "keep them the same" to "an outline of broad concepts" to "different approaches to choose from, with lots of example language." To meet the needs of many on such a broad continuum of needs was challenging. A notebook approach was considered, with dividers for each major topic. The subcommittee determined an innovative approach to models by developing the concept of an electronic loose-leaf notebook. Each conceptual model area would be tabbed and include a range of information and resources. A user manual would be developed and each board would be provided a copy. A computerized presentation would allow Member Boards easy access and the ability to download all or parts of the models. Sections could be updated as needed, rather than waiting several years for revision. It would provide quality assurance because the master copy would have access for changing limited to authorized National Council staff, but the up-to-date master copy would always be available to Member Boards. The electronic format is expected to address multiple requests and provide a rich source of regulatory information that will support Member Boards in regulating nursing practice. User guides would be developed to share with Member Boards to promote their interest and use of the resource. The computerized format would allow dissemination of this resource to an audience beyond the boards of nursing.

A mock home page for the models to reside will be presented at a Annual Meeting forum. Feedback will be requested regarding whether or not the contemplated format is useful and useable and if it would meet Member Board needs.

The following outline for content was developed:

1. Introduction and suggestions for use
2. Definitions/glossary
3. Powers and authority of board
4. Conceptual outline and visual model/diagram
5. *Model Nursing Practice Act* (NPA) language for the identified topic

6. Relevant caselaw
7. *Model Nursing Administrative Rules*
8. Rationale for rules
9. Side-by-side presentation of Model NPA and Model Rules
10. Education approval (same topics as identified under Category III)
11. Licensure (same topics as identified under Category III)
12. Discipline (same topics as identified under Category III)

Future Activities

- Presentation of a "mock" model home page in a forum at 1997 Annual Meeting.
- Continued model development is planned for FY98 and will incorporate any direction or decisions regarding multistate practice. The subcommittee recommends that, once a draft of the proposed language is prepared, feedback be sought from Member Boards and other interested groups.

Meeting Dates

- February 23-25, 1997
- April 6-8, 1997

Recommendations to the Board of Directors

1. That the Board provides feedback regarding the framework developed for addressing each topical area for inclusion in the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*, the principles that have guided the subcommittee's work, and the subcommittee's plan for obtaining additional feedback at the 1997 Annual Meeting.

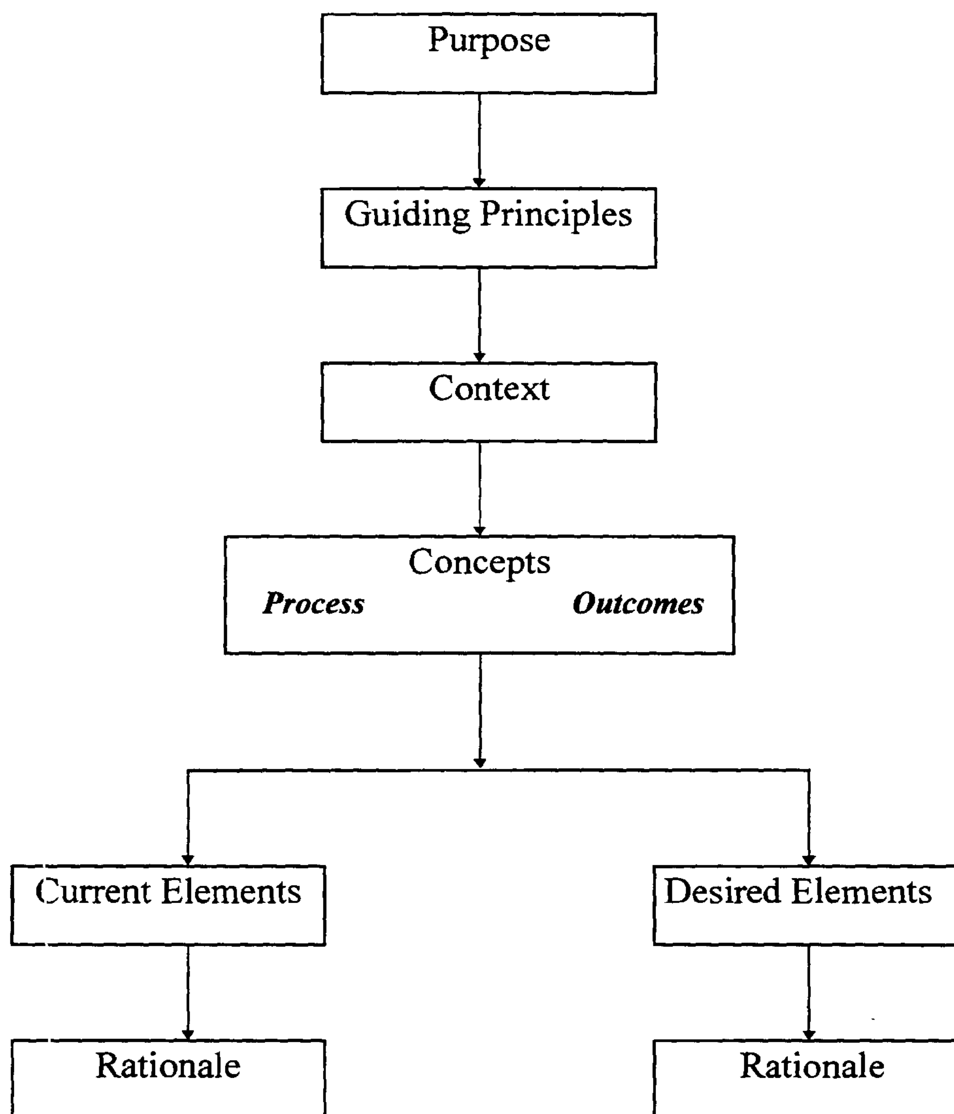
Attachments

A .... Framework for Model Development, *page 35*
B .... Worksheet for Model Development, Topic #1 – Nursing Education, *page 37*

Attachment A

Framework for Model Development

Each conceptual topic will be developed as indicated below. These topics include: powers and authority of board, definitions, education program approval, licensure, discipline, exemptions/exceptions and special topics.



Attachment B

Worksheet for Model Development
Topic #1 - Nursing Education

Purpose

To assure that the public is protected from the unauthorized, unqualified practice of nursing, nursing education programs are required to meet the essential criteria identified by the boards of nursing. Such criteria set standards so that:

- consumers (the patients receiving nursing care through student practice) are assured of safe student-provided nursing care;
- students being educated are assured of access to the educational opportunities necessary to prepare them to apply for entry into nursing practice through licensure at a designated level; and
- consumers (the patients who are the recipients of nursing care from nurses prepared in the nursing education program) are assured of safe nursing care.

Guiding Principles

Model Nursing Practice Act /Administrative Rules for nursing education programs shall:

1. promote public safety in an ever-changing health care environment;
2. allow for multiple entry/exit points on the continuum of nursing education;
3. affirm that lifelong learning is essential for safe practice (as reflected in a nurse's Personal Accountability Profile, or PAP, as recommended by the Nursing Practice & Education Committee);
4. recognize the increasing diversity in the student population; and
5. accommodate the increasing variety of traditional and nontraditional clinical sites and educational processes while still maintaining essential standards for effective nursing education.

Context

- Environmental factors
- Changes in technology
- Exploding information and knowledge
- Cultural diversity among patient and provider populations
- Integrated systems and organizational structure
- Interdisciplinary demands and interdisciplinary opportunities (partnering)
- Consumer needs and wants
- Need for professionals to develop the ability to recognize current and desired levels of competence, the value of competence, and to identify personal practice boundaries in consideration of personal competence and client safety

Concepts

Process – Nursing education provides:

- access to knowledge and principles;
- access to skill development, including critical thinking;
- access to opportunities to apply knowledge, skills, abilities (KSAs) and decision making;
- access to opportunities for values clarification, role modeling and the development of professional accountability and competence; and
- access to clinical opportunities to apply what has been learned.

Concepts

Outcomes – Nursing education produces graduates who:

- possess nursing KSAs;
- are able to apply KSAs and critical thinking at a novice level;
- have developed the values foundation necessary for professional accountability and continued competence;
- are able to use written and human resources to find, validate and use information to meet client needs; and
- are able to practice within ethical and legal parameters.

Model Content for Nursing Education Program Approval

Those elements needed today by boards of nursing (as determined by review of current statutes).

Current Elements	Rationale
1. **Authority to promulgate rules/regulations pertaining to nursing education program approval**	Authority to promulgate rules/regulations pertaining to nursing education provides boards the opportunity to protect the public through the interpretation, clarification and operationalization of the authority to regulate nursing education programs. State nursing program approval provides the opportunity for objective board evaluators to view the program with new eyes, thus providing checks and balances to assure that the program produces nurses capable of providing safe nursing care, and also that the needs of the student consumer and patients receiving nursing care from students are met. The board also provides an available, independent and objective forum for consideration of concerns regarding nursing education programs.
	Comment: Boards of nursing vary in the organization and format of practice acts and rules. Some jurisdictions address authority to promulgate rules under the power and authority of the board; others reference within specific content areas addressed by the statute.
2. **Determine standards for nursing education**	Authority to develop standards for educational programs provides boards a means for determining the parameters within which jurisdictional educational programs function. It assures a level of consistency between programs so that students obtain at least minimal educational content and learning opportunities from all programs, thus addressing the informational asymmetry encountered by the consumer student who is making decisions regarding education. This provides protection for the students as consumers of education.
	Comment: Boards of nursing vary in the organization and format of practice acts and rules. Some jurisdictions address authority to promulgate rules under the power and authority of the board; others reference within specific content areas addressed by the statute.
3. **Approve nursing education program curricula**	Authority to approve curricula allows boards to specify content or other curriculum requirements for nursing education programs. It assures a level of consistency between programs so that students obtain at least minimal educational content and learning opportunities from all jurisdictional programs. This assures the public that nurses prepared by a program have been educated in the essential elements of nursing needed for safe nursing care. It also addresses the informational asymmetry encountered by the consumer student who is making decisions regarding education. The student consumer of education is assured that sufficient opportunities for learning are in place, with the breadth and depth of content needed to prepare them at the selected nursing level.

4. **Survey nursing education programs**	Authority to survey schools allows boards access to the school setting, resources, students and faculty to review the operation of the program, thus providing additional sources of review information. Monitoring and evaluative tools also afford opportunities for improvement to the educational programs.
5. **Approve nursing education programs**	Authority to approve programs is granted the majority of boards of nursing. In addition to providing information to the consumer student choosing an educational program, approval authority reflects the history of nursing board involvement with nursing programs not affiliated with educational institutions. Nursing is an applied science, where clinical learning is obtained by caring for real patients, with real problems and needs. Boards of nursing provide objective "second eyes" to assure that the needs of consumers for nursing care and the needs of students for learning opportunities are provided in a safe and supervised environment. With the authority to approve programs comes the authority to rescind approval. This authority safeguards consumers and students: programs that cannot meet the standards and requirements for safe nursing practice are prevented from operating.
6. **Maintain listing of approved nursing education programs**	The authority to maintain a list of approved nursing programs is a service to consumer students and others looking for information regarding nursing education.
7. **Recognize national accrediting agencies**	Some boards of nursing use the accreditation reports of other agencies, particularly for ongoing review and approval. State may be authorized to recognize the accreditation of agencies which meet identified requirements.
	Comment: Some state boards of nursing are approved by the U.S. Department of Education as accreditation bodies.
8. **Collect data**	Most boards of nursing are directed to collect and maintain various types of data.
	Comment: Boards of nursing vary in the organization and format of practice acts and rules. Some jurisdictions address directives regarding activities such as data collection under general powers and authority of the board; others may address such requirements under specific topical areas.
9. **Conduct studies and research**	Boards of nursing are often directed to conduct studies and research related to nursing.
	Comment: Boards of nursing vary in the organization and format of practice acts and rules. Some jurisdictions address directives regarding activities such as data collection under general powers and authority of the board; others may address such requirements under specific topical areas.

10. **Consult**	Boards often consult with nursing education programs (either formally or informally, depending upon whether directed to consult by the legislature, or consulting as a means of implementing program approval activities). Consultation can promote the understanding of requirements and alert boards to specific issues and problems encountered by a particular program as well as ongoing trends and issues related to nursing education.

Development of Desired Elements

This table was designed to illustrate how key elements of education may be expected to change over the next few years.

Here and Now	Vision for Future
■ Knowledge/principles	■ Great increase in the availability of information, knowledge; emphasis needed on principles and application in multiple settings, situations ■ Also need time management, work redesign, preparation for intensity of work, organizational/ systems theory
■ Access to skills	■ Skill – mostly simulated, through lab
■ Development of professional accountability informal, less emphasis in curriculum, more reliant on expertise of faculty to incorporate into clinical experiences, etc.	■ Need greater for values clarification, role development, professional accountability foundations
■ Clinical opportunities more available	■ Fewer clinical opportunities ■ Limited settings ■ Need for an additional experiential component to better prepare nursing graduates for the reality of the health care environment. Possible approaches identified to provide that additional experience include intern/extern programs and structured mentor/preceptor programs.

Model Content for Nursing Education Program Approval – Desired Elements

This section discusses the "what could be" – future-oriented components designed to stimulate thought about the future of nursing education and regulation.

The presentation of major concepts and a blueprint format is an approach designed to concentrate on those most important elements needed to prepare an individual for nursing licensure. A blueprint approach may assist boards to avoid the temptation to micro-manage educational programs through the development of detailed, prescriptive requirements.

Desired Elements	Rationale
1. **Glossary of terms**	Any work that can contribute to creating a more uniform use of language pertaining to regulation is desirable. This was one of the areas identified by the Pew Task Force.
2. **Authority to promulgate rules**	This authority is critical to allow the board of nursing to interpret, clarify and operationalize the regulatory activity. Rules and regulations must be congruent with the law.
3. **Determine standards for nursing education programs**	Flexibility – with minimal mandatory requirements for approving curricula, conducting surveys, maintaining lists of approved schools, collecting data, conducting studies – moving away from detailed requirements allows programs to be creative in their approaches to educational experiences for students. Boards could also be creative in the approaches identified to survey and evaluate nursing education programs. The intent is for the board of nursing to provide broad parameters for the educational program to work within and guidelines as to what elements the board views as critical and essential. The actual "how to" would be left to the schools in dialogue and communication with the board.
4. **Identify the role and benefits of board of nursing involvement in nursing education program approval**	Boards of nursing are unique in the role that boards play in nursing education. This reflects nursing's history of schools located in hospitals rather than educational institutions. This also is related to the fact that nursing students learn with real patients, with real problems, in real-life situations. But, perhaps the most important reason that boards continued to be involved with program approval is the lack of consistency in the prerequisite education to prepare an individual for nursing licensure. There are four separate degrees that lead to an individual being allowed to sit for the NCLEX-RN® examination. There is also great variation in licensed practical/vocational nursing educational programs. There is a need for an objective body with broad overview to identify the common elements of those programs that prepare an individual for licensure and to participate in the creation of an examination to test those candidates.
5. **Outcomes of nursing education**	This requires careful articulation of what are the desired outcomes. More work will be required to assure that important aspects of nursing care, such as client outcomes and satisfaction, are included.

	Comment: Nursing is largely a process profession, so for some aspects of nursing, the process is an outcome. (For example, a nurse cannot decide that today "I am going to change this client's life by talking about his problems and concerns"; rather, that nurse must provide the process by which this may happen – providing privacy, being alert to particular clues, presenting information at optimal time for learning, etc.)
6. **Consult**	If boards are less prescriptive in their requirements, then they will need to be prepared to communicate proactively with educational programs, so that programs will use the increased flexibility and ask for assistance in improving nursing education. This will require both parties to operate differently than in the past – more proactive consultation, less reaction. How the transition period, moving from highly prescribed to a more general blueprint approach, is conducted will be key to the success of the flexible approach.

Report of the Finance Committee

Committee Members
Charlene Kelly, NE, Area II, *Treasurer and Chair*
Lorinda Inman, IA, Area II
Barbara Morvant, LA-RN, Area III
Ellen Toker, PA, Area IV
Jerry Walker, HI, Area I

Staff
Jennifer Bosma, *Executive Director*
Thomas Vicek, *Director of Administrative Services*

Relationship to Organization Plan
Goal V................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective B..........Maintain a sound resource management system for the National Council.

Recommendations to the Board of Directors
1. **That the NCLEX® candidate fee be set at $120 from October 1, 1999, to September 30, 2002.**

   Rationale

   With regard to the National Council's portion of the fee, the committee considered three pricing models and recommended the one which projected a $39 amount to fund continued additions and enhancements to Member Board services as historically experienced. Further, the committee recommended an additional $3 be added to the National Council portion of the fee to allow for candidate volume to fall somewhat below the 150,000 per year level used in the various pricing models. Candidate volume, which has a major effect on National Council costs and revenue, was based on a survey of nursing education program graduation projections through the 1998-99 academic year. Actual 1995-96 candidates and the 1997 through 1999 projections reflect four straight years of declining candidate volume. With regard to the Chauncey Group International portion of the fee, the committee supported the negotiated price of $78, which would be the per candidate payment to the Chauncey Group at a 150,000 candidate volume level.

2. **Recommended FY98 operating and capital expenditure budgets.**

3. **Recommended Richmond Capital Management, Inc., as the firm to manage the fixed income portion of the investment portfolio.**

4. **Recommended use of an index fund for the common stock portion of the portfolio.**

5. **Recommendations are made throughout the year to the Board of Directors regarding the impact of proposed activities.**

Highlights of Activities
- Reviewed the quarterly financial statements and recommended their approval to the Board of Directors.
- Reviewed data from candidate projection research study and adjustments to improve accuracy of the study, and recommended that the Board make adjustments in the current year budget and financial forecasts based on the study.
- Met with the auditors from Ernst & Young, and reviewed the audited 1996 financial statements and management letter.
- Reviewed the fiscal impact of continuing National Council support of computer hardware and Internet access for Member Boards.

- Monitored insurance coverage, investments, all expenditures more than $15,000 and financial policies.

Meeting Dates

- October 29, 1996
- January 17, 1997
- May 6, 1997
- August 7-8, 1997

Recommendations to the Board of Directors

1. That the NCLEX candidate fee be set at $120 from October 1, 1999, to September 30, 2002.

2. Recommended FY98 operating and capital expenditure budgets.

3. Recommended Richmond Capital Management, Inc., as the firm to manage the fixed income portion of the investment portfolio.

4. Recommended use of an index fund for the common stock portion of the portfolio.

5. Recommendations are made throughout the year to the Board of Directors regarding the impact of proposed activities.

Board of Directors Report

Board Members

Tom Neumann, WI, President
Margaret Howard, NJ, Vice-President
Charlene Kelly, NE, Treasurer
Joey Ridenour, AZ, Area I Director
Linda Seppanen, MN, Area II Director
Nancy Durrett, VA, Area III Director
Marie Hilliard, CT, Area IV Director *(through December 1996)*
Anna Yoder, MA, Area IV Director *(beginning January 1997)*, Director-at-Large *(through December 1996)*
Laura Poe, UT, Director-at-Large
Gregory Howard, AL, Director-at-Large *(beginning January 1997)*

Staff

Jennifer Bosma, *Executive Director*
Doris Nay, *Associate Executive Director*

Relationship to Organization Plan

The Board of Directors is responsible for oversight of all tactics to accomplish the Organization Plan under its bylaws duty to supervise the affairs of the National Council between the meetings of the Delegate Assembly. Additionally, the Board bears unique responsibility in several specific areas, as follows:

Goal IV ....Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective C ....Facilitate communication between National Council, Member Boards, and related entities.

Goal V.................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective C ....Maintain a system of governance for the National Council that facilitates leadership and decision-making.
Objective E ....Develop and implement a systematic approach for shaping health care policy related to regulation.

Recommendations to the Delegate Assembly

1. **That the Delegate Assembly adopts the amendment to Article V, Section 2 of the Bylaws, Election of Officers.**

   #### *Rationale*

   This amendment was proposed by the Elections Committee. The amendment and the rationale are found behind the Bylaws tab. The Board of Directors supports the recommendation which clarifies the process and provides an opportunity for the delegates to express their preference.

2. **That the Delegate Assembly adopts the amendment to Article V, Section 1.c. of the Bylaws, Elections.**

   #### *Rationale*

   This amendment was proposed by the Committee on Nominations. The Board of Directors supports the recommendation as a preferred means of identifying a chairperson for the committee.

3. **That the Delegate Assembly adopts the amendment to Article X, Section 1.a. of the Bylaws, Examination Committee.**

Rationale

This amendment was proposed by the Examination Committee. The Board of Directors supports the recommendation as a structure which will expedite the work of the committee and relieve some of the excessive workload experienced in recent years.

4. **That the mission of the National Council be revised to read: "The mission of the National Council of State Boards of Nursing is to lead in nursing regulation by assisting Member Boards, collectively and individually, to promote safe and effective nursing practice in the interest of protecting public health and welfare."**

Rationale

The proposed mission makes clear what the organization does, who it serves, and what are its underlying beliefs. It is congruent with the purpose statements found in the bylaws and articles of incorporation, which emphasize boards of nursing acting together on matters of common concern affecting public health, safety and welfare.

5. **That the wording of Organization Plan objectives be modified to read as follows:**
I.H. Provide a comprehensive approach to assessing continued competence.
II.A. Analyze the environment for trends and issues affecting the regulation of nursing practice.
III.A. Analyze the environment for trends and issues affecting the regulation of nursing education.

Rationale

Objective I.H. currently states, "Identify the role of a board of nursing related to continued competence." The Board believes that the organization has, in adopting the 1996 position statement, moved beyond identification of role and progressed to a stage more aptly described by the proposed wording. Objectives II.A. and III.A. currently include the modifier "health care" before "environment." The Board believes that there are other aspects of the environment (e.g., the regulatory community, technological developments) which may also affect the regulation of nursing practice and education, and thus suggests deleting the limiting modifier in these two objectives.

6. **That the Chauncey Group International be selected as the NCLEX® examination test service for the period October 1, 1999, through September 30, 2002, according to the terms and conditions negotiated by the Negotiating Team (reported behind Tab 10-N).**

Rationale

The Board of Directors believes that the terms and conditions negotiated with Chauncey are responsive to the evaluation of Chauncey's services carried out last year. The continuation of the same services which have proven very satisfactory for the past three-plus years, with the addition of clear performance standards in key areas, will provide the quality examination program which Member Boards and candidates expect.

7. **That the NCLEX examination candidate fee be set at $120, from October 1, 1999, to September 30, 2002.**

Rationale

The proposed candidate fee incorporates the price negotiated with the Chauncey Group International and a portion for the National Council. At the 150,000 annual candidate volume projected for FY99, the National Council will pay Chauncey $78 for each candidate; however, if the volume falls below 150,000, the National Council will pay Chauncey $80.80 for each candidate. The National Council portion was projected by the Finance Committee to be $39 per candidate, to accommodate additions and enhancements to services as historically experienced. (See the Finance Committee report behind Tab 9 for further information on the projection of the National Council portion.) The $120 fee recommendation, supported by the Finance Committee, adds the $78 for Chauncey and $39 to support National Council services to Member Boards; additionally, the Board voted that: 1) candidates would likely be more accurate in submitting a $120 than a $117 payment, and 2) a $3 contingency sum also was recommended by the Finance Committee in case the

volume would fall below 150,000 later in the contract. The $120 fee would be reflected in the standard Member Board contract for the next renewal following this fall's, i.e., to take effect October 1, 1999.

8. **That the Member Board contract include the following language to facilitate the provision of an electronic licensure verification information system (ELVIS) for Member Board use:**

   Paragraph 10 (new language in italics): Council Use of Candidate Data: [Member] Board hereby authorizes Council to use any and all candidate data collected for the *purposes of (1) administering the nurse licensure examinations, including but not limited to,* identifying candidates approved for the examination, determining their status as first-time, repeat and/or multiple application candidates, *preparing the examination results related to the validity and psychometric integrity of the nurse licensure examinations, and (2) developing and maintaining a comprehensive national data bank of information on nurse licensees for use by Member Boards of the Council in evaluating applicants for endorsement, in monitoring disciplinary actions and in any other licensing-related actions authorized by applicable state and federal law. Candidate data collected hereunder shall not be disseminated to parties other than the Member Boards or used for other purposes without prior approval by the Member Board.*

Rationale

The Licensure Verification Task Force has worked to carry out the charge from the 1996 Delegate Assembly to move toward full development of an electronic licensure verification system, including a fee payment mechanism. Particulars of implementation plans are described in its report behind Tab 10-M. The proposed contract amendment makes provision for data to be infused into the database from NCLEX examination applicant files. If adopted by the Delegate Assembly, the language will be part of the standard contract offered to each jurisdiction this fall, extending through September 30, 1999.

Comments on Recommendations from Standing Committees

1. The Board supports the recommendation of the Examination Committee for the adoption of the proposed *NCLEX-RN® Test Plan.*
2. The Board supports the recommendation of the Nursing Practice & Education Committee for the adoption of the position paper on terminology related to *approval* and *accreditation.*

Highlights of Activities

Goal I. Licensure and Credentialing

- **NCLEX Examinations**

The Board of Directors has provided feedback to the Examination Committee on the proposed *NCLEX-RN® Test Plan* revisions, and supports the Examination Committee's recommendations. In response to a recommendation by the Examination Committee, prompted by the failure of certain test sites operated by Educational Testing Service to meet specifications, the Board required that testing cease until the sites are brought up to specifications. The Board concurred with the Licensure Examination Comparison Task Force that the completion of its project, comparing the Canadian and NCLEX licensure examination should be deferred to next year.

- **Computerized Clinical Simulation Testing (CST®)**

The Board adopted the recommendation of the CST Task Force regarding the selection of Member Boards to implement their proposed studies on regulatory uses of CST for education and evaluation.

- **Advanced Practice Registered Nurses (APRNs)**

With regard to regulation of APRNs, the Board of Directors approved the curriculum guidelines and regulatory evaluation criteria, as developed through the Family Nurse Practitioner Pharmacotherapeutics and Prescriptive Privileges Project funded by the Division of Nursing.

The Board also continued to monitor the progress of certifying organizations for nurse practitioners in demonstrating the appropriateness of their examinations for regulatory uses. All organizations have made significant progress, though not all have completed the third-party review and reporting process.

The American Nurses Credentialing Center (ANCC) underwent a review by mutually-agreed-upon consultants in summer 1996. The ANCC has responded to the recommendations in that report with a plan of actions, and has

provided quarterly updates to the National Council on progress. The ANCC has also submitted to review by the National Commission on Certifying Agencies (NCCA), supplemented by criteria requested by the National Council, but has not yet met all requirements for accreditation. It has committed to pursuing the process.

The National Certification Board for Pediatric Nurse Practitioners and Nurses (NCBPNP/N), the American Academy of Nurse Practitioners (AANP) and the National Certification Corporation (NCC) for the Obstetric, Gynecologic and Neonatal Nursing Specialties submitted to NCCA review, attained accreditation and forwarded to the National Council reports on the NCCA criteria and the supplemental criteria specified by the National Council, thus completing the agreed-upon process. The reports state that all criteria are substantially met.

The Board has endorsed a recommendation by the APRN Task Force to institute an annual reporting mechanism for organizations certifying APRNs to assure that current information is readily available to Member Boards concerning APRN examination and certification programs, and any changes related to the criteria for evaluating regulatory sufficiency.

In terms of coordination with the Multistate Regulation Task Force's work, the Board reviewed and responded to the APRN Task Force's draft uniform licensure requirements, and also concurred with the APRN Task Force's request that consideration be given to including APRNs in the model for multistate practice being proposed by the Multistate Regulation Task Force.

■ **Unlicensed Assistive Personnel**

The Board requested staff to gather additional information related to the regulation of Unlicensed Assistive Personnel (UAPs). As Member Boards continued, at the Area Meetings, to express needs related to information and regulatory strategies in this area, the Board focused resources on research on nurse aides and other types of UAPs for FY98. In addition, the Board provided guidance and feedback throughout the year at the request of the UAP Task Force.

Goal II. Nursing Practice

The Board provided direction throughout the year to staff regarding issues related to the federal government's involvement in activities related to discipline: the implementation of the provisions requiring boards of nursing to report to the National Practitioner Data Bank, the possibility of access to criminal background data, and the sharing of disciplinary data with certifying organizations.

Throughout the year, the Board provided guidance and feedback, as requested by the Nursing Practice and Education Committee, Subcommittee to Revise Model Act and Rules, and the Discipline Modules Task Force.

Goal III. Nursing Education

The Board provided direction to the Subcommittee on Approval/Accreditation regarding performing an assessment of Member Boards' needs regarding approval/accreditation, but waiting until a later date to survey other organizations. The Board approved the recommendation that the National Council host a roundtable discussion of involved players during FY98. The Board of Directors has encouraged the committee and staff throughout the year to monitor and actively maintain contact with initiatives related to accreditation, such as the National League for Nursing Accreditation Commission, the American Association of Colleges of Nursing alliance and the accreditation project sponsored by the University of California at San Francisco, Center for the Health Professions.

The Board directed and approved the development of an *Emerging Issues* on developments related to nursing education accreditation and approval.

Goal IV. Information

■ **Meetings**

The Board identified the goals and benefits of Area and Annual Meetings to Member Boards and to the organization, and developed suggestions to respond to concerns expressed on attendee evaluations. The schedule of meeting every third year in Chicago was altered so that Annual Meetings in the future will be rotated among Areas as follows: I (1998), III (1999), II (2000), IV (2001). Directors-at-Large will be funded to attend Area Meetings beginning in FY98 to represent the Board of Directors and be responsive to Member Boards.

■ **Educational Offerings**

The Board approved the proposed calendar of activities of the Institute for the Promotion of Regulatory Excellence for FY98. As 1997 activities under the Institute's auspices, the Board approved a public policy conference in conjunction with the workshop on multistate regulation, and a day of dialogue on discipline just prior to the 1997 Annual Meeting. The board has deferred a decision on the Institute Task Force's recommendation regarding the 1998 Regulatory Day of Dialogue, pending a complete review of 1997 Area Meeting attendees' evaluations.

■ **Communications**

In response to recommendations of the Communications Evaluation Task Force, the Board approved and directed that committees and staff use the Communications Evaluation Process Matrix to evaluate National Council's communications products on a regular basis. The Board also agreed to convene a similar task force on a triennial basis.

■ **Computer Services**

In response to requests by Member Boards at Area Meetings, the Board has directed staff to perform a survey to determine which licensure/monitoring software vendors are currently being used by Member Boards, and to invite vendors to exhibit at the 1997 (and 1998) Annual Meetings. The Board provided the resources to upgrade hardware and software for the NCNET computers in Member Board offices during the past year, thereby increasing hard drive size and speed, transitioning all computers to a Windows 95 operating environment, providing unlimited Internet access accounts to each Member Board, and establishing NCNET as a secure Member Board-only Intranet service. The Board has determined that with increasing computing capabilities on the state level, by 2002 it aims to discontinue providing hardware support directly and automatically to Member Boards; software support will, however, be continued indefinitely.

■ **Licensure Verification**

With respect to licensure verification, the Board has provided feedback to the Licensure Verification Task Force throughout the year on the development of the Nurse Information System database to support the electronic licensure verification information system (ELVIS). The Board determined that the recovery of developmental costs may take place over an extended time period, in order to keep the cost of the service to candidates as low as possible. The Board has also concurred with the selection of one preferred fee payment model, but allowing latitude for other models to fit unique needs of individual jurisdictions. Finally, the Board strongly supports the concept that the licensure verification service will only be of value if the database is as complete as possible, and thus has endorsed the use of NCLEX examination application data for building the database. A statement to be added to the NCLEX candidate bulletin, as well as other appropriate NCLEX documents, has been approved.

In view of changes being voted on by the 1997 Delegate Assembly with regard to Member Board contract provisions, the Board of Directors approved the offer to extend the current Member Board contracts, under the same terms and conditions, through March 31, 1998. This should allow ample time for contracts to be disseminated to each Member Board following the Delegate Assembly action, and to complete the state processing for approval prior to expiration. The Board also agreed to offer to any Member Board that so desired, an option to add "prepaid travel expenses" for National Council meetings to its contract.

Goal V. Organization

■ **Organizational Planning**

At a retreat on November 13, the Board; Long Range Planning Task Force; chairs of the Examination, Nursing Practice & Education, and Multistate Regulation committees; and senior staff were led by Dr. Jamie Orlikoff in consideration of the foundations for long range planning (also known as "strategic decision-making"). The first issue addressed was the mission statement, which revealed a disparity between existing statements of purpose and the mission. Over the next several meetings, the Board, with the assistance of the Long Range Planning Task Force, developed a revision of the mission statement which was presented for discussion at the Area Meetings. Following input from the Area Meetings, the Board invited Dr. Orlikoff to its May meeting for a follow-up session. Further modifications to the proposed revised mission statement clarified the nature and order of the organization's current

priorities. The Board also adopted a role statement which can be appended to the mission statement when further elaboration is appropriate:

The role of the National Council of State Boards of Nursing is to serve as a consultant, liaison, advocate, and researcher to Member Boards, and as an education-information resource to the public and policy makers.

As a complement to the discussion of mission ("who we are"), the Board also considered the organization's vision ("who we want to be beyond three to five years from now"). The Board adopted the following statement as an expression of its vision for the organization's future:

The National Council of State Boards of Nursing will advance optimal health outcomes by leading in health care regulation worldwide.

The Board has made a commitment to work toward devoting 80 percent of its time at each meeting to its unique role of planning and strategic decision-making, and not more than 20 percent to monitoring committee and staff activities. This year, the Board has begun to accomplish this goal by instituting a substantial "environmental updates" time at the beginning of each meeting at which board members and staff identify and evaluate implications of developments in areas related to nursing practice, education, government, and other organizations related to nursing regulation. The board plans to decrease monitoring time by implementing new guidelines and operating principles which increase the autonomy and responsibility of committees for accomplishing their charges. Work on the elements of a three-year long-range plan will continue at the Board's fall retreat.

Following the drafting of tactics to accomplish the Organization Plan in FY98 by the Long Range Planning Task Force, Research Advisory Panel chair and senior staff, the Board directed that committee chairs be asked to provide input on prioritization of the tactics. At its May meeting, the Board used this input to eliminate some tactics and rate the importance of the rest, to serve as guidance for the development of the budget and work plans for FY98.

■ **Board Competencies**

The Board requested research to identify necessary competencies for members of the Board of Directors. A delphi study involving present and past members of the Board of Directors was undertaken and resulted in the identification of six competency areas for board members and an additional area for the president. The competencies were shared with the Committee on Nominations at an in-person dialogue with the committee, will be included by the Committee on Nominations in future calls for nominations, and will be considered by the Committee on Nominations in developing a slate of qualified candidates. The competencies were also used as a basis for development of new board job descriptions.

■ **Finances**

The Board, upon recommendations presented by the Finance Committee, adopted and subsequently monitored and adjusted FY97 operating and capital expenditure budget; appointed Richmond Capital Management to manage the more than 85 percent of the National Council's reserves in fixed-income (bond) investments and adopted an index fund for the 10 percent to 15 percent in equity investments.

■ **Special Services Division**

The Board monitored the activities of the Special Services Division. On several occasions, it rendered specific guidance regarding whether or not a project being considered would conflict with the mission, in any way detract from public protection, or harm the reputation of the organization.

In response to the 1996 Delegate Assembly's request to investigate "smart card" technology, the Special Services Division has provided the attached report on the state of the art (See Attachment A).

■ **Liaison**

A full schedule of liaison meetings was accomplished either through visits between the presidents and executive directors of each organization, or through attendance of the organization's representatives at a meeting of the board of directors. The "board-to-board dialogue" method was used over the past year with the National League for Nursing, the American Association of Colleges of Nursing, the American Organization of Nurse Executives, and the National Organization for Associate Degree Nursing. The executive-level liaison meeting was used with the American Nurses Association, the Commission on Graduates of Foreign Nursing Schools, the Division of Nursing, the National Association for Practical Nurse Education and Service, and the National Federation of Licensed Practical Nurses.

- **Multistate Regulation**

Throughout the year, the Board has received reports and provided input to the progress of the Multistate Regulation Task Force. The Board authorized the funding for the studies proposed by the task force to survey the needs and concerns of the delivery system, nurses, Member Boards, and board attorneys relative to multistate practice and regulation. In addition, the Board authorized subsidies for the Member Board workshop on multistate regulation and the public policy conference, held in June 1997.

The definition of telenursing proposed by the task force was reviewed by the Board on several occasions, and approved as a preliminary, or working, definition for dissemination and discussion prior to finalization as an organizational position.

Future Recommendations by the Board of Directors

Following the June 4 Multistate Regulation (MSR) Workshop for Member Board representatives, the MSR Task Force will make recommendations to the Board, which the Board plans to act upon at its June 25-27 meeting. The supplemental report of the Board to the Delegate Assembly will include actions and recommendations made by the Board at this meeting. Additional actions and recommendations may be made by the Board at its pre-Delegate Assembly Board meeting and reported to delegates on-site at the Annual Meeting.

Meeting Dates

- August 11, 1996 *(post-Delegate Assembly meeting)*
- September 18, 1996 *(telephone conference call)*
- November 13, 1996 *(Board retreat)*
- November 14-15, 1996
- January 7, 1997 *(telephone conference call)*
- February 12-14, 1997
- March 11, 1997 *(telephone conference call)*
- May 14-16, 1997
- June 5, 1997 *(met jointly with MSR Task Force)*
- June 25-27, 1997
- August 17-18, 1997 *(pre-Delegate Assembly meeting)*

Recommendations to the Delegate Assembly

1. That the Delegate Assembly adopts the amendment to Article V, Section 2 of the Bylaws, Election of Officers.

2. That the Delegate Assembly adopts the amendment to Article V, Section 1.c. of the Bylaws, Elections.

3. That the Delegate Assembly adopts the amendment to Article X, Section 1.a. of the Bylaws, Examination Committee.

4. That the mission of the National Council be revised to read: "The mission of the National Council of State Boards of Nursing is to lead in nursing regulation by assisting Member Boards, collectively and individually, to promote safe and effective nursing practice in the interest of protecting public health and welfare."

5. That the wording of Organization Plan objectives be modified to read as follows:
   I.H. Provide a comprehensive approach to assessing continued competence.
   II.A. Analyze the environment for trends and issues affecting the regulation of nursing practice.
   III.A. Analyze the environment for trends and issues affecting the regulation of nursing education.

6. That the Chauncey Group International be selected as the NCLEX® examination test service for the period October 1, 1999, through September 30, 2002, according to the terms and conditions negotiated by the Negotiating Team (reported behind Tab 10-N).

7. That the NCLEX examination candidate fee be set at $120, from October 1, 1999, to September 30, 2002.

8. That the Member Board contract include the following language to facilitate the provision of an electronic licensure verification information system (ELVIS) for Member Board use:

   Paragraph 10 (new language in italics): Council Use of Candidate Data: [Member] Board hereby authorizes Council to use any and all candidate data collected for the *purposes of (1) administering the nurse licensure examinations, including but not limited to,* identifying candidates approved for the examination, determining their status as first-time, repeat and/or multiple application candidates, *preparing the examination results related to the validity and psychometric integrity of the nurse licensure examinations, and (2) developing and maintaining a comprehensive national data bank of information on nurse licensees for use by Member Boards of the Council in evaluating applicants for endorsement, in monitoring disciplinary actions and in any other licensing-related actions authorized by applicable state and federal law. Candidate data collected hereunder shall not be disseminated to parties other than the Member Boards or used for other purposes without prior approval by the Member Board.*

Attachments

A .... Report on Smart Cards, *page 9*

Attachment A

Report on Smart Cards

Staff

Darcy Colby, *SSD Project Manager*

Relationship to Organization Plan

Goal V.................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

Objective H.........Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division (SSD).

Background

Executive Summary

1. Smart cards could become a beneficial tool for Member Boards to use in the execution of their mission to promote public protection.
2. A "closed" smart-card licensing system, i.e., a system only available to Member Boards and their licensees, would be cost-prohibitive to build and would not effectively leverage the technology to the maximum benefit of the public.
3. An "open" smart-card licensing system, i.e., a system built in partnership with nurse employers, would be more financially feasible and maximize the technology's promise as a public protection tool for Member Boards.
4. Based upon the relatively slow adoption of consumer-type smart-card applications in the United States, a comprehensive build-out of the computer network necessary to facilitate a smart-card licensing system is five to 10 years away.
5. Member Boards should consider a step-wise migration from the use of paper identification documents to plastic cards with built-in security features in order to prepare for the eventual adoption and build-out of a smart-card licensing system.

What makes a plastic card smart? A smart card has an integrated circuit embedded in the plastic that allows for the storage of much more data than non-smart identification cards. With this enlarged memory comes enhanced functional capabilities, including the capability to record and transfer information to and from various remote computer networks. Increased memory also allows for the recording of different types of data such as fingerprint images or other biometrics. Whereas today a paper nursing license can carry only simple licensee data such as name, address, license type, license number and expiration date, a smart nursing license could include disciplinary data, continued competency records, NCLEX® examination results, as well as professional history and educational transcripts. In addition, a smart-card nursing license would have the capability of performing certain operating-system functions useful for reliable identification in security-sensitive environments. Consequently, smart cards could become a useful tool for Member Boards to use in the execution of their mission to promote public protection.

The successful implementation of a smart-card licensing system is dependent on whether the system operates as an open or closed system. Any smart-card system consists of a network of card writers, card readers and databases that allow encoding of data on the smart card. In a closed system, information exchange would be possible only between the board of nursing database and the licensee. There are many reasons why such a closed system is not optimal. Currently, the average amount of interaction between a board of nursing and a licensee is only once or twice every two years, when the licensee is required to renew his or her license. The functionality of the license is often limited to employer verification of valid licensure at the time of hiring. Actual information exchange between a licensee and a board of nursing is minimal. Thus, the lack of frequent contact between a licensee and a board of nursing prohibits a smart-card licensing system from providing the valuable functionality of real-time data transfer. A closed smart-card licensing system would also be cost-prohibitive to build and would not effectively leverage the technology to the maximum benefit of the public.

An open smart-card licensing system, i.e., a system built in partnership with nurse employers, would be more financially feasible and maximize the technology's promise as a public protection tool for Member Boards. How

could this be accomplished? In an open system, the board of nursing and National Council, in cooperation with nursing employers, would design a system that integrates the nurse's license and the nurse's employee identification card. The board of nursing network and nurse employer network would independently encode separate sections of the multi-application card. These interoperable networks would allow for real-time transfer of data. By implementing a multi-application smart-card licensing system, the smart cards would have the necessary frequency of contact needed to support the basis of the system, thus enabling the board of nursing to encode the card with the most recent data. Boards of nursing benefit not only from the fact that opportunities exist to share costs, but also from the fact that they can better accomplish their mission of public protection while maximizing current technology. An open smart-card licensing system could allow Member Boards to:

- greatly expand the amount and types of data that the nurse can carry on his or her person, including the archiving of educational history, NCLEX examination results, continued competence records, credentials and disciplinary actions;
- provide for real-time, high-security verification of license authenticity through the use of biometric identifiers;
- provide for near real-time updates of disciplinary actions against a licensee; and
- restrict physical access to pharmaceuticals for nurses whose licenses are subject to restriction.

How could an open smart-card licensing system operate? A future scenario follows.

Susan B. Nurse is issued a smart-card license by her board of nursing upon passing the NCLEX-RN® examination. The state board of nursing encodes the smart card with Susan's license information, including name, address, license type, expiration date, license number, etc. Susan's smart card is enhanced with a photograph, a signature strip and a hologram for heightened security. Additional information such as Susan's NCLEX examination results, educational background and work history are stored on the board's main network, which are accessible from remote locations via the Internet using a secure server and the "key" on the card chip as authentication. Susan's license also contains biometric information, including fingerprint recognition.

Susan applies for a nursing position at Hospital X, a national hospital that has partnered with the board of nursing and has been allocated a portion of the smart card for its use. Hospital X can verify the validity of Susan's license via the smart card she was issued by her board of nursing. Hospital X can identify Susan by the photograph on the smart card, as well as via the biometric data within the card. Upon confirming Susan's identity and valid licensure, Hospital X hires Susan onto its nursing staff. Hospital X encodes Susan's smart card with information pertinent for her employment. Susan uses her smart card to clock in and out of work, thus automatically tracking her hours per shift. Her smart card also serves as her identification badge, granting or denying access into specified areas of the hospital. Hospital X also utilizes Susan's card to grant her access to pharmaceuticals. Each time Susan uses her smart card, any information that the board of nursing adds to her file will be automatically uploaded onto the card in real time as well. Thus, when Susan reports to work and her smart-card license is read, information is automatically transferred and updated at that time.

Three months after issuing the smart-card license, the board of nursing discovers the need to take disciplinary action against Susan and restrict her license. The board of nursing updates Susan's file with the necessary information so that, when she clocks in for work the next day, a notification flag will inform Hospital X of the newly updated status. Hospital X can then take the appropriate actions to prevent Susan from practicing beyond her stipulation. The board of nursing can, thus, provide a higher level of public safety and protection with this real-time system of information transfer. Once Susan has been removed from her restricted status, the board of nursing updates the information on Susan's smart-card license file. Susan may then resume unrestricted practice, as her smart-card license status will be re-established with the updated information transferred from the board of nursing.

Currently, there are approximately 70 million smart cards in existence within the health care industry worldwide. Such applications include identification cards, prescription cards, medical emergency cards and health passports. Many of the current smart cards are multi-application cards that rely on interoperability to function. It is estimated that by the year 2000, approximately 150-300 million smart cards will be implemented within the health care industry alone. The European Community has implemented a Healthcare Professional Card (HPC) with uses such as electronic identification, access control to information systems, keys for electronic signatures of stored and transmitted electronic documents, and access control to patient data.

Unfortunately, the implementation of smart cards in the United States has not been as successful as our European counterparts. As technology advances, the cost barriers that once kept many U.S. industries from

seriously considering the use of smart cards will decrease, facilitating heightened uses and applications, especially within the health care and regulatory industry. Lower costs will make a more cost-effective business case for the implementation of smart cards in the health care industry. Moreover, based upon the relatively slow adoption of consumer-type smart-card applications in the United States, a comprehensive build-out of the computer network necessary to facilitate a smart-card licensing system may be five to 10 years away.

For an open smart-card licensing system to be implemented by boards of nursing, three major systematic changes must occur. First, the trend of consolidating the large number of existing employers to a smaller number of major national health care providers will facilitate implementation. The fewer number of employers allows for network systems with a common set of standards to be more easily adopted and integrated. Second, advances in smart-card technology must continue to move forward, thus driving down the costs of implementing a complete system of smart-card licenses and interoperable networks. And third, smart-card technology must be embraced by American citizens. Security issues must be addressed in such a way as to provide assurance to the American public that a smart-card system provides advanced information transfer without violating privacy.

Appendices

A .... Glossary of Terms, *page 13*
B .... Card Technology – Comparative Features, *page 15*
C .... "Open" Smart-Card Licensing System Diagram, *page 17*

Appendix A

Glossary of Terms

Authentication: A technique to confirm the identity of a card or a computer system.

Biometric Identification: Biometrics is the technique of studying physical characteristics of a person such as finger prints, hand geometry, eye structure or voice pattern. Biometrics, used in the security industry, refers to the automatic identification or identity verification of individuals using physiological, or behavioral, characteristics.

"Closed" Smart-card System: A system in which only one party has ownership of all the available space on a smart card. Applications are not shared with any other outside parties. Any data exchange is between only the issuer and holder of the smart card.

Contact Card: Instead of a magnetic stripe at the back of the card, there is a chip embedded inside the card with a metal contact pad on the surface to interface with the reader/writer. This type of card is called a contact card. It must be inserted into a read/write unit before use. It receives its power from this unit.

Contactless Card: Contactless smart cards also exist. Again, they are usually ISO-standard size (wallet size), but may be slightly thicker and might not be flexible. This type of card communicates with the reader by radio frequencies. The operating range of a contactless card ranges from one millimeter to several meters.

Encryption: The process of converting ordinary language into code. Also referred to as encoding.

Integrated Circuit (IC) Card: The intelligence of the integrated circuit chip on a smart card allows it to protect the information being stored from damage or theft. IC cards have a storage capacity of up to eight kilobytes (2,000 characters). The microchip's storage capacity also enables it to perform certain operating system functions which, when combined with sophisticated encryption capability, can insure cardholder privacy while offering reliable security and identification uses.

Interoperability: The ability to exchange information between two systems so that the information can be processed meaningfully. Each system maintains the ability to grant and deny access to each area of the network. Interoperability is based on the premise that a common set of standards has been developed and adopted by all network systems involved. Interoperability does not mean complete interchange.

Magnetic Stripe Card: A plastic card with a magnetic stripe encoded bits of information in binary form. The storage capacity of a magnetic stripe card is less than 900 bytes. Most bank cards utilize the magnetic stripe. Magnetic stripes are not inherently secure.

Multi-application: The capability of a smart card to be used in more than one application. An example of multi-application is a smart card with biometric identification functionality, debit/credit functionality and information access functionality. A smart card may have multi-applications in either an open or closed smart-card system.

"Open" Smart-card System: A system in which two or more parties are allocated "real-estate" on a smart card for encoding their own data and functionality. All network systems in an open system must apply the same common set of standards to provide optimal interoperability.

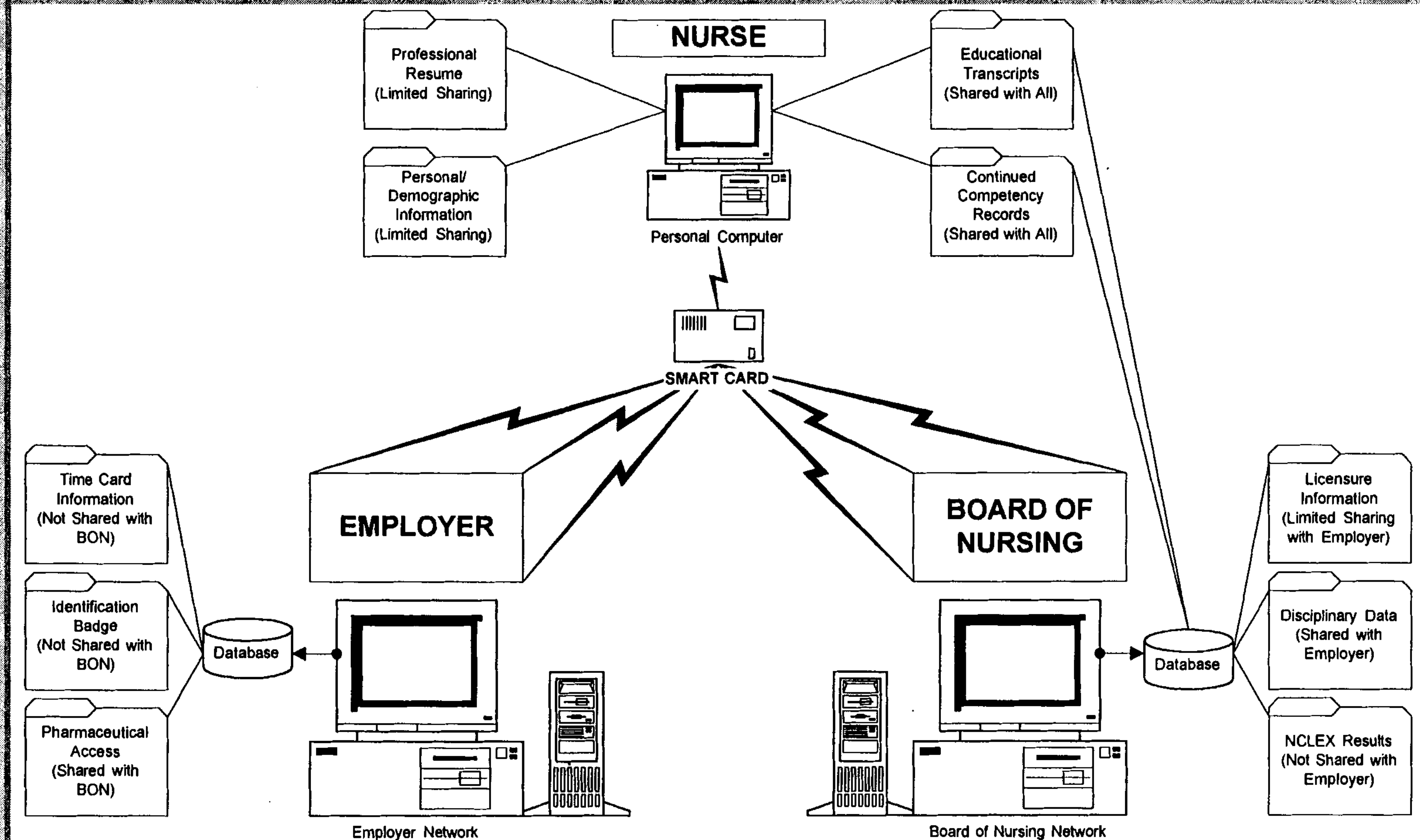
Optical Memory Card: Digitized data are written permanently on the card by laser. The data are written as nonerasable pits etched onto 2500 linear tracks per card. An optical memory card has write once, read many (WORM) capability. The storage capacity is approximately four megabytes (2.8 million characters).

Security Features: Components that can be added to a standard plastic card to heighten the security of the card. Examples of security features include signature strips, holograms, magnetic strips, biometrics and encryption.

Smart Card: A smart card stores information on an integrated microprocessor chip located within it. There are two basic kinds of smart cards. An "intelligent" smart card contains a central processing unit – a CPU – that actually has the ability to store and secure information and "make decisions," as required by the card issuer's specific applications needs. Because intelligent cards offer a read/write capability, new information can be added and processed. The second type of card is often called a memory card. Memory cards are primarily information storage cards that contain stored value which the user can "spend" in a pay phone, retail, vending or related transaction. The portability of the device makes it possible for individuals to carry large amounts of important data on their person.

Card Technology - - Comparative Features

	Paper Card	Magnetic Stripe Card	IC (Smart) Card	Optical Memory Card
	N/A	200 -900 Bytes (150-475 characters)	8 -64 Kilobytes (up to 2,000 characters)	4.1 Megabytes (up to 2.8 million characters)
	N/A	Magnetic	Integrated Circuit(s)	Optical
	Poor	Excellent	Fair	Excellent
	Poor	Fair	Excellent	Good
	Low (less than $1.00 per card)	Low (about $.50 - $1.50 per card)	High (about $5 - $20 per card)	Medium (about $5 - $8 per card)
	N/A	$20 - $80	$60 - $400	$2,000 - $3,000
	Data are printed on the paper card via a line printer or laser printer. No other data are stored on the card other than what is printed.	Bytes of data are written (encoded) on the magnetic stripe in the same manner that data are written onto a computer tape. Data are read (swiped) by a card reader device at the point of service.	Contains an embedded programmable computer chip that has been drilled into the plastic card. Data are written on the chip at written on the chip at the time of card personalization. Updates can be written to the chip on an ongoing basis.	Write Once Read Many (WORM) technology allows data to be written on an area only once. Data are not erasable.
	Used to identify the card holder only.	Ability to serve as a tool to identify the cardholder and access database information efficiently and economically.	Allows for data segregation. Also used to transport information, in isolated environments or in situations requiring enhanced card or network security and authentication.	Allows for data segregation. Also used to transport information, in isolated environments or in situations requiring enhanced card or network security and authentication.
	Inexpensive and easy to produce.	More secure than the paper license. Good application for storing minimal data that are accessed frequently. Durability is very good. Relatively inexpensive.	High memory capabilities allow for storage of large amounts of data. Multi-application capabilities to reduce costs and enhance uses. Several levels of security protect the data on the card or accessible by the card. Not easily duplicated.	Maximum optimal memory capability. Designed to be durable and highly secure. Record permanence assures audit trail. High rate encoding at lowest cost per stored byte.
	Very easy to duplicate and tamper. Information is limited to that contained on the card itself.	Somewhat easy to duplicate. Lack of readers to access the data on the magnetic stripe.	High cost and the lack of uniform standards and interoperability in the industry.	High cost of readers and the lack of uniform standards and interoperability in the industry. Relatively new technology, not in mass use



INFORMATION TRANSFER

Nurse: Has access to all BON and Employer Information. Shares Continued Competency Record Information and Educational Transcripts with both the BON and Employer. Can choose whether to share Professional Resume and/or Personal/Demographic Information with either the Employer, BON or both.

Employer: Has access to BON Disciplinary Data and Licensure Information. Has access to Nurse's Educational Transcripts and Continued Competency Records. May have access to Nurse's Professional Resume and/or Personal/Demographic Information if access is granted by the Nurse. Does not share Time Card Information or Identification Badge Information with the BON.

BON: Has access to Employer Pharmaceutical Access Information. Has access to Nurse's Educational Transcripts and Continued Competency Records. May have access to Nurses Professional Resume and/or Personal/Demographic Information if access is granted by the Nurse. Shares Disciplinary Data, Continued Competency Records and Licensure Information with the Employer. Does not share NCLEX results with Employer.

Supplemental Report of the Board of Directors

Board Members

Tom Neumann, WI, *President*
Margaret Howard, NJ, *Vice-President*
Charlene Kelly, NE, *Treasurer*
Joey Ridenour, AZ, *Area I Director*
Linda Seppanen, MN, *Area II Director*
Nancy Durrett, VA, *Area III Director*
Anna Yoder, MA, *Area IV Director*
Gregory Howard, AL, *Director-at-Large*
Laura Poe, UT, *Director-at-Large*

Staff

Jennifer Bosma, *Executive Director*
Doris Nay, *Associate Executive Director*

Relationship to Organization Plan

Goal IV ....Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective C ....Facilitate communication between National Council, Member Boards, and related entities.

Goal V................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective C......... Maintain a system of governance for the National Council that facilitates leadership and decision-making.
Objective E.........Develop and implement a systematic approach for shaping health care policy related to regulation.

Recommendation to the Delegate Assembly

1. **That the National Council endorses a mutual recognition (i.e., driver's license) model of nursing regulation and authorizes the Board of Directors to develop strategies and services, including an interstate compact and information system, needed to assist boards of nursing with implementation.**

Rationale

The Multistate Regulation (MSR) Task Force presented its work at the Member Board MSR Workshop in Arlington, Virginia, June 4, 1997. The Board supports the recommendation proposed by the task force on the basis of the outcomes of that meeting. It is responsive to the input received from Member Boards and it acknowledges the primary components that would be required to bring this concept to fruition, i.e., an interstate compact and an information system. The MSR Task Force's report contains a wealth of data supporting this recommendation. The adoption of the above motion has fiscal implications for Member Boards and the National Council. Fiscal information, in addition to that which was presented at the June MSR Workshop, is being gathered and will be presented at the Annual Meeting.

Background

The members of the Board of Directors attended the June 4 MSR Workshop and subsequently met with the MSR Task Force to discuss the formulation of a recommendation for the Delegate Assembly. The Board and task force also collaborated to arrange the schedule for forum time, so that one-and-one-half hours on Friday morning will be available for this significant discussion.

Highlights of Activities

- **Reporting disciplinary actions to the federal government**

Member Boards have received notice of the recent announcements by the Health Resources and Services Administration of the U.S. Department of Health and Human Services to implement the mandatory reporting of nurse disciplinary actions to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) in the near future. Given the desirability of the continued existence of the National Council's Disciplinary Data Bank, which provides online and monthly summary reporting to Member Boards at no charge, the Board proposes that the National Council serve in the role of agent on behalf of boards of nursing. The Federation of Chiropractic Licensing Boards passed a resolution that the Federation would be agent for its member boards at its June annual meeting.

The Board of Directors plans to submit a resolution to the Resolutions Committee which would, if adopted, empower the National Council to act as reporting and querying agent for Member Boards to the NPDB and the HIPDB. Each individual Member Board would then have the option to include this service in an agreement with the National Council; the National Council would be obligated to modify the DDB system as needed to comply with federal requirements; and Member Boards would report their actions to the National Council for entry into the DDB and transmission to the federal program.

Meeting Dates

- June 25-26, 1997
- August 17-18, 1997

Recommendation to the Delegate Assembly

1. That the National Council endorses a mutual recognition (i.e., driver's license) model of nursing regulation and authorizes the Board of Directors to develop strategies and services, including an interstate compact and information system, needed to assist boards of nursing with implementation.

Report of the Bylaws Task Force

Task Force Members

Sharon Weisenbeck, KY, Area III, *Chair*
Charlet Grooms, OH, Area II
Doris Nuttelman, NH, Area IV
Ruth Ann Terry, CA-RN, Area I

Staff

Doris E. Nay, *Associate Executive Director*

Relationship to Organization Plan

Goal V.................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective C ....Maintain a system of governance for the National Council that facilitates leadership and decision-making.

Recommendations to the Board of Directors

1. **That the Board of Directors considers recommendations from the Bylaws Task Force regarding bylaw amendments (Attachment A) and develop analysis to forward with recommendations to the Delegate Assembly.**

Rationale

The current bylaw language, proposed amendments and rationale for each proposed bylaw amendment can be found in Attachment A.

Background

The role of a Bylaws Task Force, excerpted from the current edition of *Robert's Rules of Order Newly Revised,* governed the work of the committee: "Bylaws contain the basic rules by which an organization relates to itself as an organization. The bylaws describe the primary characteristics of the organization, prescribe how the organization functions and include those rules so important that they cannot be changed without previous notice to the members and a two-thirds majority vote by the members. In order to provide the greatest freedom for the organization to act, the bylaws should be no more restrictive nor more detailed in specification than necessary."

The Bylaws Task Force should critically examine each recommended bylaws amendment as follows:

- identify what is new about the proposed amendment and how it differs from the existing bylaws,
- identify and eliminate inconsistencies or ambiguities,
- review accompanying rationale for proposed revision,
- discuss probable long-range effect of the provision, and
- determine recommendation and supporting rationale.

The Bylaws Task Force reviewed proposed bylaws changes submitted by the Elections Committee, Committee on Nominations and Examination Committee and prepared its recommendations and supporting rationale for consideration by the Board of Directors. The parliamentarian was asked to review and comment on all proposed bylaws. Her comments relate to Proposed Amendment #1, submitted by the Elections Committee:

Suggested Change: *Proposed Amendment #1, Article V, Section 2, (Paragraph 3), the words in parentheses could be shortened to read: (two nominees for each position to be filled).*

While I do not encourage such great specificity to be included in the bylaws, I have reviewed it closely and now believe that it must be that detailed to be clear and to allow for this method of election.

One concern expressed by the Bylaws Task Force was what should be done if, on the first ballot in the election of the directors-at-large, there is a tie vote for the last position. [For example, there are seven nominees for the two positions of directors-at-large, a majority vote is 48, and the following votes are received: Nominee A - 30,

Nominee B - 18, Nominee C - 16, Nominee D - 12, Nominee E - 12, Nominee F - 4 and Nominee G - 3. The bylaw proposal would call for a second ballot between the top four nominees, and there is a tie for the fourth position.] The answer is that, as in the example given, the top five nominees would remain on the ballot for the second balloting.

This answer is supported by the National Council's parliamentary authority, *Robert's Rules of Order Newly Revised*, 9th Edition, page 433, in the following statement: "Similarly, if some candidates receive a majority but are tied for the lowest position that would elect, all of those candidates also remain on the next ballot."

Highlights of Activities

The Bylaws Task Force reviewed a memo submitted to the Long Range Planning Task Force by the Communications Evaluation Task Force. The Communications Evaluation Task Force suggested that consideration be given to studying the potential for different tiers of membership and consider creating an "associate membership" to give past board of nursing members and staff a means of staying connected with the National Council. After review and discussion, the Bylaws Task Force agreed that a study of the issue of an "associate membership" would best be accomplished by a careful review of all issues, not just this issue in isolation.

Meeting Dates

- April 30, 1997

Recommendations to the Board of Directors

1. That the Board of Directors considers recommendations from the Bylaws Task Force regarding bylaw amendments (Attachment A) and develop analysis to forward with recommendations to the Delegate Assembly.

Attachments

A .... Proposed Bylaws Amendments, *page 3*

Attachment A

Proposed Bylaws Amendments

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

1. Bylaws Amendment proposed by the Elections Committee

Article V. Nominations and Elections

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
Section 2. Election of Officers. Election of officers shall be by ballot of the Delegate Assembly during the Annual Meeting. Write-in votes shall be prohibited. If a candidate does not receive a majority vote on the first ballot, re-balloting shall be limited to the two nominees receiving the highest numbers of votes. In case of a tie on the re-balloting, the choice shall be determined by lot.	Section 2. Election of Officers. Election of officers shall be by ballot of the Delegate Assembly during the Annual Meeting. Write-in votes shall be prohibited. Election of all officers except Directors-at-Large: if a candidate does not receive a majority vote on the first ballot, re-balloting shall be limited to the two nominees receiving the highest number of votes. In case of a tie on the re-balloting, the choice shall be determined by lot. Elections of Director-at-Large: if the necessary number of candidates does not receive a majority vote on the first ballot, re-ballotting shall be limited to the nominees receiving the highest number of votes (two nominees	During the 1996 elections, combining both a large number of potential candidates and the need to elect two Directors-at-Large resulted in the need for not only a second ballot, but also election by lot. While procedures were in place to accommodate this situation, questions were raised by delegates, Election Committee members and staff regarding the process and the fairness of the current process to elect Directors-at-Large.	The Bylaws Task Force supports the proposed wording, which clarifies the process and provides an opportunity for the delegates to speak.

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

1. Bylaws Amendment proposed by the Elections Committee (cont.)

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
	if one position is to be filled; four nominees if two positions are to be filled). If the necessary number of candidates does not receive a majority vote on the second ballot, re-balloting shall occur among all remaining candidates. If the necessary number of candidates does not receive a majority on the third ballot, the candidate(s) with the most votes shall be declared the winner. If there is a tie between individuals with the most votes, then the choice shall be determined by lot.		

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

2. *Bylaws Amendment proposed by the Committee on Nominations*

Article V. Nominations and Elections

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
Section 1.c. Election. The committee shall be elected by ballot of the Delegate Assembly at the Annual Meeting. A plurality vote shall elect. The member receiving the highest number of votes shall serve as chair.	Section 1.c. Election. The committee shall be elected by ballot of the Delegate Assembly at the Annual Meeting. A plurality vote shall elect. At the first committee meeting, the members of the committee shall elect, from its membership, the committee chair. The first meeting of the committee shall be held concurrent with the first meeting of the Board of Directors in the subsequent fiscal year.	The current system has three disadvantages that do not exist in the proposed change. The current system: • penalizes the Areas that nominate multiple candidates. Because the committee chair is the candidate who receives the highest number of votes, if one Area has three candidates for the Committee on Nominations, and another Area has only one candidate, it is almost impossible for the Area with three candidates to have one of those candidates become the committee chair. • conducts the same election for membership on the Committee on Nominations as it does for committee chair. That is one election for two very different positions that require different sets of skills.	The Bylaws Task Force supports the proposed amendment based on the rationale.

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

2. Bylaws Amendment proposed by the Committee on Nominations (cont.)

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
		• allows for the election of an individual to chair even though that person may not be interested or willing to function as chair of the committee. This proposed change eliminates the previously mentioned disadvantages, as well as provides the committee members with the opportunity to meet members of the Board of Directors and observe the Board in action so as to better understand the function of the Board. Thus, the committee's ability to select qualified candidates is enhanced.	

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

3. *Bylaws Amendment proposed by the Examination Committee*

Article X. Committees

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
Section 1. Standing Committees. Members of standing committees shall be appointed by the Board of Directors. a. Examination Committee. The Examination Committee shall be comprised of at least six members, including one member from each Area. One of the committee members shall be a licensed practical/vocational nurse. At least six alternates shall be appointed, and an alternate may be called on at any time to serve temporarily as a member of the committee and have all the responsibilities and rights of full membership when called to serve as a member. The committee chair shall have served as a member of the committee prior to being appointed as chair. The Examination Committee shall provide general oversight of the NCLEX® examination, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly.	Section 1. Standing Committees. Members of standing committees shall be appointed by the Board of Directors. a. Examination Committee. The Examination Committee shall be comprised of at least six members, including one member from each Area. One of the committee members shall be a licensed practical/vocational nurse. The committee chair shall have served as a member of the committee prior to being appointed as chair. The Examination Committee shall provide general oversight of the NCLEX® examination, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the	The current bylaws refer to an outdated concept; that of "alternate" committee members who would substitute for committee members who could not attend a regularly scheduled meeting. The alternate members have a vote on committee business items. In their current restructuring plan, the Examination Committee proposes the formation of a subcommittee, the Examination Committee Item Review Subcommittee, whose *only* function would be to review new, referred and basepool items and recommend disposition to the Examination Committee. The Item Review Subcommittee would meet five times per year. With the change to computerized testing, the master item pool has quadrupled in size. Instead of reviewing specific examination forms four times per year (as in paper-and-pencil mode), the Examination Committee is now responsible for having	The Bylaws Task Force supports the change and recognizes the need for Examination Committee subcommittees to assist in the fulfillment of its responsibilities.

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
3. Bylaws Amendment proposed by the Examination Committee (cont.)			
	fulfillment of its responsibilities.	approved all items in a configured pool. The intent to create three master pools has dramatically increased item production needs. This production in turn has caused the Examination Committee to change the method that they are currently using to review items because the workload is too great. Currently, the Examination Committee is meeting six times a year for six days at a time to keep up with their charge. Formation of a subcommittee for item review would allow the Examination Committee to continue to fulfill its responsibilities of general oversight of the NCLEX examination process, examination item development and quality assurance of items. This would result in a more manageable workload for the Examination Committee, which would allow a greater amount of time to be spent on other examination business. The new structure would also increase the opportunities for	

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
3. Bylaws Amendment proposed by the Examination Committee (cont.)			
		Member Boards to be involved in the examination process. Instead of the 12 Member Boards currently represented by the Examination Committee, a potential of 24 boards could be lending their regulatory expertise to examination development.	

Report of the Long Range Planning Task Force

Task Force Members
Sharon Weisenbeck, KY, Area III, *Chair*
Charlet Grooms, OH, Area II
Doris Nuttelman, NH, Area IV
Ruth Ann Terry, CA-RN, Area I
Joey Ridenour, AZ, Area I, *Board of Directors' Liaison*

Staff
Doris E. Nay, *Associate Executive Director*

Relationship to Organization Plan
Goal V..............Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective A.........Implement a planning system to guide the National Council.

Recommendations to the Board of Directors
1. **That the Board considers input from the Long Range Planning Task Force in its discussion relating to long-range and short-range planning for the National Council.**

Background
Following the retreat with the Board of Directors (Attachment A), the Board asked the Long Range Planning Task Force to look at the organization's mission and purpose statements and develop future scenarios for discussion at the Area and Annual Meetings. The task force discussion focused on the congruency of the mission statement with the vision statement, the articles of incorporation and the purpose statement stated in the bylaws; organizational authority and decision-making; and the current planning process. During these discussions, it became apparent to the task force members that the issues at hand involved more than just the mission statement and that a more in-depth examination of the National Council's mission and organizational structure was essential.

Following is an overview of the Long Range Planning Task Force discussion (Section I) and suggestions (Section II) for consideration by the Board of Directors.

Section I: Task Force Discussion

A. Mission and Purpose Statements

The Long Range Planning Task Force first looked at the current mission and purpose statements stated in the articles of incorporation and the bylaws:

Mission Statement adopted by the 1996 Delegate Assembly:
The mission of the National Council of State Boards of Nursing is to advance the safe and effective practice of nursing in the interest of protecting the public's health and welfare.

Purpose stated in the 1985 Articles of Incorporation:
Educational and charitable purposes including the lessening of the burdens of government by providing an organization through which boards of nursing act on matters of common interest and concern affecting the public health, safety, and welfare including the development of licensing examinations in nursing.

Purpose stated in Bylaws adopted by the 1994 Delegate Assembly:
The purpose of the National Council is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

The task force came to the conclusion that the National Council exists because of and on behalf of its membership and that the National Council lessens the burdens of government by assisting Member Boards to act and counsel together to advance the safe and effective practice of nursing. This led to the following answers to the following foundational leadership questions:

- *What do we (National Council) believe?* Boards of nursing are responsible for regulatory activities to assure safe and effective practice of nursing.
- *Whom do we (National Council) serve?* Member Boards who, in turn, serve to protect the public.
- *What do we (National Council) do?* Provide a forum for collaboration, support and enhancement of effective and sound nursing regulation.

B. Vision

The task force then looked at the current vision statement adopted by the Board of Directors in 1995 for internal use: *The National Council will be a worldwide leader in the regulation of nursing.*

The task force agreed that a vision statement should describe the organization and its potential impact, as well as be inspirational and directional. As it relates to the National Council, the task force concluded that the vision statement should:

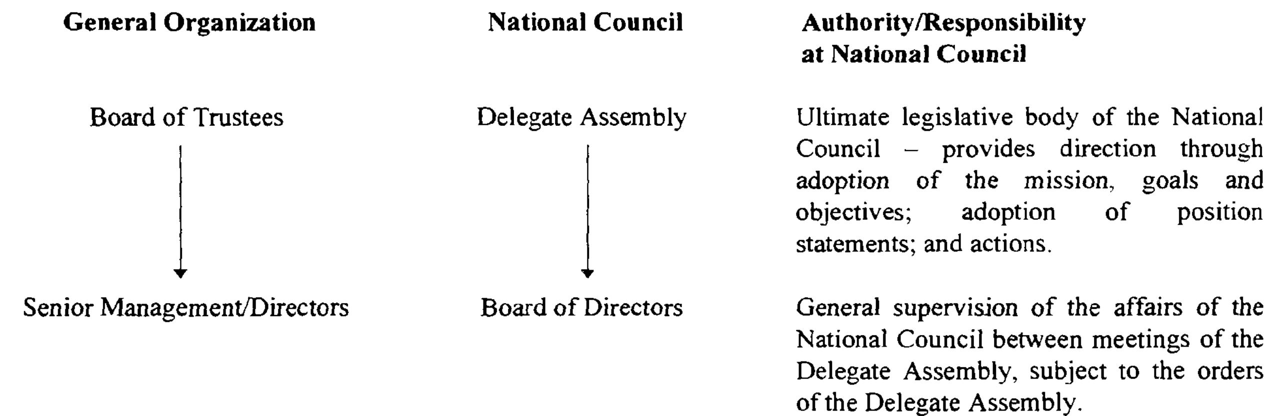
- be congruent with the mission,
- be broader than just National Council's 61 jurisdictions,
- involve being a leader, and
- express the *end* of regulation, not just regulation as a means.

The following draft vision statement incorporating these components was considered by the task force: *Guide Member Boards in maintaining their leadership roles in the advancement of nursing through the regulation of national and international (worldwide) nursing practice.*

C. Authority

In considering the long-range planning process and related organizational structure of the National Council, a comparison of a general organizational structure with National Council's structure was used a basis for a discussion of authority/responsibility.

Authority and Decision-making Models



General Organization	National Council	Authority/Responsibility at National Council
Board of Trustees	Delegate Assembly	Ultimate legislative body of the National Council – provides direction through adoption of the mission, goals and objectives; adoption of position statements; and actions.
↓	↓	
Senior Management/Directors	Board of Directors	General supervision of the affairs of the National Council between meetings of the Delegate Assembly, subject to the orders of the Delegate Assembly.

The Long Range Planning Task Force concluded that the present organizational structure stated in the bylaws does not prohibit the Board of Directors from taking a significant leadership role in the organization, particularly in the long-range planning process. The current structure stated in the bylaws allows for Delegate Assembly and Board of Directors' leadership of the organization.

D. Planning

The task force then considered the current long- and short-range planning processes for the National Council.

Current Long-range Planning Process

- Staff generate "directional objectives" for two to four years in the future based on environmental scans, Member Board surveys, committee/task force input, etc.
- Long Range Planning Task Force reviews the "directional" objectives.
- Board of Directors reviews and adopts the "directional" objectives for internal planning use.

Current Short-range Planning Process

- Staff generates tactics for next fiscal year based on Member Boards surveys, committee/task force input, prior long-range plans.
- Four-day senior staff meeting results in the development of tactic worksheets.
- Long Range Planning Task Force reviews tactics thoroughly and modifies them as appropriate.
- Board of Directors reviews, modifies tactics as indicated based on Delegate Assembly action(s) and impact on the organization, then adopts tactics for next fiscal year.

The following areas in need of improvement (perceived flaws) in the current planning process were identified and discussed by the task force:

- Process is too removed from the Board of Directors; Board needs to be more involved with the planning process.
- A future focus needs to be developed by the Board of Directors.
- Planning belongs to the Board of Directors, not a committee; planning responsibilities are nondelegable.
- Linkage of planning and accountability needs to be strengthened.
- The assumption that the membership knows about everything is faulty; there are gaps in the base of knowledge of organization.
- Structure of the organization may not clearly indicate roles (e.g., Delegate Assembly, Board of Directors and staff).

E. Discussion Summary

In summary, as a result of the two days of discussion, the Long Range Planning Task Force: 1) identified a need to revisit the mission statement in relation to the three foundational leadership questions: What does the organization believe? Whom does it serve? What does it do?; 2) noted that the National Council has an extensive short-range planning process but an underdeveloped long-range planning process; and 3) agreed that the current organizational structure stated in the bylaws allows for Delegate Assembly and Board of Directors' leadership of the organization.

Section II: Task Force Suggestions

The task force offered the following suggested actions to be used as a basis for discussion by the Board.

- **Action needed: Mission – Determine revision to propose to Delegate Assembly, if any.**

The task force developed four revised versions of the mission statement, all of which incorporate the answers to the three foundational leadership questions: assisting Member Boards, safe and effective nursing practice as ultimate "end," and Member Boards acting and counseling together.

Possible revisions of the mission statement:

  - The National Council of State Boards of Nursing assists Member Boards to protect the public health and welfare by acting and counseling together for regulation which advances and assures the safe and effective practice of nursing.
  - The National Council of State Boards of Nursing assists Member Boards to act and counsel together to protect the public's health and welfare through regulation of the safe and effective practice of nursing.
  - *For the protection* or *in the interest* of public health and welfare, the National Council of State Boards of Nursing assists Member Boards to act and counsel together to advance the safe and effective practice of nursing.

- The mission of the National Council of State Boards of Nursing is to assist Member Boards to act and counsel together for the advancement of safe and effective practice of nursing in the interest of protecting the public's health and welfare.

- **Action needed: Planning – Determine the future long-range planning process and implement it.**

Based on its discussion and belief that the long-range planning process is nondelegable, the task force identified the Board of Directors as the body having the leadership role responsibilities for this process and offers the following suggestions that would change the current planning process and result in the strengthening of the organization:

- Board of Directors takes responsibility for planning – spends 80 percent of time in planning.
  How? Board of Directors holds initial discussions; reviews mission, vision, values, goals and objectives; and develops a three-year plan. This year and next year, work to get to this point. Possibly consider devoting a portion of the May 1997 meeting to lay out a schedule for completing revisions and determining where Delegate Assembly interaction/approval fits.
- Board of Directors be visionary in scope and prepare for the future.
  How? Invite chairs to a planning meeting(s); hold a one-day retreat with chairs once the mission, vision and values are well in place; use a facilitator (consider inviting Dr. Orlikoff again).
- Board of Directors *leads* throughout planning efforts/initiatives, uses committees/special committees as resources, e.g., to devise potential processes and follow-up work.
  How? Board should direct committees, not other way around. Long Range Planning Task Force's role is to stimulate and facilitate solidifying of mission and vision, see that changes are implemented to get long-range planning process in place and, finally, the task force would be abolished in 1998.
- Board of Directors *believes* in and supports what goes forward and articulates its support as an issue is introduced (e.g., Board president or other Board member speaks on each issue).
- Provide education to bring everyone to same foundation (Board of Directors first, committees, delegates, Member Boards), e.g., history resources available, role, mission.
- Determine whether or not the bylaws require changes to enhance the implementation of a long-range planning process.

Once the elements of the long-range plan (mission, vision, values, goals, objectives) are in place, the following are suggested timelines for the total planning process:

- *Fall* – Review mission, vision, goals and objectives and develop updated long-range plan at a Board retreat with chairs and staff leadership team.
- *Winter/Spring* – Long Range Planning Task Force, Research Advisory Panel, chair and staff leadership team generate tactics for next fiscal year, followed by staff preparing tactic worksheets (in the future, if the Long Range Planning Task Force is not in existence, perhaps a Board committee could meet with the staff leadership team to generate the tactics).
- *Summer* – Evaluation, organizational assessment to feed into the following year's plans.

- **Action needed: Educational program – Decision to develop (or not develop) an educational program for the membership and assignment of this responsibility (e.g., to a Board of Directors' committee or the whole Board, Institute for the Promotion of Regulatory Excellence Task Force).**

The Long Range Planning Task Force believes that a major educational program must be designed and brought to the membership by the Board of Directors. The Board takes the leadership to provide an opportunity for the membership to take an in-depth look at the National Council. The program should address the following (and perhaps other) issues:

1. historical, philosophical and organizational foundations of the National Council (a common knowledge base);
2. the authority/responsibilities for the leadership of the organization given to the Delegate Assembly and Board of Directors by the bylaws;
3. the respective roles of the Delegate Assembly, Board of Directors, committees and staff;
4. the mission of the National Council in terms of what it believes, whom it serves and what it does; and
5. the future direction – values and vision of the National Council.

The task force requested that the Board consider beginning this educational program immediately. Time was allotted on the Area Meeting agenda for the president to begin the discussion related to organizational planning. The task force strongly encouraged the Board of Directors to take a leadership role to achieve a common understanding of the role of the National Council membership and staff in the long-term planning of the organization. The members of the Long Range Planning Task Force are committed to assist the Board in its endeavors related to organizational planning.

- **Action needed: Short-range planning – Prioritize the proposed tactics for FY98, pending the action/s of the 1997 Delegate Assembly.**

The Long Range Planning Task Force, chair of the Research Advisory Panel and senior leadership staff met to draft the tactics to accomplish the National Council's Organization Plan for FY98. Nearly 115 tactics were proposed.

In preparation for drafting the FY98 tactics, the group used a "layered" process to elicit the implications for the FY98 plan from each of the following relevant areas:

1. our foundational documents (articles of incorporation and bylaws, mission and vision, goals, objectives),
2. expressed Member Board needs*, and
3. environmental data (environmental scans; current literature regarding nursing, health care delivery system, and regulation).

**Member Board Data Sources*

1994 Trend Analysis

Items listed: NCLEX® examination, analysis and influence of federal legislation, communicate regarding regulatory issues, provide nursing regulation statistics and data, provide services to Member Boards

1996 Survey of Importance of Objectives

Highest importance ratings: exams (including job analysis and CST®), consistency in licensing, APRN issues, UAP issues, documents regarding practice, analysis of education issues.

1996 "Are We Doing the Right Things?" Survey

Highest importance ratings: information regarding nursing regulation, NCLEX-related services, evaluation of nurse practitioner exams, licensure verification, telecommunications practice, DDB services, a regulatory description of nursing, the perceived importance of nursing regulation.

Consideration of each of the areas in turn led to the following list of essential criteria for the FY98 plan. As the group then proceeded to address each existing objective in turn, and possible tactics for its implementation in FY98, that objective was compared to the criteria. All criteria had at least one linked objective, and most had multiple objectives to assure that they are met.

I. Bylaws and Articles of Incorporation: Based on these, our plans must include:
   - exams (NCLEX examination) related to licensure;
   - public health (outcomes), safety and welfare;
   - common interests and concerns;
   - a way to address diverse perspectives and approaches;
   - regulatory issues; and
   - lessening burdens of Member Boards (e.g., efficient delivery of services, relief through synergy, value-added).

II. Mission and Vision: Based on these, our plans must:
   - reflect a collective representation of Member Board interests to national and even global levels;
   - offer the "best in class" for each endeavor, *if* National Council is best-suited to provide the program/services due to its capacity/competencies;
   - promote visibility of the work done, and (more broadly) of the boards of nursing and of nursing regulation overall; and
   - position Member Boards/National Council to offer their regulatory expertise in relevant arenas.

III. Goals: Based on these, our plans must include:
- assistance to Member Boards with their significant functions (i.e., discipline, licensure, education, and practice);
- analysis as a key service (including identification of key data, strategies);
- exchange of information important to nursing regulation;
- ways to enhance leadership and decision-making in the nursing regulatory community;
- solving our item writer/reviewer shortage; and
- establishing partnerships for research.

IV. Environmental data

A. Based on Member Board input, our plans must include:
- board of nursing structures, including role of executive officers;
- provision for timely alerts to Member Boards regarding practice issues, changing patterns;
- regulatory implications of "blending of roles" (e.g., UAP, techs (including surgical), EMTs, CMAs, PAs, midwives, PN/RN/APRN); and
- effective regulatory practice, e.g., multistate regulation, entry-into-practice, re-entry.

B. Based on external environment data, our plans must:
- acknowledge interstate/inter-country practice;
- provide for databases (on issues, on licensees);
- ensure inclusion and understanding of the employer's perspective (e.g., improve health outcomes, satisfy consumers, have competent practitioners, control costs and liability);
- develop and articulate regulation's contribution to the health care system (e.g., quality assurance, consumer information);
- provide an approach to continued competence which is collaborative and acknowledges regulatory implications of redeployment;
- show awareness of underutilization's impact on regulation;
- include collaboration and communication with other stakeholders;
- face the issue: what preparation is needed to do what? and who defines the what?
- provide for education of stakeholders regarding what nursing/regulation is all about;
- incorporate effects of faculty (number, qualifications, role modeling) on preparation of safe, competent nurses and needs for different approaches; and
- acknowledge regulatory implications of new technologies for education (e.g., distance learning) and practice (e.g., telepractice).

Finally, the group scanned the list from the perspective of stakeholders (i.e., those who affect or are affected by nursing regulation) to see if any additional criteria should be added to assure that no significant areas of their interest were overlooked. The following two criteria were added:
- incorporates consumer concern regarding criminal convictions; and
- addresses inclusion, understanding and analysis of third-party payer's perspective and relationship to regulation, e.g., quality control.

During the meeting, the group identified questions to be brought to the Board of Directors for its consideration/deliberation:
- How do we deal with Member Boards' diverse needs and concerns vs. common needs?
- What is "public protection?" Should we be addressing "safe health outcomes?"
- Does the vision statement correctly reflect the vision?
- How does National Council relate to/support Member Boards' authority in their respective states?
- Should the planning process be reversed, e.g., the Board of Directors develop the plan and send it out for evaluation?

The following questions relate directly to the current organization plan. During its deliberations, the Board of Directors was asked to consider the following: Should a change be made to the current objective/s? If so, when: at the 1997 Delegate Assembly or after the Trend Analysis scheduled to be conducted in FY98?

The current objective is presented in italics and suggestions for modification appear below it.

I.G. *Promote consistency in the licensure and credentialing process.*

- Should the word *promote* be changed to *evaluate*?

I.H. *Identify the role of a board of nursing related to continued competence.*

- Should 1) *identify* be changed to *support* or 2) should the phrase *provide a comprehensive approach* be substituted for *identify the role of a board of nursing* or 3) should the objective be deleted and subsumed in I.G.?

II.A. *Analyze the health care environment for trends and issues affecting the regulation of nursing practice.*

III.A. *Analyze the health care environment for trends and issues affecting the regulation of nursing education.*

- Is the current wording *health care environment* too narrow? What about education issues?

The proposed tactics to accomplish the Organization Plan in FY98 were then finalized by the group. Subsequently, the chairs of National Council committees/special committees and senior staff members were asked to prioritize the tactics before review by the Board of Directors. Respondents were asked to judge the value of each proposed tactic in light of the mission and vision of the National Council, using a five-point scale, ranging from essential to not particularly important. Committee chairs were asked to consider their committee perspective and board of nursing perspective, but evaluate each tactic in terms of the overall benefits to the organization and its membership. A copy of the results of the survey was provided to the Board of Directors at its May meeting.

Future Activities

During FY98, a trend analysis survey will be conducted (activity deferred from FY97).

Meeting Dates

- November 13, 1996 *(retreat with Board of Directors)*
- November 14, 1996 *(met with Board of Directors)*
- December 17-18, 1996
- April 28-29, 1997

Recommendations to the Board of Directors

1. That the Board considers input from the Long Range Planning Task Force in its discussion relating to long-range and short-range planning for the National Council.

Attachments

A .... Summary of Long Range Planning Retreat, November 13, 1996, *page 9*

Attachment A

Summary of Long Range Planning Retreat November 13, 1996

The Board of Directors; Long Range Planning Task Force; chairs of the Examination, Nursing Practice & Education, and Multistate Regulation Committees; and senior staff members participated on November 13, 1996, in a retreat facilitated by Dr. Jamie Orlikoff. The purpose of the retreat was to achieve consensus about strategic direction and objectives for the National Council and to understand how these translate into long-term action plans. The purpose also included achieving a common understanding of the role of the board and other groups in long-term planning for the organization. Orlikoff has consulted for the past 12 years with primarily health care groups on governance and strategic planning issues. Prior to that, he served as director of governance with the American Hospital Association.

The Nature of Change

Orlikoff described the change process in health care and society in general as being fundamentally different than it has been in the past. (References: *The Second Curve* by Ian Morrison.)

In the past, organizations have been required to manage stability, interrupted by brief periods of incremental change. Presently, the change process is more aptly described by two disconnected curves, such that the organization's challenge is to master the "curve" representing the environment and opportunities which currently exist, and also to determine when and how it must leap to the next "curve" representing its next reality. The risk of not leaping at the appropriate time is organizational "death" or at least temporary entanglement in the "danger zone" between the curves. The change in the nature of change means that the environment is no longer forgiving to organizations which fail to leap to the next curve, and they risk irrelevancy at minimum or dissolution at worst. Among organizations which do "make it" from Curve A to Curve B, the most effective make the leap quickly, rather than desperately "grabbing" for the tail of Curve B on the way down from Curve A.

Within the context of the two-curve change, Jamie Orlikoff distinguished planning to respond to what *will* happen (which is virtually impossible to predict at long range), from planning to *make something* happen.

Roles in Governance

In an incremental change environment, boards primarily monitored an organization's activities and spent relatively little time on what might or should happen in the future. In a "two-curve" change environment, a board must leverage its most precious commodity, time, differently: spending 80 percent determining what it desires to have happen in the future and only 20 percent monitoring the past.

The Health Care Environment

Health care is one of only three major sectors in this country that has not already moved through fundamental change, the others being higher education and the federal government. In years past, the inefficiencies of the health care system have allowed certain paradoxes to go unresolved, e.g., that the better health care becomes, the longer people live and ultimately more resources must be devoted to health care. Orlikoff predicts that the changes necessary to address these are just beginning, and consequently the current chaos, will continue for another 15 to 20 years.

Systems Thinking

Organizations within complex contexts such as health care benefit from mastering systems thinking. Orlikoff described eight common myths that block systems thinking:

1. My reality is *the* reality! (There are multiple realities.)
2. Separating self from external reality. (We help create reality.)
3. Focusing on event vs. process. (Cause and effect are separate in time and space.)
4. Fragmentation thinking. (Whole is greater than the sum of its parts.)

5. The enemy is out there. (We have met the enemy – he is us!)
6. Big change requires big action. (A few well-focused actions working together produce significant change.)
7. The organization is like a machine. (It is an organic, living system.)
8. The illusion of control. (There is no absolute control.)

The Mission

Beginning to get to the fundamentals of planning specific to the National Council, Orlikoff introduced discussion of the organization's mission. Adherence to the mission in decision making is a safeguard boards use to assure that, even though everyone will not be pleased by their decisions, the decisions are consistently based rather than subject to situation-by-situation criteria. A mission should be specific enough that some would not be able to subscribe to it, and would therefore be unwilling to be a part of that board or organization. A good mission statement tells "who you are, who you're not, what you value and what you don't." Orlikoff related three essential "critical leadership questions" to which any governing board needs common answers if the mission statement is to fulfill its key role in guiding decisions about the future:

1. What do we believe?
2. Whom do we serve?
3. What do we do?

Related to point one, the mission represents a unified belief system which is appropriate to guide all decisions. Related to point two, it is important to have a common prioritized set of "customers" for an organization. Related to point three, Orlikoff pointed out that consistency between the beliefs/customers and the activities pursued was essential to avoid "organizational drift" and ineffectiveness. The mission implicit in the strategies pursued should be the same as the one that is actually stated.

The retreat participants each wrote their view of the mission of the National Council. It was noted that in the participants' versions of the National Council's mission, there was a good degree of consistency in basic beliefs about protection of the public through nursing regulation being key values of the organization. There was less consistency on "whom do we serve" in that some focused on supporting and assisting Members Boards and some more directly on the public. Regarding what the organization does, some cited specific purposes (e.g., examinations) and others focused on public policy. In addition, it was noted by participants that at least two other statements that could be construed as mission exist: the purpose as stated in the bylaws and the purpose as stated in the Articles of Incorporation. The "keeping" of the mission is most appropriate to the Board of Directors. This is because the staff have their livelihood as a vested interest, which could cause them to make decisions based on self-interest instead of true to the mission. Likewise, the Member Boards have their own survival to look after, and while nine out of 10 times, that may be in perfect alignment with the mission, it is crucial that a party without a survival interest be looking after the mission the one out of 10 times that there is a conflicting interest. Orlikoff pointed out that this reasoning comes out of the "fallacy of composition," which states that one cannot assume that what is good for individuals in the group is always good for the group and vice versa.

An organization's life cycle can be superimposed on Curve A. The life-cycle points might include birth, childhood, adolescence, early adulthood, middle adulthood, old age and death. These points relate to increasing mastery by an organization of its environment, including the ability to reap benefits from its endeavors within that environment. As one progresses along the curve toward old age and death, the benefits may still be there but the endeavors are losing their relevancy because of environmental change. Orlikoff challenged the retreat participants to gather in small groups to identify where the National Council is on Curve A, what are the characteristics of Curve A and what are the characteristics of Curve B – whether what "will" happen or what we can "make" happen?

In general, the responses from the four small groups were quite consistent in terms of describing the following characteristics for Curve A:

- Revenue: primarily from the NCLEX® examination.
- Structure: Delegate Assembly sets direction; Board provides interim leadership and policy-setting; committees and staff have roles under board direction, with possible exception of standing committees. Leadership is a shared responsibility. Membership is "closed." Contracts with many "partners."
- Relationships: important internal relationships are between and among Member Boards (including within Areas), Delegate Assembly, Board, committees and staff. Important external relationships are those with candidates, consumers, nurse educators, nurse licensees, nursing professional organizations, state and federal

governments, other regulators, nurse employers, accrediting bodies, and contractors/vendors for services needed.

- Culture: emphasis on what would benefit all/most Member Boards; value of equal/fair representation in National Council governance and activities; very high Member Board and individual levels of participation.
- Current Issues: regulation – purpose, extent, best approaches (e.g., multistate practice, privatization, board roles); levels of nursing personnel – scopes of practice, UAPs, APRN credentialing (including nurse practitioner exams for regulatory purposes); continuing practice – continued competence, discipline; societal movements – states' rights, managed care, consumerism; nursing education – entry requirements and specialty accreditation.
- Current Activities: credentialing exam-related services; discipline resources; legislation and policy monitoring; practice and regulation-related research; information clearinghouse; model policy statements; special services.

The small groups were consistent in believing that the National Council's current location on Curve A is between middle and old age; with one group believing that was true only for the organization's NCLEX examination endeavors, but all others were in a childhood stage.

There was a "lack of interesting differences" in describing the characteristics of Curve B, which may be indicative that the groups had discussed it before and just brought up the same ideas again, or that participants really do have a good handle on the future they intend to "make happen."

- Revenue: proportionally less from the NCLEX examination; more from Special Services Division (including certification and accreditation activities) and other services such as electronic licensure verification, publications, license processing; alternatively, programs will have to be constrained or cut.
- Structure: open up membership to others, e.g., international regulatory bodies; changes in the Delegate Assembly structure or function to allow for more timely responses; Delegate Assembly may become more representative (House of Representatives model) or less representative (more power vested in Board, who would be elected "at large" and not tied to representation of regions or segments of the membership); consumers may play a larger role, e.g., as organizational partners, as electors of the Board).
- Relationships: important internal relationships are between and among Member Boards, though they may have changed in their structure and function; Committee on Nominations may change (e.g., chaired by past president) as requisite qualifications for and duties of Board leadership change; committees and staff may be relatively unchanged. Important external relationships shift somewhat away from nursing organizations and more toward regulatory and governmental organizational relationships. Accreditors of nursing education programs may be a new important relationship. Relationships with candidates, consumers, nurse educators, nurse licensees are anticipated to be relatively unchanged. Vendor relationships may shift as National Council considers taking on aspects of testing services, but also acquires new SSD partners.
- Culture: mindset may shift to a public/private partnership framework entailing centralized functions combined with local (state) authority and enforcement; there may be more emphasis on serving consumers, public accountability and regulation for "quality" not just "minimum safety."
- Issues: regulation – public accountability, outcomes, best approaches (e.g., board existence, roles); measurement of competence (e.g., CST®); access to information regarding individual providers; different roles for nurses: settings, independence, client characteristics and needs; state boundaries more seamless to health care.
- Activities: credentialing services of more kinds, to a broader range of constituents, and using more technology; legislative advocacy expands; greater range of activity for Special Services Division; continue monitoring, discipline resources, regulatory research.

Participants discussed the implications of the Curve A/Curve B thinking as applied to the National Council. It was noted that the Delegate Assembly's final authority is a tension within the system. In terms of the entire organization coming along from Curve A to Curve B, Orlikoff stated that, in his experience, it is unlikely that all will move in concert, but that possibility is heightened if the Board spends time on the organization's future rather than its past. The worst situation is when some in the organization are fixated on Curve A, while others are just as firmly fixated on Curve B.

Turning Curve A/Curve B thinking into strategy was illustrated by Orlikoff. Looking at a sample conclusions about Curve B, need for structural nimbleness and Board leadership, the Board might consider potential alternative strategies, such as delayering so that Member Boards relate more directly to constituencies, regional regulatory bodies replace both National Council and Member Boards, or more nationalization of regulatory functions in

National Council. To select a strategy, the market's influence needs to be assessed, including telecommunications, government, health care delivery and other aspects. The Board integrates this information and draws conclusions about appropriate governance structure, product lines, staff structure. Working through scenarios to develop contingency plans is a fruitful approach as well. In the process, there is a natural dialectic of "thesis-antithesis - synthesis" which is somewhat impeded by built-in barriers in the National Council's structure. The worst long-range planning approach is to focus on developing specific tactics to prosecute Curve A features. In other organizations, this strategy has led to serious decline.

With respect to follow-up to this session, participants and the facilitator identified agreeing on a mission, prioritizing the customer base, raising these concepts to the broader Member Board/Delegate Assembly group and resolving the structural/authority issues as being the key next steps. Vehicles might include development of "issue papers" from the Curve A/Curve B material, teleconference or video presentation of the concepts, and/or a special meeting of the Delegate Assembly.

Report of the Multistate Regulation Task Force

Task Force Members

Joan Bouchard, OR, Area I, *Chair*
Charles Bennett, CA-VN, Area I
Iva Boardman, DE, Area IV
Shirley Brekken, MN, Area II
Faith Fields, AR, Area III
Patty Hayes, WA, Area I
Mary Kinson, NH, Area IV
Celinda Kay Leach, IN, Area II
Elizabeth Lund, TN, Area III
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Staff

Jennifer Bosma, *Executive Director*
Susan Williamson, *Director of Credentialing and Practice*

Relationship to Organization Plan

Goal V................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

Objective G.........Continue developing the concept of a model which incorporates the characteristics of multistate practice.

Recommendation to the Board of Directors

1. **That the Delegate Assembly endorses a mutual recognition (i.e., driver's license) model of nursing regulation and authorizes the Board of Directors to develop strategies and services, including an interstate compact and information system, needed to assist boards of nursing with implementation.**

Rationale

Analysis of the information gathered by the task force and input from representatives of Member Boards at the June 1997 MSR Workshop support the mutual recognition model as an approach to multistate regulation of nursing practice. After consideration of a continuum of models, the task force recommends this model as: 1) the simplest approach that is workable, and 2) an approach which would facilitate multistate practice without risk to public safety.

Background

The 1996 Delegate Assembly directed the Board of Directors to continue developing the concept of a regulatory model that incorporates the characteristics of multistate practice by directing activities which included the following:

1. evaluate the magnitude of the needs of consumers, nurses, and health care delivery systems for multistate practice;
2. evaluate the impact of state-level regulatory processes on the multistate licensing concept;
3. identify core licensure requirements for multistate practice;
4. evaluate potential future implications for board of nursing role and function related to multistate practice;
5. identify mechanisms for effective cross-state disciplinary processes;
6. analyze current laws and regulations for potential impact on multistate practice;
7. explore the feasibility of a demonstration or pilot project with possible external funding; and
8. explore other potential options that would facilitate multistate practice.

As a result of this motion, a 12-member task force was created to fulfill the charge, and a team of National Council staff members was formed to direct the collection of data to support the task force's activities. This report outlines the activities of the task force for the past year.

Statement of the Problem

The task force began by asking the question, "Why is regulatory reform necessary to meet the needs of a changing health care delivery environment?" and subsequently developed the following statement:

Regulatory reform is necessary to meet the needs of a changing health care delivery environment for the following reasons:

- new practice modalities and technology are raising questions regarding issues of current compliance with state licensure laws;
- nursing practice is increasingly occurring across state lines;
- nurses are practicing in a variety of settings and using new technologies which may cross state lines;
- expedient access to qualified nurses is needed and expected by consumers without regard to state lines;
- expedient authorization to practice is expected by employers and nurses; and
- having a nurse demonstrate the same licensure qualifications to multiple states for comparable authority to practice is cumbersome and is neither cost-effective nor efficient.

Vision Statement, Features of a Desired System and Criteria for Evaluating Models of Regulation

As work began to accomplish the charge from the Delegate Assembly, the task force identified a vision statement, features of a desired system and the criteria for evaluating models of regulation.

- **Vision for Nursing Regulation**

Regulation supports the public's protection and access to nursing care within a seamless practice arena on a national scope. Competent nurses can care for clients wherever they are, based on the best care delivery methodology. States' rights to determine who does and does not practice are respected.

"A state nursing license recognized nationally and enforced locally."

- **Features of a Desired System**

The task force discussed the features of a desired system of regulation that would facilitate nursing practice across state lines. Six features were identified as important in a reformed regulatory environment:

1. state-based authority,
2. a license linked to state of residence,
3. a central database of licensees,
4. uniform licensure requirements,
5. revenue/cost neutral to the Member Boards, and
6. expedient processing of licensure applications.

- **Criteria for Evaluating Models of Regulation**

As one of its first activities, the task force developed a set of criteria to be used as a framework to evaluate potential models of regulation. The criteria are:

- requires anyone practicing nursing to be accountable for complying with all laws governing practice;
- delineates a source of legal authority for scope and location of practice and discipline;
- is compatible with state sovereignty;
- promotes an expeditious discipline process while ensuring protection of due process for all parties;
- assures a licensed nurse has demonstrated the knowledge, skills and abilities to provide safe and effective nursing care;
- establishes standards for education, licensure and discipline;
- provides effective monitoring of the practitioner's competency and professional conduct;

- provides for the protection of the public by dissemination of information about disciplinary action within and across the jurisdictional boundaries;
- provides for an open system of information exchange;
- eliminates the barriers to interstate practice;
- facilitates interstate commerce;
- is administered in a cost-effective and cost-conscious manner; and
- generates revenue to support operations.

Highlights of Activities

The remainder of this report describes the work of the task force under each component of the 1996 Delegate Assembly motion as stated at the beginning of this report.

- **Evaluate the magnitude of the needs of consumers, nurses and health care delivery systems for multistate practice**

Since August 1996, the task force has obtained data from multiple sources in the effort to identify the magnitude of the need for multistate practice. These sources included surveys of Member Boards, surveys of a sample nurse population, informal questions asked via e-mail and newsletters, and interviews with key leaders in the health care delivery system.

Formal Nurse Survey

The task force authorized a nationwide survey of a random sample of nurses to determine how many held nursing licenses in multiple states, the reasons for the multiple licenses and the perceived effectiveness of the current licensure process. Surveys were sent to 6,000 licensed nurses – 3,000 registered nurses (RN) and 3,000 licensed practical/vocational nurses (LPN/VNs). A response rate of 60 percent was obtained. Of the nurses who responded, 17 percent held more than one license and 8 percent (10 percent of RNs and 7 percent of LPN/VNs) worked in more than one state – up to as many as 50 states – during the previous 12 months.

Of the total group, 8 percent had applied for a license in an additional state within the previous three years. They reported that the most "hard/unreasonable" aspects of this process were the turnaround time and costs.

The nurses who held multiple licenses did so for a number of reasons. A common reason was the desire to "keep a license in my original state of licensure." Those nurses who worked in multiple states were most likely to cite "my job requires me to provide care in multiple states," or "to increase my employment flexibility." Those with multiple licenses or practicing in multiple states were most likely to report that a single license, recognized everywhere in the country, would be a "great advantage" for them. Overall, 31 percent of the respondents reported a single license would be a "great advantage" for them.

Informal Nurse Survey

Since December 1996, the task force conducted an informal survey among nurses by requesting feedback on the following questions:

1. Are you aware of nurses who are currently practicing across multiple states due to the requirements of their jobs? If yes, in what settings and how (e.g., via telephone, travel, computer, etc.)?
2. Do you believe the current state-by-state licensing system will need to change? If yes, why?

These questions were published in *Issues* and the *MSR Task Force Communiqué* and on the National Council's World Wide Web page (http://www.ncsbn.org), as well as were sent to Member Boards for inclusion in their newsletters. Responses from 658 nurses have been received. While these responses cannot be considered representative of the population of nurses as a whole, they do provide interesting insights on emerging needs for multistate practice authority.

More than 60 percent of the respondents answered "Yes" to Question 1, saying they know of nurses whose jobs require them to practice in multiple states. And more than four out of five of the respondents (82 percent) answered "Yes" to Question 2, saying they believe the current system will need to change.

Those who know nurses who practice in multiple states answered Question 2 somewhat differently from those who do not. Of those who *do* know such nurses, 89 percent believe the system will need to change. Of those who do *not* know such nurses, only 31 percent believe the system will need to change.

Of those who elaborated on Question 1, about three times as many mentioned travel or physically working in more than one state than mentioned telephone or computers as the ways nurses practice in multiple states.

The comments on Question 2 indicated some uncertainty. Some who believe the system will need to change wanted to retain some state-level authority. On the other hand, some respondents who felt the current system will not need to change added notes wishing for more consistent requirements and applications procedures across states.

Delivery System Executives

In December 1996, the National Council contracted with TVG, Inc., to conduct a qualitative research project to: 1) explore the current and projected use of nursing professionals within a variety of health care settings to deliver health care on an interstate basis, 2) determine current knowledge and attitudes concerning the interstate practice of nurses, and 3) solicit ideas to address interstate licensing issues. TVG is the largest independent market research and consulting organization serving the health care industry and has been conducting research projects with the managed care segment from the time the managed care industry began to significantly impact the health care marketplace.

To meet the goals of the study, in-depth telephone interviews were conducted with senior executives and key decision-makers in a variety of health care settings. Forty interviews were conducted. Interviews with the respondents lasted 45-60 minutes and covered a range of issues. The discussions loosely followed a topical guide jointly developed by the National Council and TVG.

A copy of the TVG report is attached (Attachment A). Key major findings are as follows:

- The majority of TVG interviewees were unsure of how to define nursing in the 1990s, outside of the traditional roles in patient care settings. They articulated that they perceive nursing to be direct, hands-on delivery of nursing care or the supervision of individuals engaged in this activity. Given this traditional operative definition of nursing, the majority of respondents were unsure if employing nurses in nontraditional roles (roles that do not directly deliver care to patients) is, in fact, nursing. Given the absence of any widely accepted guidelines, the respondents stated their organizations define such positions as non-nursing and, therefore, do not believe that they are employing nurses who deliver care across state lines.
- The absence of a new operative definition for nursing makes it difficult for health care organizations to judge whether or not particular functions involve nursing. They reason that nurses may essentially be following algorithms developed by medical staff and, therefore, the delivery of such information does not constitute the practice of nursing.
- Respondents agreed that fewer nurses will be employed in hands-on care in the future, but that demand will increase in nontraditional areas.
- Given a traditional operative definition of nursing, the majority of respondents do not perceive the interstate practice of nursing to be a significant issue.
- When asked about what a licensure system should look like to serve the needs of the current and emerging health care industry, most participants suggested a system similar to the system for driver's licenses.

Telenursing Definition

The task force had concerns regarding the apparent ambiguity of the health care industry as to what constitutes nursing practice and the occurrence of unregulated practice across state lines. This led the task force to develop a draft definition of telenursing (Attachment B). This draft was circulated to Member Boards for comments. The task force will then revisit the definition prior to the Delegate Assembly.

Consumer Needs

A recent publication, *1997 Environmental Assessment – Redesigning Health Care for the Millennium: An Assessment of the Health Care Environment in the United States,* by VHA, Inc., and Deloitte & Touche LLP, provided a valuable resource in assessing consumer needs of the health care system. This study reported that employers, who buy health care for their workers, are most concerned with geographic coverage, cost and clinical quality factors. Consumers, when asked what matters most to them, state they value factors such as having access to a consistent health care provider and having a provider who spends enough time with them. These considerations outweigh free choice of provider, convenient hours and having no limits on procedures or specialists.

Previously, attempts to measure quality were focused primarily on how well providers rendered health care. Now, increasingly, the emphasis has shifted to "demand side" or how consumers make health care decisions. The

report states the consumer clearly demands to be an active participant in health care decisions and that this demand is being "directed and influenced by programs such as 24-hour nurse advice telephone services and Internet health care information."

The task force asked the Citizens Advocacy Center (CAC), "What are the consumer's preferences and demands in regards to regulation of health care?" The answer was that the consumer expects a safe health care practitioner and is likely unaware of the process in place that assures how safe practice happens. The consumer knows that someone regulates the quality, but is not likely to care how the quality is accomplished, unless something goes wrong. For this reason, CAC suggested that asking the population at large to identify preferences, or even asking them to select the most advantageous regulatory approach, would not likely yield much useful information regarding regulation. The consumer simply wants the assurance of a safe health care provider. CAC suggested that the most useful information could be gathered by questioning consumers who are already knowledgeable of the regulatory system, such as consumer members of regulatory boards. The task force determined that consumer member input had been obtained as the various boards of nursing discussed this issue throughout the past year.

Other Activities to Access Magnitude of Need

Throughout the year, the task force kept abreast of activities occurring in the external environment. Of particular interest were those activities of federal and state governments in terms of telehealth and its relation to licensure issues, trends in managed care and demand management delivery systems, changes in nursing practice and nursing education, the impact of technology on the way that government offers services and programs to its citizens, the consumer demand movement and the way other professional groups are responding to the rapid growth of telehealth activities. The task force spent considerable time discussing numerous reports and legislative proposals, including: U.S. Department of Commerce Joint Working Group on Telemedicine's *Telemedicine Report to Congress*, Senator Conrad's (ND) *Comprehensive Telehealth Act of 1996 and 1997*, Senator Wyden's (OR) *The Medicare Modernization and Patient Protection Act of 1997*, National Institute of Medicine Report's *Telemedicine: A Guide to Assessing Telecommunications in Health Care*, The Center for Telemedicine Law's *Telemedicine and Interstate Licensure* and the Western Governors' Association's *Telemedicine Action Report*. In addition, the task force will be watching with interest the discussion on telemedicine which is the agenda for the July 1997 National Governor's Association meeting.

- **Evaluate the impact of state-level regulatory processes on the multistate licensing concept**

To evaluate the impact of state-level regulatory processes on the multistate licensing concept, the task force received feedback from Member Boards, board attorneys and central agency administrators.

Member Board Survey

Member Boards were surveyed in October 1996 and results collected until May 1997. Forty-six responses were received. The two questions asked and summaries of the Member Boards responses follow.

1. *What do you see occurring in your jurisdiction in the way of multistate nursing practice?*

Boards of nursing identified numerous ways in which multistate practice was occurring, with the most frequent responses including more health care and educational systems operating across state lines, increase in telenursing and more individuals crossing state lines to practice.

2. *Please identify any current regulatory process used in your jurisdiction which must not be forgotten as the MSR Task Force considers potential ways of facilitating multistate practice.*

Among the current processes that boards of nursing listed were differing disciplinary provisions, revenue issues, education issues, differing administration practices, differing legislation provisions, scope of practice issues, advanced practice registered nurse laws and regulations, and mandatory reporting provisions.

Board Attorney Interviews

Interviews with more than 30 board attorneys identified issues of concern other than discipline which included revenue issues, dealing with caseload backlogs and priorities, political interests, the possible confrontation between federal powers and state rights, and achieving trust between boards. The information collected through these

interviews was used to clarify the legal questions and identify possible approaches to dealing with these issues. The issues are addressed in later sections of this report.

Central Agency Administrators

To broaden the input on state-level issues, the work of the task force was presented and discussed at the Council of Licensure, Enforcement and Regulation (CLEAR) meetings in October 1996 and January 1997, as well as at a meeting of a CLEAR subgroup of central agency administrators in April 1997. Among the issues this group raised were potential impact on revenue, impact on disciplinary workload and processes, and legal implications. Two special mailings related to this issue were done to the entire mailing list of central agency administrators and one to autonomous agency administrators.

- **Identify core licensure requirements for multistate practice**

The task force included uniform licensure requirements as an initial component of its deliberations to identify a model for implementing multistate licensure and worked in conjunction with the Nursing Practice & Education Committee (NP&E) and the Advanced Practice Registered Nurse (APRN) Task Force to define those requirements. Draft uniform requirements were developed for RNs, LPN/VNs and APRNs. To determine the congruence of current jurisdictional licensure requirements with the draft uniform requirements, a scattergram of the various states' licensure requirements was prepared, sent to Member Boards for correction and returned so that each criterion depicted the range of current licensure requirements around the uniform requirement.

Subsequently, the task force decided that uniform licensure requirements would not be necessary to initiate the proposed mutual recognition model, but uniform requirements remain an ultimate goal. The task force suggested the Board of Directors charge the NP&E Committee with the primary responsibility of completing their development. This will facilitate continued organizational focus on uniform licensure requirements development while the MSR Task Force continues to focus on other multistate regulation issues.

- **Evaluate potential future implications for board of nursing role and functions related to multistate practice**

The task force spent considerable time discussing social and political challenges to state government to provide faster and more value-added services with diminished resources. The average citizen can now access within seconds vast amounts of information, and his/her expectations of how government services should be delivered will become more demanding. The task force discussed ideas about how the concept of a multistate practice model might facilitate boards' ability to meet the future demands of nurses, employers of nurses, state and federal governments, and consumers.

Early in the process, the task force considered a continuum of models. A fiscal analysis was done on each model. As additional information came in from the various surveys and attorneys, the focus narrowed to one model (mutual recognition/driver's license model). A more comprehensive analysis was then done on this model, including revenue that would be lost to state boards of nursing, possible new revenue sources and additional costs that would occur with implementation of the model at state and national levels. Such a system would contain relevant licensure and disciplinary information to enable tracking and coordination among states where an individual nurse may practice. The task force began to identify components of an electronic information system to enhance the speed and reliability of licensure and disciplinary data between states.

- **Identify mechanisms for effective cross-state discipline processes**

The impact on discipline activities and other legal implications of multistate practice are critical issues. For more than two years, representatives of the National Council have participated in discussions exploring the legal environment related to telehealth and multistate practice. Part of the work identified by the task force included looking at the legal issues presented by taking disciplinary action when nursing practice occurs in multiple states. The task force identified a need to obtain information, feedback and ideas from the attorneys who advise Member Boards. Accordingly, more than 30 attorneys responsible for advising boards of nursing across the country were interviewed regarding multistate legal issues. Concerns identified by board attorneys included: 1) jurisdictional issues; 2) the variations in state's confidentiality laws and statutes resulting in barriers to sharing of information; 3) legal issues surrounding telehealth/telenursing; 4) how nurses in monitoring programs would be accommodated; 5) equal protection issues; and 6) the differences between states in definitions, violations process, sanctions, case

disposition criteria and standards of proof. Most attorneys interviewed viewed identification of unsafe nursing practice, effective prosecution, board action and board monitoring of disciplined nurses as very challenging when dealing with the geographic issues, given frequently limited resources, a mobile work force, and a changing and complicated health care delivery system. In addition to describing issues and problems, the board attorneys also proposed possible approaches for dealing with these issues. The questions and issues raised by this group assisted the task force to focus the work of an invited panel of legal experts.

- **Analyze current laws and regulations for potential impact on multistate practice**

The next step in working with current laws and regulations for potential impact on multistate practice was to assure that the most critical legal issues had been identified, clarify those issues and develop approaches to deal with the legal challenges. To do this, the MSR Task Force convened an expert legal panel.[1]

The expert legal panel reviewed the work of the task force, discussed numerous legal issues, advocated for the simplest approach that is workable and, in the end, recommended the task force pursue a model of mutual recognition, similar to a driver's license. The rationale for this model included:

- mutual recognition is the closest model to the existing system;
- mutual recognition reflects the legal concept of Full Faith and Credit between U.S. jurisdictions;
- mutual recognition could be implemented incrementally;
- work could proceed on multiple fronts: some states could move forward immediately, based on interpretation of current law, while other states could move forward creating a pathway by either interstate compact or legislative change; and
- implementation could begin without uniform requirements, although boards might agree to move toward a goal of uniform requirements.

The panel recognized that, for this model to work, boards would need to share data and develop ways to deal with discipline issues and confidentiality.

At the second meeting, the panel reconvened via audioconference to further discuss legal issues. Though concerns continued around specific discipline approaches, a single license approach was agreed to be viable with an interstate compact as the best means for accomplishing implementation. The interstate compact is the mechanism utilized in the driver's license system. It provides a means for defining the relationships from state to state with regard to discipline. A draft of the components of a compact for nursing regulation is being prepared for discussion at the 1997 Delegate Assembly.

[1]Staff worked with Bob Waters of the Arent Fox Law Firm in Washington, DC, who is affiliated with the Center for Telemedicine and considered an expert in the field, to host the meeting. National Council staff invited attorneys representing state boards, including a state umbrella regulatory board; another professional regulatory organization; National Council's attorney; and an MSR Task Force representative. Waters invited a law professor whose expertise was in constitutional and cyber-law, a former legislative aide to Senator Conrad, an attorney working as a project director for the Health Care Finance Administration, and two representatives of a multistate business corporation that provides health services across state lines. This created a mix of experience, expertise and perspective, allowing the issues to be addressed from a variety of viewpoints.

- **Explore the feasibility of a demonstration or pilot project with possible external funding**

The task force considered several possible pilot directions, but concluded that they were premature prior to direction from the 1997 Delegate Assembly. Moving to implement a pilot project proved to be difficult without a specific model to provide a framework for the questions to be asked or the product to be evaluated. Demonstration projects, as well as projects involving the database, are possible future directions, as is the possibility of obtaining external funding.

- **Explore other potential options that would facilitate multistate practice**

Based on the vision, problem statement, features of a desired system and criteria for evaluating models, a continuum of models for nursing regulation was developed, described and analyzed (Attachment C). The task force seriously considered various regulatory models including the current licensure process, mutual recognition, fast endorsement, single-state license plus a multistate option, single-state or multistate option, multistate license with

state "carve out" multistate license and federal license. The task force identified the pros and cons of each model from the perspective of various stakeholders, including the licensee, board of nursing, employer and consumer.

As the task force was identifying the various models for consideration, information was being compiled and analyzed from the various surveys, the fiscal and legal discussions, and the legal expert panel. As a result of this considerable input, the task force decided to pursue a proposed mutual recognition model with similarities to driver's license model.

The task force compared the mutual recognition model to the current regulatory process in relation to the areas of initial licensure, practice across states, change to a new state of licensure, renewal, lapse/re-entry/reinstate license and discipline. This comparison revealed that much of the current licensure process would still be in place with modifications. Although there are many details still to be worked through with this model, general concepts under this model are as follows: The nurse would accept at initial licensure that she/he can practice in other states, but acknowledge she/he is subject to each state's practice act and discipline. Practice across state lines would be allowed whether physical or electronic, unless the nurse is under discipline or monitoring agreement that restricts practice across state lines and/or within the "home" state. The nurse would have only one licensing record. A central information system would be in place to keep the record current and accessible to the state boards, and the nurse would need to only renew in one state. An interstate compact would define disciplinary relationships between the involved states.

■ **Other Activities**

A major goal of the task force this year was to keep Member Boards and the public-at-large informed of the activities of the task force. To this end, the task force developed a communication plan. A Multistate Regulation Resource Packet was developed, information was put on National Council's Web site, a multistate concept paper was developed and widely circulated to all interested parties, and the task force published articles for *Issues*, the National Council's quarterly newsletter with a readership of more than 10,000. In addition, the communication plan included the approximately monthly distribution of two versions of the *MSR Task Force Communiqué*: one version for general dissemination and another more detailed version for Member Boards (Attachment D). A special edition of the *MSR Task Force Communiqué* was prepared for governors and state officials in view of related discussions planned for the National Governors' Association meeting in late July.

Numerous presentations were given by task force members and staff at Area Meetings and various other organizational and governmental meetings. The National Council participated as observers of the Congressional Joint Working Group on Telemedicine and as a member on its Licensure and Legal Issues Subcommittee. Representatives of the National Council participated in sessions on the topic of multistate regulation at the American Telehealth Association meeting, Atlantic Rim Network Transatlantic Telemedicine Summit, American Academy of Nursing Conference on the Future of Nursing and Regulation, and Friends of the National Library of Medicine Health Information Infrastructure '97. The National Council was specifically referenced in the Telemedicine Report to Congress, and language from the National Council was incorporated into the report including the replacing of the word *telemedicine* with *telehealth*.

The task force sponsored the conference "Public Policy and the Public's Health: Local to International Perspectives" during June 1997 in conjunction with The Center for Health Policy at George Mason University. The objective of the conference was to give boards of nursing a foundational framework to evaluate public policy issues and develop strategies to influence policy decisions. At the conclusion of the conference, the task force sponsored a one-day interactive workshop with Member Boards where the proposed mutual recognition/driver's license model for multistate practice was presented and feedback and comments obtained. The consensus of the workshop participants was that the task force should move forward with further refinement of this model and the components of an interstate compact for consideration at the 1997 Delegate Assembly.

Future Activities

- Refinement of the mutual recognition/driver's license model.
- Development of components of an interstate compact.
- Refinement of the draft definition of telenursing.
- Additional activities as determined by the Board of Directors and Delegate Assembly.

Acknowledgment

The task force would like to express its appreciation to the Member Boards, Board of Directors, members of the NP&E and APRN committees, National Council staff, and the numerous other people who offered comments, expertise and ideas to the task force throughout the year. The work of this task force would not have been possible without their support and commitment.

Meeting Dates

- September 25-28, 1996
- October 28, 1996 *(telephone conference call)*
- December 3-5, 1997
- February 3-5, 1997
- May 1-3, 1997
- July 21-22, 1997

Recommendation to the Board of Directors

1. That the Delegate Assembly endorses a mutual recognition (i.e., driver's license) model of nursing regulation and authorizes the Board of Directors to develop strategies and services, including an interstate compact and information system, needed to assist boards of nursing with implementation.

Attachments

A .... TVG, Inc., The Interstate Practice of Nursing: An Assessment of Current Practices in the Health Care Industry, *page 11*

B .... Draft NCSBN Definition of Telenursing, *page 25*

C .... Continuum of Models for Regulating Nursing Practice, March 1997 Draft, *page 27*

D .... *MSR Task Force Communiqué* Mailings, *page 39*

Attachment A

TVG, Inc., The Interstate Practice of Nursing: An Assessment of Current Practices in the Health Care Industry

I. INTRODUCTION AND METHODOLOGY

The National Council of State Boards of Nursing (NCSBN) contracted with TVG, Inc., to conduct a qualitative research project centered on exploring the current and projected use of nursing professionals within "managed care" to deliver health care on an interstate basis. It is our understanding that the NCSBN has become increasingly aware of a trend toward employing nurses in positions that require them to counsel and/or deliver care in multiple states through such practices as preauthorization, case management and demand management. This practice raises concerns over licensing. Therefore, the NCSBN's overall objective was to gain a perspective on the extent of the practice and future trends in this regard. More specifically, the objectives of the research included:

- Exploring the current use of nursing professionals in a variety of health care settings as it involves the potential for the interstate practice of nursing.
- Identifying the types of organizations that currently employ nurses in positions that require an interstate use of their skills.
- Establishing, to the extent possible, the number of nurses engaged in positions requiring interstate practice in key organizations.
- Determining current knowledge and attitudes concerning the practice, and to explore future plans and/or projections regarding the use of nurses in this manner.
- Exploring the needs of various segments of the health care industry relative to the current and future employment of nurses, and to solicit ideas for addressing the licensing issue.

In order to meet the goals of the study, in-depth telephone interviews were conducted with senior executives and/or key decision makers in a variety of institutions. A total of 40 interviews were conducted. Interviews with the respondents lasted from 45-60 minutes and covered the range of issues of interest to the NCSBN. The discussions loosely followed a topical guide, which follows this report, jointly developed by the NCSBN and TVG, with actual interview flow determined by the interviewees' responses. Interviews were conducted by Christopher Sutherland, PhD, and John Haig, PhD, of TVG. Many participants were provided with an honorarium to compensate them for their participation.

The remainder of this document contains an executive summary of the findings and conclusions from the interviews. As with all small-scale qualitative research, the reader is reminded that the findings are directional in nature and not necessarily translatable to the population as a whole.

II. KEY FINDINGS

- **Outside of traditional roles in patient care settings, respondents are unsure of what constitutes nursing in the 1990s.**

The respondents in this study are unsure of how to define nursing. They routinely commented that traditional nursing, the direct care of patients (with its associated planning for both inpatient and outpatient care) is easy to define and identify. The use of nurses in nontraditional nursing and/or health care positions raises more questions. For example, many respondents questioned whether nurses employed in positions preauthorizing emergency visits or surgery are engaged in nursing, and noted that the nurses, while drawing on their clinical/medical knowledge, are essentially following algorithms. These algorithms have been developed under the leadership of the medical staff. The majority of respondents questioned whether nurses in these positions are functioning as nurses, or in some other capacity.

Defining nursing is important to the respondents. Without a clear definition, they were unsure if employing nurses in nontraditional nursing roles (roles that do not directly deliver care to patients) is, in fact, nursing. In the absence of any widely accepted guidelines, or even discussion about the issue of which they are aware, the

respondents routinely noted that their organizations define such positions as non-nursing. Consequently, they do not believe that they are employing nurses who deliver care across state lines. This uncertainty concerning what nursing **is**, was expressed by a wide variety of respondents, including nurses in executive positions.

- **The absence of any new operative definition for nursing makes it difficult for health care organizations to judge whether particular functions involve nursing or not.**

Respondents agreed that direct case management, in-home nursing across state lines and travel to other states to supervise or practice in direct patient care settings constitutes the interstate practice of nursing. In these instances, the participants agreed that nurses need to be licensed in (or have their license endorsed) in each of the states in which they practice. They noted that they demand such credentialing. However, other areas of health care are more unclear to the respondents – whether nurses or physicians are functioning in a professional capacity that requires licensure, or whether they are functioning in a medical or executive capacity that might build on their professional knowledge, but does not involve hands-on application of that knowledge. Within the managed care and demand management industry, there is even wide disagreement as to whether advice lines staffed by nurses constitutes the delivery of health care that requires licensing. Many respondents indicated that the advice offered in such settings is "scripted," that the algorithms involved were developed by physicians and others operating in a professional capacity (and properly licensed), and that the delivery of such information does not involve nursing, as it could be delivered by any trained individual. Conversely, many respondents agreed that this type of activity is a gray area, and that it is likely that the nurses involved in delivering the advice and the patients utilizing such services would likely agree that it is nursing.

The scope of the issue of interstate nursing is difficult to define or quantify. The absence of any generalized understanding of what constitutes the delivery of nursing care that requires licensing has led many organizations to conclude that recent innovations such as demand management or telemedicine are not, in the strictest legal sense, engaged in the delivery of nursing care. This attitude is reportedly reinforced by the perceived inattention to the issue at a national level. For example, an executive at one of the largest demand management services in the nation related the organization's effort to gain clarification on the issue from the National Council over the past several years. In the absence of any clear direction or policy, such organizations have concluded that, for all practical purposes, the practices they are engaged in are acceptable under current licensing standards.

- **Given a traditional operative definition of nursing, the majority of respondents do not perceive the interstate practice of nursing to be widespread, or to be a problem.**

The majority of respondents perceive nursing to be direct, hands-on delivery of medical care, or the supervision of individuals engaged in this pursuit. Using this operative definition, few individuals in the organizations involved in this study perceive the interstate practice of nursing to be a significant issue. The various types of organizations breakdown as follows:

Hospitals: Respondents associated with hospitals, whether chain, independent or specialty, generally believe that their involvement in the interstate practice of nursing is insignificant. These respondents reported that some case management *does* occur across state lines, but that the nurses involved are typically licensed or endorsed in the states in which they practice. Specialty hospitals, or hospitals which draw patients from a regional, national or international base, noted that case management is coordinated with local nurses/nursing organizations that actually deliver any required care. The nurse involved in case management may not be licensed in the state that the patient resides, but the respondents do not believe that a nurse involved in case management after discharge, who is coordinating care for the patient in their home state/country, is involved in the type of nursing that requires licensure in that state. They believe that such care is either transmitting the information from an existing pathway/algorithm, or advisory in nature. Actual nursing care, they note, is delivered on the local level. One administrator noted that nurses involved in the emergency transport of patients via helicopter in a multistate area are not reviewed for certification/licensure in all the states involved. Importantly, this was not an issue that had arisen in the past, and had never been addressed. The institution was/is not deliberately ignoring licensure issues, it simply never perceived a problem or potential exposure in this area.

Home Health: Respondents associated with home health agencies believe that the interstate practice of nursing happens only on rare occasions, and routinely reported that agencies near state borders require nurses to be licensed or endorsed in each of the states where they practice. Where telemedicine has made inroads, it remains on a local level, and is used to manage the number of on-site visits to a particular client. Therefore, the function is usually not

regionalized, and is used on a local/regional basis. The individual(s) employing the technology are typically the same individuals who, on other occasions, visit the client and deliver any needed care. Consequently, they are licensed in the states where the care is being delivered, either hands-on care or remote care using telemedicine technology. One agency *did* note that interstate care does occur in cases where a nurse is employed and the patient/client travels. This is perceived to be a very small segment of the market and is not a situation that has raised any significant concerns over licensure.

Nursing Homes: Respondents associated with chains of nursing homes maintain that nurses engaged in direct patient care, or in supervision of nurses, are licensed in all states in which they practice. If a nurse is transferred to another state, either temporarily or permanently, they are reportedly required to be licensed or endorsed in that state. Many respondents agreed that educational efforts may be multistate, and that nurses in executive positions may have multistate responsibilities (including states in which they may not be licensed/endorsed) but they routinely contended that such pursuits are not "nursing" as it is commonly understood or defined.

Managed Care/Insurance Industry: Respondents associated with managed care organizations and various insurance companies generally believe that the interstate practice of nursing is either insignificant, or not their concern. The belief that the incidence of interstate nursing is insignificant is frequently linked to the perception that functions such as preauthorization, disease management, etc., are not nursing, rather they are functions that have clearly delineated guidelines/algorithms and that the employment of nurses in such positions is not an extension of the practice of nursing, but rather a corollary function that operates more smoothly if the individual holding a position involved in that function has a clinical/medical background. Essentially, the perception is that this is not nursing, a perception that is tied to the current operational definition of nursing. In the case of demand management and/or help lines, the respondents are divided. Those running such functions believe that it is a function that is not nursing in the traditional sense and, consequently, not nursing. Those who agree that such a function is likely nursing tend to be those who subcontract such functions to specialized firms and argue that any licensing issues relative to the interstate practice of nursing are the concern of the subcontractor.

Telemedicine/Demand Management Firms: Respondents associated with these firms generally contend that the nurses they employ are not engaged in the interstate delivery of nursing care. They argue that the nurses they employ are following strict guidelines/algorithms established by panels of physicians or even individual physicians in the clients home states. The nurses are simply communicating either existing information or are contacting the physicians to solicit specific responses which are in turn passed along to the client. As in the case of managed care respondents, these participants generally do not believe that this function is nursing in the traditional sense. Given the absence of any widely accepted alternative operational definition of what constitutes nursing, these individuals do not perceive that nursing care is being delivered across interstate lines. Conversely, they *do* acknowledge that many of the nurses they employ, and very like the vast majority of patients, would contend that such activity is nursing. They acknowledge that they employ nurses both for their clinical background/knowledge as well as for their marketing impact on corporate clients and patients. However, they contend that the delivery of information provided by these nurses is just the delivery of information; it is *not* nursing. Importantly, one of the largest firms engaged in demand management believes that this function, when it employs nurses, likely does constitute the interstate practice of nursing. This respondent related ongoing efforts over the past several years to clarify the issue with the NCSBN and other professional nursing organizations. Reportedly, the organization is frustrated with the lack of response and/or clarification from these bodies.

- **Respondents agreed that fewer nurses will be employed in hands-on care in the future, but that demand will increase in nontraditional areas.**

All respondents agreed that a combination of technological advances and cost will decrease the overall employment of nurses in direct hands-on care in the future. Conversely, most respondents speculated that individuals with a nursing education, along with experience, will become increasingly sought after for a variety of positions ranging from demand management, to disease management, to telemedicine. All respondents expect that technology will be increasingly applied to the health care industry and that fewer people will be providing services to regional and even national audiences. As previously noted, the respondents are not convinced that employing nurses in such areas involves the practice of nursing, rather, it takes advantage of a nurse's education and work experience.

As noted earlier, defining what constitutes nursing is vitally important. In the absence of any new operational definition, the respondents note that the traditional definition of nursing is the guideline. These respondents are not

necessarily opposed to such activities being defined as nursing (although resistance is to be expected in many cases particularly if it is perceived to impact hiring/costs) and to nurses being licensed in multiple states. Rather, they currently do not believe such activities constitute the practice of nursing and, while they acknowledge that nurses may be functioning in multiple states in the position they hold, they see little problem insofar as such activity is not nursing.

- **The majority of respondents suggest a licensing system for nurses similar to driver's licenses.**

The participants see the current system of licensure as unwieldy, archaic and out of touch with the direction that the marketplace is moving. The general feeling is that the growth areas of health care are nontraditional areas such as telemedicine, demand management, outcomes measurement and disease management. While the respondents perceive that nurses are "naturals" for filling positions in these areas, they do not necessarily believe that they are exclusively nursing roles. Consequently, they noted that a complicated nursing licensure system, such as currently exists, if it were to be strictly enforced (that is, if any nurse engaged in these areas is forced to be licensed in any state in which she/he may have contact with clients) the demand for nurses would fall. Many respondents noted that they would simply seek out other health care professionals, or train other professionals, to fill such positions.

When asked about what a licensure system should look like to serve the needs of the current and emerging health care industry, most participants suggest a system similar to drivers' licenses. They noted that, while you are licensed in one state, you can drive in any state, being required to change licenses only if you move. The respondents noted that such a system would not only simplify licensing issues for nurses and make them more attractive as employees, but it would provide them with a way to quickly check on overall credentialing. Many respondents expressed concerns over abuses in the current system, relating instances where they have encountered nurses who have a valid license in one state, but have had their license suspended or revoked in another state. These respondents believe that a coordinated national system would eliminate this type of situation.

A minority of respondents noted that the current system of licensure is adequate and preferred to see the development of national certification programs in areas such as demand management, outcomes measurement, etc. They claimed that such certification programs would provide them with highly trained employees that meet national standards and who could practice nationwide from any location.

Draft Topical Guide
Impact of Health Care Delivery Changes on the Nursing Profession

1. Introduction and purpose of the study.
   a. To understand the future direction of health care, especially within the managed care sector, and most specifically as it relates to the nursing profession.
   b. Clarify study parameters, i.e., consultative market research.
      1) Sponsorship by the NCSBN.
      2) Provision of a summary of findings.
   c. Confidentiality and audiotaping.

2. Background information.
   a. Position in health care organization.
      1) Role and responsibilities?
   b. Type of organization (e.g., MCO, hospital, specialty hospital, demand management, etc.)?
   c. Size of organization?
   d. Describe all the various divisions and/or affiliated units that make up the organization (e.g., HMO, PHO, PPO, IPA, SNF, long-term care, home health, regional/national reference lab, nursing home, etc.).
      1) Divisions/departments of the organization?
      2) Key internal health care policy decision makers?
      3) Breadth of services offered?
   e. How is the organization evolving?
      1) Where do you picture the organization being in one year? Explain.
      2) Where do you picture the organization being in five years? Explain.
   f. What major trends in health care financing and/or delivery do you see as having major impact on your organization during the next five years? Explain.

3. Overview of the organizational structure and services.
   a. MANAGED CARE
      1) Describe current efforts relative to health education, disease/demand management?
         a) Who manages internally?
         b) Who internally actually provides the service (e.g., case management, demand management, etc.)?
         c) Which, if any, are contracted services? Explain.
            (1) What companies are providing such contract services?
         d) Describe the application of technology to medical management in your organization (e.g., electronic medical records, case management, demand management, etc.).
         e) Describe the extent to which these programs are interstate vs. intrastate?
            (1) Implications of interstate programs? Explain.
            (2) Where do you see the organization in five years vis a vis interstate programs? Explain.
      2) Overall trends? Explain.
   b. HOSPITALS
      1) Describe current/strategic growth plans. (Health care areas and geographic growth.)
      2) Where do you see your organization currently relative to an intrastate vs. interstate presence?
         a) Barriers?
         b) Implications?
      3) Other trends likely to impact on your delivery of health care services within the next five years? Explain.
   c. HOME HEALTH CARE
      1) Description of services provided/staff duties.
      2) Current system's advantages and disadvantages.
      3) Describe current/strategic growth plans. (Health care areas and geographic growth.)

4) Where do you see your organization currently relative to an intrastate vs. interstate presence?
   a) Barriers?
   b) Implications?
5) Other trends likely to impact on your delivery of health care services within the next five years? Explain.

d. LONG-TERM CARE FACILITIES
   1) Description of services provided/staff duties.
   2) Current system's advantages and disadvantages.
   3) Describe current/strategic growth plans. (Health care areas and geographic growth.)
   4) Where do you see your organization currently relative to an intrastate vs. interstate presence?
      a) Barriers?
      b) Implications?
   5) Other trends likely to impact on your delivery of health care services within the next five years? Explain.

e. DEMAND MANAGEMENT/CASE MANAGEMENT PROVIDERS
   1) Description of services provided/staff duties.
   2) Current system's advantages and disadvantages.
   3) Describe current/strategic growth plans. (Health care areas and geographic growth.)
   4) Where do you see your organization currently relative to an intrastate vs. interstate presence?
      a) Barriers?
      b) Implications?
   5) Other trends likely to impact on your delivery of health care services within the next five years? Explain.

4. Overview of roles/responsibilities of nursing professionals within the organization.
   a. Current role(s) of nursing professionals within organization (roles that currently/potentially impact on license).
   b. Type(s) of nursing professionals impacted? Explain.
      1) Nurse practitioners?
      2) RNs?
      3) LPNs?
   c. Ways the role of nurses have changed over the past five years within the organization [specify by level, e.g., RN vs. LPN]?
   d. Increasing or decreasing responsibilities [PROBE FOR SPECIFICS]?
   e. Future (expected) changes in roles nursing professionals will fill? Explain.
      1) Organizational rationale/impact?
      2) Impact on nursing professionals, especially as it relates to licensing issues?
   f. Future (potential) changes in roles nursing professionals will play in health care delivery?
      1) Organizational rationale/impact?
      2) Impact on nursing professionals, especially as it relates to licensing issues?

5. Logistical issues related to responsibilities of nursing professionals.
   a. Number/percentage of nurses with interstate patient contact and/or management (demand and/or case) responsibilities?
   b. Current licensing and/or medical-legal issues related to interstate care and/or management of patients? Explain.
      1) Types of programs/services involved?
      2) Necessity for nursing professionals to have specific license for the state where patients being cared for/managed reside? Explain.
      3) Other issues? Explain.
   c. Future licensing and/or medical-legal issues related to interstate care and/or management of patients? Explain.
      1) Types of programs/services involved?

    2) Necessity for nursing professionals to have specific license for the state where patients being cared for/managed reside? Explain.
    3) Other issues? Explain.

6. Projected/potential changes impacting nursing professionals.
   a. Current areas of concern to nursing professionals within your organization? Explain.
   b. Projected areas of growth/change likely to impact nursing professionals in the future? Explain.
   c. Is the role of nursing professionals likely to grow or to shrink in the next five years? Explain.
   d. Are the numbers of nursing professionals employed by your organization (and by the health care industry in general) likely to expand or decrease in the next five years? Explain. (PROBE on marketing impact of nursing professionals as well as health care impact.)
      1) IF GROW: In what area(s) is growth most likely to occur? Explain.
      2) IF DECREASE: In what area(s) is the decrease likely to occur? Explain.
   e. Influence of hi-tech innovations (e.g., telemedicine, computer technology?).
      1) Primary care?
      2) Health education/disease prevention?
      3) Hospital care?
      4) Mental health care?
      5) Disease management?
      6) Demand management?
      7) Long-term care?
      8) Home health care?
      9) Other? Specify.

7. Concluding thoughts.

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Excepts From TVG Interviews

Director of Nursing Resources, Washington

The only time that we've run into some of the interstate issues right now is that we also run, through another division, a health promotion division what's called an "employee health-at-work" program ... where we have nurses that go out and do immunizations at worksites. And in our area, that's right on the Oregon/Washington border. The issue's been raised about registered nurses and licensed practical nurses from Washington going into Oregon to do injections.

The question came to me because I deal with a lot of scope of practice issues and the questions is, can a nurse that's licensed in the state of Washington deliver care, i.e., give an injection? In this case in the state of Oregon, the answer is no.

I think that the National Council of the State Boards of Nursing should be looking at this issue. I do believe it is their purview, but I believe that it's part and parcel of a larger issue around licensing and regulation, and it's not just in nursing, it's in other fields and areas, too. But, for example, if I just think of terms in the nursing component and I look at the inconsistencies state-to-state in the nursing categories, I have to ask the questions, do care needs of patients drive those inconsistencies, or do politics drive those inconsistencies?

I would like to have some way, for example, to have a mechanism that was not cumbersome to work with, around licensed people going into another state for some aspects of care delivery. I don't know if you do that by opening the whole thing wide and, like, you have a U.S. license, if you will, vs. the state by state, or whether you restrict that by task, activities, proficiencies. I don't know what the best way is.

I think we have to look at the interstate issues because I think only looking at in a state is simply too isolating and I'm not sure that it furthers the cause. I think it often creates more dilemmas in practice. I don't know what the happy medium is. I don't know if there is a happy medium. I think that our state regulatory policies need to be looked at; I don't what the outcome should be of that.

Vice President of the Nurse Line Service

Nurse Line ... provides education and information to individuals who access the service voluntarily through a 1-800 number ... . We have five call centers throughout the United States and average about 65,000 calls a month into the service ... . If they have symptoms, we will educate them based on prewritten medical guidelines that were written by physicians, approved by physicians ... . When that call reaches the call center itself, it will look across a wide-area network at, say, our Ohio call center for our first available nurse, if there's not one available in Minnesota. It will continue to look back and forth to the first available nurse.

So somebody could be in a couple of buildings away from the call center in Ohio, but end up talking to San Antonio?

Correct.

I just had surgery. I received zero preoperative instructions from the hospital and zero postoperative instructions ... we see less education and information provided by nurses in the hospital, and the need for the individual to have that kind of education and information has skyrocketed.

The [nurses] are licensed in the state that the call center is in.

To what extent have you thought about ... is it an issue at all, the licensing for them, giving information to somebody who's in a different state?

Well, to date, they're not providing care. They're just giving information. And you can get that from the ... if you call the American Cancer Society, you can get information from them. It's not even a registered nurse giving you that information.

Who's on the phone at those places?

I'm not sure, but it is not registered nurses. It's just a trained ... .

Why do you have registered nurses as opposed to, say, semi-skilled laborers, high school graduates, chimps?

Again, we're using medical terminology. And the medical community has created medical terminology that is not always easily understood by an average lay person. And because that's a role that nurses have played for years, of being the health educators, this is an excellent opportunity for them to utilize their nursing knowledge.

We only hire nurses who have at least five years of clinical experience. We do insist on 20 CEUs a year. And we provide ongoing training for our staff.

So they have to have five years of clinical experience, but this is not clinical information?

Because that is clinical information that they're getting, in terms of, say, what is a fever. You know, it's pretty easy for us to say the normal temperature is 98.6, because that's nursing knowledge. But it's not providing care, it's strictly just giving information that they could find in a book if they wanted to.

Well, do people call in and say ... "Should I go to my doctor?"

Yeah, they do do that.

Why isn't that nursing care?

Well, no care is rendered here. And they always have the option of doing what they want to do.

If I independently talked to the nurses – you've got, I don't know, a couple hundred nurses there total - and asked them, polled them on whether or not they were delivering nursing services, what would they say?

They would say they're delivering nursing education and information.

Nursing education and information. OK.

Which is very different than care. And again, we're not ... nurses can't diagnose. So there's no care ... there's really nothing that we can do other than, based on what you're telling me, this is what your options are this evening.

Actually, it would be wonderful to have cross-state licensure, just have a national licensure, because anymore more nurses are moving – or all of us, it's a pretty mobile society. And I know that with my Minnesota RN license, I can move to any state and pretty much apply and get another RN licensure without having to do very much.

Director, Clinical Programs, Demand Management

I'm hoping we'll get a national credentialing, a national licensure. Because that's where it has to go.

I guess the question is, are they delivering nursing services per se?

Yes, they are.

Has it been an issue, the legality/ethics of ... providing services to a patient who's in a different state?

Of course it's an issue. It hadn't ... come to the attention of anyone until we became a ... successful entity. Now it is. And I think that it's only a matter of time that all of this will be coming up as far as nursing, a national licensure for nursing and one for physicians. And that's the issue, and I think it's a very important issue.

My guess is that we follow the law, that we're practicing in the state. Because the nurses practicing in the state .... I don't think it's clearly identified that they can't give information. Now, I'm talking about patient information, like patient teaching, out to people in different states. Nurses give patient information all the time, I'm sure, that live in different states. So I'm not sure that that's very clear in the statutes. And everything I've read in the nurse practice acts really don't talk to telecommunication at all. They talk to the practice of nursing in the sense of direct patient care. And that's what they speak to. If they speak to that at all.

How clear is that distinction between direct patient care and the care that is being given through your nurse triage line?

It's different. We're really doing patient education.

But to the extent that you're relaying information, the nurse is certainly able to do that based on her Colorado Nurse Practice Act. She's able to give that information. The question is, can she give it to a person in another state?

I don't think that's been ... I think people have conjectured about it. But I don't think it's been stated that you can or cannot.

First of all, I think that telecommunications needs to be really sort of ordained or blessed or whatever as a new way of nursing that has ... that will need to have excellent nurse leaders supposing the practice. So I think that that's one thing that needs to occur – to realize that this is the age that Inga Borgmarsh and everybody was telling would come. That there'd be a telecommunications system driven by nurses that really gave everyone access to health care. So in that event, I think that that's the first thing that needs to happen is the awareness that this is a legitimate type of nursing practice.

Secondly, I think what needs to occur is there needs to be discussion and there needs to be standards of care for this kind of nursing practice, just like there's standards of care for emergency nursing and critical care nurses and things like. So we need to develop standards, and that's already starting off in many state nursing organizations, that's starting to develop.

And so I would say that telecommunications would be an area that you would want a certification in, a subspecialty. And then I think the larger discussion is, "what is telecommunication nursing and how do we license it."

If you're saying that perhaps it could be a subspecialty certification, is there also in addition to that a need to bring it into the basic licensing?

No. Because the skills are the same. You use the nursing process. You really use your scientific method and you learn everything there is to learn about that. I think it would be subspecialty certification just like the other areas are, because you're learning specific ... you've learned your basic stuff and now we're just saying, well, you're going to use this algorithm as your assessment tool instead of a stethoscope and a blood pressure cuff. So it's really a subspecialty.

Do you know of parallel efforts that are already going on to do things regarding licensing of physicians?

No, I think that that's going to be a hard nut to crack. It won't happen in my lifetime. No, I think it will take probably five to 10 years for physicians to agree on something unless there's a huge push by the government at the national level to do it.

So it sounds like you're saying that any initiatives on nursing should take place independently and not try to ...?

Correct. I think it would be forever in deadlock if we went at it together. I think it will happen. I think nursing tends to be a little more progressive than medicine, and we will try to work to solve the issue.

I think it would be nice to have nurses deal with something quicker and faster than physicians do. It would be really nice role modeling. I think it will bring it up because it's something that everyone knows is standing out there, ready to be discussed. And people have been reticent. And I think it's the only way we're going to get any health care reform, and get good practice in health care reform is to get things like this moving.

VP, Telecenters

Some states don't consider what we do to be nursing at all, from a very legal and technical perspective.

Because of the wording, I think, of some of the definitions of nurse services, it causes a little consternation, if you will, from state to state.

Nurses generally define nursing services to include a level of education and information delivery at the bedside or in the clinic or the doctor's office. This is something that nurses do almost second nature. And from a nurse's perspective, most of the time our staff – I'd say 90 percent to 95 percent of our staff – feels they do more "nursing" here than they can do today at the bedside.

It sounds like you're saying you're aggressively explored the legality of it as well as ...

We would very much, as an organization, like to help shape this position.

I think that some level of ... some federal level approach is probably the right way to go. I'm not sure that this board actually has that position or power right now. But I think what we're seen right now is that there are certain companies, certain organizations, certain types of practice that have a need for a broader licensure than what currently exists – a different type of licensure.

I think licensure is one approach. We are very interested in credentialing telephone nurses and being a part of that.

Is that separate from licensure?

Yes, it is. You can be a credentialed oncology nurse specialist and have a special certificate which only allows you to practice under the restrictions of your license. So I can't take my oncology certificate and go into any state.

Would you credential those nurses who are doing this special kind of practice of nursing?

That's what we'd like to see. We'd like to be a part of that. I think you first have to set some standards for this specialty.

Is that preferable to simply including this as part of a single nursing license that has total reciprocity?

I think it's different. What I would not be in favor of would be the kind of situation where nurses who are seated in a certain state have to be licensed separately in each state.

That, to me, is an outdated answer. That's just taking the old solution and applying it to a new and very different issue. What I would consider to be appropriate is to have a different level of licensure that would allow a nurse to practice across state lines.

I think just a licensure at a state level or anything that would look like letting each state make their own determination would be inadequate.

I can recall in the last 10 years needing information and contacting this National Council, and getting no information, no position, no acknowledgment that it existed. So this is tremendous. I think this is a tremendous acknowledgment of a real and growing situation, and I applaud them for taking these steps. I think what they could do next is, after they have a chance to understand the depth and breadth would be to gather some folks together and let the people who are doing it help them, and give them real insight and understanding of some of the information that you will pull out for them.

Manager, Health Care Info

Are any of the nurses licensed in the states where the patients are?

Not to my knowledge, unless it's a coincidence.

Is that an issue? Have you thought about it, worried about it, etc.?

It has not been an issue thus far because, again, we're not coming up with any kind of treatment plan or giving them specific direction that's individualized. The nurse triage line, however, will jump over that line and give the patients ... come up with a specific plan based on the patient and their history, because once this gets going, we will have on our database medical information about these folks. The proposals always included that there will be an RN doing the triaging. They will get what we call an information specialist who is not an RN at first. And then it will be moved over. They may also have an option, and we've not decided, to push one if you want information, if you need to talk directly to a nurse, push two.

And I'm trying to piece this together, and I'm starting to think, oh my goodness, what happens with such and such? We're here in Maryland and someone calls from California, where do you have to be licensed?

It's interesting that you called on the same day someone from the National Council called and left me a message. But I know they're working on this issue, and I had wanted some information. Basically, there is not very much information out there because no one has done much of anything. I think they're just starting to look at it, but I'm sort of in that loop now.

My understanding is that the nurse has to be licensed in the state that they're answering the phone in.

That's based on what regulation?

That there is no other kind of regulation.

I've given this a lot of thought. I can tell you in all the phone calls I've made, from the American Nurses Association to the state board of nursing for our state, this is a hot topic.

I think that most people want to do something about it and have some clear direction from a regulatory body.

Who?

The nurses themselves. And I've had a little bit of input because I've been out to Detroit, Michigan, to see one, I have been to West Virginia, we also sent someone to New Hampshire, so you know everyone's kind of thinking about this, and knows enough to know that some decision's going to have to be made so we have some clear direction. But since nothing has been changed, then we just follow the Nurse Practice Act in our states, and that's all that we go on.

President/CEO of MCO

And we definitely do cross state lines. Most of these nurses are housed in our corporate headquarters in Connecticut. But they clearly administer ... certainly what they do over the phone is done in Connecticut, but also into New Jersey and New York.

So where are they licensed for their actual nursing practice?

Well, the only reason I'm hesitating to answer that is I don't believe that - in fact, I'm virtually sure - since they're not actually practicing clinical nursing, they are really ... . The easiest way to sort of appreciate it is that I think that the regulatory bodies of these nurses is not dissimilar for nurses that work for insurance companies and doing claims review. And so these nurses do not require licensure to perform their jobs for us. Because they're not actually seeing patients or treating patients.

Are they talking to patients?

Oh yeah.

But that patient, again, may be in a different state?

Right. Again, if you want to make an editorial comment ... . I mean, I don't consider this an earthshaking issue. It would actually be ... I mean, if I would have my druthers, I would want this National Council to conclude that this is kind of much ado about nothing. As a matter of fact, I think that it's important that the health plan have uniform standards, in fact I would say uniformly high quality standards. And the easiest way for us to assure that is if we have kind of a seamless delivery system that operates across state lines. And by requiring state licensure or requiring whatever it is that you're going to do ... I've seen bills written in a lot of different ways on this in state legislatures to kind of require that a nurse doing business in a state either be physically or licensed in that state. I don't see what purpose that serves. I certainly don't see that it is advancing the quality of care by doing that.

... it really is pretty irrelevant to us whether that employee is a licensed nurse in any particular state.

I'm not even sure if we even attempt to discern that, frankly.

Well, if it is doing that, is that an argument at any level that this National Council should do something proactively like making nursing license reciprocity the way drivers license's reciprocity is truly seamless, no extra? Or again, is that silly and worthless?

Again, I'm coming more down on the side of your last comment just because ... I guess my attitude is, where's the beef? I don't see there having been ... I don't see the patient being put in danger here. I don't see there being, other than perhaps some isolated anecdotes, I don't see there being any substance to the argument that our patients are being treated poorly or somehow being treated in a malpractice fashion because of anything that we do here. And yet, the solution to this non-problem might be a rather expensive and obtrusive bureaucracy which could damage some of the innovation and entrepeneuralism that's characterized our industry. So again, other than perhaps some anecdotal situations, I'm not sure that we need anything at this point.

If someone asked the question of the nurses who are doing this utilization with your case management, are you providing nursing services, would they likely say yes or no?

With one exception, I think they would say no. And the one exception is a program that we haven't even put in place now, where we actually have it going up on April 1. Maybe you're familiar with it. It's a 24-hour, 7-day-a-week nurse advice line. The problem is, I can't speak with any authority on our experience here, because we haven't even put it up yet. But we're doing it in tandem with some national organizations who frankly market this. And we're basically contracting it out to them.

So what I'm saying is that a lot of the questions that you're asking would be pretty germane to their business, and indirectly to our business since we're going to be using them come April 1. But we're also relying on them to deal with the issues that you're talking about.

Your assumption is that EMC Squared will have worked out the legal kinks in this issue?

That's the whole point I'm trying to make. Exactly.

What we need to do – we, the managed care plans – is operate with the highest quality standards, and maybe these accrediting bodies that accredit us, the NCQA and the organizations that give us our kind of "Good Housekeeping" seal, maybe there should be something in the way they look at us to assure that we are only employing high-quality nurses. And, in fact, I would not be adverse to that if they took a look at the credentials of the people that we're using to do this stuff. But trying to do it state by state, when this industry's consolidating, and most of us are operating across state lines, that doesn't seem to be making any sense to me. And what I fear more than anything else is that whatever solution we come up with is going to be far worse than any problem that we're dealing with right now.

MCO/All Types – Medical Director

Well, people are trying to make it an issue on the politics and the regulatory side. Again, the licensing aspect being a state issue is built on an old model. And things like that usually lag many, many years behind what's actually going on. And that's a political issue that I don't think we're going to get resolved in our lifetime. Most of our physicians in the health plan care level, we usually require that they have licenses in every state that they have some impact on. We don't do that with our nurses.

The ultimate impact is ultimately with the physician. And it hasn't been an issue that I know of on our nursing side, in our preauthorization units and our care management people. And we do have nurses who cover multiple states sometimes, and if they do actually see people, then we require them to have licenses in the states that they work in.

But then those cases require the nurses to hold the licenses?

If they're in the field. If they're telephonic, no. For physicians, yes.

It's just economics. You're talking money. This has nothing to do with patients and people.

This is all politics and money. It's all built around an archaic system of the licensing and the power to license and the power to collect dollars.

There may be some element of risk, but it's minimal. Or we accept it. We have armies of [lawyers], more than we need.

There should a be federal license.

Or federally mandated that they all be the same or transferable. Every place has different requirements. It's ridiculous. And most of them are just hoops that they jump through, and have little value.

Vice President of Registered Nurses

Okay. Addressing the national licensure issue. That would be advantageous to us for many reasons, more than just the obvious reasons that I've cited as far as the process of going through licensure in every state. The process and the expense that it incurs for our travelers, the time that it takes. Obviously those are clear advantages for a company like ours. But one advantage, that I don't know if anyone's thought about, is the ability to keep records on the nurses' licensure status at a national level. Unfortunately, there are times when you will have clients that perhaps have their license under investigation in a state, have had their license revoked in a state. Very, very serious occurrences. Yet, if you place them in a state that requires only verification from their original state of licensure, you may not know that this person has a drug addiction problem, has other issues that are very serious issues to consider when you're employing a nurse. Because that's a very slow process. They do try to notify all the states, but it's by mail. It's in addition to all the other work that they carry. So it becomes a low priority. That's my perception. I'm not saying that they really don't care about it. I'm saying that in the reality of a full day, it does not get handled in what I would consider to be a timely fashion, and therefore some dangerous people are able to move from state to state and continue to practice. And to me, that is the number one reason why we should consider a national licensure

so that all of that information is kept on a national level, and it will weed out the bad egg from the nursing profession.

Attachment B

Draft NCSBN Definition of Telenursing

Telenursing is the practice of nursing over distance using telecommunications technology. The nurse interacts with the client at a remote site, using this technology, to electronically send and receive client health status data, initiate and transmit therapeutic interventions and regimens, and monitor and record client response and nursing care outcomes.

Attachment C

Continuum of Models for Regulating Multistate Nursing Practice

March 1997 DRAFT
Multistate Regulation Task Force

Vision for Nursing Regulation:

A state nursing license recognized nationally and enforced locally.

Features of a Desired System:

- State-based authority
- Linked to state of residence
- Central database
- Uniform licensure requirements
- Revenue/cost neutral to Member Boards
- Expedient processing of licensure applications

Statement of the Problem:

Regulatory reform is necessary to meet the needs of a changing health care delivery environment.

- New practice modalities and technology are raising questions regarding issues about compliance with state licensure laws.
- Nursing practice is increasingly occurring across state lines.
- Nurses are practicing in a variety of settings and using new technologies.
- Expedient access to qualified nurses is needed and expected by consumers.
- Expedient authorization to practice is expected by employers and nurses.
- Having a nurse demonstrate the same licensure qualifications to multiple states for comparable authority to practice is cumbersome and is neither cost-effective nor efficient.

Criteria for Evaluating Models of Regulation:

1. Requires anyone practicing nursing to be accountable for complying with all laws governing practice.
2. Delineates source of legal authority for scope and location of practice and discipline.
3. Assures licensed nurse has demonstrated the knowledge, skills and abilities to provide safe and effective nursing care.
4. Establishes standards for education, licensure, and discipline.
5. Promotes an expeditious discipline process while ensuring protection of due process for all parties.
6. Provides effective monitoring of the practitioner's competency and professional conduct.
7. Provides for the protection of the public by dissemination of information about disciplinary action within and across the jurisdictional boundaries.
8. Provides for an open system of information exchange.
9. Is compatible with state sovereignty.
10. Eliminates the barriers to interstate practice.
11. Facilitates interstate commerce.
12. Is administered in a cost-effective and cost-conscious manner.
13. Generates revenue to support operations.

Continuum of Models

Based on the foundations above, the Multistate Regulation Task Force has identified a continuum of models for nursing regulation which are described and analyzed on the following pages. These are offered for Member Board review and input. The task force also offers for consideration its belief that models which are based on uniform

licensure requirements and a central database of licensee data will effectively meet needs of consumers, licensees and delivery systems.

First, each model's characteristics are presented. Second, a chart presents an analysis of each model from the perspective of stakeholders (boards of nursing, licensees, employers, consumers) and how well it solves the problems articulated in the "statement of the problem."

Model Characteristics

Single-State License (Current Model)

- Each state sets own licensure requirements, which are similar but differ in detail
- Endorsement, with licensure verification obtained by applicant from one or more previous states of licensure, is used to obtain authorization to practice in other state(s) – process takes several weeks to months (temporary licenses are available in most states)
- A central disciplinary data bank is available and used by some boards for query during endorsement
- A current license to practice is required in each state where practice occurs

Mutual Recognition (similar to driver's license; used in European Community)

- Each state sets own licensure requirements, which may be similar but differ in detail
- States voluntarily enter into an agreement to legally recognize the licenses issued by other states, regardless of differences in standards; a licensee may practice in any state participating in the agreement under the license issued by her/his state of residence
- A central disciplinary data bank would continue to be available; electronic licensure verification information system (ELVIS) would become irrelevant without endorsement, but a centralized licensee database may be useful for identification of licensees/jurisdictions in sharing information related to disciplinary investigations

Fast Endorsement (similar to current system, but with electronic licensure verification information service)

- A set of common data elements is identified
- A central disciplinary data bank would continue to be available; would be connected ELVIS containing data for each licensee on each of the common data elements
- Technology would be applied in additional ways to reduce processing time to a target of less than 24 hours (perhaps on-the-spot)
- A current license to practice is required in each state where practice occurs

Single-State plus Multistate Option

- A set of uniform licensure requirements is identified and adopted by participating states for the optional multistate license
- Each state sets own single-state licensure requirements, which are similar but differ in detail
- Each nurse must maintain a full, current single-state license in her/his state of residence (meeting all state-specific requirements), and may choose in addition to obtain a multistate license (meeting all uniform licensure requirements as determined/issued by state of residence)
- States voluntarily enter into an agreement to legally recognize the multistate licenses issued by other states; a licensee may practice in any state participating in the agreement under the multistate license issued by her/his state of residence
- A central disciplinary data bank would continue to be available; would be connected with licensee database containing data for each multistate licensee on each of the uniform requirements (would require some expansion of the ELVIS database currently in development)

Single-State or Multistate Option

- A set of uniform licensure requirements is identified and adopted by participating states for the optional multistate license
- Each state sets own single-state licensure requirements, which are similar but differ in detail
- Each nurse selects either the single-state or multistate license in her/his state of residence and must maintain one or the other, meeting all requirements of the license selected (as determined/issued by state of residence)

- States voluntarily enter into an agreement to legally recognize the multistate licenses issued by other states; a licensee may practice in any state participating in the agreement under the multistate license issued by her/his state of residence
- A central disciplinary data bank would continue to be available; would be connected with licensee database containing data for each multistate licensee on each of the uniform requirements (would require some expansion of the ELVIS database currently in development)

Multistate License with State "Carve-Out"

- A set of uniform licensure requirements is identified and adopted by participating states for the multistate license
- Each nurse applies in her/his state of residence and is issued a multistate license, unless she/he falls into the definition of a state "carve-out" for a special in-state-only license
- Carve-outs may be defined by states to meet unique needs (e.g., serving unique patient populations, career mobility for a unique nurse population, legislative mandates, etc.)
- States voluntarily enter into an agreement to legally recognize the multistate licenses issued by other states; a licensee may practice in any state participating in the agreement under the multistate license issued by her/his state of residence
- A central disciplinary data bank would continue to be available; would be connected with licensee database containing data for each multistate licensee on each of the uniform requirements (would require some expansion of the ELVIS database currently in development)

Multistate License

- A set of uniform licensure requirements is identified and adopted by participating states for the multistate license
- Each nurse applies in her/his state of residence and is issued a multistate license (only type available)
- States voluntarily enter into an agreement to legally recognize the multistate licenses issued by other states; a licensee may practice in any state participating in the agreement under the multistate license issued by her/his state of residence
- A central disciplinary data bank would continue to be available; would be connected with licensee database containing data for each multistate licensee on each of the uniform requirements (would require some expansion of the ELVIS database currently in development)

Federal License (There are multiple variations in the way this could be implemented; the method below represents some degree of state implementation in issuance of licenses and discipline.)

- A set of uniform licensure requirements is identified and imposed on states for the federal license
- Each nurse applies and is issued a federal license by her/his state of residence
- States must recognize the federal licenses issued by other states; a licensee may practice in any state participating in the agreement under the federal license issued by her/his state of residence
- A central disciplinary data bank would continue to be available; would be connected with licensee database containing data for each federal licensee on each of the uniform requirements (would require some expansion of the ELVIS database currently in development)

MODEL	STAKEHOLDER	ANALYSIS
Single-State License (Current)	Licensee	■ Must anticipate practice and obtain license in each state ■ Must meet differing licensure and practice requirements in each state ■ Held accountable to board in each state of *licensure*
	Board of Nursing	■ Allows autonomy in setting requirements, processes and fees for licensure ■ Leads to differing requirements and timelines and thus between-state comparisons
	Employer	■ Must anticipate states of practice for each nurse and assure licensure in each state ■ When multistate practice is frequent, costs and time for obtaining additional licenses may be impediments to care delivery and may lead to ignoring requirements
	Consumer	■ Recourse may not be available in consumer's state if there is noncompliance with licensure laws. ■ Access to needed care provided by nurses licensed only in another state(s) may be slowed ■ Overall costs of the health care system may increase due to the need for licensure in each state of practice for each nurse
	Evaluation	The current licensure system does not effectively address: ■ questionable compliance with state licensure laws ■ increasing multistate practice ■ practicing with a variety of settings and technologies ■ expedient access ■ expedient authorization ■ need to redemonstrate essentially the same qualifications to each state The system lacks two features of a desired system: ■ uniform requirements ■ expedient processing of licensure applications

MODEL	STAKEHOLDER	ANALYSIS
Mutual Recognition	Licensee	■ May practice in multiple states under one license, reducing time and expense of licensure ■ Need not anticipate new states of practice in advance, if they are participating ■ Held accountable to board in each state of practice
	Board of Nursing	■ Recognizes out-of-state licenses granted on the basis of different requirements, thus giving up some control over qualifications of those practicing in state ■ Revenue from verification, endorsement and renewals of multiple licenses is foregone; may recoup by increasing fees
	Employer	■ Need not anticipate additional states of nurses' practice in advance, in participating states ■ Reduces time and expense associated with multistate practice; differing requirements may invite "beating the system"
	Consumer	■ Recourse is available in state where consumer is regardless of where nurse resides or location of delivery system headquarters ■ Access to care provided by nurses residing/employed in other participating states is seamless ■ Overall costs of the health care system may decrease if savings from eliminating duplicate processes result in lower fees
	Evaluation	Mutual recognition deals more effectively than the current system with compliance with licensure laws (by removing the reason for noncompliance) and with increasing occurrence of multistate practice. It offers consumers expedient access and expedient authorization for practice to nurses and employers. There is mobility without repeated demonstration of qualifications. However, mutual recognition lacks a key feature of a desired system: • uniform requirements. Revenue neutrality may also be difficult to attain given the extent to which other fees need to be raised.

MODEL	STAKEHOLDER	ANALYSIS
Fast Endorsement	Licensee	■ Must anticipate practice and obtain license in each state ■ Held accountable to board in each state of *licensure*
	Board of Nursing	■ Allows state autonomy in setting processes and fees ■ Timelines for endorsement are likely to be more similar across states ■ Verification fees would be foregone with electronic medium; may be recouped by increasing endorsement fees ■ May access licensee data via a centralized database
	Employer	■ Must anticipate state of practice for each nurse and assure licensure in each state ■ Reduces time associated with obtaining authority for multistate practice ■ When multistate practice is frequent, cost may discourage licensure law compliance
	Consumers	■ Recourse may be more difficult to pursue when the nurse or employer fails to comply with licensure laws in the state where consumer is ■ Access to needed care by nurses residing/employed in other participating states is accomplished more quickly, but not seamlessly ■ Overall costs of the health care system may increase due to the need for licensure in each state of practice for each nurse
	Evaluation	Fast endorsement deals more effectively than the current system with increasing occurrence of multistate practice. It increases expedient authorization for practice to nurses and employers. Access by consumers is not significantly increased, and mobility still requires repeated demonstration of qualifications because licensure must still be held in each state of practice. Fast endorsement has all features of a desired system except uniform licensure requirements.

MODEL	STAKEHOLDER	ANALYSIS
Single-State + MSL Option	Licensee	■ May exercise option for MSL which authorizes practice in multiple states under one license, reducing time and expense of licensure ■ Must also maintain single-state license, meeting all unique state requirements ■ Need not anticipate new states of practice in advance if hold MSL and states participate ■ Held accountable to board in each state of *practice*
	Board of Nursing	■ Allows state autonomy in setting processes, fees and single-state requirements ■ Uniform requirements are set by *shared* instead of *autonomous* decision-making ■ For those opting for MSL, revenue from endorsement and verification is foregone; may recoup by increasing other fees ■ Must maintain dual license processing systems ■ May access licensee data via a centralized database
	Employer	■ For nurses holding MSL, need not anticipate additional states of practice in advance ■ Reduces time and expense associated with obtaining authority for multistate practice
	Consumer	■ Recourse is available in state where consumer is for all nurses holding MSL, regardless of where nurse resides or location of delivery system headquarters ■ Access to needed care provided by nurses residing/employed in other participating states is seamless when nurses hold MSL ■ Overall costs of the health care system may decrease if savings from eliminating duplicate licenses result in lower fees
	Evaluation	To the extent that nurses practicing multistate obtain MSL, this model more effectively encourages compliance with licensure laws and addresses increasing multistate practice. It offers consumers expedient access, employers and nurses expedient authorization, and mobility without redemonstration of qualifications. It has all features of desired system. It requires boards to maintain dual systems.

MODEL	STAKEHOLDER	ANALYSIS
Single-state OR Multistate	Licensee	■ May exercise option for MSL which authorizes practice in multiple states under one license, reducing time and expense of licensure ■ If opt for MSL, need only meet the uniform requirements ■ Need not anticipate new states of practice in advance if hold MSL and state participates ■ Held accountable to board in each state of *practice*
	Board of Nursing	■ Allows state autonomy in setting processes, fees and single-state requirements ■ Uniform requirements are set by *shared* instead of *autonomous* decision making ■ For those opting for MSL, revenue from multiple-license-related processes is foregone; may recoup by increasing fees ■ Must maintain dual license processing systems ■ May access licensee data via a centralized database
	Employer	■ For nurses holding MSL, need not anticipate additional states of practice in advance ■ Reduces time and expense associated with multistate practice
	Consumer	■ Recourse is available in state where consumer is for all nurses holding MSL, regardless of where nurse resides or location of delivery system headquarters ■ Access to needed care provided by nurses residing/employed in other participating states is seamless when nurses hold MSL
	Evaluation	To the extent that nurses practicing multistate obtain MSL, this model more effectively encourages compliance with licensure laws and addresses increasing multistate practice. It offers consumers expedient access, employers and nurses expedient authorization, and mobility without redemonstration of qualifications. It has all the features of a desired system. It requires boards to maintain dual systems.

MODEL	STAKEHOLDER	ANALYSIS
Multistate with Carve-Out	Licensee	■ May practice in multiple states under MSL, reducing time and expense of licensure ■ Need not anticipate new states of practice in advance, if state participates ■ Held accountable to board in each state of *practice*
	Board of Nursing	■ Allows state autonomy in setting processes and fees ■ Uniform requirements are set by *shared* instead of *autonomous* decision making ■ Revenue from multiple-license-related processing is foregone; may be recouped by increasing other fees ■ The carve-out option allows flexibility for special needs, but means maintaining dual systems ■ May access licensee data via a centralized database
	Employer	■ Need not anticipate additional states of nurses' practice in advance, in participating states ■ Reduces time and expense associated with multistate practice
	Consumer	■ Recourse is available in state where consumer is, regardless of where nurse resides or location of delivery system headquarters ■ Access to needed care provided by nurses residing/employed in other participating states is seamless
	Evaluation	This model more effectively eliminates noncompliance with licensure laws being violated now due to multistate practice. It offers consumers expedient access, employers and nurses expedient authorization, and mobility without redemonstration of qualifications. It has all the features of a desired system. It requires boards with a carve-out to maintain dual systems. States retain autonomy to set licensure requirements within the carve-out.

MODEL	STAKEHOLDER	ANALYSIS
Multistate License	Licensee	■ May practice in multiple states under MSL, reducing time and expense of licensure ■ Need not anticipate new states of practice in advance, if state participates ■ Held accountable to board in each state of *practice*
	Board of Nursing	■ Allows state autonomy in setting processes and fees ■ Uniform requirements are set by *shared* instead of *autonomous* decision making ■ Revenue from multiple-license-related processing is foregone; may be recouped by increasing other fees ■ May access licensee data via a centralized database
	Employer	■ Need not anticipate additional states of nurses' practice in advance, in participating states ■ Reduces time and expense associated with obtaining authority for multistate practice
	Consumer	■ Recourse is available in state where consumer is, regardless of where nurse resides or location of delivery system headquarters ■ Access to needed care by nurses residing/employed in other participating states is seamless
	Evaluation	This model more effectively eliminates noncompliance with licensure laws being violated now due to multistate practice. It offers consumers expedient access, employers and nurses expedient authorization, and mobility without redemonstration of qualifications. It has all the features of a desired system, although it gives up state autonomy to set own licensure requirements.

MODEL	STAKEHOLDER	ANALYSIS
Federal License	Licensee	■ May practice in multiple states under federal license, reducing time and expense of licensure ■ Need not anticipate new states of practice in advance anywhere ■ Held accountable to board in each state of *practice*
	Board of Nursing	■ May allow state autonomy in setting processes and fees ■ Uniform requirements are imposed by federal government ■ Revenue from multiple-license-related processing is foregone; may be recouped by increasing other fees
	Employer	■ Need not anticipate additional states of nurses' practice in advance in any state ■ Reduces time and expense associated with multistate practice
	Consumer	■ Recourse is available in state where consumer is, regardless of where nurse resides or location of delivery system headquarters ■ Access to needed care provided by nurses residing/employed in other participating states is seamless
	Evaluation	This model eliminates noncompliance with licensure laws being violated now due to multistate practice. It offers consumers expedient access, employers and nurses expedient authorization, and mobility without redemonstration of qualifications. However, federal licensure lacks a key feature of a desired system: • state-based authority. Revenue neutrality may also be difficult to attain given constraints which may be imposed by the federal government.

Attachment D

MSR Task Force Communiqué Mailings

(revised 6/23/97)

Publication	Audience	Readers	Dissemination Method	Dissemination Date
12/96 Member Board (blue)	Member Boards	61	*Newsletter*	12/13/96
	Board members, where NC can mail directly	494	Mailed	1/13/97
	Member Boards	61	NCNET	12/20/96
12/96 Public (green)	Member Boards	61	*Newsletter*	12/13/96
	Issues, FARB, CLEAR, Interprof. Workgroup and PR mailing lists	2,324	Self-mailer	1/13/97
	Exhibiting	Varies	Distributed at meetings, exhibits, etc.	Continuous basis
	Public	65 hits	Public Web site http://www.ncsbn.org	12/20/96
1/97 Member Board	Member Boards	61	*Newsletter*	1/24/97
	Board members	494	Mailed	1/27/97
	Member Boards	61	NCNET	1/29/97
1/97 Public	Member Boards	61	*Newsletter*	1/24/97
	Issues, FARB, CLEAR, Interprof. Workgroup and PR mailing lists	2,324	Self-mailer	1/27/97
	Exhibiting	Varies	Distributed at meetings, exhibits, etc.	Continuous basis
	Public	42 hits	Public Web site	1/30/97
	MB request	600	Requested/mailed by ND BON	2/12/97

Publication	Audience	Readers	Dissemination Method	Dissemination Date
2/97 Member Board	Member Boards	61	*Newsletter*	3/7/97
	Board members	494	Mailed	3/8/97
	Member Boards	61	NCNET	3/13/97
2/97 Public	Member Boards	61	*Newsletter*	3/7/97
	Issues, FARB, CLEAR, Interprof. Workgroup, PR and Pew lists	2,324	Self-mailer	3/8/97
	Exhibiting	Varies	Distributed at meetings, exhibits, etc.	Continuous basis
	Public	68 hits	Public Web site	3/13/97
	MB request	566	Requested/mailed by ND BON	4/8/97
4/97 Member Board	Member Boards	61	*Newsletter*	4/18/97
	Board members	565	Mailed	4/21/97
	Member Boards	61	NCNET	4/23/97
4/97 Public	Member Boards	61	*Newsletter*	4/18/97
	Issues, FARB, CLEAR, Interprof. Workgroup, PR, Pew and ND BON lists	2,800	Self-mailer	4/21/97
	Exhibiting	Varies	Distributed at meetings, exhibits, etc.	Continuous basis
	Public	46 hits	Public Web site	4/23/97

Publication	Audience	Readers	Dissemination Method	Dissemination Date
5/97 Public	Member Boards	61	*Newsletter*	5/30/97
	Issues, FARB, CLEAR, Interprof. Workgroup, PR, Pew and ND BON lists	3,000	Self-mailer	6/4/97
	Exhibiting	Varies	Distributed at meetings, exhibits, etc.	Continuous basis
	Public	8 hits	Public Web site	6/10/97
6/97 Special edition	Member Boards	120	To be distributed (2 per MB) at the June MSR Workshop for distribution to state legislators as part of MSR informational packet.	6/5/97
	Public	21 hits	Public Web site	6/10/97

Report of the Special Services Division

Staff
Jennifer Bosma, *Chief Executive Officer*
Philip LaForge, *Marketing Director*
Nancy Chornick, *SSD Testing Manager*
Darcy Colby, *SSD Project Manager*
Holly Wilson, *SSD Project Assistant*

Relationship to Organization Plan
Goal V.................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective H.........Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division (SSD).

Recommendations to the Board of Directors
No recommendations.

Background
The Special Services Division (SSD) was created by action of the 1994 Delegate Assembly. Its purpose is to advance the mission of the National Council by offering services and products that can generate income to support National Council programs. National Council bylaws require that all net income produced by SSD be returned to the National Council general operating fund. During 1997, SSD focused on developing a base of core revenue-generating activities, including the Certification Examination for Practical and Vocational Nurses in Long-term Care (CEPN-LTC™), the plastic license project, Nursing Information Retrieval System (NIRS©) and nursing educator workshops. SSD also worked with volunteer committees, Board of Directors and National Council staff to harvest additional business concepts for further research and development.

Highlights of Activities
- **CEPN-LTC**

SSD provides project management services to the National Association for Practical Nurse Education and Service (NAPNES) for its long-term care credentialing program. A total of 682 licensed practical/vocational nurses (LPN/VNs) have been tested as of April 30, 1997. Highlights for the past fiscal year are:
- instituted credential release on-site on January 15, 1997;
- initiated pilot staff development promotion with Sun Healthcare, Albuquerque, New Mexico;
- mailed approximately 6,000 CEPN-LTC bulletins to respondent LPN/VNs from program inception; and
- sold approximately 5,000 Mosby study-guide books from program inception.

- **Plastic nursing license project**

Most Member Boards currently issue licenses in a paper document format. SSD developed a program to help Member Boards migrate their paper license issuance program to one using more durable and secure plastic cards. Three Member Boards are currently under contract with SSD for production and distribution of plastic licenses.

- **NIRS project**

The NIRS is the set of comprehensive databases, containing nursing and medical information, that support Computerized Clinical Simulation Testing (CST®). In 1996, SSD formed a strategic partnership with Lippincott-Raven Publishing (LRP) whereby LRP will develop NIRS-derived products for introduction to the nursing education and clinical marketplaces. During 1997, SSD and LRP conducted a focus group of potential nursing educator-users of NIRS; prepared a product design document for the first product offering, the Nursing Care Plan Creator; and selected a software company to complete programming necessary to bring the Nursing Care Plan Creator to market.

- **Nursing educator workshops**

  SSD produced seven "Assessment Strategies for Nursing Educators" seminars on an area representative basis. In addition, SSD will produce an "Introduction to CST" seminar as part of the CST long-range public relations campaign.

Future Activities

Develop existing start-up projects into long-term income contributors to the National Council operating fund. Continue the research and development effort required to find and launch new business concepts.

Recommendations to the Board of Directors

No recommendations.

Attachments

A .... Review of Adherence to SSD Administrative Policies/Finances, *page 3*

Attachment A

Review of Adherence to SSD Administrative Policies/Finances

1. **No revenue generation activity shall detract in any manner from: the protection of the public health, safety and welfare; the promotion of nursing competence; and the reputation of the National Council.**
   All projects are subjected to this screen in the research phase. No project currently in the implementation phase would result in any compromise.

2. **Consideration shall be given to the consequences of a project for the benefits to National Council which are derived from relationships with other organizations.**
   There have been no projects implemented that would precipitate adverse consequences to existing National Council relationships.

3. **Before each project is approved for implementation, it must have a business plan which includes at least the following components: anticipated benefits and consequences of the project, resources needed (money, time, expertise), market analysis, return on investment projections, potential exit strategies, and milestones (financial and other) which must be met for project completion.**
   Business plans for CEPN-LTC, nursing educator workshops, NIRS and the plastic nursing license project have been submitted to the CEO and approved for implementation.

4. **Before approving a project for implementation, the governing entity shall direct that the data in the business plan be validated from sources independent of the persons proposing the project (i.e., perform "due diligence"). The larger the investment involved, the greater the expectation that these sources will be external to the National Council.**
   SSD routinely submits all business plans to the director of administrative services for review of financial projections.

5. **Every approved project should have an anticipated rate of return greater than the return that could be obtained by investing the funds in investment vehicles specified in the organization's investment policies.**
   All projects currently under study, or in the implementation phase, are projected to provide long-term returns in excess of rates earned by vehicles specified in National Council investment policies. Initial financial results from the nursing educator workshops indicate that the project may not meet long-term projections. The project is under review for continuance.

6. **If a project involves a market or a technology which is new to the National Council, a joint venture should be considered.**
   The potential benefits or drawbacks (financial or otherwise) of partnering are researched routinely. SSD agreements are already in place as follows:
   - NAPNES – co-develop CEPN-LTC;
   - Mosby Publishing – develop a study and review text for CEPN-LTC;
   - ASI, Inc. – test vendor for CEPN-LTC;
   - Mosby Continuing Education Division – co-produce four workshops for nursing educators;
   - Lippincott-Raven Publishing – product development and sales agreement for NIRS-derived products and services; and
   - Cardpro Services, Inc. – production and mailing of plastic licenses for Member Boards.

7. **$600,000 shall be allocated from the National Council's undesignated, unrestricted fund balance for financing potential revenue-generating projects. The Finance Committee's recommendation shall be sought prior to any Board of Directors' decision relative to this guideline.**
   Through May 31, 1997, SSD has incurred $458,000 in losses against the $600,000 allocation.

8. **Any net revenue over expense generated shall be reviewed annually by the Board of Directors who shall determine the extent to which such funds shall be transferred to the unrestricted/undesignated fund balance. The Finance Committee's recommendation shall be sought prior to any Board of Directors' decision relative to this guideline.**
   No net income has been generated. A net contribution to the National Council operating budget of $50,750 is budgeted for FY97.

Report of the Communications Evaluation Task Force

Task Force Members
Roselyn Holloway, TX-RN, Area III, *Chair*
Isabelle Boland, OH, Area II
Sandra Evans, ID, Area I
Mary Ellen O'Hurley, CT, Area IV

Staff
Heather Freise, *Communications Manager*

Relationship to Organization Plan
Goal IV ....Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective C ....Facilitate communication between National Council, Member Boards, and related entities.

Recommendations to the Board of Directors
1. **That the Board of Directors approves the implementation of the Communications Evaluation Process Matrix (Attachment A).**

Rationale
Currently, there is no formal review process for National Council communications; therefore, the task force developed an evaluation tool, the Communications Evaluation Process Matrix. The tool breaks communications projects into four categories: regular publications, multimedia, face-to-face/personal and one-time publications. To effectively review publications in a timely manner, the task force suggested that regular publications, multimedia and face-to-face/personal communications be evaluated on a three-year cycle, while one-time publications would be reviewed on their one-year anniversaries. To ensure that one-time publications used after their anniversary dates remain current, these publications would also be reviewed on a five-year cycle to determine whether or not the information provided is obsolete.

2. **That the Board of Directors encourages National Council committees to utilize the Communications Evaluation Process Matrix to evaluate publications related to their committees as a committee function.**

Rationale
For the National Council and its committees to continue developing quality publications, the task force members agreed that all committees should use the Communications Evaluation Process Matrix to evaluate their respective communications. By using this tool, committees would be able to determine whether or not their communications are effective, timely and reaching the right audience.

3. **That the Board of Directors continues to convene the Communications Evaluation Task Force on a triennial basis, beginning in early FY99, to review comprehensive evaluation results of National Council communications for the purpose of providing direction and suggestions for changes.**

Rationale
The task force decided that meeting annually is no longer necessary, but rather meeting on a triennial basis would be sufficient to review the three categories of comprehensive evaluations and offer suggestions on National Council communications. The task force suggested that it be reconvened in early FY99, following the evaluation of the multimedia and face-to-face/personal communications categories, and then continuing every three years thereafter. (A comprehensive evaluation of regular publications was already completed and reviewed by the FY96 Communications Evaluation Task Force; therefore, this type of publication will not require review by the task force until FY2000.)

Background

As directed by the Board of Directors, the Communications Evaluation Task Force used the NCLEX® Program Evaluation Matrix as a starting point for developing a communications evaluation tool. Task force members met with several National Council staff to discuss available survey methods and then reviewed past publications surveys conducted by the organization.

The task force developed the Communications Evaluation Process Matrix as a method of offering the National Council guidance on evaluating its publications. In addition, the task force agreed that committees would benefit by using the tool to evaluate their communications projects.

In developing the communications evaluation tool, the task force identified: various types of communications projects, who the primary evaluator should be, the suggested method of evaluation, the frequency of evaluation, and the criteria with which to evaluate each project. Further detail is provided in Attachment A.

Highlights of Activities

- **Suggestions for change**

During its meeting, the task force discussed additional ways to improve National Council communications and made several suggestions to the Board of Directors and other National Council committees and staff, as follows.

- The task force encouraged the Board of Directors to continue allowing the National Council to utilize user groups to assess multimedia projects such as, but not limited to, NCNET and the public World Wide Web site.
- The task force suggested that staff add National Council's public Web address (http://www.ncsbn.org) to publications whenever possible. And, the task force suggested that online publications include user surveys, if possible.
- The task force suggested that staff produce an annual list of all publications published by the National Council.
- The task force suggested to the Executive Officers Group that the members discuss the need to get information from the National Council directly to board members.
- The task force suggested to the Long Range Planning Task Force that its members study the different tiers of membership, considering the creation of an "associate membership" to allow past board members and board staff a means of staying connected with the National Council. The task force stressed that an "associate member" would not be eligible to hold national board office or sit on a national committee, but would still receive *Issues*, information about attending meetings/conferences, etc.

Future Activities

The task force has completed its charge.

Meeting Dates

- December 12-13, 1996

Recommendations to the Board of Directors

1. That the Board of Directors approves the implementation of the Communications Evaluation Process Matrix (Attachment A).

2. That the Board of Directors encourages National Council committees to utilize the Communications Evaluation Process Matrix to evaluate publications related to their committees as a committee function.

3. That the Board of Directors continues to convene the Communications Evaluation Task Force on a triennial basis, beginning in early FY99, to review comprehensive evaluation results of National Council communications for the purpose of providing direction and suggestions for changes.

Attachments

A .... Communications Evaluation Process Matrix, *page 3*
B .... Areas: Types of Communications Projects, *page 5*

Attachment A

Communications Evaluation Process Matrix

Area: (See Attachment B for description of areas: multimedia, face-to-face/personal, regular publication-ongoing, regular publication-serial, and one-time publication)

Category: (Name/type of communications project)

Component	Primary Evaluator	Method	Frequency		Criteria
Purpose	Board of Directors	Open	In-depth (triennial)	Ongoing (Informal)	Fits within strategic plan, mission and tactics/ outcomes.
Effectiveness	Users Staff				Content meets project's purpose. Design reflects project's purpose. Relevant audience is reached through project. Information is not duplicated in other projects, unless message requires repeating.
Relevance	Board of Directors Committees Staff				Content is current, accurate and appropriate for project's purpose. Frequency of information is adequate for project's purpose. Information is provided in a timely fashion given the message.
Accessibility	Users Staff				Project is considered affordable by target audience. Information/project is easily accessible by target audience. Direct delivery vs. board delivery.
Fiscal Impact	Board of Directors Finance Committee Staff				Cost-benefit ratio is positive. Anticipated sales projections are met.
Format	Users				Project's design presents clear, concise information (i.e., print is readable). Project's editing meets journalistic standards. Project enhances the image of the National Council.

Attachment B

Areas: Types of Communications Projects

The following types of communications projects should be used to fill in *Area* on the Communications Evaluation Process Matrix.

Comprehensive Evaluation on a Three-Year Cycle

Multimedia *(begins 1997)*
Examples include:

- Web sites,
- videos,
- computer educational disks, and
- audiotapes.

Face-to-Face/Personal *(begins 1998)*
Examples include:

- Board of Directors/staff liaison meetings,
- media calls,
- exhibiting, and
- videoconferencing/teleconferencing.

Regular Publications *(begins 1999)*
Ongoing (available for a time-limited period)
Examples include:

- *Member Board Profiles*,
- *Book of Reports*, and
- test plans.

Serial
Examples include:

- *Issues*,
- *Insight*,
- *Newsletter for Member Boards*, and
- *Policy Currents*.

Comprehensive Evaluation on One-Year Anniversary*

One-time Publications
Examples include:

- brochures,
- research publications,
- special projects (CAT, CST®), and
- press release campaign.

* After first-year anniversary, the project could be moved into the regular publication category if it becomes a reoccurring communications project.

* Any one-time publication used for more than five years will be reviewed at its five-year anniversary to determine obsolescence. If the information provided is obsolete, National Council may revise or pull publication. If information is deemed current, publication remains on shelves and is scheduled for another review in five years.

Ongoing, Informal Evaluations

Whenever necessary, evaluations of National Council communications projects can be done through use of:

- Web surveys (about Web, online publications),
- informational readership surveys in publications, or
- other methods.

Report of the Institute for the Promotion of Regulatory Excellence

Task Force Members
Lucille Baldwin, AL, Area III, *Chair*
Leona Beezley, KS, Area II
Michael McCleery, WY, Area I
Mildred Flores Rodriguez, PR, Area IV

Staff
Sue Davids, *Meetings Manager*
Lea Newson, *Administrative Assistant, Communications*

Relationship to Organization Plan
Goal IV ....Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective C ....Facilitate communication between National Council, Member Boards, and related entities.

Recommendations to the Board of Directors
1. **That the implementation of the Institute for the Promotion of Regulatory Excellence Calendar of Activities be approved.**

Rationale
The task force's role is to serve as a clearinghouse for all National Council educational offerings and perform the following tasks: survey Member Board needs, distribute Call for Papers/Topics, identify and prioritize needs, match needs with proposals, identify delivery methods, choose educational offerings according to needs, recommend appropriate structural units for program development, assure the quality of the program, deal with emerging issues and budget annually for continuing education program(s). Activities surrounding the development of a comprehensive program for Member Boards should be systematically planned in advance.

2. **That the National Council conduct a one-day, self-supporting educational offering, "Changing Health Care Environment: Trends That Impact Member Boards," including topics such as legislation, political climate and the process of changing laws, surviving transition (e.g., board structure) and adapting to change; to be held in conjunction with the 1998 Area Meetings as the Regulatory Day of Dialogue. Further, it is recommended that a single Regulatory Day of Dialogue Program Planning Committee be appointed in August by the Area Directors, with one member representing each Area, to develop and plan the one-day program.**

Rationale
To meet the needs of the majority of Member Boards, as indicated by the 1997 Institute for the Promotion of Regulatory Excellence Member Board Needs Survey, the task force agreed that a single offering incorporating trends in the regulatory arena was needed. Given that Member Boards expressed a preference of holding educational offerings in conjunction with Area and Annual Meetings and that the Annual Meeting schedule already provides many educational opportunities for Member Boards, the task force agreed that the proposed offering should be conducted in conjunction with Area Meetings, more specifically, as the 1998 Regulatory Day of Dialogue. Agreeing that the Member Board Needs Survey reflected the overall interests of all Member Boards, the task force suggests that this one-day educational event be planned by a representative from each Area, who is appointed by the Area Directors, to thereby compose a four-member program planning committee. With this approach, there is one program planning committee, as opposed to four, and the one-day offering is identical among all four Areas.

3. **That the National Council sponsor a one-day, self-supporting educational offering on the topic of discipline, to be planned by the Discipline Resource Modules Task Force and conducted on the day prior to the 1997 Annual Meeting.**

Rationale

The task force reviewed an educational proposal, accompanied by a preliminary program and submitted by the Discipline Resources Modules Task Force to hold an offering "Dialogue on Discipline II—Complex, Convoluted and Confounding: Discipline and Alternative Program Challenges," to be held in conjunction with the 1997 Annual Meeting. Based on Member Boards' interest in compliance and monitoring issues, as indicated by the Member Board Needs Survey, the task force agreed that this proposed offering was timely and should be offered.

Background

The task force reviewed and discussed the eight educational offerings offered annually by the National Council, six mechanisms of educational offering needs assessment (e.g., surveys, meeting evaluation comments, Call For Topics) used by the National Council and its role as defined by the Board Committee on Continuing Education in October 1995. In addition, the task force reviewed results from the 1997 Member Board Needs Survey and Call for Topics to suggest offerings to be sponsored by the National Council, as well as to determine future implementation plans for the Institute for the Promotion of Regulatory Excellence.

Highlights of Activities

■ **Calendar of activities**

In addition to developing a calendar of activities for the Institute, the task force also made other conclusions concerning the process of selecting educational offerings that meet the needs of Member Boards. The task force agreed that the Member Board needs assessment for educational offerings should be a coordinated effort and comprehensive in nature, addressing needs in all areas of education. Because there is a need for continual needs assessment, Member Boards should be given the opportunity to respond year-round. In addition, the task force agreed that the scope of the Call for Papers, used to select educational/research programs for the Annual Meeting, should be expanded to allow presenters to submit proposals for any National Council educational offering. The Call for Papers should include an educational plan, which is a list of all educational offerings, both recurring and potential, that National Council will offer during a given year, to be developed in the fall by the task force. The educational plan will also be publicized via other communication channels to allow Member Boards to plan and budget for attending the offerings.

■ **1997 Member Board Needs Survey results**

The task force reviewed the responses from 46 Member Boards to the 1997 Member Board Needs Survey, which is designed to identify topics of interest to Member Boards and preferred delivery methods. Based on input received this year, the following topics were of significant interest to Member Boards: trends impacting Member Boards, multistate regulation, telenursing, federal legislation, political climate, surviving transition in the regulatory arena, unlicensed assistive personnel, alternative healing techniques, advanced practice licensure, compliance and monitoring. The most preferred delivery methods for educational offerings were as part of the Annual Meeting and Area Meetings.

■ **Selection of programs for the 1997 Annual Meeting**

The 1997 Call for Papers was distributed at the 1996 Annual Meeting to all attendees who received a copy of the proceedings book. It was mailed to Member Boards in October 1996 and December 1996 with the *Newsletter*. It was mailed to every accredited school of nursing across the country in October. Twenty-four abstracts were received, with 10 from Member Boards and 14 from educators/others. The task force reviewed all abstracts, selecting eight presentations and one alternate to complete the 1997 educational/research sessions. In addition, four abstracts were selected for poster sessions. Three presenters of the selected abstracts accepted the invitation.

Proceedings books will continue to be published and one copy distributed to each meeting attendee upon registration. The task force determined that speakers must agree to provide a written copy of their presentations for

publication in the proceedings book. The task force also determined that presenters not submitting their papers by the deadline would be deemed ineligible to present. These conditions were reflected in the acceptance letter.

Volunteer moderators will continue to be sought for the educational sessions. Invitations to serve are extended in the spring with the general Call for Volunteers in the *Newsletter*.

Future Activities

In accordance to its responsibilities as the coordinating group of the Institute for the Promotion of Regulatory Excellence, the task force will continue to review educational proposals, survey Member Board needs and recommend educational offerings to be offered by the National Council in FY98. In addition, the task force will continue to plan and select educational programs to be held in conjunction with the 1998 Annual Meeting.

Meeting Dates

- March 5-7, 1997

Recommendations to the Board of Directors

1. That the implementation of the Institute for the Promotion of Regulatory Excellence Calendar of Activities be approved.

2. That the National Council conduct a one-day, self-supporting educational offering, "Changing Health Care Environment: Trends That Impact Member Boards," including topics such as legislation, political climate and the process of changing laws, surviving transition (e.g., board structure) and adapting to change; to be held in conjunction with the 1998 Area Meetings as the Regulatory Day of Dialogue. Further, it is recommended that a single Regulatory Day of Dialogue Program Planning Committee be appointed in August by the Area Directors, with one member representing each Area, to develop and plan the one-day program.

3. That the National Council sponsor a one-day, self-supporting educational offering on the topic of discipline, to be planned by the Discipline Resource Modules Task Force and conducted on the day prior to the 1997 Annual Meeting.

Report of the Research Advisory Panel

Panel Members

Mary Pat Curtis, MS, Area III, *Chair*
M. Christine Alichnie, PA, Area IV
Mary Jo Gomey-Moreno, CA-RN, Area I
Patricia McKillip, KS, Area II

Staff

Carolyn J. Yocom, *Director of Research Services*

Relationship to Organization Plan

Goal IV ....Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective D.........Conduct and disseminate research pertinent to the mission of the National Council.

Recommendation to the Board of Directors

1. **That the Board of Directors considers the input of the Research Advisory Panel during its deliberations concerning the FY98 Organization Plan.**

Rationale

Based on a discussion of major topics of concern during the 1997 Area Meetings, members of the Research Advisory Panel identified the following research priorities:

- the need to continue to monitor quality of care/staff mix research as it relates to the use of unlicensed assistive personnel (UAPs);
- the need to implement a previously identified study examining the relationships between UAPs' activities, their preparation (i.e., education, training) and the degree of supervision by licensed nursing personnel; and
- the need to perform a role delineation study.

Following review of the current FY97-FY99 research agenda and consideration of current research needs of the organization, the following conclusions were reached:

- there should be no changes in the ongoing research studies/projects currently identified on the three-year research agenda (i.e., job analysis studies and related activities, Computerized Clinical Simulation Testing (CST®), Nurse Information System (NIS), regulatory effectiveness, disciplinary statistics/trends, graduation statistics, informational databases, etc.);
- a trend analysis study should be performed in FY98 to identify issues affecting the regulation of nursing; and
- unless additional input is provided, the proposed performance of the sexual misconduct study should continue to be deferred.

Background

The roles and functions of the Research Advisory Panel are to:

- provide input to the Long Range Planning Task Force and research staff regarding the development and annual updating of a formal, forward-looking research agenda for the National Council;
- assist representatives of Member Boards in identifying/framing researchable issues;
- provide input to the Resolutions Committee, Board of Directors and research staff regarding: 1) the advisability of adopting resolutions/motions directing the National Council to conduct a specific research study, and 2) the fit of proposed studies within the National Council's research agenda; and
- provide consultation to staff regarding methodological issues.

Highlights of Activities

The Research Advisory Panel met twice, via telephone conference call, in FY97. The panel's first meeting was devoted to member orientation and a review of the FY97 research activities. Following attendance of each member at one of the four 1997 Area Meetings, the panel met again to identify issues raised by Member Board representatives that have implications for the development of a research agenda covering FY98-FY2000. Issues identified were as follows:

- multistate regulation of nursing and the impact of telehealth care;
- roles, responsibility and supervision of UAPs;
- blending of roles/differentiation of practice of licensed and unlicensed nursing personnel; and
- degree of uniformity/commonality in disciplinary remedies across jurisdictions.

The panel also reviewed information summarizing current research initiatives, such as those related to the CST project, job analysis studies, regulatory effectiveness study and the disciplinary outcomes study.

Future Activities

Members of the Research Advisory Panel will be in attendance at the Annual Meeting to provide assistance to Member Board representatives regarding the identification of research needs and to provide input to the Resolutions Committee and Board of Directors. Prior to the conclusion of FY97, the panel will recommend, as needed, modifications to the FY98 research agenda.

Meeting Dates

- February 27, 1997 *(telephone conference call)*
- April 24, 1997 *(telephone conference call)*

Recommendations to the Board of Directors

1. That the Board of Directors considers the input of the Research Advisory Panel during its deliberations concerning the FY98 Organization Plan.

Attachments

A .... Proposed Research Agenda FY98-FY2000, *page 3*

Attachment A

Proposed Research Agenda FY98 - FY2000

Activity	Frequency	FY98	FY99	FY2000
Job Analysis Studies (JAS)				
Entry-level RNs	Every 3 years		X – May	
Entry-level LPN/VNs	Every 3 years			X – May
Nurse aides	Every 3 years	X – Fall		
Nurse practitioners	Undetermined			
Employment trends – newly licensed RNs and LPN/VNs	Every quarter	XXXX	XXXX	XXXX
Definition of entry-level practice period	Periodically			
Evaluation of JAS methodology				
Entry-level RNs	Every 3 years	X		
Entry-level LPN/VNs	Every 3 years		X	
Nurse Aides	Every 3 years			X
Role Delineation Study	Every 5 years (approx.)			
Determine methodology		X		
Perform study		X	X?	
UAP Congruence Study				
Determine methodology		X		
Perform study		X	X	
Monitor/Disseminate UAP Research re: Impact on Quality of Care		X	?	?
Family Nurse Practitioner Pharmacology Project				
Complete initial project	One-time only			
Complete dissemination activities (contract extension through 10/97)		X		
Computerized Clinical Simulation Testing (CST) Project	Through FY99			
Complete R&D		X	X	
Delegate Assembly decision			X	
Initiate implementation plan (if DA approval)				X

Activity	Frequency	FY98	FY99	[illegible]
Regulatory Effectiveness Study	In development			
Identify outcome indicators		X		
Plan protocol		X		
Implement data collection		X		
Regulatory "report card"			??	??
Regulatory Management of Chemically Impaired Nurses	Project completion in FY97			
Secondary data analysis				
Disciplinary Statistics/Trends Project	Ongoing			
Identify approach/methodology	Complete in FY97			
Implement	(Quarterly)	XXXX	XXXX	XXXX
Regulatory Effectiveness Study (HRSA $)	Project completion in FY97			
Nurse Information System (NIS) Project	Ongoing			
Finish R&D		X		
Implement		X	X	X
Databases				
Member Board Profiles update (data collection – summer qtr.)	Full – even years	X (start)	X (finish)	X (start)
	Partial – odd years	X (finish)	X (start)	X (finish)
APRN regulatory requirements (data collection – summer qtr.)	Update – odd years	X (finish)	X (start)	X (finish)
Licensure and Examination Statistics (data collection – summer qtr.)	Annually	X	X	X
Survey databases (Member Board and National Council)	Ongoing	X	X	X
Long Range Planning (Organizational)				
Mission statement evaluation	Every 3 years		X	
Organization plan objectives: importance study	Every 3 years		X	
Organization plan objectives: effectiveness study	Every 3 years		X (start)	X (finish)
Trend analysis study	Every 3 years	X		
Finance Committee				
Graduation statistics (candidate projections)	Annual	X	X	X

Report of the Disciplinary Data Bank Task Force

Task Force Members

Dorothy Fulton, AK, Area I, *Chair*
Carolyn Bryan, ND, Area II
Teresa Mullin, VA, Area III
Kathryn Schwed, NJ, Area IV
Sheree Zbylot, MS, Area III

Staff

Vickie Sheets, *Director for Practice and Accountability*

Relationship to Organization Plan

Goal II.................Provide information, analyses, and standards regarding the regulation of nursing practice.
Objective D.........Provide for Member Board needs related to disciplinary activities.

Recommendations to the Board of Directors

1. **That the Board of Directors approves to continue to maintain the Disciplinary Data Bank (DDB).**

Rationale

The continued need for the DDB has been questioned in light of the National Practitioner Data Bank (NPDB) planning to implement nurse and other health care practitioner reporting by January 1, 1998. The task force members believe that the DDB provides services that the NPDB is not designed to provide: specifically, monthly reports of all actions taken against nursing licenses in the previous month. The NPDB requires that an entity know identifying information regarding the person being queried. Because of the monthly updates on actions across the country and other unique services provided by the DDB, the task force recommends that the DDB be maintained regardless of the status of the NPDB.

Background

The National Council implemented the DDB in 1983 to assist Member Boards to communicate disciplinary actions taken against nurses' licenses across the United States and its territories. Although participation in the DDB is voluntary, Members Boards have consistently used this service, with 100 percent reporting among the state boards (the territories and District of Columbia have not participated) in the last two years. Currently, the DDB has electronic capabilities for reporting and inquiry services. This allows boards to flag individuals who have a connection with that jurisdiction and have had action taken by another board. Obtaining additional information from the board taking action is an important way to prevent nurses from moving from state to state, ahead of the licensing authorities.

The DDB has disciplinary information regarding more than 40,000 nurses. Reports listing the discipline actions reported in the preceding month are sent to Member Boards monthly. The DDB also shares information with the branches of the military, the Public Health Service and the American Association of Nurse Anesthetists Recertification Council.

One of the major activities undertaken with the DDB this year has been a technical upgrade to be accomplished through changing from Informix to Access software programming. The objectives of the upgrade include improved user screens, creating an easier-to-use environment for the DDB and greater facility for report generation.

The Board of Directors appointed the Disciplinary Data Bank Task Force to advise staff regarding Member Board DDB needs, services and promotion. The task force, budgeted for one meeting, was scheduled to meet late in the year to accommodate the programming transition.

Highlights of Activities

- **DDB demonstration**

The task force members, as part of their orientation to the DDB, had the opportunity to view the new electronic reporting and inquiry screens while in the National Council office. The new screens and environment will facilitate

Member Board access to the DDB, as well as provide opportunities to better meet Member Boards needs for reports and special services.

- **Review of current forms and reports**

Plans for updating current report forms, monthly reports and developing special reports upon request were reviewed by the task force members, who offered suggestions and comments for better meeting Member Boards needs.

- **Identification of needs for statistical data**

The task force identified data elements that would be particularly useful for boards to track, as well as uses for those statistics.

- **Discussion of implications of NPDB reporting for Member Boards**

The task force was updated on the status of implementation of mandatory reporting by boards of nursing to the NPDB. Preliminary analysis of the possibility of the National Council serving as an agent for Member Board reporting and inquiry of the NPDB was begun.

Future Activities

- Pilot a revised DDB reporting form and report formats as they are developed.
- Promote electronic DDB operations.
- Contribute information and articles for planned *Newsletter* features.
- Serve as advisory group to staff regarding DDB services.

Meeting Dates

- May 19, 1997
- July 10, 1997 *(telephone conference call)*
- August 14, 1997 *(telephone conference call)*

Recommendations to the Board of Directors

1. That the Board of Directors approves to continue to maintain the Disciplinary Data Bank (DDB).

Report of the Discipline Modules Task Force

Task Force Members

Nan Twigg, NM, Area I, *Chair*
Giovanni Di Paola, CT, Area IV
Thania Elliott, LA-RN, Area III
Laura Langford, IN, Area II
Jane Werth, AZ, Area I

Staff

Vickie Sheets, *Director for Practice and Accountability*

Relationship to Organization Plan

Goal II.................Provide information, analyses, and standards regarding the regulation of nursing practice.
Objective D.........Provide for Member Board needs related to disciplinary activities.

Recommendations to the Board of Directors

1. **That the Board of Directors approves the task force's plan for the chemical dependency resource module (Attachments A and B).**

Rationale

The major charge to the task force was the development of resources to support Member Boards in licensure decisions involving chemical dependency. To fulfill this charge, the task force members developed a *Chemical Dependency Handbook for Boards of Nursing*, which provides a variety of information, resources and tools for Member Boards dealing with chemical dependency issues. The task force addressed discipline approaches and alternative program approaches in developing this resource module. The board handbook can be used for orientation of new board members and staff, other educational purposes, review of discipline cases, decision-making regarding whether or not a case should be referred to an alternative program or should proceed through the discipline process, and informing discipline decisions that involve chemical dependency.

2. **That the Board of Directors provides feedback as to the work begun on the criminal/fraudulent behavior module and authorize continued work on the criminal/fraudulent behavior module in FY98.**

Rationale

The task force has begun to collect information regarding this topic and develop plans for a resource module to support licensure decisions involving individuals with criminal convictions and/or fraudulent behavior. This module topic also was adopted by the 1996 Delegate Assembly. As the Board may recall, the task force chair expressed concern regarding the group's ability to complete both topics this year, as the chemical dependency issue was very daunting, and was assured that completing one module with a good start on the second would be satisfactory progress. The chemical dependency module consumed the majority of both scheduled meetings.

The task force also suggests that a task force(s) continue to work on discipline issues that are addressed under the Goal II objective in the Organization Plan. Future module topics to consider are nursing practice/quality of care cases and the role of professional accountability and ethics in discipline.

The task force members believe that disciplinary activities by Member Boards epitomize the public's perception of enforcement. The recommendations of the Pew Taskforce and the work of the Citizen Advocacy Center support this belief. Disciplinary action can be considered the most stringent board activity addressing continued competence. Both financial and human resources of boards are consumed by disciplinary activities. It is critical that the knowledge and experience of Member Boards who deal with discipline on a daily basis be used to direct and support the development of additional resources. Based on the comments of board members, board staff and investigators, those cases involving nursing practice/quality of care issues present special challenges in investigations, decision-making and determination of effective remedies.

Background

For the past four years, the Board of Directors has appointed a task force to work on developing discipline resources for Member Boards. Those discipline resources have included educational offerings for investigators, a report on case analysis, a resource notebook and an educational packet on professional boundaries/sexual misconduct. The 1996 Delegate Assembly adopted a resolution directing the National Council to develop additional discipline resource modules. The topics identified for the next discipline resources were chemical dependency and criminal/fraudulent behavior. The Disciplinary Resource Modules Task Force was directed to develop these modules.

Highlights of Activities

- **Second Annual Conference for Alternative Program Directors**

  The task force members participated in this conference as part of the first task force meeting.

- **Review of literature and resources**

  The task force reviewed various books, articles, Internet materials, feedback from meetings and conferences, and other resources addressing chemical dependency. The task force also reviewed information on the National Council's efforts to facilitate Member Boards' access to federal criminal data and the focus groups held by Health Resources and Services Administration to discuss collection of fraud/abuse data, reporting to the National Practitioner Data Bank and the implications for boards of nursing.

- **Developed discipline resources focusing on chemical dependency**

  The task force developed a comprehensive resource for Member Boards, *Chemical Dependency Handbook for Boards of Nursing,* which will be introduced at the Dialogue on Discipline just prior to the 1997 Annual Meeting (Attachment A). This resource includes a variety of information and tools to support Member Boards dealing with chemically dependent nurses and addresses the discipline and alternative program approaches. In addition, a modified version is planned for inclusion on National Council's World Wide Web site (http://www.ncsbn.org). The modified version will be directed toward nurses, employers and the public.

- **Revised model alternative program guidelines**

  The task force reviewed and revised the model guidelines for alternative programs for inclusion in the *Chemical Dependency Handbook for Boards of Nursing.*

- **Developed a brochure for consumers**

  Something's Not Right is a brochure developed for consumers that addresses chemical dependency in health care professionals.

- **Planned development of a discipline module focusing on criminal/fraudulent behavior**

  The task force planned development of a criminal/fraudulent behavior module. Cost-effectiveness of criminal history checks and the administrative feasibility were discussed. Information from the Area III Regulatory Day of Dialogue was shared. The question of whether or not past criminal convictions can reasonably predict future behavior or if the use of criminal convictions unreasonably discriminate for past actions (for which the individuals have already made retribution to society) was debated and could be the topic of a future white paper. Concern was voiced about some individuals being able to plea bargain to lesser offenses, while the underlying behavior might be more risky than the behavior underlying the felony conviction of individuals with less skillful attorneys. That led to consideration of how boards can better identify and deal with underlying behavior and actions rather than how the court labels those actions. Other ideas under consideration by the task force include developing a decision tree to guide the discussion regarding different types of criminal convictions. The task force also discussed criminal history checks and considerations for the Multistate Regulation Task Force.

- **Planned a second *Dialogue on Discipline***

  The task force planned and proposed to the Institute for the Promotion of Regulatory Excellence that the National Council present an educational day focusing on discipline to be held in conjunction with the 1997 Annual

Meeting in Chicago. The chemical dependency resources developed by the task force will be debuted at the *Dialogue on Discipline*.

Future Activities

- Present *Dialogue on Discipline* in conjunction with 1997 Annual Meeting.
- Continue development of a criminal/fraudulent behavior module.

Meeting Dates

- February 27 - March 2, 1997
- April 17-19, 1997

Recommendations to the Board of Directors

1. That the Board of Directors approves the task force's plan for the chemical dependency resource module (Attachments A and B).

2. That the Board of Directors provides feedback as to the work begun on the criminal/fraudulent behavior module and authorize continued work on the criminal/fraudulent behavior module in FY98.

Attachments

A .... Outline for *Chemical Dependency Handbook for Boards of Nursing, page 5*
B .... Outline for *Chemical Dependency Handbook, page 7*
C .... Program Plan for 1997 Dialogue on Discipline, *page 9*

Attachment A

Outline for *Chemical Dependency Handbook for Boards of Nursing*

I. Introduction and Purpose

II. Background
  A. The Illness of Chemical Addiction/Dependency
    1. Signs and Symptoms
    2. Impact on Nursing Practice
  B. Discipline Process
    1. Investigations
    2. Informal Methods for Discipline Case Resolution

III. Guidelines for Boards of Nursing
  A. Criteria for Determining Whether Case Is Appropriate for an Alternative Program or Should Be Referred for Investigation, Possible Discipline
  B. Decisions Points in the Discipline Process
  C. Decision Points for Alternative Programs
  D. ADA Considerations and Other Legal Issues

IV. Chemical Dependency Evaluations
  A. Elements
  B. Notice
  C. How Boards Use Information

V. Chemical Dependency Treatment Programs
  A. Criteria for Treatment Programs
  B. Managed Care Issues

VI. Drug Testing
  A. Testing for Alcohol
  B. Testing for Other Drugs
  C. Resources

VII. Alternative Programs - Nondisciplinary Approaches
  A. Policy Discussion
  B. Model Program
    1. Guidelines
    2. Policies
    3. Agreement/Forms
    4. Suggested Legislative/Rule Language

VIII. Return to Work Issues
  A. Readiness
  B. Conditions
  C. Monitoring
  D. Relapse

IX. Information for Public Members and Administrative Law Judges
   A. Information About Nursing
   B. Information About Professions

X. When Enough is Enough
   A. Support Moments of Insight - "*It is OK that you can't be a nurse right now.*"
   B. Repeat Offenders
   C. Resources for Vocational Counseling

XI. Other Resources
   A. Glossary of Terms
   B. Workshop Models
   C. Other Information and Bibliography

Attachment B

Outline for *Chemical Dependency Handbook*

This modified handbook is planned for an audience of nurses, employers and the public.

I. Introduction and Background
   - A. The Illness of Chemical Dependency or Addiction
     1. Signs and Symptoms
     2. Impact on Nursing Practice
   - B. Discipline Process (modified)

II. Guidelines for Boards of Employers and Clients (what to send with complaint)
   - A. Complaint Process
   - B. ADA Considerations and Other Legal Issues

III. Chemical Dependency Evaluations (modified)

IV. Chemical Dependency Treatment Programs
   - A. Criteria for Treatment Programs
   - B. Managed Care Issues

V. Drug Testing (modified)

VI. Alternative Programs - Non-Disciplinary Approaches Policy Discussion

VII. Return to Work Issues
   - A. Readiness
   - B. Conditions
   - C. Monitoring
   - D. Relapse

VIII. Information for Public Members and Administrative Law Judges
   1. Information About Nursing
   2. Information About Professions

IX. When Enough is Enough
   1. Moments of Insight - *"I can't be a nurse right now."*
   2. Repeat Offenders
   3. Resources for Vocational Counseling

X. Other Resources
   - A. Glossary of Terms
   - B. Workshop Models
   - C. Other Information and Bibliography

Attachment C

Program Plan for 1997 Dialogue on Discipline

Complex, Convoluted and Confounding: Discipline and Alternative Program Challenges

8:00 a.m. - 8:30 a.m.	Registration
8:30 a.m. - 8:45 a.m.	Welcome, Introductions
8:45 a.m. - 9:30 a.m.	Keynote: Anger in Regulatory Situations Reflects an Angry Society
9:30 a.m. - 10:30 a.m.	Practical Approaches and Tools for Defusing Anger (Panel)
10:30 a.m. - 11:00 a.m.	Break
11:00 a.m. - 12:00 p.m.	Dual Diagnosis: Implications for Regulation
12:15 p.m. - 1:30 p.m.	Networking Luncheon – Professional Accountability, the Gestalt of Nursing Practice
1:45 p.m. - 4:45 p.m.	Value Deficits and Unethical Behavior: Is Change Possible? ■ Development of Professional Values: Where, When, How Does It Occur? ■ Discussion of Case Scenarios: Can These Nurses Be Returned to Safe Practice? ■ Designing Effective Remedies: Elements to Consider ■ Criminal and Fraudulent Behavior: How To Distinguish Between Reasonably Predicting Future Behavior and Unreasonably Discriminating for Past Actions
4:45 p.m. - 5:00 p.m.	Concluding Remarks and Evaluation

Report of the APRN Coordinating Task Force

Task Force Members

Katherine Thomas, TX-RN, Area III, *Chair*
Genevieve Deutsch, CA-RN, Area I
Judith Hendricks, DE, Area IV
Mary Ann Rosencrans, OH, Area II
Kathleen Stillion-Allen, UT, Area I

Staff

Susan Williamson, *Director of Credentialing and Practice*
Carolyn Hutcherson, *Senior Policy Advisor*

Relationship to Organization Plan

Goal I ....Provide Member Boards with examinations and standards for licensure and credentialing.
Objective E ....Provide a comprehensive approach for the regulation of advanced nursing practice.

Recommendations to the Board of Directors

1. **That the Board approves discontinuation of the APRN Certification Clearinghouse, rescind Policy 14.7 and replace this policy with one based on an APRN Certification Organization Annual Report.**

   Rationale

   The task force determined that, in lieu of the former Clearinghouse, the emphasis should be on ensuring that Member Boards have sufficient information to make decisions about use of national certification as a component for granting state legal authority for advanced practice registered nursing (APRN). The Clearinghouse document included data that are addressed by the National Commission on Certifying Agencies (NCCA) accreditation process, and there is not a need to place the burden of redundant reporting on the certifying organizations. The task force crafted an annual report form, including comprehensive information about each certifying examination that is not contained in the NCCA approval process but is useful to Member Boards. Baseline information will be collected from each certifying organization and then updated annually. The NCCA accreditation report, including the supplemental criteria, will also be attached.

2. **That the Board requests the Multistate Regulation (MSR) Task Force to include APRN practice in the proposed mutual recognition model for regulation of nursing practice.**

   Rationale

   The MSR Task Force proposed "driver's license"-type mutual recognition model was shared with the APRN Task Force. The task force discussed both the model and the MSR Task Force's decision to not include APRNs due to the complexities related to the physician relationship with advanced practice nurses. The task force identified the vision for multistate APRN practice as the same as the vision articulated by the MSR Task Force: a state-based license, recognized nationally and enforced locally. Three questions were considered: what does APRN practice offer the consumer? What do APRNs want? And, how to achieve the vision? The task force concluded the APRN brings all the attributes of a registered nurse (RN) to an advanced level in health care services for achievement of optimal client wellness (including diagnosis and treatment of illness). The mutual recognition model will address most of the APRN activities, with exception of unrestricted practice across state lines within the appropriate scope of practice. The preferred unrestricted practice includes no mandate for physician collaboration/supervision, ability to prescribe appropriate medications, ability to order laboratory and diagnostic tests, and regulation solely by boards of nursing. Mechanisms to achieve the vision might include changing laws in each state to achieve mobility and multistate practice or federal preemption. The task force discussed the merits of the mechanisms, anticipated concerns from both medicine and nursing, and outlined possible strategies.

Highlights of Activities

- **Certification for nurse midwives (CNMs)**

The American College of Nurse Midwives (ACNM) Certification Council (ACC) allows non-nurse midwives (later identified as "professional" midwives – does not include lay midwives) to take the same credentialing examination that is administered for CNMs. Specific concern was identified by Ohio, whose nurse practice act states that the board can only use an examination as a basis for legal authority for advanced practice nursing if that examination is only administered to registered nurses.

Tom Abram, legal counsel, met with the task force to discuss whether or not any legal impediments exist to using the same examination for nurses and non-nurses. A number of questions were raised about credibility of the examination, as well as a board's ability to rely on the examination as a basis for granting authority for advanced nursing practice. It was agreed that this issue has political, legal, psychometric and credibility dimensions, but use of the examination for "professional" (non-nurse) midwives does not render the test legally invalid for CNMs, except as, in the case of Ohio, where it is prohibited by state law.

National Council's director of testing services and other test development employees advised that, based on the job analysis, the examination is psychometrically sound to measure advanced knowledge, skills and abilities for nurse midwifery.

The task force spoke by telephone with Dr. Carol Howe, president of the ACC. Four major issues were expressed by the task force to Howe:

1. based on the law in Ohio, after September 1997, no new nurse midwives can be authorized to practice in Ohio;
2. legislatures might challenge boards of nursing for using this examination based on concerns about whether or not this examination tests advanced nursing practice;
3. if boards of nursing defer to national standards developed by professional bodies, they might then have to determine whether the "professional" midwife were practicing nursing without a license; and
4. in a time of great push toward uniformity of regulatory standards, this development appears to be a major divergent event.

The task force sent a survey to Member Boards asking if they had any regulatory language about advanced practice examinations being administered only to nurses, whether or not they had discussed the issue, and whether or not they anticipated that entities outside nursing would raise questions about non-nurses taking the exam. Forty-four out of the 56 boards regulating RNs responded. The results of the survey showed that five states did have language that examinations must be administered only to RNs. Sixteen boards had discussed the issue, and 20 anticipated questions from entities outside nursing.

The issue was brought up at the APRN Leadership Roundtable where Mary Barger from the ACC and Joyce Roberts from the ACNM were present and spoke. Midwives see themselves in a dual identity of nursing and midwifery, usually with the role allied more with midwifery than either nursing or medicine. The question was asked if CNMs are advanced practice nurses, the answer given was that they are nurses who have entered the advanced practice of midwifery.

- **Use of NP certification for regulatory purposes**

The task force continued to monitor the progress of certifying organizations for nurse practitioners in demonstrating the appropriateness of their examinations for regulatory purposes. Additional details are included in the Board of Directors' report.

- **APRN Leadership Roundtable**

The Roundtable was held on May 9, 1997, and hosted by the APRN Task Force. Of the 21 organizations invited, all but four attended. The agenda allowed for organizational sharing and an update of the health care environmental issues effecting advanced nursing practice. The remainder of the time was spent on discussion of the MSR Task Force's proposed model, certification by NCCA update and the National Council annual report, as well as implications of non-nurses taking the nurse midwifery examination.

Future Activities

- In an effort to support Member Boards, a fact sheet will be prepared containing the opinions given by National Council's attorney and director of testing services. The question, "Is midwifery nursing?" will be put to the

ACNM asking its opinion and seeking clarification of the issue. The ACNM response will be included in the fact sheet.

- A resource packet will be developed for use by Member Boards. The information in the packet will include: National Council position papers, background of APRNs, definitions of advanced practice in model practice act and rules and regulations, state definitions of advanced practice, Member Board surveys, summary of federal legislation, education issues, curriculum issues, legal issues, prescriptive authority information, direct-entry issues, a glossary of terms and references on the World Wide Web.
- The task force will continue to monitor all issues related to advanced practice and education, monitor the merging of the nurse practitioner and clinical nurse specialist roles, monitor the regulatory implications of the advanced practice role and potential merging of roles, develop strategies for multistate regulation of advanced practice nurses and monitor impact of changes in advanced practice on Member Boards.

Meeting Dates

- October 16-18, 1996
- February 5-7, 1997
- May 8-10, 1997

Recommendations to the Board of Directors

1. That the Board approves discontinuation of the APRN Certification Clearinghouse, rescind Policy 14.7 and replace this policy with one based on an APRN Certification Organization Annual Report.

2. That the Board requests the Multistate Regulation (MSR) Task Force to include APRN practice in the proposed mutual recognition model for regulation of nursing practice.

Report of the Computerized Clinical Simulation Testing (CST®) Task Force

Task Force Members

Debra Brady, NM, Area I, *Chair*
Monica Collins, ME, Area IV
Dorothy Fiorino, OH, Area II
Peggy Hawkins, NE, Area II
Helen Taggert, GA-RN, Area III

Staff

Anna Bersky, *CST Project Director*

Relationship to Organization Plan

Goal I ....Provide Member Boards with examinations and standards for licensure and credentialing.
Objective C ....Conduct research and development regarding computerized clinical simulation testing (CST®) for initial and continued licensure.

Recommendation to the Board of Directors

1. **That the Board approves selection of Arizona, Delaware, Mississippi, Oregon, Oklahoma, Washington and West Virginia-RN as participants in the initial evaluation of Member Board use of CST for registered nurse (RN) education and evaluation.**

Rationale

Eight completed applications were received from Member Boards for participation in the exploration of Member Board use of CST. Uses to be explored include:

- continuing education,
- component of the evaluation of individuals being disciplined,
- component of the evaluation of nurses returning to practice after a period of absence, and
- other continued competence applications (e.g., prerequisite for licensure renewal).

Upon completion of the review of applications, it was determined that all eight met the established selection criteria:

- indicates an intent to address at least one component of the major evaluation study questions,
- projects inclusion of at least 10 participants for each use of CST to be evaluated,
- identifies a location for administration of CST to participants,
- identifies staff who will oversee the proposed evaluation, and
- indicates a willingness to sign the necessary agreements with the National Council *(CST Software License Agreement* and *Evaluation Study Participation Agreement*).

Background

CST has been under research and development in collaboration with the National Board of Medical Examiners (NBME) since 1988. It is believed that CST permits a more authentic assessment of examinee application of the clinical decision-making process to the management of client care. In CST there are no testing cues in the form of questions or answer options. This testing methodology uses patient scenarios that are based on real-life situations and requires the use of free-text entry for the specification of client care activities.

At the beginning of each clinical encounter, the examinee is presented with a brief description of the client situation. The examinee then proceeds to the "Client Care" screen where requests for nursing activities can be specified. From this screen, requests for chart review are specified by "clicking" on the desired chart component. Requests for nursing assessments and interventions are specified by typing the desired nursing action into the free-text entry box labeled "patient" or into the box labeled "family/significant other." When a free-text request is

entered, a 30,000-plus term nursing activity database is searched for a lexical match to the request. When a match is found and confirmed by the examinee, a client response is presented and simulation time moves forward.

In addition to being interactive, the CST simulations are also dynamic, in that client condition changes over time, both in response to nursing action (or nonaction) and as the underlying health problem unfolds. Because of the temporal nature of CST, examinee actions can be evaluated based not only on the level of correctness of action, but also on the timing and sequence, or prioritization, of actions.

Phase I (1988-93) of the CST project included the initial development of CST. Field and pilot study results provided preliminary evidence that CST is feasible to develop and administer, and that it is a potentially valid and reliable exam. In 1991, the National Council's Delegate Assembly directed that the investigation of CST as a potential component of the NCLEX-RN® examination continue. Phase II of the CST project (1994-96) has included the development and programming of the specifications of a new simulation system and enhancement of the Nursing Information Retrieval System (NIRS©), the relational database of nursing and medical information that underlies the CST system and contributes to the efficiency and flexibility of case and scoring key development and exam administration. Phase III of the CST project (1996-99) includes CST case and scoring key development and a pilot study designed to evaluate the psychometric soundness and legal defensibility of CST as a potential component of the NCLEX-RN examination.

In 1999, the results of the pilot study will be reported to the Delegate Assembly, which will make a decision regarding the use of CST as a component of the NCLEX-RN examination. During Phase III of the project, other Member Board uses of CST, such as education and the evaluation of continued competence, will also be explored.

Highlights of Activities

- **Formation of CST Task Force/Examination Committee (CSTTF/EC) Work Group**

Three members from the CST Task Force (most recently, Debra Brady, Dorothy Fiorino, Peggy Hawkins) and three members from the Examination Committee (most recently, Sheila Exstrom, Deborah Feldman, Richard Peterson) formed a work group to set guidelines for the development of CST cases, examinations, scoring mechanisms and standard-setting procedures that will be used during preparation for the 1998 CST pilot study. During the last year, the work group has had one conference call and two meetings. The work group developed the following: *Guidelines for CST Case and Examination Form Development* and *Guidelines for Scoring Key Development.* In addition, the work group has approved: a tracking system for the validation of CST scoring key content, process and procedures for selection of CST case development and scoring key development committee members, security measures for CST field testing and the scoring key development process to be explored during the CST pilot study. Two members of the CSTTF/EC Work Group have also attended a CST Case Development Committee (CDC) meeting.

- **CST case development**

Three CST CDC meetings were held during the year. Work on 32 CST cases is in progress.

- **CST scoring key development**

Twelve members and eight alternates were selected for the Scoring Key Development Committee (SKDC). Scoring key development was initiated in spring 1997 and will continue through spring 1998. Work on 21 CST scoring keys is in progress.

- **CST pilot study**

The CST Task Force reviewed applications from 215 nursing education programs preparing individuals for RN licensure, who expressed an interest in participating in the CST pilot study. These programs were located within the 10 jurisdictions selected by the Board of Directors in June 1996 (California, Florida, Illinois, New Jersey, New Mexico, New York, Ohio, Texas, Virginia and Washington). Ninety-five schools were selected (65 participants and 30 alternates) by the CST Task Force for participation in the pilot study. Selected schools of nursing will receive CST orientation and practice software for the 1997-98 academic year. To participate, schools must agree to recruit their students as study participants and provide all study participants with practice in using the CST software. CST software license agreements and research participation agreements are currently being negotiated with the selected schools.

- **Development of a CST communications plan and policy regarding acceptance of CST speaking engagements**

Both a CST communications plan and a policy regarding the acceptance of CST speaking engagements were recommended to, and approved by, the Board of Directors.

Future Activities

- Recruit students for participation in CST pilot study (schools of nursing).
- Initiate school of nursing use of CST for the purpose of orienting students to use of CST in preparation for the pilot study.
- Initiate CST pilot study in April 1998.
- Initiate board of nursing use of CST for registered nursing education and evaluation.
- Complete CST cases and scoring keys for the FY98 research studies.

Meeting Dates

- July 9, 1996 (*CSTTF/EC Work Group telephone conference call*)
- September 10, 1996 (*telephone conference call*)
- October 15-16, 1996
- October 17, 1996 *(CSTTF/EC Work Group meeting)*
- February 3-4, 1997
- February 5, 1997 *(CSTTF/EC Work Group meeting)*
- May 7-8, 1997

Recommendation to the Board of Directors

1. That the Board approves selection of Arizona, Delaware, Mississippi, Oregon, Oklahoma, Washington and West Virginia-RN as participants in the initial evaluation of Member Board use of CST for registered nurse (RN) education and evaluation.

Report of the Licensure Examination Comparison Task Force

Task Force Members
Julia Gould, GA-RN, Area III, *Chair*
Beth Furlong, NE, Area II
A. Joyce Johnston, PA, Area IV
Louise Shores, OR, Area I

Staff
Anthony R. Zara, *Director of Testing Services*

Relationship to Organization Plan
Goal I ....Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B ....Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendations to the Board of Directors
1. **That the Board allows the task force to delay completion of the charge until FY98.**

Highlights of Activities
As reported last year, the expected outcomes for this task force were to develop a formal contrast and comparison of the Canadian Nurses Association (CNA) and National Council entry-level nursing competencies, share information about test development and develop an increasingly collaborative relationship. The project's history contains several external events that have affected the projected timelines. Starting in FY96, activities at the CNA have affected the project's workflow: their executive director relinquished her duties during February 1996 (to take the executive director post at the International Council of Nurses) and a new executive director was hired, and the federally funded National Nursing Competency Project to develop lists of competencies for the "family of nurses" (practical nurses/nursing assistants, registered nurses and registered psychiatric nurses), scheduled to be completed during 1996, has not been completed. These situations have taken much CNA effort and have drawn attention away from the licensure examination comparison project. In November 1996, the CNA board of directors approved new directions for the Canadian Nurses Association Testing Service (CNATS), establishing it as a separate business entity. This structural change was scheduled to occur in March 1997.

During this year, the National Council has learned more about the environment in which the CNA functions. The provincial licensing entities are customers of the CNATS, purchasing the examinations which they then use as a basis for licensure decisions. It is a similar arrangement to National Council's relationship to its jurisdictions; like National Council, CNATS also needs to be responsive to the provinces and their positions. The concept of the licensure examination comparison activity was developed by National Council's Board of Directors through the tactic development process (thus providing our organizational approval), but it has not yet been formally approved by CNA's governing body. CNA is in the process of working with the provincial authorities to develop their goals for this activity and obtain the necessary approvals.

As this year's activities delaying the project were taking place in Canada, National Council's Examination Committee was also in the process of revising the *NCLEX-RN® Test Plan* for presentation to the 1997 Delegate Assembly for its decision. Given the existing environmental factors, the task force reported to National Council's Board of Directors that it believes delaying completion of its charge until FY98 is a prudent course of action. The Board agreed to lengthen the timeline so that the formal comparison of CNATS and the NCLEX® examination would be scheduled for completion sometime next fiscal year. This timing change will preserve National Council's opportunity to work collaboratively with a sister organization in another country to produce a jointly developed examination comparison and also to continue to develop a collegial and collaborative relationship.

Future Activities

The National Council has been in regular contact with CNATS staff about proceeding with this project. CNATS staff assured the National Council that the provincial regulatory bodies seem inclined to pursue the project. The provincial regulators are meeting in June 1997 at the ICN 21st Quadrennial Congress. The National Council has requested time on their agenda to discuss the project and determine their interest.

National Council's Licensure Examination Comparison Task Force will work during FY98 to continue moving the project forward. The task force will specifically develop: 1) the framework for conducting the examination comparisons, 2) the expected outcomes of the project, 3) a gameplan for accomplishing the tactic, and 4) an evaluative framework for determining the level of success of the project.

Meeting Dates

- January 15, 1997 *(telephone conference call)*
- February 11, 1997 *(telephone conference call)*
- March 4, 1997 *(telephone conference call)*

Recommendations to the Board of Directors

1. That the Board allows the task force to delay completion of the charge until FY98.

Report of the Licensure Verification Task Force

Task Force Members
Mark W. Majek, TX-RN, Area III, *Chair*
Donna M. Dorsey, MD, Area IV
Anita Ristau, VT, Area IV
Florence Stillman, MO, Area II
Dianne Wickham, MT, Area I

Staff
Melanie Neal, *NIS Program Manager*

Relationship to Organization Plan
Goal I..................Provide Member Boards with examinations and standards for licensure and credentialing.
Objective G.........Promote consistency in the licensure and credentialing process.

Recommendations to the Board of Directors
1. **That the Board of Directors approves the following language to be added to the NCLEX® candidate bulletin in order to allow use of data for the purposes of Electronic Licensure Verification Information System (ELVIS): "The information provided on this application may be used in all licensing related actions and for other purposes authorized by applicable state and federal law."**

   #### *Rationale*
   Information collected via the NCLEX examination application form has long been considered a potential source of data for the Nurse Information System (NIS). The success of ELVIS depends on the inclusion of NCLEX examination application data in the NIS. This data will provide the necessary identifiers to match licensees across states so boards can use ELVIS to accurately identify candidates with multiple licenses and detect disciplinary actions that other boards have reported. Through NIS development activities, we know that many states cannot provide these identifiers due to legal and policy restrictions on data release, or lack of technical resources. Use of NCLEX examination application data would provide a reliable source of identifiers and demographic information on all new licensees, as provided by the applicant. Inclusion of language to permit use of the data for licensure purposes was strongly suggested by legal counsel in spring 1996.

2. **That the Board of Directors determines if Paragraph 10 of the Member Board contract should be revised as follows (new language is in italics): "10. Council Use of Candidate Data. Board hereby authorizes Council to use any and all candidate data collected for the *purposes of (1) administering the nurse licensure examinations, including, but not limited to,* identifying candidates approved for the examination, determining their status as first-time, repeat and/or multiple application candidates, *preparing the examination results related to the validity and psychometric integrity of the nurse licensure examinations and (2) developing and maintaining a comprehensive national data bank of information on nurse licensees for use by Member Boards of the Council in evaluating applicants for endorsement, in monitoring disciplinary actions and in any other licensing related actions authorized by applicable state and federal law. Candidate data collected hereunder shall not be disseminated to parties other than the Member Boards or used for other purposes without prior approval by the Board.*"**

   The current Paragraph 10 reads as follows: "10. Council Use of Candidate Data. Board hereby authorizes Council to use any and all candidate data collected for the limited purposes of identifying candidates approved for the examination, determining their status as first-time, repeat and/or multiple application candidates, preparing the examination results information to be returned to Board and conducting studies related to the validity of the nurse licensure examinations, the results of which will be reported only in the aggregate. The names are provided for this purpose only and any and all other uses are strictly prohibited, unless agreed to by Board prior to said use being made."

Rationale

Following the NIS feasibility study conducted in 1990-91, National Council began negotiating NIS data collection agreements with Member Boards. The purpose was to demonstrate to the Robert Wood Johnson Foundation that Member Boards were committed to NIS and could provide data required to build the system. Changes in NIS due to the ELVIS project have made the current NIS contracts outmoded, because boards need only agree to participate in a Member Board-only service.

Based on these considerations, the revision of paragraph 10 of the Member Board contract is recommended. This revision would allow NCLEX examination candidate data to be used in NIS, which is now focused on board-only services. In addition, this revision will help to ensure that National Council can meet the Robert Wood Johnson Foundation requirements to maintain an unduplicated count of nurses and a database on nurse characteristics. Additionally, per the grant obligations, and with specific Member Board permission, data could be provided to third-party researchers. NIS is the actual database containing licensee and disciplinary data. ELVIS is the query service allowing Member Boards access to NIS data for the purposes of licensure verification. The proposed change in the Member Board contract is a streamlined method of handling this new structure of licensee databases and Member Board services and makes contract management simpler for both Member Boards and National Council.

3. **That the Board of Directors allows flexibility in determining the cost recovery period for ELVIS development costs.**

Rationale

The task force believes it is necessary to set the ELVIS fee at the 1997 Delegate Assembly to allow boards of nursing a year's lead time to change rules or state laws that may impede their participation in ELVIS. They are recommending to offer use of ELVIS in FY98 at no charge, because development and data loading will continue throughout that year. In addition, the no-fee year is intended to give boards time to implement fee payment mechanisms in their own jurisdictions.

Because ELVIS is still under development, current fee estimates contain some unknown factors. The risk in setting a fee in August 1997 is that more cost factors could come to light during FY98, resulting in the need for a higher fee. The task force balanced the need for boards of nursing to know the fee as early as possible against the need to know more about the system before setting the fee. Allowing flexibility in the cost-recovery period permits setting a fee now without need to change the fee if additional information changes current estimates.

Background

ELVIS is a service to Member Boards that is based on the NIS database, currently under development by the National Council. While ELVIS is the service provided to boards and the set of screens used to access licensure data, NIS is the actual database containing the licensure and other nurse information. Because the need for an electronic licensure verification system became apparent, NIS development has focused on developing and providing ELVIS to boards. Constructing the necessary components for ELVIS both continues and provides a building block for NIS development.

Highlights of Activities

- **Contact with Member Boards**

Task force members have made contacts with Member Boards to discuss ELVIS and payment issues. In addition, task force members made detailed presentations at the 1997 Area Meetings, providing information on the timeline for ELVIS, operating ELVIS, and payment options and models.

- **ELVIS payment models**

The task force identified three models for payment:

  - In **Model I**, the candidate would send the license application form and endorsement fee to the board of nursing and a separate ELVIS registration form and fee to the National Council. This model most closely resembles the current method used in the NCLEX examination process.

- In Model II, the candidate sends all fees and applications to the National Council and the National Council, in turn, sends the license application form and endorsement fee to the board of nursing.
- In Model III, the candidate sends all fees and applications to the board of nursing, and the board sends the ELVIS registration form and fee to the National Council.

- **ELVIS payment options survey**

A survey was conducted in January 1997 to determine the best method for obtaining payment from endorsement candidates to support the costs of developing and operating ELVIS. Results showed that 90 percent of the 50 boards responding can implement Model I (see Attachment A for diagram). However, several Member Boards may have difficulties with Model I, and one board found Model I impossible to implement. The task force has determined that alternatives must be available for those boards. In addition, survey responses showed that most respondents prefer Model I.

- **ELVIS operations**

An optimally functioning ELVIS is anticipated when boards contribute key data (i.e., name, address, license number, mother's maiden name, Social Security number, date of birth, licensure and discipline information, and nursing education information); provide monthly updates containing changes in their licensee data; allow use of NCLEX examination application data; cause candidates for endorsement to pay a fee to National Council to support system maintenance; and agree to eliminate verification fees.

For boards not yet able to use ELVIS, the task force is aiming to offer an e-mail system that is also paperless. When receiving a request for endorsement, a board would send e-mail to jurisdictions in which the applicant reports licensure. Those boards would respond via e-mail with the licensure verification. To effectively participate in the e-mail verification system, boards also would eliminate verification fees and the endorsing board would initiate the verification inquiry, rather than the candidate for endorsement.

Future Activities

- Make first release of ELVIS available in October 1997, *at no fee* to Member Boards for use while data loading and development continue.
- Present an update on ELVIS use and monitor Member Board feedback at the 1998 Area Meetings.
- Report to the 1998 Delegate Assembly on the first year of ELVIS use, preparations for release of the next version of software and fee implementation.
- Provide the next version of ELVIS and implement fee and payment model in October 1998.

Meeting Dates

- December 11-12, 1996
- March 7-8, 1997
- April 30, 1997 *(telephone conference call)*
- May 30, 1997 *(telephone conference call)*

Recommendations to the Board of Directors

1. That the Board of Directors approves the following language to be added to the NCLEX candidate bulletin in order to allow use of data for the purposes of Electronic Licensure Verification Information System (ELVIS): "The information provided on this application may be used in all licensing related actions and for other purposes authorized by applicable state and federal law."

2. That the Board of Directors determines if Paragraph 10 of the Member Board contract should be revised as follows (new language is in italics): "10. Council Use of Candidate Data. Board hereby authorizes Council to use any and all candidate data collected for the *purposes of (1) administering the nurse licensure examinations, including, but not limited to,* identifying candidates approved for the examination, determining their status as first-time, repeat and/or multiple application candidates, *preparing the examination results related to the validity and psychometric integrity of the nurse licensure examinations and (2) developing and maintaining a comprehensive national data bank of information on nurse licensees for use by Member Boards of the Council*

in evaluating applicants for endorsement, in monitoring disciplinary actions and in any other licensing related actions authorized by applicable state and federal law. Candidate data collected hereunder shall not be disseminated to parties other than the Member Boards or used for other purposes without prior approval by the Board."

The current Paragraph 10 reads as follows: "10. Council Use of Candidate Data. Board hereby authorizes Council to use any and all candidate data collected for the limited purposes of identifying candidates approved for the examination, determining their status as first-time, repeat and/or multiple application candidates, preparing the examination results information to be returned to Board and conducting studies related to the validity of the nurse licensure examinations, the results of which will be reported only in the aggregate. The names are provided for this purpose only and any and all other uses are strictly prohibited, unless agreed to by Board prior to said use being made."

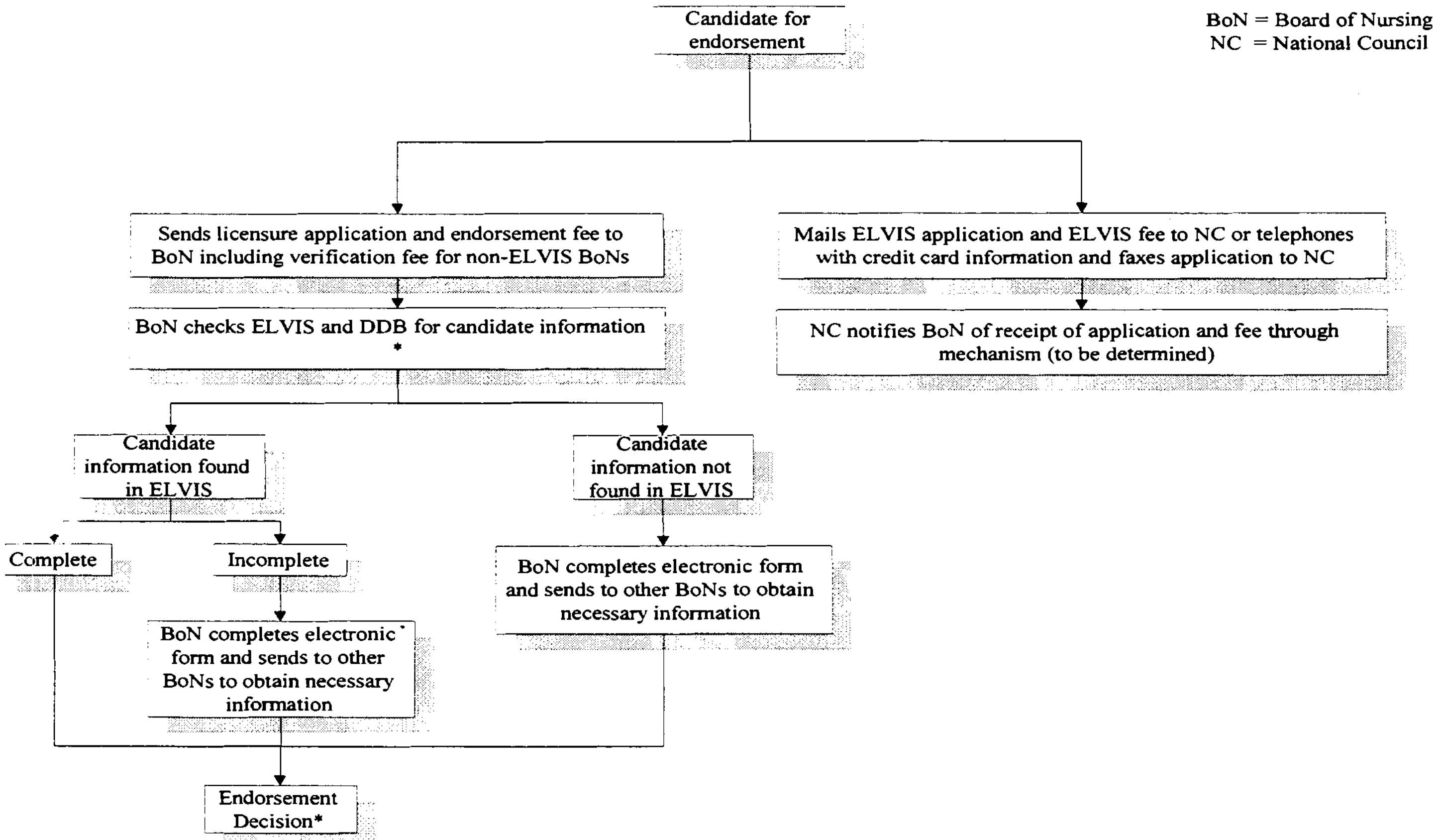
3. That the Board of Directors allows flexibility in determining the cost recovery period for ELVIS development costs.

Attachments ,

A .... License Verification Payment Method - Model I , *page 5*

Attachment A

License Verification Payment Method - Model I



*Endorsement granted contingent on fee payment to NC

1/14/97

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Report of the NCLEX® Negotiating Team

Committee Members

Donna Dorsey, MD, Area IV
Sheila Exstrom, NE, Area II
Faith Fields, AR, Area III
Tom Abram, *Legal Counsel*
Jennifer Bosma, *Executive Director*
Anthony Zara, *Director of Testing Services*

Relationship to Organization Plan

Goal I ....Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B ....Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendations to the Board of Directors

1. **The NCLEX® Negotiating Team presents the contract negotiated with The Chauncey Group/Sylvan Prometric to the Board without recommendation.**

Background

The NCLEX Negotiating Team was appointed by the Board of Directors and charged with negotiating a contract with The Chauncey Group/Sylvan Prometric for NCLEX examination testing services for the time period beginning October 1999. The Board authorized negotiations based on the positive results of the NCLEX examination test service evaluation completed in April 1996 and presented to the Delegate Assembly in the *1996 Book of Reports*, Tab 10, Attachment A.

The NCLEX Negotiating Team met with representatives of The Chauncey Group and Sylvan on several occasions in person, by video conference and by telephone conference call. The discussions generally centered on two areas: 1) current contract services needing improvement, and 2) future contract services and terms. Current services that were discussed as needing improvement included meeting the current item development expectations, fixing administration system problems, and alleviating the performance and configuration problems with ETS testing centers.

Regarding the future contract terms, the discussion included item pool maintenance, new pricing structures, contract length, The Chauncey Group/Sylvan relationship, performance metrics and standards as a basis for incentives and disincentives, and Computerized Clinical Simulation Testing (CST®) issues. The new contract was constructed with the overriding concept that the National Council did not desire to contract for any additional new services, but rather wanted quality refinements of the currently defined contract services.

The term of the proposed contract is three years, for the testing period October 1, 1999, to September 30, 2002. The scope of work was developed to reflect refinement of the current NCLEX examination testing services. Contract additions include specific performance incentives/disincentives for The Chauncey Group/Sylvan related to: meeting item production targets, currency of all item validations, correct item content, speed of item display to the candidate and accurate candidate results reporting. These performance incentives/disincentives are in addition to the existing 30/45-day rule for candidate appointments (within 30 days of the call for appointment of an eligible first-time candidate and within 45 days for an eligible repeat candidate).

The proposed pricing for the new contract is:

Volume of Candidates	Best Pricing Offer From CG/SLS	Percentage Increase From Current Price
140,000 - 149,999	$80.80	19.1 percent ($68 current pricing)
150,000 - 159,999	$78.00	14.7 percent ($68 current pricing)
160,000 - 169,999	$75.50	22.6 percent ($62 current pricing)
170,000 - 179,999	$73.50	17.7 percent ($62 current pricing)
180,000 - 189,999	$71.00	14.5 percent ($62 current pricing)

The percentage increase column shows the percentage increase in The Chauncey Group/Sylvan offer price vs. the current NCLEX examination per candidate price for the applicable candidate volume category (with the 150,000 - 159,999 volume range currently predicted as the most likely range for the years covered by the proposed contract).

Meeting Dates

- August 16, 1996
- October 1, 1996
- October 21, 1996 *(telephone conference call)*
- October 29, 1996 *(telephone conference call)*
- November 4-5, 1996
- December 12, 1996 *(telephone conference call)*
- January 3, 1997 *(telephone conference call)*
- January 15-17, 1997
- March 11, 1997 *(videoconference call)*

Recommendations to the Board of Directors

1. The NCLEX® Negotiating Team presents the contract negotiated with The Chauncey Group/Sylvan Prometric to the Board without recommendation.

Report of the Unlicensed Assistive Personnel Task Force

Task Force Members

Marie Fisher, ME, Area IV, *Chair*
Judy Botranger, AZ, Area I
Vicky Burbach, NE, Area II
Polly Johnson, NC, Area III
Wynne Simpkins, OH, Area II

Staff

Vickie Sheets, *Director for Practice and Accountability*

Relationship to Organization Plan

Goal I ....Provide Member Boards with examinations and standards for licensure and credentialing.
Objective F ....Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel (UAP).

Recommendations to the Board of Directors

1. **That the Board provides feedback to the task force regarding the document, *Role Development: Critical Components of Delegation, Curriculum Outline.***

   #### *Rationale*

   The task force members believe that this resource can be used in multiple ways by Member Boards in working with nurses regarding delegation issues. It is designed for use by board members and staff doing presentations on the topic of delegation; nurse managers improving the ability of staff nurses to implement the delegation process and UAPs to receive delegation; and could be adapted as self-study for individual nurses. The task force believes that this type of role development and support in the use of delegation is needed and would like to receive feedback from the Board of Directors and Delegate Assembly on its content and possible uses.

2. **That the Board provides feedback regarding the additional tools which the task force has developed as resources for Member Boards and nurses regarding delegation, and the task force's concept for an evolving resource folder, made up of documents and information pertaining to delegation and the use of UAP in various settings.**

   #### *Rationale*

   Rather than creating a single paper containing the various tools that were developed by the task force to assist nurses in the appropriate use of UAPs in various settings, the task force developed the concept of an evolving resource folder. The sample tools that are attached would be compiled in a folder, with a cover, table of contents and brief description of each. Any or all of these tools could be added to the National Council World Wide Web site (http://www.ncsbn.org) for further distribution. The task force plans to include guidelines and suggestions for use for each element of the folder. In addition to the curriculum outline described previously and the attached tools, the task force would also include the 1996 delegation paper. The task force members wanted to present their work in a different format then the usual concept paper.

Background

The UAP Task Force first began as a subcommittee of the Nursing Practice & Education (NP&E) Committee to update the previous work of the NP&E Committee regarding delegation and further explore the implications of the use of UAPs for nursing regulation. The critical nature of the work with the UAP topic was recognized by the development of an objective in the National Council Organization Plan: *provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel (UAP).* The task force has been directed to develop strategies to assist Member Boards in addressing UAP issues.

Highlights of Activities

- **Review of literature and resources**

The task force members reviewed various articles, feedback from meetings and conferences, met with the director of research services for updates on current UAP research studies and discussed at length the appropriate use of UAPs in a variety of settings.

- **Developed and piloted resources and tools to provide strategies for addressing UAP issues**

The task force developed a number of resources for use by Member Boards in addressing UAP issues, including the following:

  - *Role Development: Critical Components of Delegation, Curriculum Outline* (see Attachment A for draft document);
  - *A Continuum of Care: Roles of the Licensed Nurse and Unlicensed Assistive Personnel (UAP)* (see Attachment B for draft document);
  - Delegation Decision-making Grid (Attachment C); and
  - *The Five Rights of Delegation* (Attachment D).

- **Presented at National Council Nurse Aide Conference**

Task force members Polly Johnson and Wynne Simpkins presented the curriculum and the various resources at the National Council Nurse Aide Conference held in Chicago, May 1-2, 1997.

Future Activities

The task force plans an additional meeting in July 1997 to discuss feedback received from Board of Directors and participants of the Nurse Aide Conference and make appropriate incorporation to the documents. The task force plans to present the various tools that were developed, as well as the 1996 delegation paper, in an evolving resource folder format. The folder will include a table of contents and brief description of each item, as well as guidelines and suggestions for use of each element in the folder.

In addition, in response to feedback from Area Meetings noting the criticality of UAP issues, the task force intends to focus future attention on studying the implications for Member Boards of the blending roles of UAPs and address the interface between licensed nurses and roles such as medical assistants and various technicians. The task force plans to continue developing strategies and resources to support Member Boards in managing these issues.

Meeting Dates

- January 4-5, 1997
- February 15-16, 1997
- March 14-16, 1997

Recommendations to the Board of Directors

1. That the Board provides feedback to the task force regarding the document, *Role Development: Critical Components of Delegation, Curriculum Outline*.

2. That the Board provides feedback regarding the additional tools which the task force has developed as resources for Member Boards and nurses regarding delegation, and the task force's concept for an evolving resource folder, made up of documents and information pertaining to delegation and the use of UAP in various settings.

Attachments

A .... *Role Development: Critical Components of Delegation, Curriculum Outline, page 3*

B .... *A Continuum of Care: Roles of the Licensed Nurse and Unlicensed Assistive Personnel in Relation to the Client, page 19*

C .... Delegation Decision-making Grid, *page 21*

D .... *The Five Rights of Delegation, page 23*

Role Development: Critical Components of Delegation Curriculum Outline

It is as important to learn the management techniques to deliver and delegate care as it is to master the clinical skill necessary for high-tech/high-touch care.

Burrus, 1993

Delegation is a management principle used to obtain desired results through the work of others, and is a legal concept used to empower one to act for another. Delegation is a concept, an art, a skill and a process. The nurse who can effectively work through others is able to expand access to nursing care, maintain and promote quality health care and facilitate the effective utilization of health care resources.

Topics	I. Licensed Nurse	II. Unlicensed Assistive Personnel
A. PURPOSE This outline is based upon information in *Delegation: Concepts and Decision-Making Process*.	The purpose of the licensed nurse sections of the curriculum outline is to facilitate nurses' understanding of the critical components of delegation and its effective applications in providing safe and effective nursing care. It addresses the staff nurse who implements the delegation process to work with unlicensed assistive personnel (UAP), the manager-level nurse working with all staff on a unit or agency team, and the nurse in administrative service involved in policy formation and assuring adequate structure and resources to support delegation.	The purpose of the UAP sections of the curriculum outline is to facilitate UAPs in understanding their role in receiving delegation from licensed nurses. It includes a basic discussion of the concept of delegation, how delegation contributes to the effective use of health resources, how delegation affects UAPs in their daily work and how/when UAPs should either request additional training and support in the delegated activity or decline the delegation.
B. LEARNING OBJECTIVES	After completion of this curriculum, the delegating nurse can: 1. Describe the nurse-UAP-client relationship. 2. Identify statutory and regulatory authority for delegation. 3. Describe thought processes and information used to arrive at decision to delegate. 4. State principles underlying effective delegation, including the *Five Rights of Delegation*. 5. Discuss practical considerations underlying effective delegation. 6. Apply the above elements to various clinical situations.	After completion of this curriculum, the UAP who performs delegated activities can: 1. Describe the nurse-UAP-client relationship. 2. Define a delegated activity and state how it is authorized. 3. Discuss the *Five Rights of Delegation*. 4. Identify steps that should be taken if the UAP does not possess the skills or knowledge required to perform a delegated activity. 5. Explain the importance of communication throughout the delegation process.

C. CONTENT 1. Background a. National perspective b. State perspective 2. Definitions **Authority** - The source of the power to act. From *Delegation: Concepts and Decision-Making Process*	Detail and extent determined per type of setting and state. The source of authority is always legal (nursing license) and may be managerial (role delineation/position description). The nurse transfers authority for the UAP to perform the delegated activity. Managerial authority cannot supersede legal authority.	Same. The authority to perform a delegated activity comes from the nurse.
Delegation - Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. From *Delegation: Concepts and Decision-Making Process*	Tasks may include a variety of nursing activities ranging from very specific activities to elements of comprehensive client care measures.	Same.
Evaluation - Final and critical step in the nursing process to review the nursing care provided, to determine the accuracy of the nursing diagnoses, the effectiveness of the nursing interventions in achieving planned goals and the need to change any aspect of the plan of care in order to better meet client needs. From: *Taber's Cyclopedic Medical Dictionary*	Evaluation is a critical step for assuring that client care needs are met and improving the quality of nursing care.	
Delegator - The person making the delegation. From *Delegation: Concepts and Decision-Making Process*	The nurse is the delegator.	This is the nurse.
Delegatee - The person accepting the delegation. From *Delegation: Concepts and Decision-Making Process*	This is the UAP.	This is the assistant to the nurse (the UAP).

Unlicensed assistive personnel (UAP) - Any unlicensed person, regardless of title, to whom nursing tasks are delegated. (Note: some states license nursing assistants.) From *Delegation: Concepts and Decision-Making Process*	Titles may differ by practice settings and organizations. Examples include: nurse aide (NA), nursing assistant, certified nursing assistant (CNA), patient care technician (PCT) and personal care attendant (PCA).	Assistive means helping the nurse accomplish nursing activities. Unlicensed means not licensed as a nurse.
Accountability - Being responsible and answerable for actions or inactions of self and others in the context of delegation. From *Delegation: Concepts and Decision-Making Process*	The nurse's accountability includes self and others. The nurse holds the UAP accountable and is accountable for the delegation decision and process, as well as the total nursing care provided.	The unlicensed person's accountability is for his/her actions only.
Supervision - The provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of the work and the resultant client outcomes. From *Delegation: Concepts and Decision-Making Process*	Supervision is an interactive process where team members contribute to the accomplishment of the work and the client outcomes. The nurse retains responsibility for this process.	Same.

Assignment - Designating nursing activities to be performed by an individual consistent with his/her licensed scope of practice.	This definition is included to describe the difference between using an unlicensed person (who has no legal scope of practice) to assist in accomplishing a nursing activity and using a licensed nurse (who has a legally defined scope of practice) to accomplish a nursing activity that *is* within the licensed nurse's scope of practice. The outcome of delegation and assignment is the same (the nursing activity is completed), the decision-making process is similar, but the authority to do the activity must be transferred to the UAP, while the licensed nurse already has legal authority. Assignment confers no transfer of authority. It is important for the licensed nurse to understand the difference between the levels of accountability for the licensed nurse when working with another licensed nurse and working with UAP. The nurse has a higher level of accountability when delegating to a UAP than when the nurse assigns to another nurse. A common use of the term assignment is to designate the overall workload, including delegation and assignment. In the content of this document the term *assignment* is not to be confused with the common use of the term *assignment* to list the workload for which all staff members are responsible.	

Licensed nurse competence - The application of knowledge and the interpersonal, decision-making and psychomotor skills expected for the practice roie, in the context of public health, safety and welfare. *This definition is taken from the National Council's* Assuring Competence: A Regulatory Responsibility.		
Unlicensed person competence - The ability to use effective communication; to collect basic objective and subjective data; to perform selected non-complex nursing activities safely, accurately and according to standard procedures; and to seek guidance and direction when appropriate. *This definition is based upon language used in the Nebraska Board of Nursing Administrative Rules.*		
3. Sources of Authority a. Federal 1) Clarify difference between federal statutes and federal regulations. 2) Discuss impact of federal requirements on employment of UAP.	The extent of this discussion will vary. In certain settings, federal law and regulations mandate employer compliance with specified requirements (e.g., in nursing homes and home health), while in other settings, there may be only state voluntary accreditation requirements.	The extent of this discussion will vary. The UAP can better understand relevant employer standards and policies if she/he is aware of the broad overview of these governmental and other accreditation requirements.

b. State 1) State statutes a) Nurse Practice Acts (NPA), (state-specific) b) Other relevant state statutes	The NPA is the source of legal authority for the licensed nurse. Nurses should have an awareness of other laws which may affect their practice (e.g., laws related to education, facility licensure and reimbursement).	There may be definitions or reference to the UAP in the NPA.
2) State rules/regulations a) Board of Nursing administrative rules/ regulations b) Other relevant state rules/regulations	The nursing rules provide further guidance regarding the regulation of nursing in a state. Other state rules/regulations should not conflict with the NPA and nursing rules/regulations.	There may be definitions or reference to the UAP in the nursing rules.
c. Employer policies and standards	Employer policies and standards should not be in conflict with NPA and nursing rules/regulations, and other relevant statutes and rules, e.g., OSHA, labor law confidentiality, patient rights, etc.	
1) Legal implications	Employer policies and standards further define the licensed nurse role in each setting	Same.
2) Nursing administrative service role in delegation policy formation. 3) Nursing administrative service assurance of adequate structure and resources to support appropriate and effective delegation.	Staff nurses participation in policy formation empowers and promotes ownership in the process. Structure and resources refers to adequate staffing, skill mix, clear lines of reporting, and sufficient equipment and supplies to meet client needs.	UAP input should also be considered. Participation empowers and promotes ownership in the process. Same.

d. Professional nursing standards 1) National Council of State Boards of Nursing and Boards of Nursing 2) American Nurses Association, National Federation of Licensed Practical Nurses and National Association for Practical Nurses Education and Service 3) Specialty Nursing Organizations 4) Other e. Other standards 1) Health care accreditation bodies (e.g., Joint Commission for Accreditation of Health Care Organizations, National Committee for Quality Assurance) 2) Other	Many of these groups have position papers and standards which can be used to inform discussion.	

4. Principles of Delegation		
a. Premises presented in National Council paper, *Delegation: Concepts and Decision-Making Process.*	See attached paper.	See attached paper.
b. Delegation decision-making process.	This is a nursing responsibility.	The delegation decision-making process is a method by which the nurse determines the best way to meet client needs by working effectively through others.
1) **Assess** the situation.	Elements assessed include client needs, the plan of care, available qualified staff, other needed resources and the available supervision for staff.	The nurse considers the client's condition, the client's care needs and care plan, the available staff and their respective abilities, and how much supervision is needed to safely accomplish the needed activities.
2) **Plan** for the activity.	Match client needs with personnel qualifications, available resources and appropriate supervision.	The nurse determines the best use of staff to achieve safe and effective nursing care for the entire group of patients for whom she/he is responsible. Every client is different, and the same activity may differ in each situation (e.g., feeding a healthy skier with two broken arms is very different from feeding a client whose recent stroke has severely limited his ability to swallow; bathing a client too weak to care for herself is very different from bathing a client with extensive and severe burns).
3) Assure appropriate **accountability**.	The nurse assumes responsibility for the nursing care provided and verifies that the UAP accepts the delegation and the responsibility for carrying out the activity correctly.	The UAP is accountable to the delegating nurse and the employer. Before accepting a delegation, the UAP should consider: 1) "Do I believe that I can perform this activity (possess the necessary skill)?" 2) "Do I have access to the necessary supplies and equipment and other needed support (e.g., someone to assist in turning a large, immobile client)?"

		3) "Do I know who my supervisor is, and how to reach him/her?" 4) "Have I informed my supervisor of my special needs for assistance and support?" 5) "Do we both understand who is doing what?"
4) **Supervise** the performance of the activity.	Supervision includes communicating directions and expectations for completion of the delegated activities; monitoring the performance of the activity, intervening if necessary; and ensuring that appropriate documentation of the activity is completed. It is the nurse's role to assist and support the UAP in the accomplishment of delegated activities.	The nurse and the UAP are important members of a team, each with an important responsibility to help a client improve his/her health status, to help a client maintain his/her level of functioning, and to meet a client's comfort needs. The UAP should ask for help when she/he is unsure about a client or situation, and alert the nurse to unusual observations or unexpected results. The UAP is assisting the nurse and an important way to accomplish this is to act as the nurse's eyes and ears when she/he is not physically present with the client. Remember that the supervising nurse checks on how all staff, including UAP, are progressing in performing nursing activities, because she/he is responsible for the nursing care. It is the nurse's job to help the UAP accomplish the nursing activities. Questions asked by the UAP or nurse inform the nurse as to the UAP's level of understanding and may alert the nurse that a UAP needs additional training.
5) **Evaluate** the entire delegation process.	Evaluation is a continuous process which can be summed up as follow-up. As the delegated activity is occurring, the delegator monitors the progress and provides feedback to the delegatee, obtains feedback from the delegatee, considers the initial assessment, alters the activity plan if needed and measures the results of the activity. Was the expected outcome obtained? What follow-up measures are needed to continue to meet the clients need?	The nurse provides feedback to the UAP and the UAP provides feedback to the nurse. This allows the nurse to measure the client's response to nursing care and if, necessary, change the nursing plan. This type of follow-up is expected; it provides a check and balance to assure the client needs are met. This is an essential part of nursing care.

5. Practical Applications of Delegation		
a. **Five Rights of Delegation** 1) **Right Task** 2) **Right circumstances** 3) **Right person** 4) **Right direction/communication** 5) **Right supervision**	Situational management describes how the nurse, regardless of the setting, balances the multiple factors involved in each client's care, as well as in coordinating the care of several clients. The **Five Rights** mnemonic device provides a useful mental checklist for nurses as they manage multiple situations.	The **Five Rights** are about the UAP and the client determining: • Is there a match between the client needs and the skills, abilities and experience of the UAP? • What is the client setting and the level of client stability? • Is the UAP is the right person to do the activity? • Can the nurse provide the UAP with appropriate direction and communication to support the UAP's efforts? • Is the nurse available to provide the supervision, support and assistance that the UAP needs?
b. Using a **Five Rights of Delegation Checklist**	Suggest using the **Five Rights** as a mental checklist, and give examples. Compare to the Five Rights of Medication Administration.	Suggest using the **Five Rights** to assist the UAP in thinking about the activities that have been delegated. "Do I have all the information I need to do this job? Are there questions I should ask?"
c. Topics for special emphasis. 1) **Communication** - a critical component	Two-way communication is an essential component of the delegation process: the importance of articulating clear expectations should be stressed. The nurse provides directions, which may include priority of the activity, expected timelines, guidelines for consulting with the nurse mid-activity ("red flags") and guidelines for reporting back completion of the delegated activity. Use of written and visual resources may be used to reinforce direction. Judgment regarding the level of detail and method of communication is dependent upon: the complexity of the activity, the UAP's experience and competency, and the availability of supervision (e.g., the UAP working in the home setting may need written and visual	The UAP may wish to repeat the directions, take written notes and ask questions. The UAP should confirm that the delegation has been understood and accepted. The opportunity for communication should be ongoing. The UAP should be encouraged to ask questions: "when in doubt, talk it out." The UAP's communication skill and style affects the working relationship with the nurse and impacts client care. Inadequate communication is the most frequent reason delegated activities are not completed as expected.

	guidelines to support his/her activities; a UAP working in an acute care facility, with close proximity to his/her supervisor, will likely have different needs.) The communication skill and style of the nurse are part of the art and skill of delegation, and directly effects the working relationship.	
2) **Evaluation** - often the missing link	Because evaluation is often the missing link, this topic deserves special emphasis. Delegation decisions and client outcomes must be continually evaluated. The UAP should be encouraged to feel a part of the health care team. UAP contributions to providing nursing care must be recognized. The nurse-UAP relationship should be evaluated. The nurse's attitude has a major impact on the working relationship with the UAP. Does this continue evaluation cycle ever end? Yes, when the nurse-UAP-client relationship has been terminated.	The UAP plays an important role in assisting the nurse. Nurses can care for more clients when working with assistive personnel than if working alone. The UAP provides important information about how the client is doing and whether expected results are being achieved or if something unusual and unexpected is occurring. The UAP should report both routine observations and specific areas of concern.
d. Application of the delegation decision-making process to various clinical situations.	The use of case studies and scenarios as well as clinical experiences of the participants can enrich this section. Include a discussion of how it feels to be the UAP assisting with care.	The use of case studies and scenarios as well as clinical experiences of the participants can enrich this section. Include a discussion of how it feels to be the nurse responsible for care.
6. Recognizing and Dealing with Inappropriate Delegation.	**Examples of when the licensed nurse should inform nursing administration services that environmental constraints are affecting the nurse's ability to delegate appropriately and effectively:** 1) Inadequate resources, including lack of qualified personnel, equipment, supplies or time. 2) A conflict of the employer policy and laws and/or regulations. 3) Inappropriate employer direction (e.g., efforts	**Examples of when the UAP should inform the supervising nurse that constraints of knowledge and circumstances affect the UAP's ability to perform safely and effectively include, but are not limited to:** 1) The UAP does not know how to do an activity. 2) When circumstances have changed significantly (e.g., client condition has changed, resources are not available or the nurse is not immediately available for backup). 3) When the UAP is working in a new area or

to coerce the nurse to delegate against the nurse's best judgment).

4) Situations when the nurse recognizes a lack of knowledge, skills, and abilities relating to the use of the delegation process (either in oneself or one's colleagues).
5) Situations when a nurse fails to accept accountability for the nursing care provided.

Practice ways the licensed nurse can negotiate with nursing administrative services for promoting an environment conducive to appropriate and effective delegation:

1) Notify your supervisor when you are faced with a lack of qualified staff, or a mismatch of staff to client needs.
2) Offer ideas for solutions rather than just complaining.
3) Bring concerns about policy/law conflict to the attention of your supervisor.
4) Consult your board of nursing, nursing association or other nursing resources for information to inform and support your position (See attached Bibliography).
5) Prepare sample documentation, develop your assertiveness skills, practice role playing difficult personal interactions.
6) Educate your employer as to the potential liability for the facility and the employer if harm were to occur to clients because of inappropriate delegation of nursing care.
7) Stand your ground when necessary. Support your position with information. Focus on client needs and safety. Be prepared to explain legal implications. Don't simply fall back on "my license won't let me do it."

with a different type of client without orientation and support. Situations are usually not clear-cut. The fact that a UAP may not like to float to other patient care areas or care for an unpleasant or difficult client does not automatically create an unsafe situation.

Practice ways the UAP communicates concerns regarding delegation by having the UAP:

1) Ask questions to make sure she/he understands what she/he is being asked to do.
2) Tell the nurse why she/he thinks she/he should not accept the delegated activity.
3) Explain to the nurse what she/he thinks would be needed to be able to accept the delegation (e.g., demonstration, observation doing the task, frequent check-ins, immediate availability for questions).
4) Offer to accept other delegation or (not to be done lightly) request a change of assignment.
5) Ask to speak to the nurse's supervisor.

At all times behave appropriately and focus concern on meeting client needs.

	At all times, demonstrate professional behavior and focus your concern on the client. **Consequences of refusing to delegate:** There may be occasions when a nurse feels that an employer has directed illegal delegation. The nurse should not be coerced into delegating inappropriately. However, if the nurse fails to follow the supervisor/employer direction the nurse may be may be faced with possible loss of employment. There also could be negative client outcomes if all work does not get done. Ideally, your supervisor and/or employer would listen to your concerns, understand the safety of the clients entrusted to their care and work with you and the rest of the team to promote an environment conducive to appropriate and effective delegation, as well as assure adequate qualified staff and other resources to accomplish the planned client activities. However, it would be naive not to recognize that the world is not always ideal. Fewer staff to care for sicker clients, stress, inadequate management skills, knowledge without the art and skill of delegation, human frailties and shortcomings are examples of factors that can contribute to uncomfortable and unsatisfying work situations.	**Consequences of refusing a delegation:** Ideally, if the delegation decision-making process is being implemented effectively, and the UAP concern is legitimate, the nurse, the UAP and the rest of the team should work out an acceptable resolution that accommodates the needs of the UAP, uses the team effectively and accomplishes the planned client activities. However, concerns regarding fewer staff to care for sicker clients, stress, inadequate management skills, knowledge without the art and skill of delegation, human frailties and shortcomings are examples of factors that can contribute to uncomfortable and unsatisfying work situations. The UAP's job may be affected. Support for the UAP may be available in a number of places - the nurse manager or head nurse, a supervisor or director, an inservice educator, a mentor or peer, the UAP's work place advocate/union representative. The UAP should be aware that there are always two sides to a story and be open to examining the situation from the nurse's perspective and learning new areas needed to add to the UAP's skills. There are times when the UAP must clarify for oneself the difference between not wanting to do and not able.
7. Outcomes of Effective Delegation a. Allows protection of public/client safety. b. Achievement of desirable client outcomes.	 a. Following the principles of delegation enhances the health outcome for public/client safety. b. The plan of care has been completed; the client's needs have been met.	

c. Achievement of potential benefits for the license nurse and the UAP.	c. Potential benefits for the licensed nurse. 1) Effective distribution of workload 2) Better use of licensed nurse time 3) Promotion of team efforts on behalf of clients 4) Provision of safe, effective nursing care 5) Increased job satisfaction of the nurse 6) Developing professional skill and expertise in delegation has a positive career impact.	c. Potential benefits for the UAP. 1) Effective distribution of workload 2) Better use of staff resources 3) Promotion of team efforts on behalf of clients 4) Assistance in providing safe, effective nursing care 5) Increased job satisfaction for UAP 6) Ability to accept and perform delegated activities is a skill transferable to many work environments
d. Reduction of health care costs.	d. Logically, if effective delegation can contribute to appropriate use of facility/agency resources and less staff turnover (thus decreased orientation and training requirements) these decreased costs should contribute to overall health care agency cost containment.	d. Competent UAP assist in the provision of nursing care may improve UAP job security and contributes to lower health care costs for everyone.
e. Facilitation of access to appropriate level of health care.	e. Appropriate utilization of health care personnel may affect the availability of health care.	e. More consumers may value and accept UAP services if UAP perform competently.
f. Delineation of the spectrum of accountability for nursing care.	f. The nurse is accountable to multiple entities: oneself, clients entrusted to care, employers who provide the opportunity to care, the licensing board which grants authority to practice and the nursing profession to which the nurse belongs. Effective use of appropriate delegation supports each health team member's role in providing care and assuring the necessary communication, feedback and assistance to promote safety and effective health outcomes.	f. The UAP is accountable to self, client, delegating nurse and employer.
g. Decreased nurse liability.	g. Liability is a broad legal term which includes every kind of legal obligation, responsibility of duty as well as being responsible for actual	g. While UAP are usually not accountable to a licensing agency, and typically do not have the "deep pockets" sought in malpractice

	harm or damage. The effective use of appropriate delegation promotes positive client outcomes with efficient use of resources. Lawsuits and discipline actions are less likely to occur when positive client outcomes are achieved.	litigation, they are responsible for their actions and behavior, and subject to employer action, sanctions by federal agencies that may fund long-term care and other health care settings, as well as being subject to personal liability suits in civil court.
D. **Evaluation of Learning Objectives** Each user of the curriculum is responsible for developing supplemental materials and methods for evaluating whether or not learning objectives were met.	The nurse: 1. Describes the nurse-UAP-client relationship. 2. Identifies statutory and regulatory authority for delegation. 3. Describes thought processes and information used to arrive at decision to delegate. 4. States principles underlying effective delegation and apply the **Five Rights of Delegation**. 5. Discusses practical considerations underlying effective delegation. 6. Applies the above elements to various clinical situations.	The UAP: 1. Describes the nurse-UAP-client relationship. 2. Defines a delegated activity and state how it is authorized. 3. Discusses the **Five Rights of Delegation**. 4. Identifies steps that should be taken if the UAP does not possess the skills or knowledge required to perform a delegated activity. 5. Explains the importance of communication throughout the delegation process.

A Continuum of Care

Roles of the Licensed Nurse and Unlicensed Assistive Personnel (UAP) in Relation to the Client

	Independent		***Partially Dependent***		***Fully Dependent***
Client Status	No identified health impairment or self-care deficit	With identified health impairment or self-care deficit	Assistance needed in ADLs and/or health maintenance activities; client has self-care deficit ***Client maintains most self-care responsibilities***	Client has sufficient number of self-care deficits to require frequent monitoring and direct interventions by health care profession ***Client maintains some self-care responsibilities***	Responsibility for care transferred to organized health care delivery system
Nurse Role	General Education and Support to promote wellness, health maintenance and disease prevention as requested by client ***Client initiated***	Care Consultation related to health impairment, includes education and support to maintain client independence ***Client or nurse initiated***	Care Coordination Nursing activities include: • needs assessment • teaching care provider to perform care activities • monitoring client status • ongoing review of care provision ***Client or nurse directs***	Care Coordination Nurse directs the care, to include assignment and delegation of activities ***Nurse directs***	Total Care Management Includes direct care, assignment and delegation responsibilities within health care system; care provided by both licensed nurses and UAP (delegated activities) ***Nurse directs***
UAP Role	May participate in client directed or requested activities ***UAP accountable to client***		May be directed by client or authorized to perform care through nursing delegation process ***UAP accountable to client or nurse***	Authorized to practice through nursing delegation process ***UAP accountable to nurse***	Authorized to perform care through nursing delegation process ***UAP accountable to nurse***

Attachment C

Delegation Decision-making Grid

The Delegation Decision-making Grid was developed as a tool to assist nurses in making delegation decisions. The tool provides a scoring mechanism for seven elements that should be considered when making delegation decisions. The rating of the identified elements assists the nurse in evaluating the circumstances, client needs and available resources (including UAP and nurse competence) to support the delegation decision. A low score would indicate that the activity could be safely delegated, a high score would caution against delegation. Each facility or agency would be expected to establish a policy regarding the level of score deemed acceptable for delegation.

Suggestions for Use:
The grid can be used:

- By nurses in planning care for a group of patients. Each worksheet can be used to score the needs of up to four clients and allows comparison of those client situations.
- By nurse managers to evaluate the delegation needs of a client unit or a client caseload.
- For staff education regarding delegation.
- For orientation of new staff, both nurse and UAP.
- For nursing education programs providing basic managerial skills for students.
- For Member Boards responding to questions about delegation (to assist in identification of elements to be considered). *(Boards may consider including this tool as part of a delegation information packet.)*
- For orientation of new board members and attorneys.
- For Member Board workshops and presentations regarding delegation issues.
- For evaluation of discipline complaints involving concerns regarding delegation.

This Delegation Decision-making Grid is based on a concept developed by the American Association of Critical Care Nurses, used in their UAP materials.

Delegation Decision-making Grid

Elements for Review		client #1	client #2	client #3	client #4
Activity/task	**Describe activity/task:**				
Level of Client Stability	**Score the client's level of stability:** 0. client condition is chronic/stable/predictable 1. client condition has minimal potential for change 2. client condition has moderate potential for change 3. client condition is unstable/acute/strong potential for change				
Level of UAP Competence	**Score the UAP competence in completing delegated nursing care activities in the defined client population:** 0. UAP - expert in activities to be delegated, in defined population 1. UAP - experienced in activities to be delegated, in defined population 2. UAP - experienced in activities but not in defined population 3. UAP - novice in performing activities and in defined population				
Level of Licensed Nurse Competence	**Score the licensed nurse's competence in relation to both the nurse's knowledge of providing nursing care to a defined population and the nurse's competence in implementation of the delegation process:** 0. Expert in the knowledge of nursing needs/activities of defined client population *and* expert in the delegation process 1. Either expert in knowledge of needs/activities of defined client population and competent in delegation *or* experienced in the needs/activities of defined client population and expert in the delegation process 2. Experienced in the knowledge of needs/activities of defined client population ***and*** competent in the delegation process 3. Either experienced in the knowledge of needs/activities of defined client population ***or*** competent in the delegation process 4. Novice in knowledge of defined population *and* novice in delegation				
Potential for Harm	**Score the potential level of risk the nursing care activity has for the client (*risk is probability of suffering harm*):** 0. None 1. Low 2. Medium 3. High				
Frequency	**Score based on how often the specific nursing care activity is performed by the UAP:** 0. Performed at least daily 1. Performed at least weekly 2. Performed at least monthly 3. Performed less then monthly				
Level of Decision-making	**Score the decision-making needed, related to the specific nursing care activity, client (both cognitive and physical status) and client situation:** 0. Does not require decision making 1. Minimal level of decision making 2. Moderate level of decision making 3. High level of decision making				
Ability for Self Care	**Score the client's level of assistance needed for self-care activities:** 0. No assistance 1. Limited assistance 2. Extensive assistance 3. Total care or constant attendance				
	TOTAL SCORE				

Attachment D

The Five Rights of Delegation

All decisions related to delegation of nursing activities must be based upon the fundamental principle of public protection. Licensed nurses have ultimate accountability for the management and provision of nursing care, including all delegation decisions. However, seldom is a single nurse accountable for all aspects of the delegation decision-making process, its implementation, supervision, and evaluation.

The Five Rights of Delegation, identified in *Delegation: Concepts and Decision-making Process* (National Council, 1995), can be used as a mental checklist to assist nurses from multiple roles to clarify the critical elements of the decision-making process. Nursing service administrators (all levels of executive/management nurses) and staff nurses each have accountability in assuring that the delegation process is implemented safely and effectively to produce positive health outcomes.

Nursing service administrators (NSA) and staff nurses must work together collaboratively and cooperatively to protect the public and maintain the integrity of the nursing care delivery system. The following principles delineate accountability for nurses at all levels from NSA to staff nurses.

Right Task

Nursing Service Administrator (NSA)	Staff Nurse
■ Appropriate activities for consideration in delegation decisions are identified in UAP job descriptions/role delineation.	■ Appropriate delegation activities are identified for specific client(s).
■ Organizational policies, procedures and standards describe expectations of and limits to activities.	■ Appropriate activities are identified for specific UAP.

Generally, appropriate activities for consideration in delegation decision-making include those:

1. which frequently reoccur in the daily care of a client or group of clients;
2. which do not require the UAP to exercise nursing judgment;
3. which do not require complex and/or multi-dimensional application of the nursing process;
4. for which the results are predictable and the potential risk is minimal; and
5. which utilize a standard and unchanging procedure.

Right Circumstances

Nursing Service Administrator (NSA)	Staff Nurse
■ Assess the health status of the client community, analyze the data and identify collective nursing care needs, priorities, and necessary resources.	■ Assess health status of individual client(s), analyze the data and identify client specific goals and nursing care needs.
■ Provide appropriate staffing and skill mix, identify clear lines of authority and reporting, and provide sufficient equipment and supplies to meet the collective nursing care needs.	■ Match the complexity of the activity with the UAP competency and with the level of supervision available.
■ Provide appropriate preparation in management techniques to deliver and delegate care.	■ Provide for appropriate monitoring and guiding for the combination of client, activity and personnel.

Right Person

Nursing Service Administrator	Staff Nurse
■ Establish organizational standards consistent with applicable law and rules which identify educational and training requirements and competency measurements of nurses and UAP.	■ Instruct and/or assess, verify and identify the UAP's competency on an individual and client specific basis.
■ Incorporate competence standards into institutional policies; assess nurse and UAP performance; perform evaluations based upon standards; and take steps to remedy failure to meet standards, including reporting nurses who fail to meet standards to board of nursing.	■ Implement own professional development activities based on assessed needs; assess UAP performance; perform evaluations of UAP based upon standards; and take steps to remedy failure to meet standards.

Right Direction/Communication

Nursing Service Administrator	Staff Nurse
■ Communicate acceptable activities, UAP competencies and qualifications, and the supervision plan through a description of a nursing service delivery model, standards of care, role descriptions and policies/procedures.	■ Communicate delegation decision on a client specific and UAP-specific basis. The detail and method (oral and/or written) vary with the specific circumstances.
	■ Situation specific communication includes: ◆ specific data to be collected and method and timelines for reporting, ◆ specific activities to be performed and any client specific instruction and limitation, and ◆ the expected results or potential complications and time lines for communicating such information.

Right Supervision/Evaluation

Supervision may be provided by the delegating licensed nurse or by other licensed nurses designated by nursing service administrators or the delegating nurse. The supervising nurse must know the expected method of supervision (direct or indirect), the competencies and qualifications of UAP, the nature of the activities which have been delegated, and the stability/predictability of client condition.

Nursing Service Administrator	Staff Nurse
■ Assure adequate human resources, including sufficient time, to provide for sufficient supervision to assure that nursing care is adequate and meets the needs of the client.	■ Supervise performance of specific nursing activities or assign supervision to other licensed nurses.
■ Identify the licensed nurses responsible to provide supervision by position, title, role delineation.	■ Provide directions and clear expectations of how the activity is to be performed: ◆ monitor performance, ◆ obtain and provide feedback, ◆ intervene if necessary, and ◆ ensure proper documentation.
■ Evaluate outcomes of client community and use information to develop quality assurance and to contribute to risk management plans.	■ Evaluate the entire delegation process: ◆ evaluate the client, and ◆ evaluate the performance of the activity.

Report of the Resolutions Committee/New Business

Committee Members

Sharon Weisenbeck, KY, Area III, *Chair*
Charlet Grooms, OH, Area II
Doris Nuttelman, NH, Area IV
Ruth Ann Terry, CA-RN, Area I
Lorinda Inman, IA, Area II, *Finance Committee Liaison*

Staff

Jennifer Bosma, *Executive Director*
Doris E. Nay, *Associate Executive Director*

Relationship to Organization Plan

Goal V.................Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

Objective C.........Maintain a system of governance for the National Council that facilitates leadership and decision-making.

Recommendations to the Board of Directors

No recommendations.

Highlights of Activities

- **Review of resolutions**

The committee met on April 30, 1997, and no resolutions were submitted as of that date. The committee will meet on August 22, 1997, to review resolutions received by August 22, 2:00 p.m.

- **Resolutions Forum**

All resolutions received will be presented by the committee as part of the forum, which will be held on August 23, 1997.

Meeting Dates

- April 30, 1997

Summary of 1996 Delegate Assembly Action and Subsequent Implementation

The 1996 Delegate Assembly adopted the following motions. Follow-up activities in response to these motions are described.

1. **Adopted the recommendation that the term used to categorize assessment-related activities performed by LPN/VNs be *data collection*. The term *data collection* is defined as: "The LPN/VN collects information, observes the client, records and reports to the appropriate person (e.g., registered nurse, physician) signs and symptoms and other pertinent data which may indicate that the client's condition deviates from normal and/or that there is a change in the client's condition. LPN/VNs contribute to the assessment of clients through data collection. The term *contribute to* denotes an active role on the part of the LPN/VN based on the LPN/VN's knowledge, skills and abilities."**

   The term *data collection* has been retained in the *NCLEX-PN® Test Plan.*

2. **Adopted the recommendation "That the definition of competence, standards for competence and position statement regarding competence developed by the Continued Competence Subcommittee be adopted as a position of the National Council."**

   The definition, standards and position statement regarding competence have been published and disseminated via the National Council World Wide Web site (http://www.ncsbn.org) and upon request. The Nursing Practice & Education Committee has used the definition, standards and principles in the position statement as foundation for its work on continued competence assessment mechanisms during FY97.

3. **Adopted the revised mission statement of the National Council: "The mission of the National Council of State Boards of Nursing is to advance the safe and effective practice of nursing in the interest of protecting the public's health and welfare."**

   The revised mission statement has been published in all places where the mission statement appears, e.g., the Organization Plan, press releases. At its fall retreat, the Board of Directors and Long Range Planning Task Force, along with chairs of the examination, nursing practice and education, and multistate regulation committees, reviewed the purpose statements of the National Council and noted a lack of clarity and coordination between these and the mission statement. Therefore, the Board has proposed revised wording for the mission statement for consideration by the 1997 Delegate Assembly.

4. **Adopted the recommendation "That the Board of Directors give final approval of the Family Nurse Practitioner Curriculum Guidelines and Regulatory Criteria for Evaluating Family Nurse Practitioners (FNPs) Applying for Prescriptive Authority and, with prior opportunity for review and comment by Member Boards, indicate organizational support as a model for use by Member Boards."**

   At its February 1997 meeting, the Board of Directors reviewed and approved the Guidelines and Regulatory Criteria and publicized this support and encouragement to Member Boards to incorporate use of the regulatory criteria in their processes for granting prescriptive authority to FNPs.

5. **Approved the National Council response to the Pew Health Professions Taskforce on Health Care Workforce Regulation report, *Reforming Health Care Workforce Regulation.***

   The National Council's response to the Pew Taskforce report was submitted to the University of California at San Francisco Center for the Health Professions, as required, prior to December 6, 1996. The response has also been publicized through *Issues* and placement on the National Council's Web site. An article published in

Surgical Services Management, a publication of the Association of Operating Room Nurses, incorporated much of the National Council's response to Pew.

6. **Adopted the recommendation that Member Boards have psychometrically sound and legally defensible nurse practitioner examinations available for their regulatory purposes and, pending the receipt of final examination evaluations and mutually acceptable plans for corrections, the Board of Directors continue to negotiate with nurse practitioner certifying organizations. If, at any time, the Board of Directors determines that significant progress is not being made, the Board is authorized to proceed with phase two of the nurse practitioner job analysis. Furthermore, the Board of Directors shall determine a mechanism for assuring continued adherence with established standards for psychometrically sound, legally defensible nurse practitioner examinations used for regulatory purposes.**

   There has been continued progress with the four national certifying organizations on a third-party review process which assures that standards for psychometric soundness and legal defensibility, as they apply specifically for regulatory uses, are met or will be met by the certification programs. By May 1, 1997, the National Certifying Board for Pediatric Nurse Practitioners and Nurses (NCBPNP/N); the National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties; and the American Academy of Nurse Practitioners were accredited by the National Commission on Certifying Agencies (NCCA). Of these, only NCBPNP/N had received from NCCA and submitted a report detailing the meeting of the additional criteria (related to regulatory purposes) specified by the National Council. The American Nurses' Credentialing Center's (ANCC) review by the NCCA remains in process; however, the earlier report submitted by that organization, performed by two outside consultants, addressed the same criteria and the ANCC's responses to the consultants' recommendations. The ANCC has submitted quarterly updates on its progress in implementing the recommendations. To date, the Board has found the progress of all organizations satisfactory. An *Issues* article and a press release have disseminated information to a wide audience regarding the current status of these negotiations. The APRN Task Force has developed a mechanism for assuring the adequacy of the certifying organizations' examinations for regulatory uses on an ongoing basis. (See task force report elsewhere in the *Book of Reports.*)

7. **Adopted the recommendation that the Board of Directors be charged to continue developing the concept of a regulatory model which incorporates the characteristics of a multistate license by directing activities including:**
   - **evaluate the magnitude of the needs of consumers, nurses, and health care delivery systems for multistate practice;**
   - **evaluate the impact of state-level regulatory processes on multistate licensing concept;**
   - **identify core licensure requirements;**
   - **evaluate potential future implications for boards of nursing role and functions;**
   - **identify mechanisms for effective cross-state disciplinary processes;**
   - **analyze current laws and regulations for potential impact on multistate practice; and**
   - **explore the feasibility of a demonstration or pilot project with possible external funding.**

   Nothing in this recommendation shall preclude the investigation of potential options which would facilitate multistate practice.

   A report of these activities shall be presented to the 1997 Delegate Assembly.

   A 12-member task force was appointed by the Board of Directors to oversee this project. The task force's report appears behind Tab 10-C in the *Book of Reports*. The culmination of the task force's work was a workshop for Member Board representatives on June 4. Recommendations to the Board of Directors and Delegate Assembly will be developed on the basis of work reported and input given at the workshop. These will be reported to the Member Boards in the addendum to the *Book of Reports*, disseminated in early August.

8. **Adopted the recommendation that:**
   - **the NCSBN continue toward full development of Electronic Licensure Verification Information System (ELVIS);**
   - **the NCSBN explore funding mechanisms to support the delivery of Electronic Licensure Verification Information System (ELVIS); and**
   - **the Member Boards be encouraged to evaluate the cost of endorsement applications using Electronic Licensure Verification Information System (ELVIS).**

   The Board of Directors appointed a five-member Licensure Verification Task Force to oversee the implementation of this charge from the Delegate Assembly. The task force's report is found behind Tab 10-M in the *Book of Reports*; recommendations to the Delegate Assembly are reported under the report of the Board of Directors.

9. **Adopted the recommendation that the NCSBN investigate the use of plastic card technology (Smart Card).**

   The Special Services Division has explored the use of plastic card technology. Plastic licenses (not "smart") are being produced under contract for the North Carolina, Nevada and California-RN boards of nursing. Smart card technology developments are summarized under the report of the Board of Directors in the *Book of Reports*.

10. **Adopted the recommendation that the NCSBN develop resource modules that will assist Member Boards in licensure decisions involving chemical dependency and criminal/fraudulent behavior.**

    The Board of Directors appointed a four-member task force to oversee the creation of the Disciplinary Modules. The task force's report is found in the *Book of Reports*.

11. **Adopted the recommendation that the NCSBN continue to monitor and disseminate information regarding ongoing and completed research addressing the impact of the substitution of UAPs for licensed personnel (RNs and LPN/VNs) on public safety.**

    Staff in the research services and practice areas have been monitoring the literature and other sources of information regarding utilization of unlicensed assistive personnel. A summary of findings is included under the report of the Board of Directors in the *Book of Reports*.

National Council of State Boards of Nursing, Inc.
Organization Plan

Including Fiscal Year 1997 Tactics

The mission of the National Council of State Boards of Nursing is to advance the safe and effective practice of nursing in the interest of protecting the public's health and welfare.

Goal I. Licensure and Credentialing

Provide Member Boards with examinations and standards for licensure and credentialing.

Objective A. Conduct job analysis studies to serve as the basis for examinations.

- Tactic 1: Revise PN job analysis study methodology.
- Tactic 2: Conduct PN job analysis study using revised methodology.
- Tactic 3: Perform periodic assessments of the work environment of newly licensed RNs and LPN/VNs.
- Tactic 4: Evaluate alternative methodologies for performance of nurse aide job analysis studies.
- Tactic 5: Implement nurse aide job analysis study.
- Tactic 6: Compare practice characteristics of RNs licensed six months or less with those in practice seven to 12 months.

Objective B. Provide examinations that are based on current accepted psychometric principles and legal considerations.

- Tactic 1: Maintain and enhance licensure examinations based on current job analysis studies.
- Tactic 2: Develop and implement mechanisms and policies for NCLEX® examination content development, for increasing volunteer participation and for decreasing the time from approval to new test plan implementation.
- Tactic 3: Develop and implement mechanisms and policies for NCLEX examination scoring, score reporting and psychometric performance analysis.
- Tactic 4: Assure the NCLEX examination is administered according to approved procedures; review and revise policies.
- Tactic 5: Provide quality customer service, including identifying information needs and facilitating development of appropriate communications activities, e.g., brochures, presentations, *NCLEX® Program Reports*.
- Tactic 6: Conduct formal contract negotiation with Educational Testing Service/Sylvan Learning System or issue RFP.
- Tactic 7: Conduct research and activities related to the NC/ETS Joint Research Committee.
- Tactic 8: Provide information about other countries' licensure examinations through developing collaborative relationships (e.g., Canada, Mexico).

Objective C. Conduct research and development regarding computerized clinical simulation testing (CST®) for initial and continued licensure.

- Tactic 1: Reinitiate CST case development and finalize procedures for introducing CST software into schools.
- Tactic 2: Reinitiate scoring key development and continue to explore procedures for scoring CST.
- Tactic 3: Initiate pilot study of Member Board use of CST.
- Tactic 4: Perform contract and technical evaluation of National Board of Medical Examiners.
- Tactic 5: Develop and initiate implementation of CST marketing plan.

Objective D. Provide a competency evaluation program for nurse aides.

- Tactic 1: Jointly develop a new OBRA-defined nurse aide assessment with The Psychological Corporation/ Assessment Systems, Inc., including written and manual skills evaluations.

Objective E. Provide a comprehensive approach for the regulation of advanced nursing practice.

- Tactic 1: Coordinate approaches to APRN regulation to include strategies for consistency in APRN regulation, including identification of regulatory options.
- Tactic 2: Monitor trends and issues related to APRNs including: evolution of clinical nurse specialist and nurse practitioner roles, state and federal legislation, health care delivery and market issues, workplace issues, and APRN education and certification.
- Tactic 3: Complete Family Nurse Practitioner Pharmacology Project.
- Tactic 4: Continue to negotiate with nurse practitioner certifying organizations to make significant progress toward psychometrically sound and legally defensible nurse practitioner examinations available for regulatory purposes.
- Tactic 5: Determine a mechanism for assuring continued adherence with established standards for psychometrically sound, legally defensible nurse practitioner examinations used for regulatory purposes.

Objective F. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel (UAP).

- Tactic 1: Implement strategies for addressing UAP issues.
- Tactic 2: Continue to monitor and disseminate information regarding ongoing and completed research addressing the impact of the substitution of UAPs for licensed personnel (RNs/LPN/VNs) on public safety.
- Tactic 3: Describe and evaluate the congruence between practice, education and supervision of unlicensed assistive personnel who provide nursing-related tasks.

Objective G. Promote consistency in the licensure and credentialing process.

- Tactic 1: Monitor issues and trends related to the licensure and credentialing of nurses, analyze for regulatory implications and plan approaches for those with greatest regulatory impact: federal/state legislation, including Americans with Disabilities Act; legal decisions affecting licensing and credentialing of nurses; endorsement and license verification issues; temporary permits; educational and examination requirements; and practice of nursing via telecommunications.
- Tactic 2: Transition to electronic licensure verification to facilitate interstate endorsement.

Objective H. Identify the role of a board of nursing related to continued competence.

- Tactic 1: Develop regulatory guidelines for use of continued competence resources (i.e., framework, definition/standards, policy/models).
- Tactic 2: Identify assessment mechanisms for a variety of uses and investigate their capabilities related to continued competence assessment; explore collaboration opportunities with other health-related organizations.

Goal II. Nursing Practice

Provide information, analyses and standards regarding the regulation of nursing practice.

Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing practice.

- Tactic 1: Implement comprehensive system to monitor issues impacting regulation of nursing practice, including: the health care delivery environment and system, other market trends affecting nursing practice, federal and state regulation and policies, changes in delivery of nursing care, telecommunications technology and movement from acute care to community-based care.
- Tactic 2: Facilitate exchange of policy and regulatory information, implications, analysis and dialogue among Member Boards and National Council.
- Tactic 3: Provide Member Boards with information and analysis based on potential implications of trends and issues for those issues with the greatest impact on regulation of nursing practice.

Objective B. Provide resources regarding health care issues which affect the regulation of nursing practice.

- Tactic 1: Coordinate analyses and development of documents that provide guidance regarding the regulation of nursing practice.

- Tactic 2: Review and revise *Model Nursing Practice Act* and *Model Nursing Administrative Rules* nursing education sections.

Objective C. Conduct research on regulatory issues related to disciplinary activities.

- Tactic 1: Conduct secondary analyses of chemically impaired nurse data.
- Tactic 2: Plan statistical analysis procedures for Disciplinary Data Bank consistent with redesigned data collection procedures.

Objective D. Provide for Member Board needs related to disciplinary activities.

- Tactic 1: Manage Disciplinary Data Bank services.
- Tactic 2: Facilitate national reporting of licensure disciplinary actions.
- Tactic 3: Develop resource modules that will assist Member Boards in licensure decisions involving chemical dependency and criminal/fraudulent behavior.
- Tactic 4: Revise model guidelines for nondisciplinary alternative programs for chemically impaired nurses and disseminate.
- Tactic 5: Sponsor annual self-supporting conference addressing issues related to nondisciplinary alternative programs for the management of chemically impaired nurses/health care professionals.

Goal III. Nursing Education

Provide information, analyses and standards regarding the regulation of nursing education.

Objective A. Analyze the health care environment for trends and issues affecting the regulation of nursing education.

- Tactic 1: Monitor issues and trends for nursing education regulation implications, planning approaches to those with the greatest regulatory impact: case management/effect on health care; community/multiple/ changing/nontraditional clinical settings*; workforce issues (impact on education); federal/state legislation/ initiatives, including ADA; articulation; faculty preparation and shortage*; curricula in delegation, supervision, nursing management; challenge of board role in program approval; accommodations granted to students with disabilities; and accreditation*. (* indicates those topics for special review)

Objective B. Provide resources regarding issues that affect the regulation of nursing education.

- Tactic 1: Coordinate analyses and development of documents that provide guidance regarding the regulation of nursing education.
- Tactic 2: Conduct a Member Board needs assessment regarding nursing program accreditation/approval.

Goal IV. Information

Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

Objective A. Implement a comprehensive repository of information.

- Tactic 1: Develop and implement information services as prioritized by the Information Master Plan (final seven services include: electronic access to online news services, licensure and examination statistics, research survey results, historic documents, nominations for office, NC awards, travel reservations; add electronic licensure verification, public policy issues tracking, videoconferencing).
- Tactic 2: Develop and implement remote training programs for Member Board staffs.

Objective B. Establish a nurse information system (NIS) for use by Member Boards and others.

- Tactic 1: Plan for and implement strategies to capture comprehensive licensee data in NIS to make the system more complete, efficient, accurate and optimize service delivery.
- Tactic 2: Develop a marketing plan to achieve the goal of making NIS self-supporting.

Objective C. Facilitate communication between National Council, Member Boards and related entities.

- Tactic 1: Maintain and enhance publications and other media communications between and among Member Boards, the National Council, the nursing community and other health care-related entities.
- Tactic 2: Maintain and enhance meeting opportunities between and among Member Boards, the National Council, the nursing community and other health care-related entities.
- Tactic 3: Develop mechanisms for boards of nursing to interact more effectively with consumers.
- Tactic 4: Provide a program of educational offerings for Member Boards, including the selection of educational programs held in conjunction with the Annual Meeting.
- Tactic 5: Provide communications opportunities for groups within Member Boards with common focus/needs.

Objective D. Conduct and disseminate research pertinent to the mission of the National Council.

- Tactic 1: Update research agenda for the National Council.
- Tactic 2: Collect, analyze and disseminate data and statistics in such areas as licensure, educational programs and regulatory functions.
- Tactic 3: Compile and disseminate abstracts of completed, ongoing and projected surveys/studies performed by Member Boards and the National Council.
- Tactic 4: Facilitate research activities of Member Boards, committees, staff groups and other relevant groups.
- Tactic 5: Redesign data collection and reporting methodologies for statistical/informational databases incorporated into Member Board accessible electronic media.

Goal V. Organization

Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.

Objective A. Implement a planning system to guide the National Council.

- Tactic 1: Implement a more efficient and effective long-range organization planning process, connected to financial accounting, built upon 1) taking meaningful incremental looks at progress, 2) automating documents and 3) streamlining board, committee and staff input.
- Tactic 2: Use environmental data and Member Board input to determine future direction for the National Council.
- Tactic 3: Facilitate intraorganizational coordination to accomplish the Organization Plan.

Objective B. Maintain a sound resource management system for the National Council.

- Tactic 1: Oversee use of the organization's assets to assure prudence and integrity of fiscal management and responsiveness to Member Boards' needs.
- Tactic 2: Assure that a proposed annual budget is presented to the Board of Directors prior to the beginning of the fiscal year.
- Tactic 3: Maintain financial policies that provide guidelines for fiscal management.
- Tactic 4: Review and revise financial forecast assumptions to maintain a current forecasting model.
- Tactic 5: Conduct the organization's financial and business affairs in an efficient and effective manner.
- Tactic 6: Assure continued high-performance information services administration and maintenance, including ongoing systems evaluation.
- Tactic 7: Manage human resources to affect the goals of the organization.

Objective C. Maintain a system of governance for the National Council that facilitates leadership and decision-making.

- Tactic 1: Identify needs, assign responsibilities and provide guidance to address topics important to the National Council's mission.
- Tactic 2: Maximize the use of volunteer resources through an effective volunteer program.
- Tactic 3: Formalize and begin implementation of a leadership development program to support nursing regulation leaders.

- Tactic 4: Promote interorganizational perspectives in decision-making.
- Tactic 5: Assure a slate of qualified candidates.

Objective D. Provide consultation and services to meet unique Member Board needs.

- Tactic 1: Respond to Member Board requests for small-scale, unique resources and/or services via the Resource Network.
- Tactic 2: Develop proposals to respond to Member Board requests for large-scale, unique services.

Objective E. Develop and implement a systematic approach for shaping health care policy related to regulation.

- Tactic 1: Facilitate inclusion of National Council (regulatory) perspective on nursing/public issues with regulatory implications at the federal/national level.
- Tactic 2: Implement systematic approaches for regulatory influence with key policy and decision-makers.
- Tactic 3: Devise strategies to influence specific health care and regulatory policy issues at the national/federal level.
- Tactic 4: Provide leadership within the nursing and regulatory communities to achieve consensus on future regulatory models which are responsive and effective in meeting changing needs of consumers and the health care delivery system.

Objective F. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes.

- Tactic 1: Develop and implement a comprehensive system to monitor and identify implications of policy issues and trends affecting nursing regulation, including federal and state legislation; NAFTA/GATS; international issues; anticipated changes in state governmental and regulatory structure; the health care environment and delivery system; and political, economic and social trends affecting regulation.
- Tactic 2: Identify regulatory outcome indicators and plan outcomes research study.

Objective G. Continue developing the concept of a regulatory model which incorporates the characteristics of multistate practice.

- Tactic 1: Evaluate the magnitude of the needs of consumers, nurses and health care delivery systems for multistate practice.
- Tactic 2: Evaluate the impact of state-level regulatory processes on the multistate licensing concept.
- Tactic 3: Identify core licensure requirements for multistate practice.
- Tactic 4: Evaluate potential future implications for board of nursing role and functions related to multistate practice.
- Tactic 5: Identify mechanisms for effective cross-state disciplinary processes.
- Tactic 6: Analyze current laws and regulations for potential impact on multistate practice.
- Tactic 7: Explore the feasibility of a demonstration or pilot project with possible external funding.
- Tactic 8: Explore other potential options that would facilitate multistate practice.

Objective H. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division (SSD).

- Tactic 1: Market workshops to nursing educators on topics including, but not limited to, test construction and CST.
- Tactic 2: Manage and market certification testing programs to PNs.
- Tactic 3: Market Nurse Information Retrieval System database-derived software to nursing educators.
- Tactic 4: Explore development of an additional test for UAPs other than OBRA-defined nurse aide test.
- Tactic 5: Investigate the use of plastic card technology (smart card).

FY97 Budget by Organization Plan, Goals and Objectives

FY97 Budget

Goal I. Provide Member Boards With Examinations and Standards for Licensure and Credentialing

A. Conduct job analysis studies to serve as the basis for examinations.

	FY97 Budget
Publications Revenue	$(3,670)
Salaries, Benefits and Taxes	96,914
Professional/Contractual Fees	47,793
Travel	30,550
Printing and Publications	14,850
Other Expenses	27,980
Allocation of Administrative Costs	24,670
Total	$239,087

B. Provide examinations that are based on current accepted psychometric principles and legal considerations.

	FY97 Budget
NCLEX® Examination Revenue	$(14,817,472)
Publications Revenue	(88,045)
Salaries, Benefits and Taxes	582,358
NCLEX Processing Costs	10,488,878
Professional/Contractual Fees	104,412
Travel	236,865
Printing and Publications	84,600
Other Expenses	45,475
Allocation of Administrative Costs	148,245
Total	$(3,214,684)

C. Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.

	FY97 Budget
Salaries, Benefits and Taxes	$315,865
Professional/Contractual Fees	330,905
Travel	100,775
Printing and Publications	14,150
Other Expenses	1,050
Allocation of Administrative Costs	80,406
Total	$843,151

	FY97 Budget
D. Provide a competency evaluation program for nurse aides.	
Royalty Income	$(420,000)
Publications Revenue	(2,000)
Salaries, Benefits and Taxes	67,794
Professional/Contractual Fees	2,400
Travel	6,000
Printing and Publications	7,500
Other Expenses	1,370
Allocation of Administrative Costs	17,257
Total	$(319,679)
E. Provide a comprehensive approach for the regulation of advanced nursing practice.	
Publications Revenue	$(2,400)
Grant Revenue	$(67,807)
Salaries, Benefits and Taxes	60,327
Professional/Contractual Fees	58,231
Travel	40,049
Printing and Publications	3,788
Other Expenses	5,253
Allocation of Administrative Costs	15,358
Total	$112,799
F. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel.	
Meeting Revenue	$(4,650)
Salaries, Benefits and Taxes	7,121
Professional/Contractual Fees	2,400
Travel	17,485
Printing and Publications	900
Other Expenses	5,000
Allocation of Administrative Costs	1,812
Total	$30,068
G. Promote consistency in the licensure and credentialing process.	
Salaries, Benefits and Taxes	$60,743
Travel	9,650
Printing and Publications	1,200
Other Expenses	675
Allocation of Administrative Costs	15,463
Total	$87,731

	FY97 Budget
H. Identify the role of a board of nursing related to continued competence.	
Salaries, Benefits and Taxes	$19,460
Printing and Publications	500
Allocation of Administrative Costs	4,954
Total	$24,914
Goal I Total	$(2,196,613)

Goal II. Provide Information, Analyses and Standards Regarding the Regulation of Nursing Practice

A. Analyze the health care environment for trends and issues affecting the regulation of nursing practice.	
Salaries, Benefits and Taxes	$49,825
Professional/Contractual Fees	2,400
Travel	3,860
Other Expenses	1,400
Allocation of Administrative Costs	12,684
Total	$70,169
B. Provide resources regarding health care issues which affect the regulation of nursing practice.	
Publications Revenue	(460)
Salaries, Benefits and Taxes	$63,318
Professional/Contractual Fees	9,840
Travel	71,605
Printing and Publications	4,750
Other Expenses	4,220
Allocation of Administrative Costs	16,118
Total	$169,391
C. Conduct research on regulatory issues related to disciplinary activities.	
Publications Revenue	$(600)
Salaries, Benefits and Taxes	11,723
Professional/Contractual Fees	6,000
Travel	6,370
Printing and Publications	2,000
Allocation of Administrative Costs	2,984
Total	$28,477

	FY97 Budget
D. Provide for Member Board needs related to disciplinary activities.	
Publications Revenue	$(540)
Meeting Revenue	(2,700)
Other Revenue	(900)
Salaries, Benefits and Taxes	46,834
Professional/Contractual Fees	14,449
Travel	19,295
Printing and Publications	20,800
Other Expenses	1,825
Allocation of Administrative Costs	11,922
Total	$110,985
Goal II Total	$379,022

Goal III. Provide Information, Analyses and Standards Regarding the Regulation of Nursing Education

A. Analyze the health care environment for trends and issues affecting the regulation of nursing education	
Salaries, Benefits and Taxes	$30,437
Professional/Contractual Fees	163
Printing and Publications	250
Allocation of Administrative Costs	7,748
Total	$38,598
B. Provide resources regarding issues that affect the regulation of nursing education.	
Salaries, Benefits and Taxes	$32,626
Professional/Contractual Fees	2,480
Travel	7,720
Other Expenses	350
Allocation of Administrative Costs	8,306
Total	$51,482
Goal III Total	$90,080

Goal IV. Promote the Exchange of Information and Serve as a Clearinghouse for Matters Related to Nursing Regulation

A. Implement a comprehensive repository of information.	
Salaries, Benefits and Taxes	$150,587
Professional/Contractual Fees	115,918
Travel	14,280
Printing and Publications	6,250
Other Expenses	126,500
Allocation of Administrative Costs	38,333
Total	$451,868

	FY97 Budget
B. Establish a nurse information system (NIS) for use by Member Boards and others.	
Grant Revenue	$(79,588)
Salaries, Benefits and Taxes	260,298
Professional/Contractual Fees	108,319
Travel	3,475
Printing and Publications	29,440
Other Expenses	110,031
Allocation of Administrative Costs	43,726
Total	$475,701
C. Facilitate communication between National Council, Member Boards and related entities.	
Meeting Revenue	$(81,475)
Salaries, Benefits and Taxes	341,983
Professional/Contractual Fees	27,625
Travel	248,046
Printing and Publications	142,450
Other Expenses	36,910
Allocation of Administrative Costs	87,055
Total	$802,594
D. Conduct and disseminate research pertinent to the mission of the National Council.	
Publications Revenue	$(950)
Salaries, Benefits and Taxes	161,799
Professional/Contractual Fees	12,380
Travel	22,385
Printing and Publications	6,650
Other Expenses	32,215
Allocation of Administrative Costs	41,187
Total	$275,666
Goal IV Total	$2,005,829

Goal V. Foster an Organizational Environment That Enhances Leadership and Facilitates Decision-making in the Nursing Regulatory Community

A. Implement a planning system to guide the National Council.	
Salaries, Benefits and Taxes	$193,540
Professional/Contractual Fees	400
Travel	20,525
Printing and Publications	4,500
Other Expenses	800
Allocation of Administrative Costs	49,267
Total	$269,032

	FY97 Budget
B. Maintain a sound resource management system for the National Council.	
Investment Income	$(816,000)
Membership Fee Revenue	(183,000)
Salaries, Benefits and Taxes	418,041
Professional/Contractual Fees	62,360
Travel	16,600
Other Expenses	725
Allocation of Administrative Costs	106,416
Total	$(394,858)
C. Maintain a system of governance for the National Council that facilitates leadership and decision-making.	
Salaries, Benefits and Taxes	$168,921
Professional/Contractual Fees	20,911
Travel	98,473
Printing and Publications	10,130
Other Expenses	18,765
Allocation of Administrative Costs	43,000
Total	$360,200
D. Provide consultation and services to meet unique Member Board needs.	
Salaries, Benefits and Taxes	$2,203
Travel	8,400
Printing and Publications	1,050
Allocation of Administrative Costs	561
Total	$12,214
E. Develop and implement a systematic approach for shaping health care policy related to regulation.	
Salaries, Benefits and Taxes	$38,750
Professional/Contractual Fees	28,215
Travel	42,575
Printing and Publications	1,400
Other Expenses	8,050
Allocation of Administrative Costs	9,864
Total	$128,854
F. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes.	
Meeting Revenue	$(20,280)
Salaries, Benefits and Taxes	33,530
Professional/Contractual Fees	5,905
Travel	55,815
Printing and Publications	500
Other Expenses	2,875
Allocation of Administrative Costs	8,536
Total	$86,881

	FY97 Budget	
G. Continue developing the concept of a regulatory model which incorporates the characteristics of multistate practice.		
Salaries, Benefits and Taxes	$119,665	
Professional/Contractual Fees	32,978	
Travel	217,350	
Printing and Publications	4,100	
Other Expenses	1,600	
Allocation of Administrative Costs	30,462	
Total	$406,155	
H. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division.		
Special Services Division Revenue	$(950,000)	
Salaries, Benefits and Taxes	275,403	
Royalties	120,000	
Marketing	160,000	
Operations	300,000	
Research and Development	110,000	
Federal/State Income Tax	22,000	
Allocation of Administrative Costs	70,105	
Total	$107,508	
Goal V Total	$975,986	
GOAL I-V TOTAL	$1,254,303	
Summary		
Total Revenue	$(17,542,537)	
Less: Total Expenditures	18,796,840	
Net (Revenue)/Expenditures		$1,254,303

Orientation Manual

Purpose

The purpose of the Orientation Manual is to provide information about the functions and operations of the National Council. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants as well as Board of Directors and committee members.

Following a brief discussion of the National Council's history, this manual will describe the organization's structure, functions, policies and procedures. More descriptive information on the National Council is available in a published orientation portfolio, available through the communications department.

History

The concept of an organization such as the National Council had its roots as far back as August 1912 when a special conference on state registration laws was held during the American Nurses Association (ANA) convention. At that time, participants voted to create a committee that would arrange an annual conference for persons involved with state boards of nursing to meet during the ANA convention. It soon became evident that the committee required a stronger structure to deal with the scope of its concerns. However, for various reasons, the committee decided to remain within the ANA.

Boards of nursing also worked with the National League for Nursing Education (NLNE) which, in 1932, became the ANA's Department of Education. In 1933, by agreement with the ANA, the NLNE accepted responsibility for advisory services to the State Boards of Nurse Examiners (SBNE) in all education and examination-related matters. Through its Committee on Education, the NLNE set up a subcommittee that would address, over the following decade, state board examination issues and problems. In 1937, NLNE published *A Curriculum Guide for Schools of Nursing*. Two years later, the NLNE initiated the first testing service through its Committee on Nursing Tests.

Soon after the beginning of World War II, nurse examiners began to face mounting pressures to hasten licensing and to schedule examinations more frequently. In response, participants at a 1942 NLNE conference suggested a "pooling of tests" whereby each state would prepare and contribute examinations in one or more subjects that could provide a reservoir of test items. They recommended that the Committee on Nursing Tests, in consultation with representative nurse examiners, compile the tests in machine-scorable form. In 1943, the NLNE board endorsed the action and authorized its Committee on Nursing Tests to operate a pooling of licensing tests for interested states (the State Board Test Pool Examination or SBTPE). This effort soon demonstrated the need for a clearinghouse whereby state boards could obtain information needed to produce their test items. Shortly thereafter, a Bureau of State Boards of Nursing began operating out of ANA headquarters.

The bureau was incorporated into the ANA bylaws and became an official body within that organization in 1945. Two years later, the ANA board appointed the Committee for the Bureau of State Boards of Nurse Examiners which was comprised of full-time professional employees of state boards.

In 1961, after reviewing the structure and function of the ANA and its relation to state boards of nursing, the committee recommended that it be replaced by a council. Although council status was achieved, many persons continued to be concerned about potential conflicts of interest and recognized the often heard criticism that professional boards serve primarily the interests of the profession they purport to regulate.

In 1970, following a period of financial crisis for the ANA, a council member recommended that a free-standing federation of state boards be established. After a year of study by the state boards, this proposal was overwhelmingly defeated when the council adopted a resolution to remain with the ANA. However, an ad hoc committee was appointed later to examine the feasibility of the council becoming a self-governing incorporated body.

At the council's 1977 meeting, a task force was elected and charged with the responsibility of proposing a specific plan for the formation of a new independent organization. On June 5, 1978, the Delegate Assembly of the ANA's Council of State Boards of Nursing voted 83 to 8 to withdraw from the ANA to form the National Council of State Boards of Nursing.

Today, the National Council's membership consists of 61 boards of nursing, including those of the District of Columbia, the Virgin Islands, Puerto Rico, Guam, American Samoa and the Northern Mariana Islands. An organizational chart depicting the relationship between the National Council and its Member Boards is attached (Attachment A).

Organizational Mission, Objectives, and Goals

The mission of the National Council of State Boards of Nursing is to advance the safe and effective practice of nursing in the interest of protecting the public's health and welfare.

The National Council has several objectives, one of which is to develop and establish policy and procedure regarding the use of licensure examinations in nursing. Another is to identify and promote desirable uniformity in standards and expected outcomes in nursing education and practice as they relate to the public interest. The National Council also seeks to assess trends and issues that affect nursing, disseminate data relating to nurse licensure and promote continued competence in nursing. To achieve these objectives, it plans and promotes educational programs; provides consultative services for Member Boards and others; and conducts research that addresses education, practice and policy-related issues. Tactics for achieving these goals are developed in accordance with organizational objectives and reflect the National Council's mission. The National Council's organization plan adds short-term activities and resources designed to accomplish the long-range goals and objectives. Tactics to implement goals are developed, assessed and refined each fiscal year and provide the organization with a flexible plan within a disciplined focus. Annually, the Board of Directors and committees participate in evaluating the accomplishment of goals and objectives and the directives of the Delegate Assembly.

Organizational Structure and Function

■ Membership

Membership in the National Council is extended to those boards of nursing that agree to use, under specified terms and conditions, one or more types of licensing examinations developed by the National Council. At the present time, there are 61 Member Boards, including those from the District of Columbia, the Virgin Islands, Puerto Rico, Guam, American Samoa and the Northern Mariana Islands. Boards of nursing may become Member Boards upon approval of the Delegate Assembly, payment of the required fees and execution of a contract for using the NCLEX-RN® examination and/or the NCLEX-PN® examination.

Member Boards maintain their good standing through remittance of fees and compliance with all contract provisions and bylaws. In return, they receive the privilege of participating in the development and use of the National Council's licensure examinations. Member Boards also receive information services, public policy analyses and research services. Member Boards who fail to adhere to the conditions of membership may have delinquent fees assessed or their membership terminated by the Board of Directors. They may then choose to appeal the Board's decision to the Delegate Assembly.

■ Areas

The National Council's membership is divided into four geographic areas. The purpose of this division is to facilitate communication, encourage regional dialogue on relevant issues and provide diversity of board and committee representation. Area directors are elected by delegates from their respective Areas through a majority vote of the Delegate Assembly. In addition, there are two directors-at-large who are elected by all delegates voting at the Annual Meeting. (See Glossary for list of jurisdictions by Area.)

■ Delegate Assembly

The Delegate Assembly is the legislative body of the National Council and comprises delegates designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates.

The Delegate Assembly meets at the National Council's Annual Meeting, traditionally held in August. Special sessions can be called under certain circumstances. Regularly scheduled sessions are held on a rotation basis among Areas.

At the Annual Meeting, delegates elect officers and members of the Committee on Nominations by majority and plurality vote respectively. They also receive and respond to reports from officers and committees and approve the annual audit report. They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly adopts the mission statement, goals and objectives of the National Council, and approves most test-related decisions, including changes in examination fees and test plans.

■ Officers

Officers of the National Council include the president, vice-president, treasurer, four Area directors and two directors-at-large. Only members or staff of Member Boards may hold office, subject to exclusion from holding office if other professional obligations result in an actual or perceived conflict of interest.

No person may hold more than one elected office at the same time. The president shall have served as a delegate or a committee member or an officer prior to being elected to office. An officer shall serve no more than four consecutive years in the same officer position.

The president, vice-president and treasurer are elected for a term of two years or until their successors are elected. The president, vice-president and treasurer are elected in even-numbered years.

The four Area directors are elected for a term of two years or until their successors are elected. Area directors are elected in odd-numbered years. The two directors-at-large are elected each year for a one-year term.

Officers are elected by ballot during the annual session of the Delegate Assembly. Area directors are elected by delegates from their respective Areas.

Election is by a majority vote. When a majority is not established by an initial ballot, reballoting takes place between the two nominees with the highest number of votes. In case of a tie on the reballoting, the choice is determined by lot.

Officers assume their duties at the close of the session at which they were elected. A vacancy in the office of president is filled by the vice-president. Other officer vacancies are filled by Board appointees until the term expires.

■ Board of Directors

The Board of Directors, the administrative body of the National Council, consists of the nine elected officers. The Board is responsible for the general supervision of the affairs of the National Council between sessions of the Delegate Assembly. The Board authorizes the signing of contracts, including those between the National Council and its Member Boards. It also engages the services of legal counsel, approves and adopts an annual budget, reviews membership status of noncompliant Member Boards and renders opinions, when needed, about actual or perceived conflicts of interest.

Additional duties include the adoption of personnel policies for all staff, appointment of committees, monitoring of committee progress, approval of studies and research pertinent to the National Council's purpose, and provision for the establishment and maintenance of the administrative offices.

■ Meetings of the Board of Directors

Meeting dates for the year are finalized by the Board of Directors during its post-Annual Meeting Board meeting. All Board meetings are held in Chicago with the exception of the pre- and post-Annual Meeting Board meetings.

Board officers are asked to submit reports and other materials for the meeting at least three weeks prior to each meeting so that they can be copied and distributed with other meeting materials. The call to meeting, agenda and related materials are mailed to Board officers two weeks before the meeting. The agenda is prepared by staff, in consultation with the president, and provided to the membership via the biweekly *Newsletter*.

Activities and materials generated during the two-week interval before the meeting are reported or distributed at the next meeting. This limits the flood of last-minute information to be distributed, read and considered during the Board meeting.

The agenda is organized around the organization plan (goals and objectives). Items for Board discussion and action are accompanied by a memo or report which describes the item's background and indicates the Board action needed. Motion papers are available during the meeting and are used so that an accurate record will result. Staff takes minutes of the meeting. A summary of the Board's major decisions is also prepared and mailed to Member Boards for their information prior to the release of approved minutes following the next Board meeting.

Resource materials are available to each Board officer for use during Board meetings. These materials, which are updated periodically throughout the year, are kept at the National Council office and include copies of the articles of incorporation and bylaws, organization plan, policies and procedures, contracts, budget, test plan, committee rosters, minutes and personnel manual.

■ Communications With the Board of Directors

Communication between Board meetings takes place in several different ways. The executive director communicates weekly with the president regarding major activities and confers as needed with the treasurer about financial matters. Quarterly reports of major activities are prepared by the staff and provided to Board officers.

In most instances, the executive director is the person responsible for communicating with National Council consultants about legal, financial and accounting concerns. This practice was adopted primarily as a way to monitor and control the costs of consultant services.

Conference calls can be scheduled, if so desired by the president. Written materials are generally forwarded to Board officers in advance of the call. These materials include staff memos detailing the issue's background as well as Board action required. Staff prepares minutes of the call and submits them at the next regularly scheduled Board meeting.

Board officers use the National Council letterhead when communicating as representatives of the National Council.

■ Committee on Nominations

National Council delegates elect representatives to the Committee on Nominations. The committee consists of four persons, one from each Area, who may be either board members or staff of Member Boards. Committee members are elected to one-year terms. They are elected by ballot with a plurality vote. The chair is that person who receives the highest number of votes.

The Committee on Nominations' function is to consider the qualifications of all candidates for Board of Director office and for the committee itself and to prepare a slate of qualified candidates. During the Delegate Assembly, additional nominations may be made from the floor.

Committees

Most of the National Council's objectives are accomplished through the committee process. Every year, the committees report on their activities and make recommendations to the Delegate Assembly or Board of Directors. At the present time, the National Council has three standing committees: Examination, Finance, and Nursing Practice and Education.

Committees and special committees are appointed by the Board of Directors to address special issues and concerns. Examples of special committees include the Unlicensed Assistive Personnel Task Force, Multistate Regulation Task Force and Licensure Verification Task Force.

Committees are governed by specific policies and procedures which may be found in National Council's policy manual. Committee membership is extended to all current members and staff of Member Boards. In the appointment process, every effort is made to match the expertise of each individual with the needs of the National Council. Also considered is balanced representation whenever possible, among Area, Board members and staff, registered and licensed practical/vocational nurses, and consumers. Consultants provide outside expertise to committees as needed, on a one-time or ongoing basis.

A National Council staff member is assigned to serve each committee. Staff work closely with the committee chairs to facilitate committee work and provide support and expertise to committee members, but they have no formal decision-making role. Agendas for the committee meetings are established by the chair. With staff assistance, the chair prepares the agenda, the call to meeting and any other documents that must be reviewed prior to committee meetings. Staff supervises the mailing of these materials, which are sent to committee members no less than two weeks before the committee meeting.

At the request of committee members, staff will analyze issues and make recommendations in accordance with committee objectives and assumptions.

■ Examination Committee

The Examination Committee consists of at least six persons, including one representative from each Area. One of these persons must be a licensed practical/vocational nurse. The committee chair must have served on the committee prior to being appointed chair. Alternates to the Examination Committee are generally individuals with prior experience on a testing-related committee. Alternates to the Examination Committee may be called on at any time to serve temporarily as a member of the committee and have all the responsibilities and rights of full membership when called to serve as a member.

The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests research important to the development of licensure examinations.

The Examination Committee provides general oversight of the NCLEX® examination process, including examination item development, security, administration and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation and preparation of written information about the examinations for Member Boards and other interested parties. The committee also regularly evaluates the licensure examinations by means of item analysis and test and candidate statistics.

One of the National Council's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is key to this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: 1) whether or not the examination actually measures competencies required for safe and effective job performance, and 2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation. There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts, and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe and effective practice.

The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills and abilities (KSA) statements or competency statements which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a cut score to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected for this process. They are trained in conceptualizing the minimally competent candidate (performing at the lowest acceptable level), and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in identification of a cut score. Taking this outcome along with other data relevant to identification of the level of minimum competence, the Board of Directors sets a passing standard which distinguishes between candidates who do and do not possess the essential competencies, thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes is the best legal defense available for licensing examinations. For most of the possible challenges that candidates might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

■ Finance Committee

The Finance Committee is comprised of one representative from each Area and the treasurer, who serves as the chair. The committee's primary purpose is to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. It also reviews financial status on a quarterly basis and provides the Board of Directors with a proposed annual budget prior to each new fiscal year.

■ Nursing Practice and Education Committee

The Nursing Practice and Education Committee consists of at least one representative from each Area. The committee's purpose is to provide general oversight of nursing practice and education regulatory issues. It periodically reviews and revises the *Model Nursing Practice Act* and *Model Nursing Administrative Rules,* and prepares other position statements and guidelines for presentation to the Delegate Assembly. It also prepares written information about the legal definitions and standards of nursing practice and education which it disseminates to

Member Boards and other interested parties. In the recent past, the committee has had a number of subcommittees to study various issues, e.g., continued competence, complex discipline cases and accreditation/approval in nursing education.

National Council Staff

National Council staff members are hired by the executive director, to whom they report. Their primary role is to implement the Delegate Assembly's policy directives and provide assistance to the Board of Directors and committees.

The National Council staff is organized into departments for the purpose of meeting the organizational objectives. The Measurement and Evaluation Department exists to accomplish the National Council's primary objective, which is to develop and establish examination-related policy and procedure. Other staff members are assigned to the Departments of: Research Services, Communications, Practice and Accountability, Practice and Credentialing, Education and Practice, Public Policy, Administrative Services and Executive Staff to assist the National Council to meet its other objectives. A list of staff and their respective titles can be found behind Tab 5.

General Delegate Assembly Information

Agendas for each session of the Delegate Assembly are prepared by the president in consultation with the Board of Directors and executive director and approved by the Board of Directors. At least 45 days before the Annual Meeting, Member Boards are sent three copies of the *Book of Reports.* This document contains annual reports and recommendations from the standing committees, Board of Directors, officers and executive director, as well as new business submitted by any member or the Board. It also contains the agenda and operating budget, as well as proposed rules for the conduct of Delegate Assembly business. Beginning in 1997, a *Business Book* will be provided to all Annual Meeting registrants which contains only those reports requiring Delegate Assembly action.

Prior to the annual session of the Delegate Assembly, the president appoints the rules, credentials, elections and resolutions committees, as well as the Committee to Approve Minutes. Prior to any special session, the president appoints at least the Rules and Credentials Committees. In either case, the president must also appoint a timekeeper, a parliamentarian and pages.

The purpose of the Rules Committee is to draft, in consultation with the parliamentarian, rules for the conduct of the specific Delegate Assembly. The Credentials Committee's function is to provide delegates with identification bearing the number of votes to which the delegate is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and Committee on Nominations. The Elections Committee conducts all elections that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits and evaluates all others in terms of their relationship to National Council's mission, goals and fiscal impact to the organization. At a time designated by the president, it reports to the Delegate Assembly.

Minutes of the Delegate Assembly are kept by the executive director, who serves as corporate secretary. These minutes are then reviewed, corrected as necessary and approved by the Committee to Approve Minutes.

The Delegate Assembly, the legislative body of the National Council, as specified in the bylaws, provides direction to:

- approve all new National Council memberships;
- elect officers and members of the Committee on Nominations;
- receive reports of officers and committees and take action as appropriate;
- establish the fee for the NCLEX examination;
- approve the auditor's report;
- adopt policy and position statements;
- adopt the mission, goals and objectives of the National Council;
- approve the substance of all contracts between the National Council and Member Boards and the National Council and test services;
- establish the criteria for and select the NCLEX examination test service;
- adopt test plans to be used for the development of the NCLEX examination; and
- transact any other business as may come before it.

General Committee Information

■ **Committee Appointments**

The appointment of representatives of Member Boards to committees of the National Council is a responsibility delegated to the Board of Directors by the bylaws. In order to facilitate this process and ensure a wide representation of Member Boards, board staff and board members, the following procedure is used.

Individuals who wish to be considered for appointment or reappointment to a National Council committee/special committee submit a Committee Volunteer Information Form. All information from this form, along with information about the number of positions available on each committee, is forwarded to the respective Area director for recommendations for appointment or reappointment. Concurrently, committee chairs are asked to provide input as to whether individuals currently serving on committees should be reappointed. The Area directors recommend to the Board of Directors the appointment/reappointment of individuals to vacant positions. The Area directors' recommendations are based on input received from committee chairs, as well as information obtained from the individuals' volunteer information form.

Prior to the Annual Meeting, the Board of Directors evaluates the qualifications of existing and potential committee chairs, makes tentative appointments for committee chairs, and reviews and tentatively approves the committee/special committee appointments that were recommended by Area Directors. During the Board's September meeting, appointments are finalized after considering the need for additional special committees required to accomplish the directives of the Delegate Assembly.

■ **Committee Minutes**

Minutes are taken at every committee meeting including telephone conference calls. Minute-taking is an extremely important responsibility because minutes serve as records of what took place at the meeting. Although minutes can be opposed by oral testimony, they are, in the vast majority of cases, legally binding once they have been adopted and certified. Thus, it is crucial that they accurately reflect the committee's process and outcomes.

Committee minutes are taken by committee members or staff, who should:

- report the date, place and time of the meeting;
- include a statement that the meeting was duly called;
- indicate the presiding officer, chair or committee member;
- indicate who served as secretary;
- record names of persons present and quorum statistics;
- record the reading, correction and adoption of minutes from the previous meeting;
- record the adjournment time;
- be clear and concise;
- not include every routine document;
- make amendments to the minutes only with the committee's approval; and
- initial any amendments.

Minutes from National Council Board and committee meetings should reflect the topic discussed and the comments and/or actions that followed.

■ **Committee Reports**

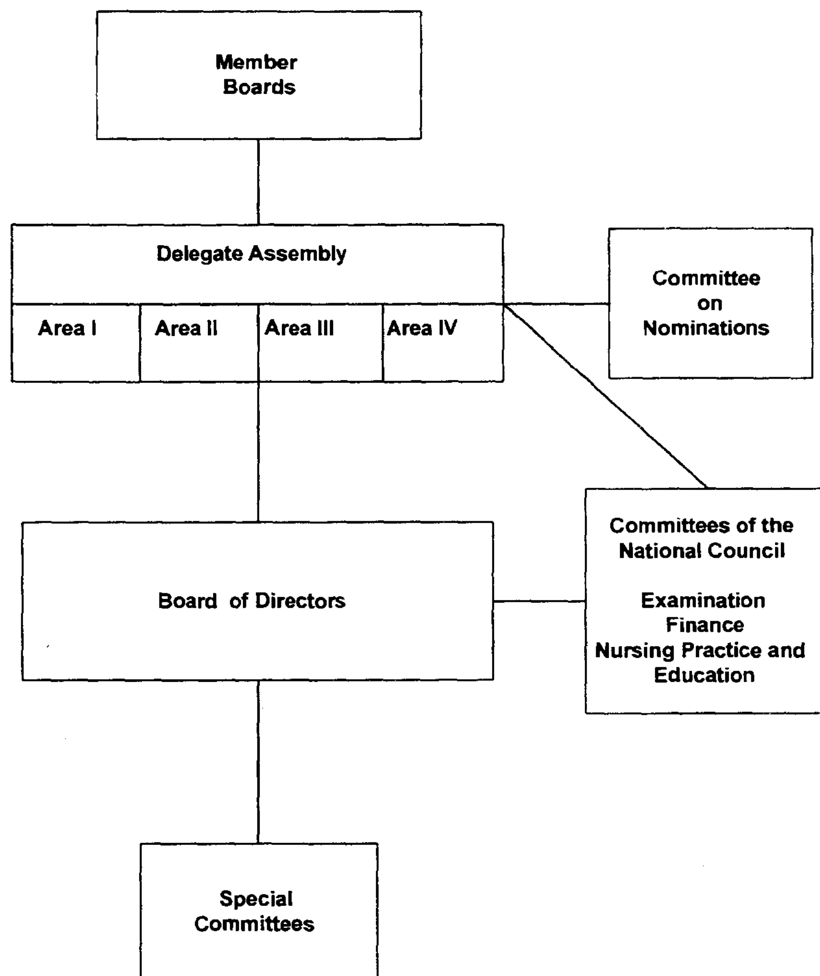
Committees requesting action from the Board submit reports to the National Council office no later than three weeks prior to each Board of Directors' meeting. The reports are written by the committee chair and committee staffperson. Staff processes the reports and supervises their mailing.

The first page of the report contains committee recommendation(s). Subsequent pages document the committee's activities in either narrative or outline format. Background and rationale for the committee's recommendation(s) should be clearly stated. The report concludes with a reiteration of the committee's recommendation(s), and fiscal impact and legal comments are indicated.

A summary of every committee meeting is reported to the membership via the *Newsletter* that follows the close of the individual meeting.

National Council of State Boards of Nursing, Inc.

Organization
as of June 1, 1997



National Council of State Boards of Nursing, Inc. Bylaws

Revision Adopted	*August 29, 1987*
Amended	*August 19, 1988*
Amended	*August 30, 1990*
Amended	*August 1, 1991*
Amended	*August 5, 1994*

Article I

■ **Name**

The name of this organization shall be the National Council of State Boards of Nursing, Inc., hereinafter referred to as the National Council.

Article II

■ **Purpose and Functions**

Section 1. ***Purpose.*** The purpose of the National Council is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

Section 2. ***Functions.*** The National Council's functions shall include but not be limited to providing services and guidance to its members in performing their regulatory functions regarding entry into nursing practice, continued safe nursing practice and nursing education programs. The National Council provides Member Boards with examinations and standards for licensure and credentialing; promotes uniformity in standards and expected outcomes in nursing practice and education as they relate to the protection of the public health, safety and welfare; provides information, analyses and standards regarding the regulation of nursing practice and nursing education; promotes the exchange of information and serves as a clearinghouse for matters related to nursing regulation.

Article III

■ **Members**

Section 1. ***Definition.*** A state board of nursing is the governmental agency empowered to license and regulate nursing practice in any state, territory or political subdivision of the United States of America.

Section 2. ***Qualifications.*** Any state board of nursing that agrees to use one or more National Council Licensing Examinations, hereinafter referred to as the NCLEX®, under the terms and conditions specified by the National Council and pays the required fees may be a member of the National Council.

Section 3. ***Admission.*** A state board of nursing shall become a member of the National Council and be known as a Member Board upon approval by the Delegate Assembly, as described in Article VII, payment of the required fees and execution of a contract for using the NCLEX.

Section 4. ***Areas.*** The Delegate Assembly shall divide the membership into numbered geographical Areas. At no time shall the number of Areas be less than three nor more than six. New members shall be assigned to existing Areas by the Board of Directors. The purpose of this division is to facilitate communication, encourage regional dialogue on National Council issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. ***Fees.*** The annual fee, as set by the Delegate Assembly, shall be payable each July 1.
** See Proviso number 1.*

Section 6. ***Privileges.*** Membership privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX, except that a Member Board that uses both

NCLEX and another examination leading to the same license shall not participate in the development of the NCLEX to the extent that such participation would jeopardize the integrity of the NCLEX.

Section 7. ***Noncompliance.*** Any Member Board whose fees remain unpaid after October 15 is not in good standing. Any Member Board which does not comply with the provisions of the bylaws and contracts of the National Council shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. ***Appeal.*** Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. ***Reinstatement.*** A Member Board in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

Article IV

■ Officers

Section 1. ***Enumeration.*** The elected officers shall be a president, a vice-president, a treasurer, two directors-at-large and a director from each Area.
** See Proviso number 2.*

Section 2. ***Qualifications.*** Members and employees of Member Boards shall be eligible to serve as National Council officers until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 3. ***Qualifications for President.*** The president shall have served as a delegate or a committee member or an officer prior to being elected to the office of President.

Section 4. ***Directors.*** Each Area shall elect a director. Two directors-at-large shall be elected by the Delegate Assembly.
** See Proviso number 3.*

Section 5. ***Terms of Office.*** The president, vice-president, treasurer and Area directors shall be elected for a term of two years or until their successors are elected. Directors-at-large shall be elected for a term of one year or until their successors are elected. The president, vice-president and treasurer shall be elected in even-numbered years. The Area directors shall be elected in odd-numbered years. Officers shall assume duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same officer position.
** See Proviso numbers 4 and 5.*

Section 6. ***Limitations.*** No person may hold more than one elected office at one time. No officer shall hold elected or appointed office or a salaried position in a state, regional or national association or body if such office or position might result in a potential or actual, or the appearance of, a conflict of interest with the National Council, as determined by the Committee on Nominations before election to office and as determined by the Board of Directors after election to office. If a current officer agrees to be presented on the ballot for another office, the term of the current office shall terminate at the close of the Annual Meeting at which the election is held.

Section 7. ***Vacancies.*** A vacancy in the office of president shall be filled by the vice-president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting.

Section 8. ***Removal from Office.*** A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly. The Board of Directors shall remove any member of the Board of

Directors from office upon conviction of a felony. A member of the Board of Directors may be removed by a two-thirds vote of the Board of Directors for failure to perform duties of the office. The individual shall be given 30 days' written notice of the proposed removal.

Section 9. ***Appeal.*** An individual removed from office by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two-thirds vote of the Delegate Assembly.

Section 10. ***Responsibilities of the President.*** The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and act as the chief spokesperson for the National Council. The president shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 11. ***Responsibilities of the Vice-President.*** The vice-president shall assist the president, perform the duties of the president in the president's absence, and fill any vacancy in the office of the president until the next Annual Meeting. The vice-president shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 12. ***Responsibilities of the Treasurer.*** The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors and Member Boards, and that annual financial reports are presented to the Delegate Assembly. The treasurer shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 13. ***Duties of Area Directors.*** The directors elected from Areas shall preside at Area Meetings of the Member Boards, and shall serve as liaison and resource persons to Member Board members and employees in their respective Areas. The Area directors shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 14. ***Duties of Directors-at-Large.*** Directors-at-large shall perform such duties as shall be assigned to them by the Board of Directors, and act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Article V

■ Nominations and Elections

Section 1. ***Committee on Nominations***

a) *Composition.* The Committee on Nominations shall be comprised of one person from each Area. Committee members shall be members or employees of Member Boards within the Area.
b) *Term.* The term of office shall be one year. Members shall assume duties at the close of the Annual Meeting at which they are elected.
c) *Election.* The committee shall be elected by ballot of the Delegate Assembly at the Annual Meeting. A plurality vote shall elect. The member receiving the highest number of votes shall serve as chair.
d) *Limitation.* A member elected or appointed to the Committee on Nominations may not be nominated for an officer position during the term for which that member was elected or appointed.
e) *Vacancy.* A vacancy occurring in the committee shall be filled from the remaining candidates from the Area in which the vacancy occurs, in order of votes received. If no remaining candidates from an Area can serve, the Board of Directors shall fill the vacancy with an individual from the Area who meets the qualifications of Section 1 of this Article.
f) *Duties.* The Committee on Nominations shall consider the qualifications of all nominees for officers and the Committee on Nominations as proposed by Member Boards or by members of the Committee on Nominations, and present a qualified slate of candidates for vote at the Annual Meeting. The committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

Section 2. ***Election of Officers.*** Election of officers shall be by ballot of the Delegate Assembly during the Annual Meeting. Write-in votes shall be prohibited. If a candidate does not receive a majority vote on the first ballot, re-balloting shall be limited to the two nominees receiving the highest numbers of votes. In case of a tie on the re-balloting, the choice shall be determined by lot.

Article VI

■ Meetings

Section 1. ***Open Meetings.*** All meetings called under the auspices of the National Council shall be open to the public with the following exceptions: (a) meetings of the Examination Committee whenever activities pertaining to test items are undertaken; and (b) executive sessions of the Delegate Assembly, Board of Directors and committees, provided that the minutes reflect the purpose of and action taken in executive session.

Section 2. ***Participation.***

a) *Right to Speak.* Members and employees of Member Boards shall be given the right to speak at all meetings called under the auspices of the National Council. Only delegates to the Delegate Assembly, members of the Board of Directors and members of National Council committees shall be entitled to make motions and vote in their respective meetings; provided, however, that the Board of Directors, committees and Member Boards may make motions at the Delegate Assembly.
b) *Interactive Communications.* Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the National Council Office.
c) *Electronic Communication and Mail.* To the extent permitted by law, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.
d) *Committees.* Committees may establish such methods of conducting their business as they find convenient and appropriate.

Article VII

■ Delegate Assembly

Section 1. ***Composition and Term.*** The Delegate Assembly shall be comprised of delegates designated by each Member Board. An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges. A National Council officer may not represent a Member Board as a delegate. Delegates and alternates serve from the time of appointment until replaced.

Section 2. ***Voting.*** Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting. A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the secretary of the National Council or a delegate of another Member Board to cast its votes.

Section 3. ***Authority.*** The Delegate Assembly, the legislative body of the National Council, shall provide direction for the National Council through adoption of the mission, goals and objectives, adoption of position statements, and actions at any Annual Meeting or special session. The Delegate Assembly shall approve all new National Council memberships; approve the substance of all NCLEX contracts between the National Council and Member Boards; adopt test plans to be used for the development of the NCLEX; select the NCLEX test service; and establish the fee for the NCLEX.

Section 4. ***Annual Meeting.*** The National Council Annual Meeting shall be held at a time and place as determined by the Board of Directors. The Delegate Assembly shall meet each year during the Annual Meeting. The official call to that meeting, giving the time and place, shall be conveyed to each Member Board at least 90 days prior to the Annual Meeting. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the

Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the National Council.

Section 5. ***Special Session.*** A special session of the Delegate Assembly shall be called upon written petition of at least ten Member Boards made to the Board of Directors. A special session may be called by the Board of Directors. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least ten days prior to the date for which such a session is called.

Section 6. ***Quorum.*** The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Article VIII

■ Board of Directors

Section 1. ***Composition.*** The Board of Directors shall consist of the elected officers.

Section 2. ***Authority.*** The Board of Directors shall have general supervision of the affairs of the National Council between the meetings of the Delegate Assembly and shall perform such other duties as are specified in these bylaws. The Board shall be subject to the orders of the Delegate Assembly, and none of its acts shall conflict with action taken by the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly.

Section 3. ***Meetings of the Board of Directors.*** The Board of Directors shall meet in the Annual Meeting city immediately prior to, and following, the Annual Meeting, and at other times as necessary to accomplish the work of the Board. Special meetings of the Board of Directors shall be called by the president upon written request of at least three members of the Board of Directors. Special meetings may be called by the president. Twenty-four hours or more notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Article IX

■ Executive Director

Section 1. ***Appointment.*** The Executive Director shall be appointed by the Board of Directors. The selection or termination of the Executive Director shall be by a majority vote of the Board of Directors.

Section 2. ***Authority.*** The Executive Director shall serve as the chief staff officer of the organization and shall possess the authority conferred by, and be subject to the limitations imposed by the Board of Directors. The Executive Director shall manage and direct the programs and services of the National Council, supervise all administrative services, serve as corporate secretary and shall oversee maintenance of all documents and records of the National Council.

Section 3. ***Evaluation.*** The Board of Directors shall conduct an annual written performance appraisal of the Executive Director, and shall set the Executive Director's annual salary.

Article X

■ Committees

Section 1. ***Standing Committees.*** Members of standing committees shall be appointed by the Board of Directors.

a) *Examination Committee.* The Examination Committee shall be comprised of at least six members, including one member from each Area. One of the committee members shall be a licensed practical/vocational nurse. At least six alternates shall be appointed, and an alternate may be called on at any time to serve temporarily as a member of the committee and have all the responsibilities and rights of full membership when called to serve as a member. The committee chair shall have served as a member of the committee prior to being appointed as chair. The Examination Committee shall provide general oversight of the NCLEX process, including examination item development, security, administration and quality assurance to ensure consistency with the

Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly.

b) *Finance Committee.* The Finance Committee shall be comprised of one member from each Area and the treasurer, who shall serve as chair. The Finance Committee shall provide general oversight of the use of the National Council's assets to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. The Finance Committee shall maintain financial policies which provide guidelines for fiscal management, and shall review and revise financial forecast assumptions.

c) *Nursing Practice and Education Committee.* The Nursing Practice and Education Committee shall be comprised of at least one member from each Area. The Nursing Practice and Education Committee shall provide general oversight of nursing practice and education regulatory issues by coordinating related subcommittees.

Section 2. ***Special Committees.*** The Board of Directors shall appoint special committees as needed to accomplish the mission of the National Council. Special committees may be subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. ***Committee Membership.***

a) *Composition.* Standing committees shall include only current members and employees of Member Boards. Special committees shall include current members and employees of Member Boards, and may include consultants or other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, consideration shall be given to expertise needed for the committee work, Area representation and the composition of Member Boards. The president, or president's delegate, shall be an ex-officio member of all committees except the Committee on Nominations.

b) *Term.* The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for re-appointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

c) *Vacancy.* A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

d) *Committee Functions.*
   1. *Budget.* Standing committees shall submit a budget request for activities prior to the beginning of the fiscal year. Special committees will be assigned a budget to use in accomplishing the charge. Committees shall not incur expenses in addition to the approved budgeted amount without prior authorization of the Board of Directors.
   2. *Policies.* Each standing committee shall establish policies to expedite the work of the committee, subject to review and modification by the Board of Directors. Special committees shall comply with general policies established by the Board of Directors.
   3. *Records and Reports.* Each committee shall keep minutes. Special committees shall provide regular updates to the Board of Directors regarding progress toward meeting their charge. Standing committees shall submit quarterly reports to, and report on proposed plans as requested by, the Board of Directors. Special committees shall submit a report and standing committees shall submit annual reports to the Delegate Assembly.

Article XI

■ Special Services Division

Section 1. ***Purpose.*** The Special Services Division of the National Council shall be the vehicle for conducting activities which are consistent with the purposes of the National Council and which relate to providing services or products primarily to parties other than Member Boards. This Article shall apply solely to activities within the jurisdiction of the Special Services Division.

Section 2. ***Scope of Activities.*** Activities within the jurisdiction of the Special Services Division shall include the development, promotion and distribution of services and products provided primarily to parties other than Member Boards but shall not include (a) the development of examinations and standards for the governmental authorization

for nursing practice in Member Board jurisdictions or (b) the development of standards regarding the regulation of nursing practice and nursing education in Member Board jurisdictions. However, with the prior approval of the Board of Directors, the Special Services Division may develop, promote and distribute services or products which include such examinations and standards at the request of one or more Member Boards and/or certifying bodies other than examinations and standards for the initial entry-level licensure of nurses.

Section 3. ***Management Authority.*** The property and activities of the Special Services Division shall be managed by an Executive who shall be appointed by, and serve at the pleasure of, the Board of Directors and who may, but need not, be the same person who serves as the Executive Director of the National Council. The Executive shall be the chief executive officer of the Special Services Division and, subject to such operating policies and guidelines, including such financial policies and limitations, as may be adopted by the Board of Directors from time to time, shall have full authority to direct the activities of the division and to enter into contracts and make other commitments on behalf of the division, which shall be binding upon the National Council.

Article XII

■ Finance

Section 1. ***Audit.*** The financial records of the National Council shall be audited annually by a certified public accountant appointed by the Board of Directors. The audit report shall be presented to the Delegate Assembly.

Section 2. ***Fiscal Year.*** The fiscal year shall be from October 1 to September 30.

Article XIII

■ Indemnification

Section 1. ***Direct Indemnification.*** To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney's fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.

Section 2. ***Insurance.*** To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. ***Additional Rights.*** Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

a) not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and
b) continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIV

■ **Parliamentary Authority**

The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern the National Council in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the National Council.

Article XV

■ **Amendment of Bylaws**

Section 1. ***Amendment.*** These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly. A two-thirds vote of the delegates present and voting is required to amend the bylaws, providing that copies of the proposed amendments have been presented in writing to the Member Boards at least 45 days prior to the session. Without previous 45-day notice, the bylaws may be amended by a three-quarters vote of the delegates eligible to vote if, at least five days prior to the meeting, notice is given that amendments may be considered at the Annual Meeting or special session.

Section 2. ***Revision.*** These bylaws may undergo revision only upon authorization and adoption by the Delegate Assembly. A committee for revision, authorized by the Delegate Assembly, shall prepare and present the proposed revision. A two-thirds vote of the delegates present and voting is required to adopt the revision, provided that copies of the proposed revision shall have been submitted in writing to the Member Boards at least 45 days prior to the Annual Meeting or special session at which the action is to be taken.

Provisos to the Bylaws of the National Council of State Boards of Nursing

1. Proviso to Article III, Section 5:
The annual fee shall be $3,000 until determined otherwise by the Delegate Assembly in conjunction with the current contract cycle.

2. Proviso to Article IV, Section 1:
The current secretary shall remain in office until the close of the 1995 Delegate Assembly.

3. Proviso to Article IV, Section 4:
One director-at-large shall be elected at the 1994 Delegate Assembly. Two directors-at-large shall be elected annually at the 1995 Delegate Assembly.

4. Proviso to Article IV, Section 5:
The term of office of the current treasurer shall be extended for one year so that the treasurer shall remain in office until the 1996 Annual Meeting.

5. Proviso to Article IV, Section 5:
Any officer currently in office or elected to office at the 1994 Delegate Assembly may serve up to five consecutive years at the same office position.

Proposed Bylaws Amendments

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

1. Bylaws Amendment proposed by the Elections Committee

Article V. Nominations and Elections

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
Section 2. Election of Officers. Election of officers shall be by ballot of the Delegate Assembly during the Annual Meeting. Write-in votes shall be prohibited. If a candidate does not receive a majority vote on the first ballot, re-balloting shall be limited to the two nominees receiving the highest numbers of votes. In case of a tie on the re-balloting, the choice shall be determined by lot.	Section 2. Election of Officers. Election of officers shall be by ballot of the Delegate Assembly during the Annual Meeting. Write-in votes shall be prohibited. Election of all officers except Directors-at-Large: if a candidate does not receive a majority vote on the first ballot, re-balloting shall be limited to the two nominees receiving the highest number of votes. In case of a tie on the re-balloting, the choice shall be determined by lot. Elections of Director-at-Large: if the necessary number of candidates does not receive a majority vote on the first ballot, re-balloting shall be limited to the nominees receiving the highest number of votes (two nominees if one position is to be filled; four nominees if two positions are to be filled). If the necessary number of candidates does not receive a majority vote on the second ballot, re-balloting	During the 1996 elections, combining both a large number of potential candidates and the need to elect two Directors-at-Large resulted in the need for not only a second ballot, but also election by lot. While procedures were in place to accommodate this situation, questions were raised by delegates, Election Committee members and staff regarding the process and the fairness of the current process to elect Directors-at-Large.	The Bylaws Task Force supports the proposed wording, which clarifies the process and provides an opportunity for the delegates to speak.

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
1. Bylaws Amendment proposed by the Elections Committee (cont.)			
	shall occur among all remaining candidates. If the necessary number of candidates does not receive a majority on the third ballot, the candidate(s) with the most votes shall be declared the winner. If there is a tie between individuals with the most votes, then the choice shall be determined by lot.		

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

2. *Bylaws Amendment proposed by the Committee on Nominations*

Article V. Nominations and Elections

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
Section 1.c. Election. The committee shall be elected by ballot of the Delegate Assembly at the Annual Meeting. A plurality vote shall elect. The member receiving the highest number of votes shall serve as chair.	Section 1.c. Election. The committee shall be elected by ballot of the Delegate Assembly at the Annual Meeting. A plurality vote shall elect. At the first committee meeting, the members of the committee shall elect, from its membership, the committee chair. The first meeting of the committee shall be held concurrent with the first meeting of the Board of Directors in the subsequent fiscal year.	The current system has three disadvantages that do not exist in the proposed change. The current system: • penalizes the Areas that nominate multiple candidates. Because the committee chair is the candidate who receives the highest number of votes, if one Area has three candidates for the Committee on Nominations, and another Area has only one candidate, it is almost impossible for the Area with three candidates to have one of those candidates become the committee chair. • conducts the same election for membership on the Committee on Nominations as it does for committee chair. That is one election for two very different positions that require different sets of skills.	The Bylaws Task Force supports the proposed amendment based on the rationale.

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

2. Bylaws Amendment proposed by the Committee on Nominations (cont.)

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
		• allows for the election of an individual to chair even though that person may not be interested or willing to function as chair of the committee. This proposed change eliminates the previously mentioned disadvantages, as well as provides the committee members with the opportunity to meet members of the Board of Directors and observe the Board in action so as to better understand the function of the Board. Thus, the committee's ability to select qualified candidates is enhanced.	

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

3. *Bylaws Amendment proposed by the Examination Committee*

Article X. Committees

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
Section 1. Standing Committees. Members of standing committees shall be appointed by the Board of Directors. a. Examination Committee. The Examination Committee shall be comprised of at least six members, including one member from each Area. One of the committee members shall be a licensed practical/vocational nurse. At least six alternates shall be appointed, and an alternate may be called on at any time to serve temporarily as a member of the committee and have all the responsibilities and rights of full membership when called to serve as a member. The committee chair shall have served as a member of the committee prior to being appointed as chair. The Examination Committee shall provide general oversight of the NCLEX® examination, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly.	Section 1. Standing Committees. Members of standing committees shall be appointed by the Board of Directors. a. Examination Committee. The Examination Committee shall be comprised of at least six members, including one member from each Area. One of the committee members shall be a licensed practical/vocational nurse. The committee chair shall have served as a member of the committee prior to being appointed as chair. The Examination Committee shall provide general oversight of the NCLEX® examination, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the	The current bylaws refer to an outdated concept; that of "alternate" committee members who would substitute for committee members who could not attend a regularly scheduled meeting. The alternate members have a vote on committee business items. In their current restructuring plan, the Examination Committee proposes the formation of a subcommittee, the Examination Committee Item Review Subcommittee, whose *only* function would be to review new, referred and basepool items and recommend disposition to the Examination Committee. The Item Review Subcommittee would meet five times per year. With the change to computerized testing, the master item pool has quadrupled in size. Instead of reviewing specific examination forms four times per year (as in paper-and-pencil mode), the Examination Committee is now responsible for having	The Bylaws Task Force supports the change and recognizes the need for Examination Committee subcommittees to assist in the fulfillment of its responsibilities.

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

3. Bylaws Amendment proposed by the Examination Committee (cont.)

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
	fulfillment of its responsibilities.	approved all items in a configured pool. The intent to create three master pools has dramatically increased item production needs. This production in turn has caused the Examination Committee to change the method that they are currently using to review items because the workload is too great. Currently, the Examination Committee is meeting six times a year for six days at a time to keep up with their charge. Formation of a subcommittee for item review would allow the Examination Committee to continue to fulfill its responsibilities of general oversight of the NCLEX examination process, examination item development and quality assurance of items. This would result in a more manageable workload for the Examination Committee, which would allow a greater amount of time to be spent on other examination business. The new structure would also increase the opportunities for	

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation

3. Bylaws Amendment proposed by the Examination Committee (cont.)

Current Bylaws	Proposed Bylaw Amendment	Rationale	Bylaws Task Force Recommendation
		Member Boards to be involved in the examination process. Instead of the 12 Member Boards currently represented by the Examination Committee, a potential of 24 boards could be lending their regulatory expertise to examination development.	

Glossary

AACN
American Association of Colleges of Nursing or American Association of Critical Care Nurses.

AANP
American Academy of Nurse Practitioners.

ACC
ACNM Certification Council, Inc.

ACNM
American College of Nurse Midwives.

AccuFacts
A searchable electronic database of National Council documents that may be distributed to the public. Accessible to Member Boards via NCNET and the public via the National Council's public World Wide Web site.

ADA
Americans With Disabilities Act.

ANA
American Nurses Association.

ANCC
American Nurses Credentialing Center.

AONE
American Organization of Nurse Executives.

APRN (also known as APN or ARNP)
Advanced Practice Registered Nurse. In the National Council's *Model Nursing Practice Act*, this level of nursing practice is based on knowledge and skills acquired in basic nursing education; licensure as a registered nurse; and a graduate degree with a major in nursing or a graduate degree with a concentration in the advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions and management of health care.

Area
One of four designated regions of National Council Member Boards.

Area I	Area II	Area III	Area IV
Alaska	Illinois	Alabama	Connecticut
American Samoa	Indiana	Arkansas	Delaware
Arizona	Iowa	Florida	District of Columbia
California	Kansas	Georgia	Maine
Colorado	Michigan	Kentucky	Maryland
Guam	Minnesota	Louisiana	Massachusetts
Hawaii	Missouri	Mississippi	New Hampshire
Idaho	Nebraska	North Carolina	New Jersey
Montana	North Dakota	Oklahoma	New York
Nevada	Ohio	South Carolina	Pennsylvania
New Mexico	South Dakota	Tennessee	Puerto Rico

Area I	Area II	Area III	Area IV
N. Mariana Islands	West Virginia	Texas	Rhode Island
Oregon	Wisconsin	Virginia	Vermont
Utah			Virgin Islands
Washington			
Wyoming			

ASI
Assessment Systems, Inc. A wholly owned subsidiary of The Psychological Corporation. The test service for NACEP (See Psych Corp) and the Certification Examination for Practical Nurses in Long-Term Care.

Blueprint
The organizing framework for an examination which includes the percentage of items allocated to various categories.

Board Member
An individual who serves on a board of directors (national level) or a board of nursing (state level).

BOD
Board of Directors of the National Council of State Boards of Nursing. (Authority: general supervision of the affairs of the National Council between meetings of the Delegate Assembly.)

Bylaws
The laws which govern the internal affairs of an organization.

CAC
Citizen Advocacy Center.

CAT
Computerized Adaptive Testing.

CCNA
Council on Certification of Nurse Anesthetists.

CDC
Case Development Committee. A committee of clinical experts that has the responsibility of developing cases for the Computerized Clinical Simulation Testing (CST®) project.

CEPN-LTC
Certification Examination for Practical Nurses in Long-Term Care.

CGFNS
The Commission on Graduates of Foreign Nursing Schools. (An agency providing credentialing services for foreign-educated nurses, as well as a certification program designed to predict success on the NCLEX-RN® examination.)

Chauncey
See The Chauncey Group International, Ltd.

CLEAR
Council on Licensure, Enforcement and Regulation. (An organization of regulatory boards and agencies, headquartered in Lexington, Kentucky.)

CNATS
Canadian Nurses Association Testing Service.

CNM
Certified Nurse Midwife.

CNS
Clinical Nurse Specialist.

CON
Committee on Nominations. The elected committee of the National Council responsible for preparing a slate of qualified candidates for each year's elections. The Committee on Nominations' members serve one-year terms.

Conrad Bill
Introduced as the Comprehensive Telehealth Act of 1997, the Conrad Bill includes four steps aimed at developing the potential of telehealth: 1) The bill makes telehealth services eligible for Medicare reimbursement. 2) It asks the secretary of health and human services to study state-to-state licensure barriers for health professionals who provide services through telehealth. 3) It requires annual telehealth reports to Congress from the Federal Joint Working Group on Telemedicine. 4) It provides grants and loans to rural hospitals, clinics, universities, libraries and other organizations to develop local telehealth networks and foster rural economic development.

CRNA
Certified Registered Nurse Anesthetist.

CSCC
Candidate Services Call Center. Sylvan's national facility for candidate scheduling and inquiry for all their examinations (formerly National Registration Center or NRC).

CST®
Computerized Clinical Simulation Testing.

CTB/McGraw-Hill
National Council's test service for the NCLEX® examination paper-and-pencil development and administration, 1981-94.

Decision Consistency
A test statistic that indicates the expected consistency of pass or fail classification decisions across different administrations of the examination. It is concerned only with classification accuracy, not with the precision of the numerical test scores, as is the reliability statistic used with paper-and-pencil examinations.

Delegate Assembly
The registration body of the National Council which comprises 61 Member Boards. Each Member Board is entitled to two votes. (Authority: provides direction through adoption of the mission, goals and objectives; adoption of position statements and actions.)

Department of Education (DOE)
U.S. Department of Education.

Diagnostic Profile
The document sent to failing candidates reflecting their performance on various aspects of the NCLEX examination by test plan content area.

DIF
Differential item functioning or a measure of potential item bias.

Direct Registration
A method of submitting candidate registrations for the NCLEX examination. Registrations are submitted by candidates, with the $88 fee, directly to The Chauncey Group. The option for telephone registration is available for $97.25.

Disciplinary Data Bank (DDB)
A National Council data management system, established in 1981, that serves as a database of disciplinary actions reported by Member Boards.

EC
Examination Committee.

Education Program Reports
See *NCLEX® Program Reports*.

EDWARD
Electronic Document Warehousing And Retrieval Database. System providing guided electronic access to all available nursing practice acts and administrative rules. Available to Member Boards via NCNET.

EIRs
Electronic Irregularity Reports. Reports written by the test center staff on the day of testing regarding any irregularities occurring during NCLEX examination testing. These reports are forwarded by Sylvan overnight to The Chauncey Group and the National Council. The National Council forwards the EIRs to the Member Board where the candidate is seeking licensure.

Electronic Access
Member Boards' direct inquiry of the National Council Disciplinary Data Bank via NCNET for information regarding disciplinary history of action(s) taken against a nurse's license.

ELVIS
Electronic Licensure Verification Information Service. A NCNET online service using NIS data to provide licensure information to Member Boards as they make licensure endorsement decisions. The development of ELVIS has been guided by the Licensure Verification Task Force (LVTF).

ETS/The Chauncey Group
Educational Testing Service is the parent company of The Chauncey Group. The Chauncey Group is the National Council's test service for the NCLEX examinations, located in Princeton, New Jersey, and engaged in educational and certification testing services.

Experimental Items
Newly written test questions placed into examinations for the purpose of gathering statistics. Experimental items or "tryouts" are not used in determining the pass/fail result.

FARB
Federation of Associations of Regulatory Boards.

Fiscal Year (FY)
October 1 to September 30 at the National Council.

HCFA
Health Care Financing Administration. (A unit of the federal government under the Department of Health and Human Services.)

HRSA
Health Resources and Services Administration. (A unit of the federal government under the Department of Health and Human Services.)

ICN
International Council of Nurses.

ICONS
The Interagency Conference on Nursing Statistics. Members include the American Association of Colleges of Nursing, American Association of Critical Care Nurses, American Organization of Nurse Executives, American Nurses' Association, Bureau of Labor Statistics, Division of Nursing (HRSA), National Center for Health Statistics, National Council of State Boards of Nursing, National League for Nursing and American Association of Nurse Anesthetists.

Insight
A triannual publication discussing issues related to nurse aides and assistive personnel, delegation to unlicensed assistive personnel and the NACEP.

Interprofessional Workgroup
The Interprofessional Workgroup on Health Professions Regulation is an ad hoc group of national federations of regulatory boards and professional associations related to nursing, pharmacy, medicine, chiropractic, dentistry, nursing home administration, social work, physician assistants, optometry, dietetics, laboratory personnel, audiology and speech-language pathology, physical therapy, occupational therapy and respiratory care. The group, which is facilitated by the National Council, was formed to respond to the recommendations of the Pew Taskforce on Healthcare Workforce Regulation, and subsequently decided to jointly plan and host a conference on continued competence.

Issues
A quarterly newsletter published and nationally distributed by the National Council.

Item
A test question.

Item Response Theory (IRT)
A family of psychometric measurement models based on characteristics of examinees' item responses and item difficulty. Their use enables many measurement benefits (see Rasch Model).

Item Reviewers
Individuals who review newly written items developed for the NCLEX-RN and NCLEX-PN® examinations.

Item Writers
Individuals who write test questions for the NCLEX-RN examination, NCLEX-PN examination and NACEP examination.

JRC
Joint Research Committee. This committee consists of three National Council and three Chauncey or ETS staff members, and two external researchers. The committee is the vehicle through which research is funded for the NCLEX examination program. Funding is provided jointly by the National Council and The Chauncey Group.

JWGT
Joint Working Group on Telemedicine. A governmentwide entity composed of more than eight member departments and agencies. The JWGT is charged with assessing the role of the federal government in telemedicine and coordinating telemedicine activities across federal cabinet agencies. Part of that task involves developing specific actions to overcome barriers to the effective use of telemedicine technologies.

Kennedy-Kassebaum
The popular name for the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Amends the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to ensure health plan portability, availability and renewability requirements for both group and individual plans. Features of HIPAA include limits on pre-existing condition exclusion periods and mandates crediting periods of previous coverage and prohibitions against discrimination based on health status, genetic information and other specified factors. Additional provisions include adoption of a standard unique health identifier for each individual, employer, health plan and health care provider for use in the health care system and a Medical Savings Account demonstration project.

KSA
Knowledge, skill and ability statements.

Logit
A unit of measurement used in IRT models. The log transformation of an odds ratio creates an equal interval, logit scale on which item difficulty and person ability may be jointly represented.

LRP
Long Range Planning. (A task force of the National Council.)

MNAR
Model Nursing Administrative Rules. (A publication of the National Council.)

Mantel-Haenszel
A well-accepted statistical procedure used to estimate the differential item functioning or potential bias of test items.

MBOS
Member Board Office System. The software used in many Member Board offices to communicate electronically with The Chauncey Group regarding NCLEX examination candidates.

Member Board
A jurisdiction which is a member of the National Council.

MNPA
Model Nursing Practice Act. (A publication of the National Council.)

MSL
Multistate License.

MSR
Multistate Regulation.

NACEP™
Nurse Aide Competency Evaluation Program. (See also NNAAP.)

NAFTA
North American Free Trade Agreement (Canada, Mexico and the United States). Addresses trade in services and contains requirements and encouragement related to harmonization of qualifications for professional practice in the three countries.

NAPNES
The National Association for Practical Nurse Education and Service.

NASD
National Association of Securities Dealers.

National Council Organization Plan
Mission, goals and objectives of the National Council as adopted by the Delegate Assembly.

NBME
National Board of Medical Examiners. NBME is the technical consultant for CST.

NCBPNP/N
National Certification Board of Pediatric Nurse Practitioners and Nurses.

NCC
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties.

NCIC
National Crime Information Center. A computerized information system operated by the Federal Bureau of Investigation (FBI) for the purpose of exchanging criminal history information among criminal justice agencies.

NC or NCSBN
Abbreviated form of National Council of State Boards of Nursing, Inc.

NCLEX-RN® Examination
National Council Licensure Examination-Registered Nurse.

NCLEX-PN® Examination
National Council Licensure Examination-Practical Nurse.

NCLEX® Program Reports
Published by The Chauncey Group twice per year, the *NCLEX® Program Reports* provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX examination. Included in the *NCLEX® Program Reports* is information about a program's performance by the *NCLEX® Test Plan* dimensions and by content areas. Data about a program's rank nationally and within the program's state also are included.

NCLEX® Quarterly Reports
The NCLEX® Quarterly Reports summarize the performance of all first-time candidates educated in a given jurisdiction who were tested in a given quarter, and the national group of candidates. They also provide a summary of the preceding three quarters' passing rates. (Previously known as green sheets.)

NCNET
National Council Network. National Council's electronic network for Member Boards, on which a variety of software services are delivered (e.g., EDWARD, DDB, EIRs, SAVHI, etc.).

Newsletter
A biweekly publication produced by the National Council and distributed to each Member Board. Items included on a regular basis: committee reports; Board of Directors' agendas, major actions and minutes; current updates on policy; report and/or analyses of federal legislation; examination statistics; notice of upcoming events; updates to National Council manuals; solicitations for persons to serve in various capacities; information from the testing department related to the NCLEX examination; and information related to National Council activities.

NFLPN
National Federation of Licensed Practical Nurses.

NIRS©

Nursing Information Retrieval System. A relational database of tables of nursing and medical information that are linked via a simple coding scheme that permits quick and efficient identification and capture of the numerous relationships which exist within and across the tables. It is designed to expedite CST case and scoring key development, quality assurance and the delivery of a CST examination.

NIS

Nurse Information System. A national database being developed by the National Council, containing demographic information on all licensed nurses and an unduplicated count of licensees and serving as a foundation for a variety of services, including the disciplinary data bank, licensure verification and research on nurses.

NLN

National League for Nursing.

NNAAP

National Nurse Aide Assessment Program. The new nurse aide certification examination being developed by the National Council during FY98 that will combine the NACEP and ASI's nurse aide certification programs.

NNRR

National Nursing Research Roundtable.

NP

Nurse Practitioner.

NP&E

Nursing Practice and Education. (A standing committee of the National Council.)

NPDB

National Practitioner Data Bank. A federally mandated program for collecting disciplinary data regarding health care practitioners. The NPDB began operation in September 1990, receiving required medical malpractice payment reports for all health care practitioners, and required reports of discipline and clinical privilege/society actions regarding physicians and dentists. Mandatory reporting of licensure actions regarding other health care practitioners, including nurses, is required by section 1921 of the Social Security Act (originally enacted in P.L.100-93, section five). Implementation of other health care practitioner reporting to the NPDB has been on hold. Currently, the Health Resources and Services Administration (HRSA) is planning implementation of section 1921. Draft rules governing reporting are expected to be published in July 1997.

OBRA 1987

Omnibus Budget Reconciliation Act of 1987 (contains requirements for nurse aide training and competency evaluation).

Ontario Model

Refers to the Regulated Health Professions Act (RHPA), which includes a general act and procedural code that applies to all regulated health professions, as well as 21 profession-specific acts. The legislation went into effect on December 31, 1993, and replaced the Health Disciplines Act and various others pieces of legislation.

PAP

Personal Accountability Profile. It provides a framework for the licensed nurse to document learning needs, learning plans and goals/objectives, strategies for development and evaluation as to whether or not goals/objectives have been achieved. It is an expected activity of all licensed nurses to reflect lifelong learning activities and application to daily practice. The profile is, in essence, the application of the nursing process to one's own competence and professional development and accountability.

Pew Charitable Trusts
A national and international philanthropy with a special commitment to Philadelphia, Pennsylvania, which supports not-for-profit activities in the areas of conservation and the environment, culture, education, health and human services, public policy and religion. The foundation was established by Joseph Pew, owner of Sun Oil Company.

Pew Health Professions Commission
The Pew Health Professions Commission was established in spring 1989 and is administered by the University of California at San Francisco, Center for the Health Professions. The mission of the Pew Health Professions Commission is to assist the nation's health professional schools in: understanding the changing nature of health care in the United States, understanding what types of health care workers will be needed for the future and with what skills, and designing and implementing programs that are capable of educating such professionals. A new commission was recently empaneled. It is chaired by former Senator George Mitchell and has been charged to address graduate education of health professionals, as well as "fundamental regulatory reforms at the state level intended to guarantee the competence and accountability of physicians, nurses, and other health professionals."

Pew Taskforce on Health Care
The Pew Health Professions Commission charged the Taskforce on Health Care Workforce Regulation to identify and explore how regulation protects the public's health and propose new approaches to health care workforce regulation to better serve the public's interest. The task force was composed of eight individuals with legal, policy and public health expertise. Its recommendations were issued in late 1995.

Psych Corp
The Psychological Corporation (TPC). The Psychological Corporation, a wholly owned subsidiary of Harcourt General Corporation, is the parent corporation of ASI. The NACEP test service who is charged to develop and maintain an evaluation for nurse aide competency as mandated by federal legislation (OBRA 1987). Assessment Systems, Inc., producer of another nurse aide exam, was acquired by TPC in 1995.

Psychometrics
The scientific field concerned with all aspects of educational and psychological measurement (or testing), specifically achievement, aptitude and mastery as measured by testing instruments.

Public Policy
Policy formed by governmental bodies. They include all decisions, rules, actions and procedures established in the public interest.

RAP
Research Advisory Panel.

Rasch Measurement Model
The item response theory model used to create the NCLEX examination measurement scale. Its use allows person-free item calibration and item-free person measurement.

Reliability
A test statistic that indicates the expected consistency of test scores across different administrations or test forms. That is, it assesses the degree to which a test score reflects the person's true standing on the trait being measured. The National Council uses the Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of the NACEP. For adaptively administered examinations, such as the NCLEX examination using CAT, the decision consistency statistic is the more appropriate statistic for assessing precision (see Decision Consistency).

RFP
Request for Proposals.

SAHVI
Storehouse of Administrative, Historical and Volunteer Information. Database that contains comprehensive National Council historical and volunteer information, as well as mailing list data. Portions of the SAVHI database are available to Member Boards via NCNET.

SKDC
Scoring Key Development Committee. Committee of clinical experts which has the responsibility of developing scoring keys for the CST project.

SSD
Special Services Division. A unit of the National Council that develops services and products, the revenue from which will go to support core programs for Member Boards.

Standard Setting
The process used by the Board of Directors to determine the passing standard for an examination, at or above which examinees pass the examination and below which they fail. This standard denotes the minimum acceptable amount of entry-level nursing knowledge, skills and abilities. The National Council uses multiple data sources to set the standard, including a criterion-referenced statistical procedure and a Survey of Professionals. Standard setting is conducted every three years for each NCLEX examination and whenever the test plan or *NACEP Blueprint* changes.

STC
Sylvan Technology Center.

Submission of Reports
A Member Board, upon taking disciplinary action, submits to the National Council Disciplinary Data Bank biographical data about the nurse and information regarding the grounds for and the disciplinary action taken by the board of nursing.

Summary Profiles
Summary profiles are no longer produced by CTB. They have been replaced by *NCLEX® Program Reports* produced by The Chauncey Group. See *NCLEX® Program Reports*.

Sylvan
See Sylvan Technology Centers.

Sylvan Prometric
The computer-based testing division of Sylvan Learning Systems.

Sylvan Learning Systems
The Chauncey Group's business partner for the delivery of computerized tests. More than 400 Sylvan Learning Centers nationwide form the core of SLS' business. SLS is a publicly traded corporation headquartered in Baltimore, Maryland.

Sylvan Technology Centers (STCs)
Sylvan Technology Centers are Sylvan Prometric's high-stakes testing centers responsible for the secure delivery of computerized examinations. There are more than 250 STCs in North America. The NCLEX examinations are administered in more than 200 STCs located in the United States and its territories.

Test Plan
The organizing framework for NCLEX-RN examination and NCLEX-PN examination which includes the percentage of items allocated to various categories.

Test Service
The organization which provides test services to the National Council, including test scoring and reporting. The Chauncey Group, along with Sylvan Prometric, is the test service for the NCLEX examinations, and ASI is the test service for the NACEP and CEPN-LTC.

The Chauncey Group
See The Chauncey Group International, Ltd.

The Chauncey Group International, Ltd.
A wholly owned subsidiary of Educational Testing Service (ETS). National Council's test service for the NCLEX examination, located in Princeton, New Jersey.

TPC
See Psych Corp.

Tri Council for Nursing
Members include the American Association of Colleges of Nursing, American Organization of Nurse Executives, American Nurses Association and National League for Nursing.

Trilateral Initiative for Nursing
A project coordinated by CGFNS and funded by the W.K. Kellogg Foundation to develop a series of papers addressing the following aspects of nursing in each of the three NAFTA countries (Canada, Mexico and the United States): standards of nursing education, approval and accreditation of nursing education programs, licensure/ registration and standards of practice, and nursing specialty certification.

UAP/ULAP
Unlicensed Assistive Personnel.

Validity
The extent to which inferences made using test scores are appropriate and justified by evidence; an indication that the test is measuring what it purports to measure. The National Council assures the content validity of its examinations by basing each test strictly on the appropriate test plan (NCLEX-RN examination or NCLEX-PN examination) or blueprint (NACEP). Each test plan or blueprint is developed from a current job analysis of entry-level practitioners.