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Annual Meeting Schedule

Incidental meeting rooms are available throughout the week and may be reserved 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, July 26

7:30 a.m.-9:30 a.m.
Registration for Optional Day Programs
Imperial Ballroom Foyer

8:30 a.m.-5:00 p.m.
Optional Day Program
Dialogue on Discipline
Imperial Ballroom Salon A

8:30 a.m.-5:00 p.m.
Optional Day Program
Dialogue on Education
Imperial Ballroom Salon B

12:00 p.m. - 1:30 p.m.
Luncheon—Dialogue on Discipline and Dialogue on Education
Skyline North

Tuesday, July

7:30 a.m.-9:00 a.m.
11:30 a.m.-5:00 p.m.
Annual Meeting Registration
Imperial Ballroom Foyer

8:00 a.m.-8:30 a.m.
Executive Officers' Light Continental Breakfast
Imperial Ballroom Foyer

8:30 a.m.-11:30 a.m.
Executive Officers' Networking Session
Imperial Ballroom Salon B

11:00 a.m.-5:00 p.m.
Poster Sessions
Imperial Ballroom Foyer

11:30 a.m.-1:00 p.m.
Lunch Break

1:00 p.m.-2:30 p.m.
Concurrent Educational/Research Sessions
- Continued Competence—Researching New Approaches to Recertification
- Ethnic Differences in Performance on the NCLEX-RN® Examination
- Developing Competencies for a Continuing Competence Program
- Ethics in Action: Nursing in the Brave New World

Imperial Ballroom Salon A, Marquis Salon I, Champagne, Rhine/Savoy

2:30 p.m.-3:00 p.m.
Poster Session and Refreshment Break
Imperial Ballroom Foyer

3:00 p.m.-4:30 p.m.
Concurrent Educational/Research Sessions
- Consumers' Perceptions of Competence in Nursing
- Public Policy and the Foreign-educated Nurse
- Factors Influencing Client Outcomes After Delegation to and Supervision of Unlicensed Assistive Personnel (UAP)
- Regulating Certified Nurse-Midwives (CNMs)

Imperial Ballroom Salon A, Marquis Salon I, Champagne, Rhine/Savoy

4:30 p.m.-5:00 p.m.
Poster Session
Imperial Ballroom Foyer

5:00 p.m.-6:30 p.m.
Early Bird Social
Imperial Ballroom Salon B

Wednesday, July 28

7:30 a.m.-2:00 p.m.
Registration
Imperial Ballroom Foyer

8:00 a.m.-9:15 a.m.
Orientation
Champagne

9:15 a.m.-11:15 a.m.
Networking Groups
- Executive Officers
- Board Members
- Board Staff-Education
- Board Staff-Practice/Discipline

Riviera, Summit, Champagne, Danube/Tigris

11:15 a.m.-11:30 a.m.
Coffee Break
Imperial Ballroom Foyer

11:30 a.m.-12:30 p.m.
Delegate Assembly
Imperial Ballroom

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

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

2:00 p.m.-3:30 p.m.
Candidates' Forum
Imperial Ballroom

3:30 p.m.-4:00 p.m.
Refreshment Break
Imperial Ballroom Foyer

4:00 p.m.-5:00 p.m.
Special Interest Groups (SIGs)
- Board Attorneys
- Chemically Impaired Nurse Issues
- LPN/VN Issues
- Member Board Presidents
- Nur*sys* Demonstration

Champagne, Danube/Tigris, Riviera, South Hampton, Summit

Thursday, July [illegible]

8:00 a.m.-2:00 p.m.
Registration
Imperial Ballroom Foyer

8:00 a.m.-9:00 a.m.
Breakfast with The Chauncey Group/Sylvan Prometric
Marquis Salon I

9:00 a.m.-10:30 a.m.
The Nursing Profession—Re-treading, Re-thinking, or Re-inventing
André B. van Niekerk, PhD, Associate Dean for Executive Degree Programs, Executive Professor of Marketing, Graziadio School of Business and Management, Pepperdine University
Imperial Ballroom

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

11:00 a.m.-12:00 p.m.
Forum Presentation
CLOSED SESSION
- Business Opportunities

Imperial Ballroom

> *Closed Session Note:* A closed session is defined as a session open to delegates and Member Board representatives only.

12:00 p.m.-1:30 p.m.
Area Luncheons
- Area I
- Area II
- Area III
- Area IV

Madrid/Trinidad, Copenhagen/Stockholm, Marquis Salon I, Consulate

1:30 p.m.-3:00 p.m.
Forum Presentations
- Finance Committee
- Commitment to Excellence Project

Imperial Ballroom

3:00 p.m.-3:30 p.m.
Refreshment Break
Sponsored by Assessment Systems, Inc.
Imperial Ballroom Foyer

3:30 p.m.-5:00 p.m.
Forum Presentations
- Agent Role for the HIPDB/NPDB
- Nursing Practice and Education Committee—Uniform Core Requirements for RN and LPN/VN Licensure
- APRN Task Force—Uniform Core Licensure Requirements

Imperial Ballroom

Friday, July 30

8:00 a.m.-10:00 a.m.
Registration
Imperial Ballroom Foyer

8:30 a.m.- 9:00 a.m.
Examination Committee Forum
CLOSED SESSION
Imperial Ballroom

> *Closed Session Note:* A closed session is defined as a session open to delegates and Member Board representatives only.

9:00 a.m.-10:30 a.m.
Forum Presentations
- Computerized Clinical Simulation Testing (CST®) Task Force
- Examination Committee Update
- Discussion of the CST Project with the Board of Directors

Imperial Ballroom

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

11:00 a.m.-12:00 p.m.
Forum Presentations
- Mutual Recognition, including Nurse Licensure Compact Model Rules and Regulations

Imperial Ballroom

12:00 p.m.-2:00 p.m.
Awards Luncheon
Marquis Salon I

2:00 p.m.-3:00 p.m.
Forum Presentations
- Nur*sys*

Imperial Ballroom

3:00 p.m.-4:00 p.m.
Delegate Assembly
CLOSED SESSION
- Business Opportunities

Imperial Ballroom

> *Closed Session Note:* A closed session is defined as a session open to delegates and Member Board representatives only.

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

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

Saturday June

7:30 a.m.-9:00 a.m.
Registration
Imperial Ballroom Foyer

7:30 a.m.-8:30 a.m.
Elections
Press Room

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
Imperial Ballroom

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

9:45 a.m.-10:45 a.m.
Open Forum
Imperial Ballroom

Open Forum Note: Attendees are encouraged to bring forward any question or comment on any topic or issue related to activities of the National Council. Attendee participation is key and will determine the topics discussed during the Open Forum.

10:45 a.m.-11:15 a.m.
Coffee Break
Imperial Ballroom Foyer

11:15 a.m.-12:30 p.m.
Delegate Assembly
Imperial Ballroom

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

2:00 p.m.-5:00 p.m.
Delegate Assembly
CLOSED SESSION*
- Business Opportunities

Imperial Ballroom

Closed Session Note: A closed session is defined as a session open to delegates and Member Board representatives only.

Information About Forums

The purpose of scheduled forums is to provide information helpful for decisions and to encourage dialogue among all delegates on the issues presented at the forum. All delegates are encouraged to attend forums to prepare for voting during the Delegate Assembly.

When are forums scheduled?

Forums begin on Wednesday, July 28, 1999, with the Candidates' Forum being first. The schedule published in the *Business Book* (see page 1 behind this tab) designates the topics to be discussed during each block of forum time. Exact times for each forum are not designated because the discussion will be continuous, advancing through the topics as time and discussion permits.

Who can participate?

All attendees are welcome and encouraged to participate in the forum discussion. *However, please note that attendance at closed session forums is restricted to delegates and Member Board representatives only.* During forums, when approaching a microphone to speak, please keep in mind that the forum facilitator will give preference to voting delegates who wish to raise questions and/or discuss an issue.

When will new business be considered?

Resolutions will be considered during the Resolutions/New Business Forum, scheduled to begin at 9:15 a.m. on Saturday, July 31, 1999. All attendees are encouraged to attend. Instructions about submitting new business, including sample motion sheets, can be found behind Tab 17. Those who plan to introduce new business are encouraged to attend the Resolutions Committee meeting on Friday, July 30, at 4:00 p.m. in the Summit Room.

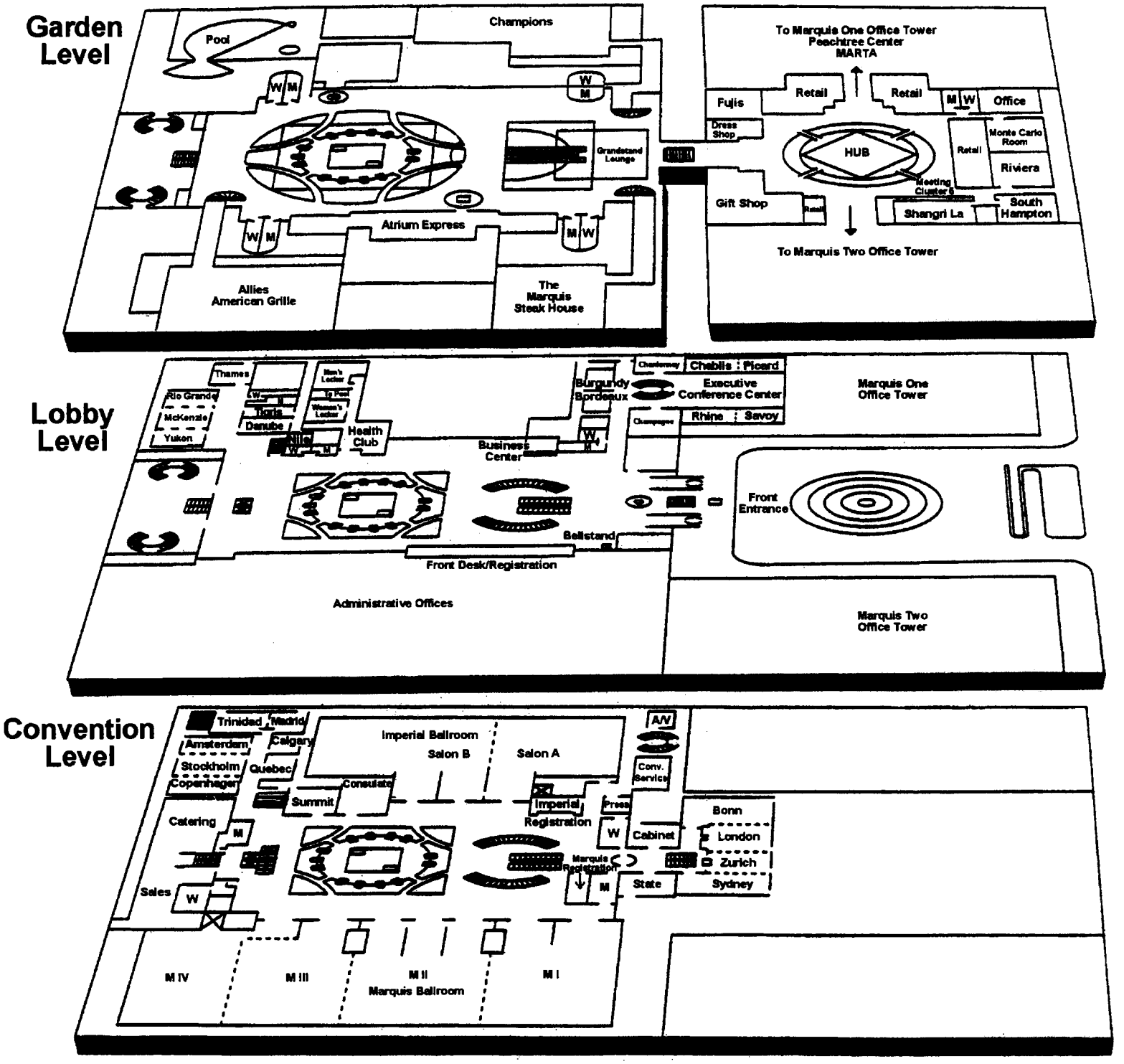
What is the Open Forum?

The Open Forum will occur between 9:45 a.m. - 10:45 a.m. on Saturday. President Joey Ridenour will serve as facilitator, and attendees are encouraged to bring forward any question or comment on any topic or issue related to activities of the National Council, regardless of whether or not the topic or issue may be under consideration for vote. Attendee participation is key and will determine the topics discussed during the Open Forum.

A note about the blue tabs:

Blue is the color used for the forum tabs, behind which is information helpful for discussion during forums and additional blank pages for attendee note-taking. The order of the blue forum tabs matches the order that each forum is scheduled.

Floor Plan of the Atlanta Marriott Marquis



Business Agenda of the 1999 Delegate Assembly

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

Wednesday, July 28
11:30 a.m. - 12:30 p.m.

Opening Ceremonies
- Introductions
- Announcements

Opening Reports
- Credentials Committee
- Rules Committee

Adoption of Agenda

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

President's Address

Friday, July 30
3:00 p.m. - 5:00 p.m.

Board of Directors' Report
- Business opportunities *(closed session for National Council delegates and Member Board representatives only)*

Saturday, July 31
9:00 a.m. - 5:00 p.m.

Election of Officers and Committee on Nominations

Nursing Practice & Education Committee Report
- Uniform core requirements for RN and LPN/VN licensure

Board of Directors' Report
- Auditor's Report
- Computerized Clinical Simulation Testing (CST®) Project

New Business
- Resolutions Committee and New Business

Board of Directors' Report
- Business opportunities *(closed session for National Council delegates and Member Board representatives only)*

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, July 30, 1999, 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, strategic initiatives and outcomes; assessment of fiscal impact; and potential legal implications. The Resolutions Committee will meet on Friday, July 30, 1999, 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, July 31, 1999, 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 result of the vote is announced.

5. Forums

A. The purpose of scheduled forums is to provide information helpful for decisions and to encourage dialogue among all delegates on the issues presented at the forum. All delegates are encouraged to attend forums to prepare for voting during the Delegate Assembly.

B. Open forum time is scheduled to promote dialogue and discussion on the issues by all attendees. Attendee participation determines the topics discussed during an Open Forum.

C. To ensure fair participation in forums, the Board of Directors may, at the Board's discretion, impose the rules of debate if needed to facilitate discussion.

Summary of Recommendations to the 1999 Delegate Assembly, with Rationale

To assist Member Boards and delegates understand and prepare to respond to recommendations being presented to the Delegate Assembly, the following recommendations, with rationale, are provided. Additional recommendations may be brought forward during the 1999 Annual Meeting.

Committee on Nominations

1. **Adopt the 1999 Slate of Candidates.** *(See Tab 4, page 3.)*

Rationale

The Committee on Nominations has prepared the 1999 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the strategic initiatives and purpose of the National Council.

Fiscal Impact

None.

Nursing Practice and Education Committee

1. **Adopt the proposed uniform core licensure requirements for initial licensure of RNs and LPN/VNs and recommend that states move toward incorporation of the uniform core licensure requirements at the state level.** *(See Tab 11.)*

Rationale

While it was determined that mutual recognition could be implemented without uniform core licensure requirements, their development has continued to be a priority. Uniform core licensure requirements will promote consistency and a general understanding of the objective of nursing regulation while facilitating accessibility of care by easing nursing practice across state lines. The proposed requirements have been developed after careful study of individual state and territorial licensure requirements, delineated in information prepared for the Mutual Recognition Task Force and the publication *Profiles of Member Boards*, continuous feedback of earlier drafts and the results of a recent survey of Member Boards regarding current requirements and the rationale for those requirements.

Fiscal Impact

None.

Board of Directors

1. **That the Auditor's report be adopted.** *(See Tab 8, page 9.)*

Rationale

The Board of Directors engages an audit firm to conduct an annual review of financial records of the National Council. As a part of its fiduciary responsibility to the Member Boards, the Board, in concert with the Finance Committee, reviews this report and directs staff to respond to concerns raised in the management letter. The Board recommends the acceptance of this audit in acknowledgment of its accountability to the delegates and in the interest of maintaining open communication about the financial status of the National Council.

Fiscal Impact

None.

2. **That National Council discontinue development activities related to computerized clinical simulation testing (CST®) being considered as a possible component of the NCLEX-RN® examination.**

Rationale

At its May 1999 meeting, the Board of Directors reviewed comprehensive information from multiple sources about the CST project. Based on its careful consideration of reports from the Finance Committee, Examination Committee, and CST Task Force, and its evaluation of the organization's fiscal resources and program priorities, the Board of Directors determined that the most responsible and prudent action was to suspend CST project activities and to bring the question of the future of CST to the Delegate Assembly for a decision at this time. This Board action is not inconsistent with last year's Delegate Assembly direction to continue the CST pilot study and bring a report back to the Delegate Assembly *no later* than August 2000.

On the basis of its review of the issues addressed in the Finance Committee, Examination Committee, and CST Task Force reports (provided to the Board in May 1999), the Board of Directors believes that ample evidence has been developed to suggest that it is not viable for the National Council to implement CST, as it has been operationalized, as a potential component of the NCLEX-RN examination. Also, based on the committee reports, its consideration of Member Board concerns raised at the Area Meetings, and its fiduciary responsibility to the organization, the Board of Directors believes that the appropriate action which provides for the best stewardship of organizational resources would be to end the CST project and discontinue investing National Council resources in CST at this time.

Copies of the Finance Committee, Examination Committee, and CST Task Force reports that were referenced by the Board of Directors at its May 1999 meeting are enclosed as Attachments A, B, and C, respectively.

Fiscal Impact

The fiscal impact for discontinuing the CST project at the 1999 Delegate Assembly is estimated to be approximately $650,000, which will be saved from the FY99 and FY00 budgets. These savings have been estimated to account for all outstanding payments to NBME and outstanding costs to discontinue the CST project. It is important to realize that these savings are related *only* to this phase of the CST pilot study project. If the CST project were to continue, additional significant fiscal resources would need to be budgeted to finance future work.

Attachments

A ... April 1999 Finance Committee Report, *page 5*
B ... April 1999 Examination Committee Report, *page 15*
C ... May 1999 CST Task Force Report, *page 19*

Resolutions Committee *(See Tab 17.)*

1. **That the National Council of State Boards of Nursing explore the feasibility of development of an English Proficiency Examination in a health care context.** ***(Submitted by: Oregon State Board of Nursing and Maryland Board of Nursing)***

Rationale

Ability to comprehend and speak the predominant language is an important component of licensure requirements. While there are English proficiency examinations currently in use to assist boards in licensure decisions, none are designed to measure the English proficiency levels for safe nursing practice.

Fiscal Impact

For the National Council in FY00: $39,680 (see fiscal impact statement in Tab 17, page 4).

Legal Implications

To be legally defensible, any English Proficiency Examination with a cut score will have to be supported by an adequate job analysis demonstrating that the level of English proficiency corresponding to the cut score is necessary for the safe and effective practice by entry-level nurses.

2. **That the National Council of State Boards of Nursing conduct research to determine appropriate cut scores for currently available examinations to establish the relationship of the examination to competency in English proficiency needed for safe practice; and based on research findings, provide recommendations to Member Boards on standards for English proficiency requirements.** ***(Submitted by: Oregon State Board of Nursing and Maryland Board of Nursing)***

Rationale

Ability to comprehend and speak the predominant language is an important component of licensure requirements. Additionally, there is no research to give guidance in establishing a required cut score for licensure.

Fiscal Impact

For the National Council in FY00: $60,760 (see fiscal impact statement in Tab 17, page 6).

Legal Implications

To be legally defensible, any English Proficiency Examination with a cut score will have to be supported by an adequate job analysis demonstrating that the level of English proficiency corresponding to the cut score is necessary for the safe and effective practice by entry-level nurses.

Attachment A

NATIONAL COUNCIL®

National Council of State Boards of Nursing, Inc.

676 North St. Clair Street
Suite 550
Chicago, Illinois 60611-2921

312 787.6555
FAX 312 787.6898

May 6, 1999

TO: Board of Directors

FR: Barbara Morvant
Treasurer

RE: Finance Committee Report

Executive Summary

The Finance Committee met on May 4, 1999, and its recommendations to the Board of Directors are indicated below.

Strategic Initiative 6: *The National Council will have the organizational structure and capacity to lead in regulation.*

Outcome 1: *A sound organizational governance and management infrastructure to advance the National Council's mission and vision.*

Board Action Requested

1. Discontinue the CST® project immediately without completion of the pilot study, and further direct staff to explore potential uses of the components of CST and that any new project activity be conceptualized as a new project needing Finance Committee review in order to fund its implementation.

Background

A copy of the memo provided to the Finance Committee is included on the following pages.

April 21, 1999

To: Finance Committee

From: Anthony R. Zara
Anna Bersky
Carolyn Yocom

Re: CST® Project Finances

Executive Summary

This report was prepared on request of the Finance Committee to provide a current evaluation of the financial aspects of the CST project. Major areas covered include: Delegate and Board financial decisions, relationship with NBME, projected timelines and costs for implementing CST for entry-level assessment, questions affecting policy decisions, and residual value of CST.

- CST Project funds budgeted FY88-FY00: $5,776,691; Project funds spent to date: $4,759,060.
- Additional psychometric research will be needed to determine specific CST-related policies. Even after the pilot research is completed in 2000, more information will be needed by boards prior to implementation of CST.
- Projected vendor: Single source contract for CST software can be with NBME only. National Council could pay $2,000,000 to acquire the software source code for CST.
- Projected time to implementation for entry-level: 5 – 8 years.
- Projected costs for CST entry-level implementation: $5,500,000 - $6,600,000. These costs include case development and scoring for CST, CST staff time, and NBME costs. No Examination Committee or staff time other than CST has been calculated in these figures.
- Projected candidate fee for NCLEX including CST: at least double the then current amount.

Committee Action Requested

The Finance Committee is requested to review the information in this report and provide recommendations to the Board of Directors about the continuation of this project.

Background

The Finance Committee requested that staff develop a report outlining the financial picture of the CST project including past, present and future projected costs. A more complete description of the project was developed for the 1998 Delegate Assembly, including project history and governance decisions. Only the relevant financial-related portion of that report will be reproduced here.

Initial Project Goals and Timelines

In February 1988, The Kellogg Foundation awarded the National Council a grant of $1,868,954 to support a three-year demonstration project designed to adapt NBME's technology, develop 20 simulations for future use in nursing licensure examinations, examine the validity and reliability of CST, and develop and implement a plan for promoting the future use of CST in nursing licensure examinations. In August 1991, the project was completed and outcomes reported to W.K. Kellogg and the Delegate Assembly.

Delegate Assembly Funding-Related Decisions

August 1987	Delegate Assembly informed of proposal submission to Kellogg Foundation.
August 1988	Delegate Assembly approves inclusion of an Objective strategy in the Long Range Plan: Investigate the feasibility of CST for initial and continued licensure.

August 1991 — Delegate Assembly directs: *That research and development of CST be continued, with a timeframe of three to four years, and including annual reports to the Delegate Assembly which evaluate progress and implications for future development.* Rationale states: Further research will enable the National Council to determine the usefulness of CST for potential applications (initial licensure, reentry, following discipline, and continued competence) in terms of practical feasibility, psychometric soundness, usefulness to Member Boards, cost/benefit, and timelines required for implementation.

August 1998 — Received CST Project overview from BOD outlining project history, financing, Delegate Assembly and Board of Directors decision-making, current status of project, and future issues (policy, transition plans), and contractual relationship with NBME. Delegate Assembly directs continuation of the pilot study and approves a delay of their decision regarding using CST as a component of the NCLEX-RN examination until no later than August 2000.

Board of Directors Funding-Related Decisions

May 1992 — Board authorizes continuation of project activities (database revisions and case development) through December 1992, using remaining Kellogg Funds and *$42,022 in National Council funds* due to delay in Kellogg decision-making re: funding request.

December 1992 — Board receives report that Kellogg denied requests for external funding, due to change in funding priorities. The Board:

- expressed its commitment to carrying out research and development of CST to establish its psychometric soundness and legal defensibility and directed the Committee and staff to explore funding options, including National Council funding
- directed staff and legal counsel to review the structure of the contractual relationship between the NBME and National Council and to negotiate appropriate changes
- *approved a request for $212,875* for FY93 CST project activities
- *established a designated fund of $75,000* for performance of a market analysis survey (to be directed at potential external uses of CST)

April 1993 — The Board approves the e*stablishment of a designated fund for a five-year CST Project in the amount of $2,965,817.* [From 1993 *Book of Reports* report of the Board: "... for the purpose of continued research and development of CST for the period FY94 through FY98, with a review of budget and progress annually. The Board believes that this major commitment is consistent with the National Council's purpose in its bylaws, with its mission, and with Goal I – identified as most important by the Member Boards."]

June 1996 — Board of Directors authorized: (1) entering into a contractual agreement with NBME for Phase III activities; (2) *incorporation of the $75,000 previously (12/92) placed in a separate designated fund into the primary CST designated fund.*

May 1998 — Board of Directors, based on recommendation of CST Task Force and staff, adopted the following motion: "Approve a delay of Delegate Assembly decision regarding the use of CST as a component of the NCLEX-RN examination until no later than the Annual Meeting of August 2000."

August 1998 — Board, based on Delegate Assembly approval of delay in reporting pilot study results, *approves additional funding of $296,980* (decision was deferred from May 1998 meeting).

November 1998 — Board of Directors approves (1) document outlining joint and complementary roles and responsibilities of the CST TF and the Examination Committee; and (2) the CST Pilot Study participant recruitment/testing contingency plan due to less than needed number of study participants in the new graduate, foreign-educated and experienced nurse categories - *Fiscal impact of implementation = $38,880 (included in the $5.7 million project costs).*

February 1999 — Board received an update on pilot study progress and approved postponement of any further exploration of, and decision regarding continued support of Member Board use of CST for applications other than initial licensure until after completion of the CST pilot study regarding the use of CST as a component of the NCLEX-RN® examination.

Funding			
1988-1993	Kellogg		1,968,954
1992-2000	NCSBN	(Designated)	3,807,737
Totals			**5,776,691**

Expenditures				
FY	**Personnel**	**NBME**	**Other****	**Total**
1988				42,746
1989	171,751	275,000	30,487	477,238
1990	199,257	450,000	149,205	798,462
1991	158,499	52,800	164,341	375,640
1992	61,634	70,000	128,418	260,052
1993	19,891	152,245	52,780	224,916
1994	165,812	17,606	78,760	262,178
1995	177,542	0	47,490	225,032
1996	194,053	75,000	78,724	347,777
1997	277,605	208,750	150,861	637,216
1998	324637	260,475	174,166	759,278
1999	333,460	160,500	281,931	*775,891
2000	346,000	139,560	104,705	*590,265
Totals	**2,430141**	**1,861,936**	**1,441,868**	**5,776,691**

*Projections as of August 1998. As of March 30, 1999, $348,525 has been spent, with $1,017,631 remaining in the FY99 and FY00 projected expenditures.

**The Other expenses include committee and staff travel, exhibiting, communications, honoraria, etc.

The newest projections for FY99 are: $390,181 for project activities; $333,460 for CST staffing ($723,641 total). For FY00 the projections are: $296,515 for project activities; $346,000 for CST staffing ($642,515 total). The FY99 and FY00 projections total $1,366,156. These estimates do not include other staff time (e.g., Testing staff) or other committee expenses (e.g., the Examination Committee). Conservative estimates for FY00 other staff time is about $115,000; other committee expenses are estimated at about $36,220

Relationship with the National Board of Medical Examiners

A complete financial picture of the CST project would not be complete without some discussion of the relationship with the NBME, which owns all rights to the CST software. The negotiations with the NBME have been extensive and at times difficult. In 1988, a letter of agreement was signed with NBME regarding a collaborative project to develop simulation software for nursing, which grants National Council a limited license to use "CBX" software during the project and specifies that at the conclusion, National Council owns the nursing simulation databases and

the default National Council databases, as well as videodisc material. In 1989, a license agreement was negotiated which gave precise terms for royalties, annual maintenance fees, and obtaining source code. In 1994, the National Council approached NBME to renegotiate certain terms of the agreement due to the constraints the original agreement placed on National Council's options for the future. The amendment provided for deferred payment of the annual fee until such time as more than $250,000 in gross revenue is earned annually by use of the CST software, provides a $2 million cap for royalty payments (which were uncapped in the original agreement), and makes the acquisition of source code contingent upon payment of a one-time $2 million fee not ongoing royalties.

Throughout all negotiations, NBME has maintained a stance of protection of its interests in its simulation software above all. Even if NBME were to go out of business or be unwilling or unable to maintain or work on CST software under contract with National Council, the National Council is precluded from sharing the software with anyone else. Their reluctance to grant us an option for source code is evident in its high cost, and in the refusal of NBME to allow The Chauncey Group International (CGI) access to meetings and documents that would have allowed CGI's participation in a study which would have helped address unresolved scoring issues. NBME has declined to give us references for their simulation clients on the basis that they "are protective of our clients and respect their privacy...This [National Council's] is not a proposal for a new client, nor is this for CCS [NBME's simulation program]...."

This stance creates the reality that NBME is the only test service partner that will be permitted to work on CST-related issues. This means that National Council can either take CST in-house or work with NBME as a sole-source vendor for CST. Issues related to the ongoing multiple-choice NCLEX examination work and the combination of CST and multiple-choice NCLEX examination information have not yet been clearly defined. From a project management standpoint, it would be best to have the CST work and the multiple-choice work conducted by the same testing organization. With separate vendors for multiple-choice testing and CST, the interface of NBME and the multiple-choice vendor will likely be very sensitive and require continual management.

Obligations to NBME

Phase III work, which extends through at least June 1999, is being invoiced at six-month intervals, with a total of five $130,000 payments. Four payments have already been made. Early termination is only possible under a breach of contract or by mutual agreement of the parties. Under the deferral of annual fees, no payments are due to NBME until such time as National Council realizes at least $250,000 revenue from use of CST. If National Council were to purchase source code, $2,000,000 plus all deferred annual fees would be due up front. Thereafter, no further financial obligation would be due to NBME, but confidentiality obligations remain indefinitely.

Projected Implementation of CST as a Part of the NCLEX-RN® Examination: Projections of Timelines and Costs

Implementation Analog: The Computerized Adaptive Testing (CAT) Experience

- The CAT transition took 12 months to acquire a testing service, then 19 additional months to complete the testing network, complete beta testing, apply go/no go criteria, transition to the new testing services, and launch the CAT NCLEX examination (31 months total).
- The cost of the CAT transition was approximately $1.5 million, including item development ($1.0 million), staffing, contract negotiations, and communications.

Much of the more detailed CST timeline development and cost estimation are scheduled to be completed after the pilot study (as per the draft transition plan). But, even given our current knowledge, we know that prior to implementation the large-scale work needing to be accomplished includes:

CST Examination Work

1. Additional Beta-test research needed to develop specific policies
2. Systematic determination of necessary case content
3. **Large-scale base case production (approximately 10x the number produced to date)
4. Develop case disguise methodologies (3 - 5 needed per base case)
5. Large-scale case tryout and analysis
6. Development of case pool maintenance concepts and plans
7. Development of production-level case scoring processes

CST Integration Work

1. *Negotiate CST contract with NBME
2. *Develop plan for transitioning NCLEX examination work to NBME (assuming NBME as NCLEX vendor)
3. *Design and implement large-scale education and communications effort
4. Determination of specifically how to combine NCLEX examination and CST information
5. Determination of passing rules and standards

* Refers to tasks that were also conducted during the $1.5 million CAT implementation. The other tasks are unique to implementing CST and should not be included in trying to parallel that transition cost.

** NBME has estimated (in a 4/22/96 letter) its case and key programming costs at $15,000 per case. CST staff estimate that that cost can be reduced to about $10,000/case. Multiplied by 220 base cases = $2.2 million. Base case development volunteer time is estimated to require about $940,000 in travel expenses. These estimates do not include National Council staffing costs or costs related to creating the case disguises.

Projections

At this stage of the CST project, it is very difficult to accurately project the timelines and costs necessary to accomplish an implementation for the entry-level examination program; as more work is accomplished, estimates may become more accurate. However, National Council has developed some experience that can provide guidance. All estimates should be taken with the caveat that they could be high or low and that National Council's and NBME's processes may become more efficient as the project progresses. We have not estimated the costs or timelines for additional research needed to determine the actual CST-related examination policies.

Given National Council's current actual case development experience with NBME, staff reports that with two dedicated FTEs, about 32 cases were developed in a year. (This also coincides with NBME's estimate that it plans to build between 25 and 40 CCS cases per year.) For a full CST implementation (not a phase-in of the methodology), it is our best estimate that more than 250 base cases will be needed. This number is contingent on several important policy decisions concerning acceptable case exposure, per candidate case overlap, etc. For the base case production alone, this effort translates into about 8 years' work at current resourcing and case complexity levels (CST staff believe that up to 50 cases can be produced per year, leading to an estimate of about 5 years work). From the volunteer and staff side, using existing procedures, it is projected that 1,021 volunteer days will be needed to produce 220 cases, mathematically this divides out to 4.1 years of every day solid work (250 days per year). CST staff report that new procedures have been tried out which increase the volunteer productivity by about 30%.

To compare this CST case exposure with the NCLEX examination, each candidate sees an average of 100 items in a 1,500 item pool (approximately 6.7%); each item is seen for one minute and is 1.0% of the candidate's examination experience. This estimated level of case development will mean each candidate will see 8 (or more) cases from a 250 case pool (approximately 3.2%); candidates will likely be thinking about each case for 20 minutes or more and each case is about 12.5% of the candidate's CST examination experience. It is conceptually difficult to compare these exposure figures directly. A higher percentage of the NCLEX item pool is exposed to any candidate, but for a much shorter period of time. Each CST case is a much bigger piece of the candidate's examination experience than any one NCLEX item. An NCLEX item is exposed in the same way to all candidates who take it; a CST case presents with the same background to all candidates, the same history and physical information, and orders are

available to all candidates, but candidates will likely progress through the cases on different paths and not see exactly the same things. Consequently, the 250-case pool estimate must be regarded as no more than an "educated guess" at this point. Additionally, with the pace of RN practice changes, development of a case maintenance process to keep the cases current will be very important. To enhance security and stretch the case pool, each base case will also likely need to be configured with between 3 and 5 disguises. This additional workload has not been estimated in this paper.

The foregoing timeline and work estimates yield the following cost estimates. Actual costs could vary from these estimates by a significant margin, if it is determined that fewer (or more) than 250 cases are needed in the pool, and/or additional operational efficiencies (or problems) are demonstrated in the pilot study.

Case development	$2,200,000	
Committee travel expenses	940,000	
Personnel (FY01 thru 05)	2,130,000	
Other	230,000	
Estimated total	$5,500,000-	$6,600,000 (depending on NBME programming costs) No Examination Committee or staff time other than CST has been calculated in these figures.

Implementation Realities

Should the National Council decide to implement CST as part of the entry-level RN licensure examination, major work will need to be accomplished. Although the transition to CAT delivery of the NCLEX examination was a huge undertaking, implementing CST will entail much more work and expense. At the time, CAT was a rather proven, much-researched measurement technology; National Council's major challenge was to implement a large national high-stakes CAT program. CST is much different in that, to date, CST is a measurement technology that has been primarily researched by two organizations, with no ongoing implementations. There will likely only be one model (e.g., NBME's) to learn from when designing National Council's implementation. Also, CST staff believes that additional research will be needed to determine the specifics of CST-related examination policies.

Related Project Questions Affecting Policy Decisions

Overriding all the financial projections is the essential question around which the cost vs. benefits issues of CST revolve is "Is CST a viable and important enhancement to the NCLEX® examination?"

Issues with Mostly-Known Answers

How long will the CST assessment need to be? Based on the 1991 field test (to be confirmed by the current pilot test), the testing time required for a sufficiently reliable CST for high-stakes assessment will be no less than four hours (8 cases x 20 minutes) and no more than six hours (12 cases x 30 minutes). The required orientation adds about ½ hour.

How will the implementation of CST affect candidate failure rates? If the examination is multiple-hurdle (see "How will licensure decisions be made?" below), it will logically result in some increase in the failure rate. All candidates now failing will still fail, since failure on the multiple-choice question (MCQ) portion will disqualify them, in itself. The candidates passing the MCQ portion and failing the CST portion will represent the proportion of increase in NCLEX-RN examination failure rate. The more dissimilar the abilities that the two types of exam are tapping, the greater the potential for candidates to pass one part and fail the other. The passing rate could be normatively determined to offset the differential failure rate, but this represents a departure from commitment to criterion-referenced as the best method for setting licensure examination standards.

What will the addition of CST to the entry-level RN licensure examination do to the candidate fee?
Unless the length of the multiple-choice question (MCQ) NCLEX-RN examination can be reduced (unlikely, since reliability will need to be maintained), "seat time" is likely to approximately double. Test development costs will include National Council and NBME staff time for case development, programming, database maintenance, scoring

services, and contract management (detailed in other parts of this report). Doubling of the test price is a conservative scenario. The operational part of the pilot test will enable more precise estimates of ongoing production costs.

Issues with Partially-Known Answers

What is the likelihood that our CST vendor could actually deliver high-stakes CST services?
In recent meetings and experiences, NBME has given facts and figures that indicate they have the capability to develop and deliver the exam. The pilot test includes case production and scoring services that may reveal more about the likelihood that the contractual relationship would be workable. NBME's confidentiality requirements make it virtually impossible for the National Council to have one test service for the NCLEX-RN examination (MCQ and CST). This materially affects National Council's ability to select a test service provider for the NCLEX examination program.

How would the addition of CST affect the operational processes for delivering NCLEX-RN examination results to candidates and boards? So far as we know, CST results will have to be processed "off-line," i.e., NBME will have to run the responses through the scoring program after candidates have finished their tests. The time span is likely to be several weeks. The pilot will yield some more information about activities involved, though may not reveal what turnaround under high-volume production circumstances would be.

Can the National Council afford the time and money to implement CST? Other sections of this report assist in addressing this question. Precise numbers of cases needed must be worked out, based on policy regarding exposure of cases/items. Preliminary production timelines and costs imply a very lengthy (more than five year) and expensive (multi-million dollar) implementation period. NBME's own progress and planning is unfortunately not sufficiently advanced to give us much help in refining projections.

Issues with Mostly-Unknown Answers
How much will CST add to the measurement quality currently provided by the NCLEX-RN examination?
Probably some incremental validity will be added, based on the outcome of the 1991 CST field test. The pilot research questions will allow some additional description of what CST is tapping. Also, the Examination Committee is considering whether or not to provide the Board of Directors with its impression of the measurement qualities of CST for the Board's May 1999 meeting.

With both multiple-choice items and CST being administered, how will licensure decisions be made?
Since the definitions of the traits being measured by MCQ and CST components of the NCLEX-RN examination differ, it is not psychometrically appropriate to combine them. A multiple-hurdle model (i.e., candidates are required to pass both CST and MCQ portions to qualify for licensure) will be most appropriate. The pilot test is designed to yield some data useful in addressing scoring questions.

Residual Value of CST Project Efforts

Given the possibility that the issue of continuation of the CST project will again be considered, an analysis of the residual value of the CST program is indicated. There are several ways to think about residual project value: (1) real assets retained, (2) potential marketability of CST assets, and (3) knowledge gained.

The real assets retained by National Council upon completion of the CST program include the database of nursing activities and the actual cases (although not within the software shell owned by NBME). One potential place where the database may have future value is in the building of free-response items within the existing NCLEX framework. One reasonable scenario would have the test driver search the database so that free-response items could be scored in real time. Outside of conducting simulations for assessment activities, the cases may have some market value for educators. A complete financial estimate is shown below:

CST® Cases: Market Potential Analysis

This analysis assumes that 30 already-developed CST cases will be made available for sale. If these cases are grouped and packaged in sets of six, five distinct products will be available to market. This analysis further assumes that the cases are deliverable to the market as is, with no additional programming required to reach full functionality. This business model assumes that National Council will contract with an established nursing publisher to package, market and support the products on National Council's behalf.

Limitations of the analysis: Further research may be required to determine:

1. Whether the existent CST cases, designed to function as part of a high-stakes examination, require additional programming to be transformed into marketable educational tools.
2. What price point CST products will actually support.
3. What staffing and overhead levels would be required to support CST case sales and CST after-sales "help" services.
4. What is the actual royalty percentage that a reputable nursing publisher would offer National Council to bring the suite of CST products to market on National Council's behalf.
5. What other CST product markets may exist outside nursing education.
6. Whether CST case income would actually be classified as related and therefore non-taxable to National Council.

Base Assumptions of the market analysis:

1. CST not incorporated into NCLEX-RN® examination.
2. Target market: RN education programs. n=1,600.
3. Product Description: 6 CST cases on CD-ROM, complete with instructor/student documentation (unlimited-use, network license)
4. Number of Distinct Products: 5
5. Product price: $395.00
6. Market share assumptions: Worst = 10%, Medium = 20%, Best = 40%.
7. Average number of distinct products acquired by each purchaser = 2.5
8. Royalty earned by National Council = 25% of product revenue
9. Royalty payable to NBME = 12% of National Council revenue
10. Staffing Requirements: .25 Product Marketing Manager; 1.0 CST Content Expert = $100,000/year
11. No additional overhead costs are accrued for the project (office, computers, etc.)
12. Tax status: Related, non-taxable

Estimation of Net Income (Loss) Derived from Product Sales:

Worst Case	**Medium Case**	**Best Case**
1,600 RN Programs	1,600 RN Programs	1,600 RN Programs
X 10% market share	X 20% market share	X 40% market share
160 buyers	320 buyers	640 buyers
X 2.5 products	X 2.5 products	X 2.5 products
400 products	800 products	1,600 products sold
X $395.00 network license	X $395.00 network license	X $395.00 network license
$158,000 product revenue	$316,000 product revenue	$632,000 product revenue
X 25% NCSBN royalty	X 25% NCSBN royalty	X 25% NCSBN royalty
$ 39,500 NCSBN revenue	$ 79,000 NCSBN revenue	$158,000 NCSBN revenue
- 4,740 NBME royalty	- 9,480 NBME royalty	- 18,960 NBME royalty
- 100,000 staff expense	- 100,000 staff expense	- 100,000 staff expense
($65,240) net loss;	($30,480) net loss;	$39,040 net profit

Knowledge Gained from the CST Project

Because the project is still underway, project resources are dedicated to looking forward and there has not yet been a significant effort to look back and determine what has been learned. One obvious lesson relates to contracting with a single source provider (e.g., NBME). It is a very disadvantageous position for the Council when an organization-critical function is locked into a single provider which holds significant proprietary rights to the operation of the function (e.g., should CST be implemented as a piece of the entry-level licensure examination process).

There has been much discussion among Member Boards about using CST for continued competence assessment. Prior to determining an assessment methodology, though, there needs to be a collaborative nursing effort to determine exactly what continued competence should entail. The collective wisdom concerning continued competence is not sufficiently developed, at this time, to plan for using CST for this purpose.

Another idea has been forwarded concerning Member Boards using CST to assure the competent practice of already-licensed nurses. Several boards conducted pilots last year. The anecdotal evidence suggests that there was not an overwhelmingly positive response to using CST in this way.

Nurse educators have long been intrigued with using CST as a learning tool. One potential difficulty is that under the current software ownership model, the costs may be prohibitive for this application.

Any or all of these other uses of CST are possible, but each would need to be researched in further detail prior to making a significant financial commitment.

Attachment B

NATIONAL COUNCIL®

National Council of State Boards of Nursing, Inc.

676 North St. Clair Street
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312 787.6555
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Date: April 26, 1999

To: Board of Directors

From: Examination Committee

Re: CST® Update from the Examination Committee

Board Action Requested

This report is provided to share the Examination Committee's analysis of the potential use of CST as a component of the entry-level examination. The Examination Committee requests your consideration of and response to the concerns articulated in this report.

Executive Summary

This report communicates an Examination Committee vote of "no confidence" for using CST as a component of the entry-level licensure examination program.

Background

The Examination Committee (EC) held a one-time meeting with the CST Task Force in 1995. At that meeting, the joint group identified characteristics of entry-level nurse candidates and the measurement methodologies that could be used to assess those characteristics (Attachment A). As the CST project progressed, it was determined that Examination Committee input was needed for developing policies and procedures that CST would utilize in its large-scale pilot study. During 1997 and 1998, two to three representatives from the EC met with the CST Task Force as a work group to assist the CST Task Force and staff develop some of these examination-related policies and procedures, to learn more about CST and provide feedback to the EC, and to attend CST development meetings. In 1997-1999, EC representatives attended case development, scoring key development, key validation, and CST rating meetings in order to understand the complete scope of CST development.

In October 1998, the Examination Committee and the CST Task Force each worked to develop an appropriate division of the remaining CST project work and recommended a structure to the Board of Directors. In addition, the EC reiterated their commitment to involvement on the CST project. The Board determined the responsibilities of the Examination Committee and the CST Task Force at its November 1998 meeting: The EC will use the "CAT" development model for interface between EC and CSTTF; that the EC assume leadership for developing a preliminary transition plan; and that joint meetings should be used as much as possible.

At their first formal joint meeting in January 1999, the Examination Committee and the CST Task Force reviewed the Board's direction and further clarified their roles and responsibilities regarding the CST project. One of the other major activities of the meeting was for EC and CSTTF to participate in a mock scoring key development session. The purpose of this participation was to inform the EC about the specific content measurement aspects of CST in a

hands-on and direct way. At the conclusion of the joint meeting a multi-page list of questions and concerns was generated by the group regarding different aspects of the CST project. The EC voiced concern at the number and magnitude of important issues that were still "unknown" at this date in the project's life span. Although the EC attempted to focus its questions on the content measurement side of CST, there were very important operational, costs, and political issues that the EC believes should be addressed with the Board.

The substantive issues discussed are listed below, organized by (1) psychometric validity/measurement issues, (2) operational issues and costs; and (3) political issues.

Psychometric Validity/Measurement

1. What is CST measuring that is different from, and in addition to, the current NCLEX® examination?

   Based on information in the CST Frequently Asked Questions #1 and discussions with the CST Task Force and staff, the EC believes that CST attempts to measure the ability of the candidate to identify what nursing assessments and actions to take over time. This is accomplished using "free-text entry" to indicate the initial assessment and/or action in the management of a single client situation. The EC notes that while no testing cues in the form of question or answer options are provided, a different form of cueing does exist in CST. That is, CST provides a list of activities from which candidates select what actions they desire rather than allow for total free-text entry.

   Thus, CST measures **what** broad assessments candidates' would like to make based on their selection of these assessments from a database list. Candidates then determine what broad actions to take based on selecting the action from a database list. The candidates must specify what they would do, but not **how** to make the assessments and not specifically **when or why** it is important to take the actions. The broad specification of many of the possible activities and assessments does not allow sufficient demonstration of entry-level nursing competence, particularly for a high-stakes licensure examination. There seems to be a lack of breadth and depth in the competencies measured by CST; candidates only need provide an identification of what action or assessment is needed. As currently configured, CST seems able to tap candidate competence in determining the general assessments, interventions and reassessments in the management of a single client, but it does not address in-depth knowledge about the quality of assessments or interventions, or the rationale for each action. The EC is also unsure to what extent CST really taps much of the higher order thinking skills such as analysis, synthesis and evaluation. The EC notes that the current multiple-choice NCLEX-RN examination also measures nursing assessments and actions that should be taken in caring for a client (without "free-text entry" and without the management of a single client over time).

   In addition, the EC noted in their joint meeting with the CST Task Force, that problem identification/Nursing Diagnosis and efficiency information is being collected but is not utilized in the measurement of examinee performance at this time. There is no method currently under investigation for using this information within CST.

2. What characteristics of the entry level nurse does the current NCLEX examination measure that CST does not measure?

   Based on Attachment A, the NCLEX-RN Test Plan, and information discussed at the joint CST meeting, CST as it has been currently developed, does not assess the management of multiple clients, supervision of others providing care, ethical issues, legal issues, and documentation—all aspects of the Management of Care section of the NCLEX-RN Test Plan. In addition, CST does not measure competencies related to how to perform procedures nor the use of therapeutic communication skills in caring for clients. CST does not assess many of the competencies necessary for caring for clients with psychosocial needs. Also, aspects of growth and development and physical assessment techniques are not captured by CST (e.g., the ways an assessment might need to be performed differently on a geriatric vs. pediatric client). Thus, there are some

areas of health promotion and maintenance that cannot be measured by CST. In summary, there are large areas in the NCLEX-RN Test Plan that are not and perhaps cannot be measured by CST at this time.

3. What are the psychometric issues that will need further exploration?

   Information will need to be collected regarding potential bias and sensitivity issues, readability level issues, performance issues relative to the complex nature of the CST software, and ADA accommodations. All of these issues will need to be researched by National Council because there are no other large scale licensure programs using simulations which have procedures for addressing these psychometric concerns. Also, since the information developed through the pilot study was gathered using volunteers on CST assessments that had no consequences, some type of beta testing will be needed to develop more specific policy-related information about CST using a randomized subject design with CST.

Operational Issues and Costs

4. How long will the CST assessment need to be and what are the cost implications of this decision?

   Based on the CST FAQ #9 and #12, information contained in the Finance Committee report to the Board of Directors (May 1999 meeting), and the Board Report to the 1998 Delegate Assembly, an operational CST would likely need to be at least eight cases per candidate and require a lengthy tutorial. This equates to about five hours of testing at a minimum, requiring a second day of testing and at least a doubling of the candidate cost. Currents cost projections show that this project would cost approximately an additional $6 million and take more than five years for a full-scale implementation.

5. What are the implications of the current contract with NBME?

   Based on the Board's 1998 Delegate Assembly report and the Finance Committee Report, the EC notes that NBME is the only test service partner that will be permitted to work on CST-related issues. The Examination Committee is very concerned about this contracting arrangement, particularly in terms of being "locked-in" to using the NBME as a single-source vendor for the entire life span of CST.

6. What are some of the important transition issues related to implementing CST?

   In addition to the high cost of the project, the amount of volunteer and staff time needed to implement such a large undertaking should not be underestimated. The EC is concerned about the sufficiency of available volunteer hours, considering the other projects underway at the National Council. Furthermore, the drain of volunteer time needed to work on panels for the development of CST should not be underestimated in light of the need to use perhaps this same pool of volunteers for the NCLEX item development panels.

7. What are some of the concerns related to the CST software?

   The EC is concerned about the ability of the CST software to be future-focused (particularly with the NBME being the only possible software developers for the system). That is, CST is currently a text-only system and written descriptions of client problems seems likely to be technologically outdated by the time of a possible implementation. Although ostensibly designed to model realistic practice, there is artificiality to how nursing actions are "conducted" in CST that is quite different than practice (e.g., can't do a whole body skin assessment, but must specify by body part). Based on concerns reported by some Member Boards in their report on the use of CST for the 1998 Delegate Assembly, the CST software is not very intuitive and will require considerable candidate training, highlighting the potential danger of CST actually assessing software system manipulation knowledge rather than nursing competence. Also, the EC is concerned that there are issues related to the testing of foreign-educated and ADA candidates regarding computer literacy, ESL, opportunity to practice, and the required reading level.

Political Issues

8. Can CST be used to measure LPN/VN competence?

   Based on the CST FAQ and Board report to the 1998 Delegate Assembly, CST is not appropriate to assess LPN/VN competence as it is currently designed. To create a CST model and cases that would be appropriate for LPN competence would require another significant research program at an unknown cost to the National Council. Since approximately 33% of the annual NCLEX volume are practical/vocational nurse candidates, the EC believes that there are unanswered issues related to this population's reaction to an implementation of CST for RNs prior to considering an investigation of CST for LPN/VNs. The EC believes that National Council should be mindful of sending a "hidden" message regarding the nature of LPN/VN practice, if it implements CST for RNs before even considering LPN/VN practice.

9. Should the Examination Committee's analysis and assessment to CST be presented to the Board at this time?

   The EC has struggled with its responsibility regarding involvement with CST since there is no formal mechanism for the committee to report its analysis of CST to the Board of Directors. In light of this, the committee is taking the initiative to share with the Board the information collected to date regarding CST and its assessments. Given its knowledge of entry-level licensure assessment and the real regulatory information needs of Member Boards, the EC voted unanimously to not support CST for an entry-level licensure implementation. There is currently sufficient evidence to know with a high certainty that CST will not be a viable element of the entry-level NCLEX-RN. There are a number of fundamentally important questions that are still open and will remain largely so even after the pilot study is complete.

Attachment C

NATIONAL COUNCIL®

National Council of State Boards of Nursing, Inc.

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312 787.6555
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Date: May 5, 1999

To: Board of Directors

From: CST® Task Force

Re: Response to Examination Committee report on CST®

Board Action Requested

The CST Task Force requests that the Board of Directors withhold making a decision as to whether CST should become a part of the NCLEX-RN® examination until after completion of the CST pilot study data analysis but no later than August of 2000.

Executive Summary:
This report communicates the CST Task Force response to the Examination Committee (EC) report of April 26, 1999, in which the EC conveys none support of CST for initial licensure. Based on analysis of the EC report, the task force has formulated responses to the issues raised in their report by providing further explanation and clarification. This report addresses: cueing in CST: measurement capabilities; incorporation of problem identification/nursing diagnosis and efficiency data into scores; measuring competencies related to psychosocial needs and growth and development; examination and practice/orientation time; vendor issues; expert panel volunteer pool; CST software functionality and its ability to be future-focused; and, CST for LPN/VN assessment.

Background

During the April 27, 1999, joint meeting of the CST Task Force and Examination Committee (EC), the EC shared a draft of their upcoming report to the Board of Directors in which they communicate their decision not to support CST as a component of the NCLEX-RN licensure examination prior to the completion of the pilot study data analysis. The CST Task Force appreciated the opportunity that the EC provided them to discuss their report and concerns. The CST Task Force, however, determined that it was necessary to submit a report addressing the issues raised in the Examination Committee report and to request that the Board of Directors withhold making a decision about the use of CST as a component of the NCLEX-RN examination until completion of the CST Pilot study data analysis, but not later than August of 2000. The CST Task Force feels that it is premature to make such a decision prior to the evaluation of the new version of the CST software and its psychometric properties. In 1996 the National Board of Medical Examiners (NBME) completed programming of the new CST model. By the spring of 1998 CST cases and initial scoring keys were completed and pilot study data collection was launched. The pilot study data analysis will address the psychometric issues put forth in the research plan as well as assist in the evaluation of the new CST model. The CST model is not set in stone. As with the MCQ-based licensure examination, that began approximately 50 years ago, it is anticipated that the sophistication of CST would also continue to evolve over time.

In making its decision, the CST Task Force requests that the Board of Directors consider the following:

- First, if CST is determined at this point not to be useful for initial licensure and the pilot study data analysis is not completed, many issues related to Member Board use of CST will remain unresolved. And, if it is not used for initial licensure, it is uncertain how it can be supported for other uses.
- Second, the CST Task Force asks that the Board consider the current status as well as the overall goal of the pilot study participant numbers. To date, 111 schools have committed to participation in the study. The table below shows the participant numbers to date. In addition to the 1,314 already tested through May 3, 1999, 240 more individuals have appointments to test at Sylvan, with new participants scheduling appointments each day. Over 2,000 new graduates have indicated a willingness to participate. Data collection is scheduled to continue through July 31, 1999. Given the amount of time remaining in the data collection period and the number scheduled to test, it seems reasonable to believe that the goal will be reached.

Category	Number tested through 12/98	Number tested 1/99 through 5/3/99	Number tested to date	Number of scheduled appointments	Goal
Foreign Educated	117	42	159		150
Experienced Nurses	180	--	180		200
Neophyte	191	--	191		100
New graduates	513	234	747		1000
Total	**1001**	**276**	**1277**	**240**	**1450**

- Third, the CST Task Force asks that the Board consider the following response of the CST Task Force to the substantive issues discussed in the draft EC report to the Board of Directors dated April 26, 1999. It is the understanding of the CST Task Force that the EC will have a conference call on Tuesday, May 4, at 3:00 pm to discuss any further changes that they might make to their report based on this response of the CST Task Force. It is the hope of the CST Task Force that they will be provided ample opportunity to consider any changes or additions that the EC intends to make regarding its April 26 report.

Psychometric Validity/Measurement

1. What is CST measuring that is different from, and in addition to, the current NCLEX examination?

A priori it should be noted that it has always been stated that the purpose of CST is to evaluate examinee application of the clinical decision-making process to the management of client care. The ability of CST to capture the assessment and intervention actions specified by examinees during a time-based dynamic simulation permits such an evaluation. It has always been noted that CST was never designed to measure the fine details of knowledge that include the how and why of nursing assessments and interventions. Further, it has always been understood that CST is not intended to replace the MCQ exam but rather to be a complement to the current exam in which the capabilities of each methodology would be maximized.

Cueing: In its report, the EC notes that while no testing cues exist (in CST) in the form of questions or answer options, a different form of cueing does exist in CST in that CST provides a list of activities from which candidates select what actions they desire rather than allow for total free-text entry. In response to this position, the CST Task Force would like to explain how free-text entry and the Nursing Activity list is used in CST.

While some CST case scoring items are based on examinee's review of components of the client chart/record, the majority of scoring items in CST are based on the feature of CST that permits the initiation of nursing actions through free-text entry. In order to accomplish this, computer intelligence was built and structured so that the computer can efficiently recognize free-text entry. The intelligence built for CST is a list of 1,250 unique nursing actions (parent terms). These nursing actions are associated with over 45,000 synonyms and a search algorithm that have been structured to efficiently recognize examinee free-text entry (for example, the system will recognize free text such as "assess urine" or "urine, assess"). The list of nursing action terms continues to evolve as new cases are developed and tested, and unrecognized examinee free-text is captured by the system. Once free-text is entered, the computer searches a match to the examinee request and a list of alphabetically matched words is presented for clarification, selection and confirmation. It should be noted that the examinee never knows whether anything he/she

types in, or anything that appears in a list for clarification and selection, is an action that is on the scoring key. This is in contrast to the type of cueing that occurs in the MCQ examination. In the MCQ-based exam, the examinee knows that for every question encountered, one of the four options presented is correct. In CST, the actual scoring items are completely invisible. The examinee never has any cue as to whether any one of the 45,000 possible actions that he/she could potentially initiate is actually on the scoring key. In fact, any action that is initiated and confirmed during a particular case could be a benefit, or it could be an inappropriate, risky or flag action for which the examinee could be penalized. Thus, CST permits the capture of behaviors, both positive and negative, that examinees initiate throughout the time-based simulation as they manage the care of the client.

Measurement Capabilities. In its report the EC notes limitations of CST related to its inability to measure examinee specification of the how, when and why of nursing actions. A limitation of CST that has always been specified is that it does not capture information about "how" or "why" an assessment or intervention is implemented. The specifics related to the "how" and "why" of nursing actions are likely most efficiently captured by the use of the MCQ methodology. However, CST does capture information about when nursing actions are implemented. Since in time advances as the simulation progresses, everything that the examinee does in CST, as well as its time and sequence related to other actions, is captured. This feature of CST permits an evaluation not only of the correctness of action but also of the timing and sequencing of actions during the management of a client throughout a dynamic simulation. For example, during a given case it is noted that the examinee first assessed the BP, the lungs, the pulse oximetry, comfort, mental/psychosocial status and patient knowledge regarding positioning. Following these assessments the examinee gave O2, turned up the IV flow rate, gave Tylenol, used attentive listening, clarified communication, initiated a referral to a psychiatric nurse and called the doctor. Based on these actions, and the known patient condition at the specific times in the case, it can be determined that the examinee performed some beneficial and some risky actions. The O2 saturation was low enough to give O2 but the BP was much too high to increase the IV rate. Although the examinee assessed the patient's knowledge about positioning and found it inadequate, he/she did not turn the patient or instruct the patient to do so. In addition, it was inappropriate to give Tylenol since the level of discomfort detected on assessment warranted administration of the stronger analgesic. Furthermore, while the mental/psychosocial assessment indicated a need for attentive listening and clarification of communication, a psychiatric nurse consult was not indicated and may be considered inefficient use of resources. It should further be noted that the ability of CST to capture the timing and sequencing of events has been optimized. Approximately one-third of the scoring items across the 20 pilot study cases incorporate the use of timing and sequencing of actions as a component of the score.

Incorporation of Problem Identification/Nursing Diagnosis into scores: In its report the EC notes that problem identification/nursing diagnosis and efficiency data are not being used in scoring. At the time that the research plan was being designed, the problem identification/nursing diagnosis functionality was being constructed by NBME and because the success of this functionality was unknown at the time, its investigation was not included in the research plan. However, since we have found that this information can be captured and scored, the incorporation of these scoring could be investigated during the pilot study if determined to be a priority, or it could be explored at a later date.

Incorporation of efficiency data into scores. Data related to the unnecessary actions that examinees take in CST is available. This data could be used to explore measures of efficiency in during the pilot study if determined to be a priority, or it could be explored at a later date.

2. What characteristics of the entry level nurse does the current NCLEX examination measure that CST does not measure?

Competencies necessary for caring for clients with psychosocial needs and dealing with aspects of growth and development

The CST Task Force believes that it is premature to draw any conclusions at this time about the degree to which CST is able to assess competencies necessary for caring for clients with psychosocial needs and with aspects of growth and development. In recent years, based on recommendations of Testing Department staff, Paulette Worcester, former EC chair, and Donna Steele, former employee of CGI, were hired because of their identified expertise, to categorize the CST nursing activity terms according to the subcategories of the NCLEX-RN Test Plan. Based on the most recent categorizations by Donna Steele (Spring 1998), 46 terms were placed in subcategory 7, Psychosocial

Adaptation; 48 terms in subcategory 8, Coping and Adaptation; and 51 terms in subcategory 9, Continued Growth and Development Through the Life Span. In total, for these test plan categories, the CST system currently recognizes 145 parent terms and over 3800 synonyms. Furthermore, at least 12 of the 20 scoring keys for the CST Pilot Study cases include scoring items related to these content areas. As the research data is analyzed, the strengths and limitations regarding the ability of CST to assess these content areas will become more apparent. In addition, the strengths and limitations of CST and the current MCQ format in evaluating these content areas have yet to be compared.

3. What are the psychometric issues that will need further exploration?

The CST Task Force agrees with the information set forth by the Examination Committee in their answer to this question.

Operational Issues and Costs

4. How long will the CST assessment need to be and what are the cost implications of this decision?

Examination and practice/orientation time

The CST Task Force agrees with most of the information set forth by the Examination Committee in their answer to this question. However, the CST Task Force would like to point out that the length of the orientation just prior to testing needs further exploration. NBME plans to provide mechanisms for practice and familiarity with the simulation system that would be available in advance of testing so that only a very abbreviated/if any orientation is needed at the time of the test. The NBME practice software is in many medical schools across the country and examinees are expected to practice prior to the testing session. Examinees are instructed as to the approximate number of cases that they should practice and the amount of time that they should spend reviewing the cases prior to the exam session. This is the model currently being used for the CST Pilot Study. Its adequacy will be evaluated as part of the research plan.

5. What are the implications of the current contract with NBME?

While there are concerns about being "locked-in" to using NBME as a single-source vendor for the life span of CST, various models for such a relationship should be identified and explored.

6. What are some of the important transition issues related to implementing CST?

Expert Panel Volunteer Pool

To accomplish implementation of CST, a pool of 150 to 175 nurse volunteers (as opposed to individuals from Member Boards who volunteer to be on National Council committees and Task Forces) over a period of 4-5 years would be needed. Subsequent to implementation it is estimated that approximately 30 volunteers/yr would be needed for ongoing work. In addition to independently recruiting volunteers for work on CST, a number of experts from the NCLEX item panel pool who don't satisfy the needs for the development of the MCQ items have volunteered to participate in CST development activities. Also, several experts who have worked on CST were encouraged to become NCLEX panel members and have subsequently served on NCLEX item panels. Given the projected needs of CST and the total number of RNs in the US and its territories, it seems reasonable to believe that continued development of CST would not exhaust the number of nurses available to work on other NC related activities.

7. What are some of the concerns related to the CST software?

Concerns related to the CST software functionality and its ability to be future-focused

- For the 1990-91 feasibility study of CST, two cases were augmented with A-V sequences. These cases used interactive videodisc and were administered from the hard drive of computers at the testing centers. Examinees receiving these test cases wore headsets during the examination so that the sound would not be heard in surrounding testing carousels. Subsequent to that study it was determined that this technology would be further investigated during the current CST Pilot Study. However, prior to the development of A-V augmentation, we were informed that due to technology limitations and the size of the test files, Sylvan could not administer a test with A-V sequences at the time the CST Pilot Study was initiated. Therefore, A-V augmentation was not explored during this study. However the CST software can easily accommodate its inclusion at any time given the suitability of hardware configurations in test administration centers.

- A second technical evaluation of NBME software is scheduled for the Fall of 1999. The purpose of the technical evaluation is to determine how the underlying simulation technology compares to current technologies and its flexibility in adapting to future technology. The first technical evaluation of NBME software was performed by SEI Information Technology in 1993. Their summary of findings stated that: "NBME is making good use of current technology to reengineer their systems. They are building flexible systems today that can be adapted to new technologies."

- Ability to do whole body skin assessment. Prior to the CST model revisions initiated after the 1991 report to the DA, a whole body skin assessment was possible in CST. However, based on scoring needs identified by multiple expert panels, it was determined that the current structure be adopted. The panels insisted, for example, that the nurse actually did have to look at each body part to conduct a whole body skin assessment. However, if it were determined by a decision-making body that the ability to perform a whole-body skin assessment at one time were a necessary feature in CST, this modification could easily be made.

- Member Board Evaluation of the Use of CST for RN Education and Assessment (discipline, continued competence, and continuing education). One of the major trends identified in reports of Member Board use of CST for RN education and evaluation was the difficulty using the clock (how to advance the clock). On average, Member Board participants reported using one practice case. Some reported using zero practice cases and one reported using two practice cases. Previous research survey results suggest that examinees do not feel comfortable using CST until taking 2 to 3 practice cases. Therefore, difficulty with any of the mechanics of CST would be expected after taking only one practice case.
  Another point identified in Member Board reports of their exploration of CST included the need to assess each vital sign (BP, Pulse, Temp, and Respiration) separately. As with the whole body skin assessment, the ability to take all vital signs simultaneously was a previous feature of CST. However, based on the scoring needs expressed by expert panels, it was determined that the current structure be adopted. However, if it were determined by a decision-making body that the ability to perform all vital signs simultaneously were a necessary feature in CST, this modification could easily be made.

- Foreign-educated, ESL, and ADA candidates
  ESL and foreign-educated candidates have participated in the CST Pilot Study. The results of data analysis will provide insight into the impact of this testing methodology. At this point we are unaware if any ADA candidates have taken CST. However, Sylvan was unable to provide any accommodations for ADA candidates during this pilot study.

Political Issues

8. Can CST be used to measure LPN/VN competence?

CST for LPN/VN assessment

It has always been stated that CST was initially designed to measure competencies inherent in the RN scope of practice. Additional research would be needed to determine if and/or how CST would need to be modified to assess LPN/VN competence.

Notes

Notes

Report of the Committee on Nominations

Committee Members

Monica M. Collins, ME, Area IV, *Chair*
Linda Roberts-Betsch, GA-RN, Area III
Barbara J. Stamp, OH, Area II
June I. Sturm-Roller, CO, Area I

Staff

Doris Nay, MA, RN, *Director of Member Board Relations*

Relationship to Strategic Plan

Strategic Initiative 6.....*The National Council will have the organizational structure and capacity to lead in regulation.*
Outcome 1.....*A sound organizational governance and management infrastructure to advance the National Council's mission and vision.*

Recommendations to the Delegate Assembly

1. **Adopt the 1999 Slate of Candidates.**

Rationale

The Committee on Nominations has prepared the 1999 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the strategic initiatives and purpose of the National Council.

Background

- **Preparation of 1999 Slate of Candidates**

By the April 29, 1999, nomination deadline, 32 individuals had submitted completed nomination forms for consideration for the 1999 Slate of Candidates. The committee finalized the slate on April 30, 1999. Recruitment efforts used by the committee this year included: a letter to Member Board executive officers to partner with the committee in the recruitment of nominees; inclusion of a call for nominations and nomination form in five editions of the *Newsletter;* a call for nominations sent directly to board members of Member Boards (where permissible); and a call for nominations with a nomination form sent directly to members of the National Council's volunteer pool. In addition, the committee made telephone calls to Member Board executive officers, as well as board members and staff of Member Boards; had face-to-face contact with attendees at the Area Meetings; and the nomination packet was placed on the VIP section of the National Council's Web site, for easy access by board members and staff of Member Boards.

The list of slated candidates, along with full biographical information for each candidate, was published in the May 28, 1999, edition of the *Newsletter* sent to Member Boards. Notified on June 17 of a candidate's desire to withdraw from the slate, the Committee on Nominations met by conference call on June 22, 1999, to revise the slate. The revised slate was sent to all Member Boards as an attachment to the June 25, 1999, *Newsletter.* Full biographical information for each candidate is included as Attachment A, starting on page 3.

Highlights of Activities

- **Committee Observation of Board of Directors' Meeting**

On November 4, 1998, 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 skills needed, the recruiting process, and procedures during the nominations and elections at the Annual Meeting. The Board offered suggestions about the nominations and election procedures, including: candidates should know beforehand that they will get an envelope with results; candidates should receive the letter in a private place, identified earlier; Elections Committee members (or anyone with pre-knowledge of results) should be cautioned not to in any way demonstrate knowledge of results before they are announced; and timekeepers should be carefully

instructed regarding when to switch from two-minute to five-minute times for speeches at the Candidates' Forum. The committee discussed the Board's input during its own subsequent meeting.

■ **Use of Area Meetings for Recruitment**

The committee members commented on the multiple benefits resulting from their attendance at the Area Meetings. Through their contact with attendees at those meetings, they were not only able to recruit attendees interested in submitting a nomination for National Council office for this year, but committee members were also able to identify attendees potentially interested in submitting a nomination for elected office next year. The committee has compiled a list of attendees who would consider the opportunity to submit a nomination for office in the upcoming year.

■ **Candidates' Forum**

The committee established the presentation order for the Candidates' Forum to be held Wednesday, July 28, 1999, from 2:00 p.m.-3:30 p.m., as follows:

- Area I, Committee on Nominations
- Area II, Committee on Nominations
- Area III, Committee on Nominations
- Area IV, Committee on Nominations
- Director-at-Large (two positions)
- Area I Director
- Area II Director
- Area III Director
- Area IV Director

■ **Nominations and Election Procedure Enhancement**

The committee determined that the following nominations and election procedures will be implemented at the 1999 Annual Meeting:

- The chair of the Committee on Nominations will notify candidates during the Candidates' Forum as to where they should meet after the election to receive the envelopes containing election results.
- Timekeepers will be instructed regarding when to switch from two-minute to five-minute times for speeches at the Candidates' Forum.
- Elections Committee members (and anyone else given advance knowledge of election results) will be required to keep knowledge of election results confidential.

Future Activities

The committee recommends that, in keeping with the National Council's initiative to identify areas where improvements could be made, a bylaws amendment be considered by next year's committee that would stagger the terms of the members of the Committee on Nominations so that two members are elected each year for a two-year term. Given the purpose of the Committee on Nominations (to prepare a slate of qualified candidates), staggering terms would provide consistency and greater efficiency on the committee and would eliminate the potential of having all new members elected to the committee each year.

Meeting Dates

- November 4-5, 1998
- April 29-30, 1999
- June 22, 1999 *(telephone conference call)*

Attachments

Attachment A

1999 Slate of Candidates

The following is an overview of the slate developed and adopted by the Committee on Nominations. More-detailed information about each candidate is provided in the subsequent pages of this attachment. 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, July 28, 1999, from 2:00 p.m. to 3:30 p.m.

Area I Director
Dorothy Fulton..... Alaska
Valisa Saunders..... Hawaii

Area II Director
Lorinda Inman..... Iowa
Patricia Schlecht ..... Ohio

Area III Director
Joan Bainer ..... South Carolina
Julia Gould..... Georgia-RN

Area IV Director
Iva Boardman..... Delaware
Judith Grybowski ..... Virgin Islands

Director-at-Large (two positions)
Kathy Apple..... Nevada..... Area I
Deborah Johnson ..... North Dakota ..... Area II
Faith Fields ..... Arkansas ..... Area III
Richard Sheehan ..... Maine..... Area IV

Committee on Nominations
Area I
Ruth Takeda..... Colorado
Nancy "Nan" Twigg..... Arizona
Helen Zsohar..... Utah

Area II
Jane Anne Conroy..... Kansas
Cordelia Esry ..... Missouri
Orpha Ruth Swiger ..... West Virginia-PN

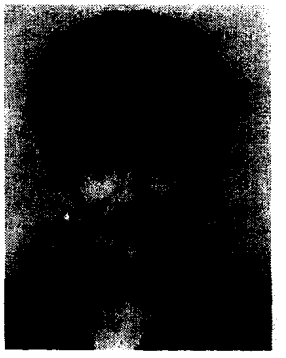
Area III
Yvonne Albert..... Alabama
Shirlene Harris..... Arkansas
Marcia Hobbs ..... Kentucky

Area IV
Monica Collins..... Maine
Judith Godsey-Wehnau..... New Jersey
Susanne Kelly ..... 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. 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
   Board of Directors, Area I Director, 1998-present
   MSR Fiscal Work Group, 1998
   Nursing Practice and Education Continued Competence Subcommittee, 1997-1998
   Disciplinary Data Bank Task Force, Chair, 1996-1997
   Nurse Aide Competency Evaluation Program Task Force, 1992-1996
   RWJ Foundation
   Colleagues in Caring Consortium, Member, 1997-present
   Sigma Theta Tau, National Honor Society of Nursing
   Member, 1990-present
   National Association of Orthopedic Nurses
   Member, 1982-1995
   President, 1993-1994
   Alaska Nurses Association, 1989-present
   Convention Committee, 1990-1991
   Alaska Nurse Practitioner's Association, 1991-1992
   Alaska Older Alaskan Commission, 1989-1993

6. Alaska Association of Nurse Executives
   Sigma Theta Tau International
   Sigma Theta Tau, National Honor Society of Nursing
   National Nurses Society on Addictions
   Theta Omicron Chapter

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

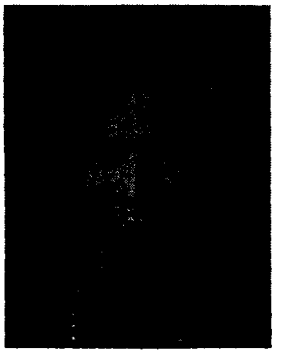
8. It has been an honor to serve as Area I Director for almost one year. This has been valuable experience at the time when the National Council is facing critical issues. My experience includes nursing, nursing education, state government, private sector, and other issues involving the first nurses strike in the state. I have an informed and objective perception of nursing and challenges faced in providing quality care.

   One of my greatest strengths is my understanding of diverse populations' rural and urban settings. I am proactive in identifying and resolving nursing and health care issues affecting all groups.

   I support the mission of the National Council. As a Board member, I will bring vision in advancing the profession of nursing.

   The National Council should continue to address the issues of multistate licensure, telehealth, impaired practice, unlicensed assistive personnel and explore the feasibility of developing a disciplinary data bank for UAPs.

Area I Director



1. **Valisa Saunders, Hawaii, Area I**

2. Chair, Hawaii Board of Nursing

3. Kaiser Permanente, Kaneohe, Hawaii

4. University of California at Los Angeles, Nursing-PAC-Gero, MN, 1983
   University of California at Los Angeles, Nursing, BSN, 1981
   El Camino College, Nursing, ADN, 1977

5. National Council
   - Resolutions Committee, 1999

   American Nurses Association
   - Council of APRNs, 1986-1997
   - Practice Institute, 1992-1995
   - Nurse Practice Cabinet Restructure Committee, 1992-1993
   - Institute of Nursing Practice, Vice-chair & Member, 1991-1993

   Hawaii Board of Medical Examiners
   - Formulary Advisory Committee, Secretary, 1994-present

   Hawaii Board of Nursing
   - Chair, 1998-1999
   - Vice-chair, 1997-1998
   - Practice Committee
     - Member, 1995-2001
     - Chair, 1997-1999

   Hawaii Executive Office on Aging
   - End of Life/Surrogate Task Force, 1998-present

   Hawaii Nurses Association
   - President, 1989-1991
   - Congress on Nursing Practice Chair/ Vice-chair, 1985-1989
   - Legislative Committee, 1985-1989

   National Conference of Geriatric Nurse Practitioners
   - Practice Committee, Chair, 1997-present

   Sigma Theta Tau, Gamma Psi Chapter
   - Finance Committee, 1985-1987

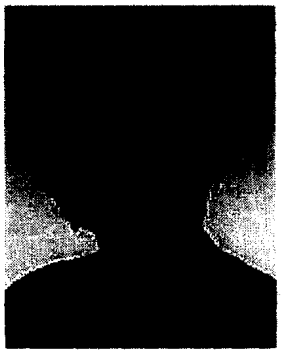
6. American Academy of Nurse Practitioners
   American Nurses Association
   American College of Nurse Practitioners
   National Conference of Geriatric Nurse Practitioners
   American Society on Aging
   Hawaii Nurses Association
   Sigma Theta Tau International

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

8. I have over 20 years of clinical, organizational and regulatory involvement with state and national perspectives. This has given me leadership experience and perspectives on issues important to nursing regulation. My clinical role as a GNP reminds me daily of our customers' needs....the consumers we are to protect as regulators. My managerial experience has given me skills to manage personnel, budgets, and many competing priorities. My computer skills keep me efficient and in touch with the rest of the world from my distant island.

   The National Council needs to continue to answer questions of Member Boards related to mutual recognition to make interstate compacts a reality. We also need the Computerized Clinical Stimulated Testing (CST®) study completed to assess its potential for use in initial testing. The National Council needs to continually assess the needs of its Member Boards. I would be privileged to serve the National Council membership from the volunteer board member perspective. Mahalo!

Area II Director



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

2. Executive Director, Iowa Board of Nursing

3. Iowa Board of Nursing

4. Loyola University, Chicago, MCH Clinical Specialist, MSN, 1976
   University of Iowa, Nursing, BSN, 1971

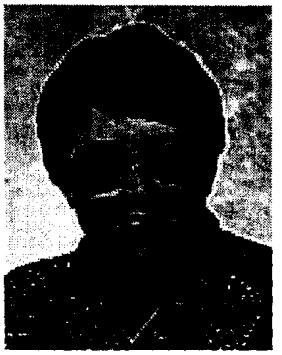
5. National Council
   Board of Directors, Area II Director, 1997-present
   Finance Committee, 1995-1997
   Resolutions Committee, 1995-1997
   Long Range Planning, 1989-1995
   Executive Officers Orientation Task Force, 1994-1995
   County Government
   ISU County Extension Council, 1997-present
   Dallas County Historical Commission, 1997-present

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

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

8. During my more than 15 year involvement with the National Council, I have served as delegate, committee member and Area II Director. I am committed to the National Council as it provides support to Member Boards in their public protection mission. Challenges for the National Council include: (1) synthesize changes within the health care environment that impact regulation of the nursing profession providing the environment for collaboration when boards address these issues, (2) continue utilizing the strategic initiatives as the blueprint to optimize the Board's effectiveness by moving toward long range or future planning and away from monitoring past activities, and (3) strengthen our presence in the regulation of the nursing profession. Thank you for the opportunity to serve as the Area II Director for the past two years.

Area II Director



1. **Patricia A. Schlecht, Ohio, Area II**

2. Board Member, Ohio Board of Nursing

3. University of Cincinnati, Cincinnati, Ohio

4. Indiana University, Pediatric Nursing, MSN, 1975
   State University College of New York at Plattsburg, Nursing, BSN, 1970

5. National Council
   Area II Regulatory Day of Dialogue Planning Committee, 1997-1998
   Ohio Board of Nursing
   Liaison to Licensure Unit, 1997-1999
   Task Force on Regulatory Outcomes, 1998-1999
   Task Force on Advisory Groups, 1997
   Task Force on Advisory Group Appointments, 1997-1998
   Education Advisory Group, 1991-1996
   Southwestern Ohio Nurses Association, 1975-present
   Vice President, 1993-1996
   Board Member, 1992-1993
   Human Rights Committee, 1989-present
   Secretary, 1990-1993
   Convention Committee Chairperson, 1993-1996
   Bylaws Committee Chairperson, 1993-1996
   Ohio Nurses Association Convention Delegate, 1993-1996
   National League for Nursing Accrediting Commission, 1987-present
   Evaluator for associate degree nursing programs
   North Central Association Accrediting Commission, 1993-present
   Consultant-Evaluator for associate degree colleges
   Area Health Education Center in Cincinnati, 1990-present
   Advisory Board Member

6. American Nurses Association
   Ohio Nurses Association
   Southwestern Ohio Nurses Association
   National League for Nursing
   Ohio League for Nursing
   National Organization for Advancement of Associate Degree Nursing
   Ohio Organization for Advancement of Associate Degree Nursing
   Association of Women's Health, Obstetric, and Neonatal Nurses
   Sigma Theta Tau
   American Association of University Professors

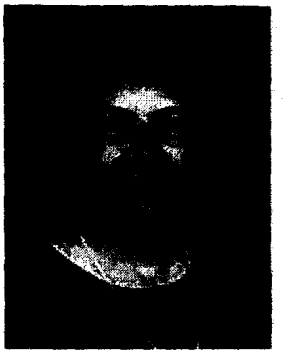
7. Date of expiration of term: December 2000
   Eligible for reappointment: No

8. I am honored to be a candidate for an office in the National Council. Personal qualities include abilities in the areas of communication, analysis of data, and presentation of data. My background in educational assessment related to my nursing program, regional colleges and national nursing programs has given insight into the evaluation process and the importance of clear criteria and outcomes.

   Within the next two years, there will be several issues related to the implementation of the interstate compact. Although much work has been done in this area, as implementation comes closer, there will be unforeseen issues needing analysis and problem solving. In addition, the National Council initiatives in outcome evaluation will require multi-level processes in an area in which I am experienced.

   I feel that I can be an asset to the National Council during this exciting time of transition, reflection and evaluation.

Area III Director



1. **Joan K. Bainer, South Carolina, Area III**

2. Program Nurse Consultant, South Carolina State Board of Nursing

3. South Carolina State Board of Nursing

4. University of South Carolina, Cola, SC, Nursing, MN, 1990
   University of South Carolina, Cola, SC, Nursing, BSN, 1988
   Englewood Hospital, Englewood, NJ, Nursing, Diploma, 1970

5. American Nurses Association
   Credentialing Committee in Nursing Administration, 1990-present
   Sigma Theta Tau
   Treasurer, 1994-1996

6. None provided.

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

8. The skills that I bring to National Council are both basic and advanced. Basic skills include a high standard of practice, high ethical and moral values, to name a few. Without these skills, the National Council mission would be jeopardized. The advanced skills clearly demonstrate the minimum standards for a competent member starting with practice based on a systems theory to include critical thinking, ability to conceptualize data and intense listening skills. Past experience as a nurse executive facilitated not only problem solving but "big picture" thinking and outcome awareness. Communication is of utmost importance to build relationships in the internal structure of the committee and external to National Council and practitioners. Supporting National Council and being accountable to delegates to make informed decisions facilitating present and future issues – MSR, UAP regulation, telenursing. Facilitate open exchange of information. Future issues for National Council are educating consumers, collaborate with Pew Commission in common goal of patient safety, and assess state nurses association.

Area III Director

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

2. Nursing Education Consultant, Georgia Board of Nursing (RN)

3. Georgia Board of Nursing (RN)

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

5. National Council
   Board of Directors, Area III Director, 1997-present
   Licensure Examination Comparison Task Force, Chair, 1996-1997
   Task Force to Implement Education Programs for Nursing Education Program Surveyors, 1994-1995
   Task Force to Develop Educational Programs for Nursing Education Program Surveyors, 1993-1994
   Nursing Practice and Education Committee
   Chair, 1993
   Member, 1989-1992
   Resolutions Committee, 1988
   Commission on Graduates of Foreign Nursing Schools
   Board of Trustees (NCSBN Representative), 1996-2000
   Trilateral Initiative – Workforce on Approval in Accreditation, 1995-1997
   Georgia League for Nursing
   Board of Directors, 1993-1997; 1998-present

6. National League for Nursing
   Georgia League for Nursing
   Sigma Theta Tau

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

8. As an education consultant, I have developed well honed regulatory skills particularly related to nursing education and the evaluation of international examination applicants. As Area III Director, my skills in strategic planning, governance, critical thinking, and decision-making have been expanded. My qualities include integrity, a profound commitment to nursing, communication skills, credibility, and organization.

   Over the next two years, National Council will need to facilitate tremendous Member Board learning curves regarding the use of sophisticated technology, testing, licensure, sharing of information, and availability of products and services. It will need to be sensitive to the fact that not all boards are in the same place. Role development about the complexities of regulation for new staff and board members will be very important. National Council must be a stakeholder in an ambiguous health care environment in which nursing manpower and consumer needs are shifting.

Area IV Director

1. **Iva J. Boardman, Delaware, Area IV**

2. Executive Director, Delaware Board of Nursing

3. Delaware Board of Nursing

4. Widener University, Nursing, MSN, 1989
   Rutgers University, Nursing, BSN, 1964
   Rutgers University, Nursing, ASN, 1962

5. National Council
   - Mutual Recognition Master Plan Coordinating Group, 1998-present
   - Multistate Regulation Task Force, 1996-1998
   - Communications Evaluation Task Force, 1995-1996
   - Committee on Nominations
     - Member, 1994-1995
     - Chair, 1993-1994
   - Subcommittee for the Study of Advanced Nursing Practice, 1992-1993

   Delaware Organization of Nurse Executive Legislative Committee, 1996-1999
   Generations Home Care
   - Board of Directors, 1995-present

   Clayont Community Center
   - Board of Directors, 1983-1997

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

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

8. Having been a regulator for the past nine years, I believe that I understand regulation and am comfortable with the analysis, implementation, and evaluation of regulation. I feel passionate about public protection. I believe that I am an effective communicator, skilled at listening, and able to enter into dialogue assertively. I believe that I am able to agree to disagree, and able to distinguish issues from personalities. I believe that I know what I know as well as that which I do not know and take ownership accordingly.

   During the next two years, the National Council must develop the nurse licensure information system to provide boards with the most complete licensee information in a single system, assist both party and nonparty state boards during the implementation of mutual recognition, continue efforts to best ascertain continued competency of licensees, and identify effective regulatory outcomes and implementation strategies.

Area IV Director

1. **Judith A. Grybowski, Virgin Islands, Area IV**

2. Chairperson, Virgin Islands Board of Nurse Licensure

3. University of Virgin Islands, Professor of Nursing

4. University of Illinois, Champaign, Ed Admin, PhD, 1987
   Emory University, Teaching/Rehab, MN, 1968
   Duke University, Nursing, BSN, 1960

5. National Council
   Mutual Recognition Discipline Work Group #2, 1999
   Virgin Islands Board of Nurse Licensure
   Chairperson, 1996-present
   Rules and Regs, 1995-1996
   Virgin Islands State Nurses Association
   District President, 1994-1998
   Executive Director, 1976-1978
   State President, 1972-1976
   American Nurses Association
   Elected member to Commission on Economic & General Welfare, 1976-1978
   Victim Advocate
   Treasurer, 1992-present

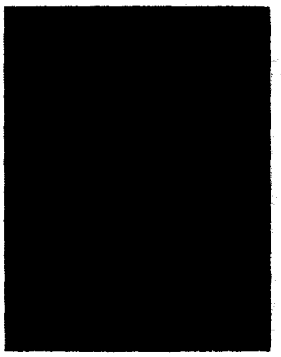
6. American Nurses Association
   Virgin Islands State Nurses Association
   Sigma Theta Tau
   American Association of University Professors
   Victim Advocate Program

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

8. The National Council is one of the most exciting and visionary organizations with which I have been associated. The energy and commitment of all members stimulates me to excel and to contribute at an optimum level. I am committed to supporting the mission of the National Council. Through this commitment, I wish to find means to assist boards in this time of rapid change and turnover of staff and appointed members to facilitate continuity and stability while growing with the learning curve. Through this, I would strive to help Board members to increase their effectiveness in regulation. As jurisdictions join the interstate compact for mutual recognition, I wish to be active to support the smaller jurisdictions to maintain their level of functioning. Furthermore, my interest is to facilitate colleagueship between education and practice for new and experienced practitioners. I am committed to the BS requirement for entry into professional nursing and the AD for entry into practical nursing. Lastly, I am committed to support and to appropriate regulation for advanced practice nurses, including the nurse midwives.

Director-at-Large

1. **Kathy Apple, Nevada, Area I**



2. Executive Director, Nevada State Board of Nursing

3. Nevada State Board of Nursing

4. University of Nevada-Reno, Nursing, MS, 1992
   University of Alaska-Anchorage, Counseling Psychology, MS, 1983
   California State University-Long Beach, Nursing, BSN, 1975

5. National Council
   Board of Directors, Director-at-Large, 1998-present
   Multistate Regulation Task Force, 1997-1998
   Executive Officer Orientation Group, 1997-1998
   APRN Coordinating Task Force, 1995-1996
   Task Force to Study the Feasibility of a Core Competency Exam for Nurse Practitioners, 1994-1995

6. American Nurses Association
   American Psychiatric Nurses Association

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

8. I believe I bring an ability to use common sense and clear thinking especially through intense and voluminous issues. I am dependable and adaptable in my performance. And most importantly, I continue to believe strongly that the priority for National Council is the implementation of the mission statement in assisting Member Boards in their role of public protection.

Director-at-Large

1. **Deborah K. Johnson, North Dakota, Area II**

2. Board Member, North Dakota Board of Nursing

3. Deborah K. Johnson & Associates, P.C.

4. Texas Women's University, Nursing, MS, 1988
   Texas Women's University, Nursing, BS, 1973

5. National Council
   Annual Meeting Volunteer, Albuquerque, NM, 1998
   North Dakota Board of Nursing
   Joint Prescriptive Authority Committee Chair, 1998-2000
   Multistate Regulation Task Force, 1998-1999
   Sanctions Task Force Chair, 1998
   North Dakota Nurses Association
   Advance Practice Pharmacology Review Presenter, 1999
   American Psychiatric Nurses Association
   Multistate Legislative Coordinator for Legislative/Governmental Affairs Committee, 1999-present
   Delegate to Congress on Advanced Practice, 1997
   American Heart Association-Dakota Affiliate
   Annual Heart Walk Committee, 1996-present
   Corporate Sponsor Committee Chair, 1999

6. American Nurses Association
   American Psychiatric Nurses Association
   American Association for Marriage and Family Therapy
   Sigma Theta Tau
   American Heart Association
   Northern Plains Family Therapy Coalition
   Lipid Nurses Task Force

7. Date of expiration of term: July 2002
   Eligible for reappointment: Yes

8. I have an interest in serving as Director-at-Large, National Council of State Boards of Nursing, because I believe organizations grow and change because people in them are committed to change and are willing to work to see that change is accomplished. As a first-time member of my state board, I have seen the issue of multistate regulation unfold and develop. I believe that nursing must take bold steps to address the changing face of our profession in the 21st century. Multistate regulation is such a bold step. I desire to take an active role in this step and in the change process.

   In my work as an APRN, psychiatric mental health, I utilize systems and adaptation theory and coalition building everyday with my clients and their systems. My work on other professional national and grassroots committees gives me the broad national focus as well as the local lens with which to see both problems and solutions.

Director-at-Large

1. **Faith A. Fields, Arkansas, Area III**

2. Executive Director, Arkansas State Board of Nursing

3. Arkansas State Board of Nursing

4. University of Central Arkansas, Nursing, MSN, 1988
   University of Central Arkansas, Nursing, BS, 1975

5. National Council
   - Mutual Recognition Interim Compact Administrators' Group, Co-chair, 1999-present
   - MSR Operations Work Group, 1997-1998
   - Multistate Regulation Task Force, 1996-1998
   - NCLEX® Negotiation Team, 1996-1997
   - NCLEX® Evaluation Task Force, 1995-1996
   - Examination Committee, Alternate, 1994-1997
   - Committee for Special Projects (CAT), 1994-1995
   - CAT Team 1, Examination Committee, 1993-1994
   - CAT Team 2, Examination Committee, 1992-1993
   - CAT Education Information Team, 1991-1992
   - Elections Committee Chair, 1991;1992; 1995
   - Communications Committee, 1990-1994

   Nurse Administrator's of Nursing Education Programs
   - Task Force on Arkansas Articulation Model, 1991-1992

   Arkansas Health Resources Commission
   - Education for Health Professions Working Group, 1994

   Arkansas Nurses Association
   - Treasurer, District 12, 1992-1995

Operations 746 Legislative Task Force, 1994-1995
Arkansas State Board of Nursing
Vice-President, 1990
Board Member, 1988-1991

6. Kappa Rho Chapter of Sigma Theta Tau
American Nurses Association
Arkansas Nurses Association

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

8. With 24 years of nursing experience in a variety of settings, the qualities and skills I would bring include the ability to see the big picture, honesty, integrity, strength to stand up for good ideas and cutting-edge possibilities—and the courage to say no, level headedness and a terrific sense of humor. My 11 years of regulatory experience includes having been a board member, board staff and an executive officer, as well as active involvement in a number of National Council committees over the past decade. I feel strongly that the National Council have a Board of Directors' member from a state implementing the interstate compact. The perspectives of a party state, as well as a nonparty state, need to be considered in addressing the complex regulatory issues we face. With the current focus on government doing more with less, we should continue to devote energies and resources toward identifying performance benchmarks and effective regulatory outcomes.

Director-at-Large

1. **Richard L. Sheehan, Maine, Area IV**

2. Board Member, Maine State Board of Nursing

3. Southern Maine Medical Center

4. Boston University, Nursing, MS, 1976
University of Maine, Counselling/Psychology, MSEd, 1973
Saint Francis College, Sociology/Psychology, BA, 1968
University of Bridgeport, Nursing, Associate Degree, 1964

5. National Council
Finance Committee, 1992-1996
Examination Committee Alternate, 1994-1996; 1990-1992; 1984-1986
Examination Committee Alternate – Team I, 1992-1994
Resolutions Committee/New Business, 1994
Examination Committee, 1987-1988
Maine State Board of Nursing, Chair, 1978-1982; 1986-1989
Governor's Task Force on Nursing Education and Supply, 1987-1989
UAP Committee, Chair, 1984-1986
Workgroup on Nursing at the BSN level, 1983
US Army Reserve
405th Combat Support Hospital Detachment I, Executive Officer, 1976-present

6. None provided.

7. Date of expiration of term: July 2003
Eligible for reappointment: No

8 Involvement with the Maine State Board of Nursing and the National Council has allowed me experiences including five terms as chair of the Maine State Board of Nursing, and membership on the Examination and Finance Committees of the National Council. These experiences gave me a profound respect for the roles and responsibilities of board members at each level.

As a board member and nurse executive, I have been intricately involved in developing, operationalizing, and revising strategic plans as living documents to successful organizations. Over twenty years in the US Army Reserve has provided me experiences in recognizing and resolving local and system-wide issues.

Issues the National Council must pursue include dialogue with nursing educators to explore the expanding needs of the public for professional care. The issues of competency in practice are important and resources must continue to support this process. The relationship between licensed and unlicensed personnel is of major concern. The National Council must continue to play a pivotal role in establishing the licensed nurse as the primary multi-skilled provider of care for public health and well being.

Committee on Nominations: Area I

1. **Ruth A. Takeda, Colorado, Area I**

2. Administrative Program Specialist, Colorado Board of Nursing

3. Colorado Board of Nursing

4. University of S. Colorado, English, BA, 1985

5. Denver Paralegal Institute
   Advisory Board, 1991-1992

6. None provided.

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

8. I have extensive experience in regulation and am organized, detail-oriented, and always strive for efficiency. I believe that the issue in the forefront is multistate licensure. I also believe that its implementation may be delayed—in the interim, the issue to focus upon is how our current regulatory systems can communicate and operate more efficiently in their ultimate aim to protect the public.

Committee on Nominations: Area I

1. **Nancy L. "Nan" Twigg, Arizona, Area I**

2. Nurse Practice Consultant, Arizona State Board of Nursing

3. Arizona State Board of Nursing

4. University of Arizona, Nursing, MSN, 1980
   University of Arizona, Nursing, BSN, 1972
   Springfield City Hospital School of Nursing, Nursing, Diploma, 1964

5. National Council
   DDB Advisory Panel Chair, 1997-Present
   Discipline Modules Task Force Chair, 1996-1997
   Board of Directors, Area I Director, 1987-1989
   Bylaws Committee, 1985; 1986
   New Mexico Board of Nursing
   Executive Director, 1984-1997
   Education Consultant, 1982-1984
   Arizona Nurses Association
   District President
   Nurses Association of the American College of Obstetricians and Gynecologists
   National Secretary, 1982-1984
   Arizona Section Chair, 1978-1980
   District I Education Consultant, 1978-1980

6. None provided.

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

8. The National Council has developed into a nationally recognized organization for the regulation of nursing because its officers, membership and staff have had the foresight to go where no one has ever gone before. The leadership has not backed away when its goals and projects have been questioned and doubts have been argued. Like computerized adaptive testing, there have been questions and doubts about the validity and practicality of moving toward mutual recognition licensure, but the leadership is guiding Member Boards into thinking and implementing a new, better way to regulate nursing in this country.

   It is exciting to contemplate what may be in the future for regulating nursing in this country, but it is important to choose leaders who can lead the membership out of the regulation box. I welcome the opportunity to be considered for the Committee on Nominations to present individuals to the membership who have the foresight to go where no one has ever gone before.

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

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

5. National Council
   Nursing Practice and Education Subcommittee on Education, Chair, 1998-present
   Committee on Nominations, Chair, 1997-1998
   NP&E Nursing Program Accreditation/Approval Subcommittee, 1996-1998
   Utah State Board of Nursing
   Board Member, 1987-1991, 1994-present
   Board Chair, 1990-1991

6. American Nurses Association
   Utah Nurses Association

7. Date of expiration of term: July 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. I have served National Council as a member of the NP&E Subcommittee on Education since 1996. My continuing work with the Utah Board and National Council reflects a personal and professional commitment to advance the nursing profession in a manner that is truly accountable for public health, welfare and safety.

   I am particularly interested in National Council taking a proactive position on the regulatory fit between boards of nursing and accredited nursing education programs, consistent with Strategic Initiative 5. As a board member and consistent with Strategic Initiative 6, I believe that I have a responsibility to demonstrate accountability for the direction our profession is taking through active participation and leadership in National Council activities, including participation on the Committee on Nominations, to which I was elected and chaired in 1997-1998.

Committee on Nominations: Area II

1. **Jane Anne Conroy, Kansas, Area II**

2. Secretary, Kansas State Board of Nursing

3. Via Christi Regional Medical Center

4. Emporia State University, Curriculum Instruction, MS, 1990
   Wichita State University, Nurse Practitioner Certificate, 1978
   Wichita St. Joseph School of Nursing, Diploma, 1976
   University of Kansas, Biology/Microbiology, BA, 1974

5. National Council
   Trend Analysis Study Focus Group, 1998-1999
   Kansas State Board of Nursing
   Practice Committee, Chair, 1997-present
   Legislative Committee, 1998-1999
   Finance Committee, 1997-1999
   Advance Practice Committee, 1992-1994; Vice-chair, 1997-1999
   Kansas State Nurses Association
   Council on Practice, 1996-1998
   Via Christi Medical Center
   Evidence Based Practice Council, 1999-present

6. Kansas State Nurses Association
   Kansas Alliance of Advanced Nurse Practitioners

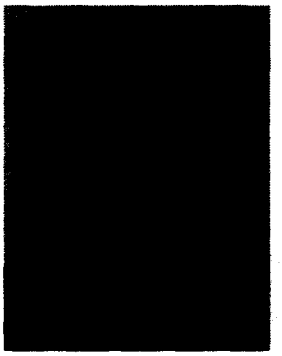
7. Date of expiration of term: July 2001
   Eligible for reappointment: Yes

8. With many changes occurring in health care at a rapid pace, nurses must break out of the paradigm of the past. It is critical that nurses look at regulatory outcomes and take the initiative to keep our profession on the leading edge.

   Multistate licensure, a comprehensive nurse database and an effective way to evaluate both entry level as well as ongoing competence are crucial to achieving this goal. National Council needs to take an active role in assisting Member Boards with these issues as well as those of discipline and telenursing for public protection.

   I intend to actively work with Member Boards and National Council to facilitate these objectives.

Committee on Nominations: Area II



1. **Cordelia M. Esry, Missouri, Area II**

2. President, Missouri State Board of Nursing

3. University of Missouri School of Nursing, Kansas City, Missouri

4. University of Kansas, Education Policy and Administration, Nursing, PhD, 1986
   University of Missouri, Nursing Education and Counseling, MEd, 1957
   University of Missouri, Nursing, BSN, 1955

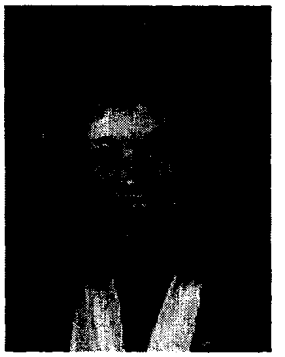
5. Missouri Association Colleges Nursing
   President, 1990-1994
   Missouri Division of Health
   Chair of Loan and Scholarship, 1992-present
   Missouri Guidance Association
   Past Officer
   Missouri League for Nursing
   Board of Directors, 1992-1996
   Missouri Nurses Association
   Board of Directors, 1990-1992
   Served on finance, education, nominating and Blue Ribbon committees during the last 10 years
   Missouri Rural Opportunities Council
   Area Representative, 1992-1998
   Sigma Theta Tau
   Counselor, 1993-1995
   University of Missouri National Alumni Association
   Treasurer, 1996-1998
   Vice-President, 1998-1999
   President-Elect

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

7. Date of expiration of term: June 2001
   Eligible for reappointment: Yes

8. If nominated and elected to a position in the National Council, I believe I would bring a knowledgeable and reasonable attitude about many of the issues facing the National Council such as mutual recognition, competency evaluation, and regulation. I have an open mind for change and appreciation of others' ideas. I have had the experience of working with many diversified groups whose actions impact the nursing profession daily. I would also bring an energy to accomplish tasks and an attitude that nothing is impossible but it also may not be able to be accomplished in a day. I believe that the priorities of the Board are determined for the next two years as work continues in helping the states with mutual recognition and in developing a method for arriving at proof of continued competence.

Committee on Nominations: Area II



1. **Orpha Ruth Swiger, West Virginia-PN, Area II**

2. Board Member, West Virginia State Board of Examiners for Practical Nurses

3. United Hospital Center

4. United Career Center, Nursing, LPN Licensure, 1974

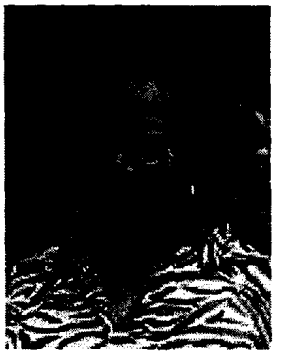
5. National Council
   Nurse Aide Competency Evaluation Program Task Force, 1993-1996
   West Virginia State Board of Examiners for Practical Nurses
   Disciplinary, 1993-present
   Chairperson, 1996-1997
   District 7 LPN
   Secretary, 1982-1984
   District 7 Alum Junior Women's Alumni
   President, 1986-1988
   North Central District
   Treasurer, 1998-1999
   Clarksburg Women's Club
   Secretary, 1992-1994

6. District 7 Licensed Practical Nurses
   National Federation of Licensed Practical Nurses
   National Association for Practical Nurse Education and Service
   District 7 Licensed Practical Nurses Alumni
   West Virginia Licensed Practical Nurses Association

7. Date of expiration of term: February 2002
   Eligible for reappointment: No

8. For the past 25 years I have been active in my profession as an LPN. My experience includes many clinical areas of health care. I have served on the West Virginia-PN Board since 1992. My term expires in 2002. I am a past chairperson and serve on the Disciplinary and Rule Revision Committee. At the National Council level I served on the Nurse Aide Competency Evaluation Program Task Force and as an NCLEX-PN® Item Reviewer. Participation by appointed board members is an ongoing issue the National Council should continue to support. I strongly support the mission statement and the initiatives of the National Council. I recognize the complexity of the numerous issues facing the National Council. I would like to use my experience and enthusiasm to select individuals that are dedicated, capable and willing to assist the National Council achieve its goals.

Committee on Nominations: Area III



1. **Yvonne Delores Albert, Alabama, Area III**

2. Board Member, Alabama Board of Nursing

3. Father Purcell Children Center

4. Troy State University, Biology, 1988
   Butler County Community College, Biology, 1981
   Wichita, Kansas Practical Nursing School, Biology, Diploma, 1980

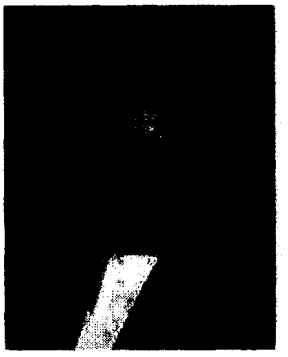
5. Alabama Board of Nursing
   Nursing Practice/Discipline Committee, 1997-1999
   Strategic Planning & Policy Committee, 1998-1999
   Competence Task Force, 1998-1999
   National Association for Practical Nurse Education and Service, 1983-1999
   Council of Presidents, Secretaries and Chief Officers, 1983-1999
   National Association for Practical Nurse Education and Service, Teller for Elections, 1998-1999
   LPN Association of Alabama
   Board of Directors, 1992-1999
   Chapter 3 President, 1992-1999
   VFW Ladies Auxiliary 10366
   President, 1997-1999

6. National Association for Practical Nurse Education and Service, Life Member
   LPN Association of Alabama
   LPN Association of Alabama Chapter 3
   VFW Ladies Auxiliary to Post 10366, Life Member

7. Date of expiration of term: December 2000
   Eligible for reappointment: Yes

8. The National Council has a rich history of electing qualified volunteers to provide leadership and services on the Board and committees. The Committee on Nominations is a pivotal vehicle for ensuring a quality slate of candidates for leadership positions. As a candidate for the Committee on Nominations, I am aware of the need for networking, group participation and communication, as well as decision-making skills necessary to present the best slate of candidates as possible. It is especially important to be able to evaluate strengths of candidates and analyze potential contributions to the leadership group. I will bring to this committee my ability to effectively work with others, especially in endeavors that have the potential to influence leadership thrusts and direction of an organization such as the National Council. My experiences and success in leadership and planning support my candidacy.

Committee on Nominations: Area III



1. **Shirlene Harris, Arkansas, Area III**

2. Arkansas State Board of Nursing

3. Baptist Health

4. University of North Texas, Denton, Texas, Admn. Higher Education, PhD, 1984
   University of Central Arkansas, Conway, Arkansas, Education, MSE, 1972
   University of Central Arkansas, Conway, Arkansas, Nursing, BSN, 1970

5. National Council
   Trend Analysis Study Focus Group, 1998-present
   Annual Meeting Delegate, 1997-1998
   Arkansas State Board of Nursing
   Board Member, 1997-present
   National League for Nursing/CDP
   Executive Committee, 1991-1994
   Arkansas Nurses Association
   Bylaws, 1991-present
   Parliamentarian, 1995-present

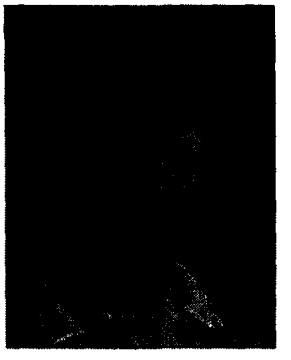
Arkansas League for Nursing Board of Directors
Secretary, 1983
Nominations Committee, 1983
Assembly Hospital School of Nursing
President, 1984-1987
Nominating Committee, 1988
National League for Nursing Board of Directors
CDP Chairman, 1991-1993
CDP Executive Committee, 1994-1995; 1997-1999
HMO Board of Directors
Member, 1984-1994

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

7. Date of expiration of term: October 2000
Eligible for reappointment: Yes

8. It would be an honor to serve as a member of the Committee on Nominations. Complex issues and challenges dominate our agendas: operationalizing mutual recognition and the informational database, nurse competency, and emerging trends. To achieve our mission, the strategic initiatives must become a reality through dynamic logistics, leadership and respectful diversity. The constituency, our greatest strength, must be prevalent in all operations to assure support and continuing success. I bring five broad perspectives: nursing education and practice, nurse regulation, public protection, and national health care. I have served in official capacity at the local, state and national levels including elected offices, committees and appointed responsibilities. As a board member for the past three years, and twice delegate to the National Council Annual Meeting, I believe my background of service, which includes nominating committees, provides me the experience necessary to be an effective committee member.

Committee on Nominations: Area III



1. **Marcia Hobbs, Kentucky, Area III**

2. Board Member, Kentucky Board of Nursing

3. Murray State University, Murray, Kentucky

4. University of Alabama, Birmingham, Nursing, DSN, 1991
University of Hawaii, Honolulu, Nursing, MS, 1984
DePauw University, Nursing, BSN, 1974

5. Kentucky Board of Nursing
Education Committee, 1996-1999
Competency Task Force, 1998-1999
Kentucky Nurses Association District 5
Secretary, 1997-present
Tennessee Nurses Association District 13
Executive Board, 1990
President, Vice President, Treasurer, Delegate, 1980s

Sigma Theta Tau
President, 1994-1996; 1998-present
Kentucky Association of Baccalaureate and Higher Degree Nursing Programs
Secretary, 1997-present

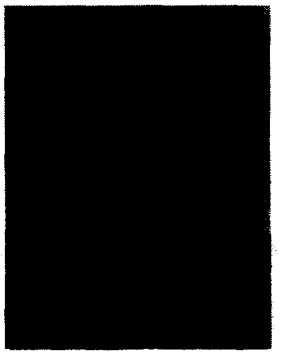
6. Sigma Xi
Alpha Chi, honor society faculty advisor
Sigma Theta Tau – Delta Epsilon Chapter
Kentucky Nurses Association

American Nurses Association
Kentucky Organization of Nurse Executives
Kentucky Association of Baccalaureate and Higher Education Programs
Calloway County American Red Cross Board
Purchase Area Health Education Consortium Advisory Board

7. Date of expiration of term: June 2002
Eligible for reappointment: Yes

8. The two most important qualities that I bring are that of being a negotiator and a creative thinker. I believe that I have demonstrated both of these qualities in the many positions that I have held. I see that the National Council will face multiple issues, but I believe that two are the most pressing. Multistate licensure will continue to be a major issue with many driving forces – some negative and some positive. It would strengthen the National Council or weaken it. The other continuing issue is that of technology which will strongly impact the databases, regulatory outcomes, and organizational capacity. We're moving so quickly that keeping abreast will be a true challenge. Decisions will have to be made utilizing futuristic thinking.

Committee on Nominations: Area IV



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

2. Chairperson, Maine State Board of Nursing

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

4. University of Maine, Education, EdD, 1997
Boston University, Nursing, MS, 1975
Boston College, Nursing, BSN, 1967

5. National Council
Committee on Nominations, 1997-present; Chair, 1998-present
Computerized Clinical Simulation Testing Task Force, 1996-1998
Maine State Board of Nursing
EMS/State Board of Nursing Liaison Committee, 1998-2002
Joint Practice Council, Chair, 1995-1996
National Interdisciplinary Steering Committee, 1993-1995
President, Secretary, 1992-1997

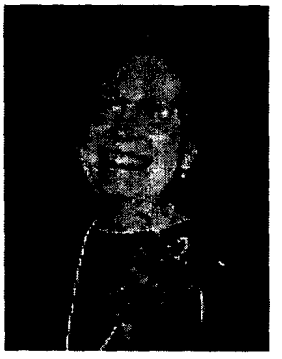
6. National League for Nursing
Sigma Theta Tau, Kappa Zeta & Omincron XI

7. Date of expiration of term: August 2001
Eligible for reappointment: Yes

8. For the past two years I have served on the Committee on Nominations, one year as a member and the other as chair. I believe my contacts with the volunteers has helped me to gain firsthand knowledge of the volunteers' competencies. In seeking candidates for the slate of officers, I kept at the helm the mission and strategic initiatives of the organization. (We) The National Council is involved in initiatives that needs the expertise of the many talented members. My initiative is aimed at supporting individuals in their decisions to seek office.

Committee on Nominations: Area IV

1. **Judith Godsey-Wehnau, New Jersey, Area IV**



2. Board Member, New Jersey Board of Nursing

3.

4. Widener University, Nursing Administration, MSN, 1991
   Thomas Jefferson University, College of Allied Health Sciences, Nursing, BSN, 1979

5. New Jersey Board of Nursing
   - Regulatory Review Task Force, 1999
   - Professional Practice Committee, 1998-present

   Home Health Assembly of New Jersey
   - Board Member, 1993-1999
   - Nominating Committee, 1998-present
   - By-Laws Committee, 1995
   - Finance Committee, 1993-present

   Southern New Jersey Perinatal Cooperative
   - Finance Committee, 1993-present

6. American Nurses Association
   New Jersey State Nurses Association
   Sigma Theta Tau
   Delta Rho Chapter

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

8. I bring to the National Council twenty years of nursing experience, first as a burn nurse and then as a nurse in community and home health care. The last eleven years have been in nursing administration as a Director of Professional Services, Executive Director, and President & CEO. I have been responsible for new agency start-up; development of policies and standards; regulatory reviews, state; federal and JCAHO surveys; and budget and finance management. I have collaborated with nursing educators to provide clinical experiences for students and to support the transition of nurses, both new graduates and experienced nurses, to home care. One of my major strengths is my strong organizational skills which is combined with a commitment to the advancement of safe nursing practice through continuing competency based education. I believe it is imperative that the National Council continue to focus on multistate licensure and regulatory outcomes over the next two years.

Committee on Nominations: Area IV

1. **Susanne M. Kelly, Pennsylvania, Area IV**

2. Vice-chair, Pennsylvania State Board of Nursing

3. D.T. Watson Rehab Hospital

4. Carnegie Mellon, Healthcare Admin., 1994-1995
   Duquesne University, Nursing, BSN, 1990
   Lilliane S. Kaufman School of Nursing, Montefiore Hospital, Nursing, Diploma, 1969

5. Pennsylvania Department of State Health Advisory Commission, 1995-1998
   Pennsylvania State Board of Nursing
   Vice-chair, 1997-present
   Delegation Committee Chair, 1995-Present
   Pennsylvania State Nurses Association
   Board of Directors, 1992-1993
   Government Relations Chair, 1990-1991
   Oregon Nurses Association
   Board of Directors, 1980-1982
   Harmarville Rehab Center
   Board Member, 1993-1996
   Joint Venture With Local Hospitals (for-profit Boards)

6. Sigma Theta Tau
   American Nurses Association
   Pennsylvania State Nurses Association
   Association of Rehabilitation Nurses
   Tristate Nursing Computer Network

7. Date of expiration of term: May 2000
   Eligible for reappointment: Yes

8. I believe this is a vital time, given National Council's strategic initiatives, for state board members to get involved at the national level. My experience on professional, regulatory and corporate boards and committees will supplement the existing expertise. In addition, my legislative and political know-how will be very useful. The three strategic initiatives focusing on changing practice settings, competence, and congruence between education and practice are priorities for protecting the public. These lead us to the need for effective regulatory outcomes and having staff and systems in place to support those initiatives. As a nurse and nurse administrator with experience in acute care, primary care, rehabilitation, long-term care and home health, the challenges of constant change and maintaining competence in any of these settings can be difficult at best. We must take every opportunity possible to assist Member Boards in regulating effectively and, where possible, consistently.

Attachment B

Composition, Election and Competencies

Composition and Election of the Board of Directors

- The Board is comprised of a president, a vice-president, a treasurer, two directors-at-large and a director from each of the four Areas.
- Directors-at-Large are elected to one-year terms, while all other Board officers are elected to two-year terms.
- The president, vice-president, and treasurer are elected in even-numbered years, and the Area directors are elected in odd-numbered years.
- A person shall have served as a delegate, a committee member or an officer prior to being elected to the office of president.
- Area directors are elected by the delegates from their respective Areas only, while all other officers are elected by the Delegate Assembly as a whole.
- A person may serve up to four consecutive years in the same officer position.
- Board officers assume duties at the close of the annual meeting at which they are elected.

Competencies for National Council's Board of Directors

- Demonstrates a commitment to the National Council and its mission.
- Has the propensity to think in terms of systems and context.
- Has the ability and eagerness to deal with values, is visionary, plans for tomorrow, thinks conceptually.
- Participates assertively in deliberations, shows moral courage to take a stand.
- Is willing to delegate, to allow others to make decisions.
- Builds meaningful internal and external relationships, and structures contact with Member Boards.
- Demonstrates self-management.

Competencies adopted 2/97 by the Board of Directors of the National Council of State Boards of Nursing, Inc.

Composition and Election of the Committee on Nominations

- The Committee on Nominations is comprised of one person from each Area.
- Committee members are elected to one-year terms.
- Each committee member is elected by the Delegate Assembly as a whole.
- Committee members shall be members or staff of Member Boards.
- Committee members assume duties at the close of the annual meeting at which they are elected.

Submitting Nominations for Office

- Nomination forms are included with multiple editions of the *Newsletter* mailed to Member Boards.
- An online nomination form is available at Member Board offices via NCNET, as well as through the Volunteer Information Program (VIP) area of the National Council's Web site. E-mail volunteer@ncsbn.org for more details.
- Additional forms are available at 312/787-6555, Ext. 161.

Competencies for National Council's Committee on Nominations

- Demonstrates commitment to the goals of the National Council by recruitment of a slate of qualified candidates.
- Conducts the business of the committee in an equitable, fair manner.
- Demonstrates accountability to the Delegate Assembly.
- Demonstrates collaboration, risk-taking and effective communication skills.
- Articulates the value of participation in the National Council.
- Enhances cooperative relationships with Member Boards in carrying out the committee's charge.

Competencies adopted 11/97 by the Committee on Nominations of the National Council of State Boards of Nursing, Inc.

Attachment C

Instructions for Using the Computerized Voting System

IMPORTANT: If you are unfamiliar with using a mouse, or have never worked with Windows or a Macintosh, please set aside time to meet Craig Moore in the on-site National Council office for a demonstration prior to the elections.

During the week, a laptop computer will be available at the registration desk for practice purposes. *All* delegates are strongly encouraged to practice prior to Saturday morning.

To vote, you will need your voting card. Be sure to bring it with you.

Step One: Check In

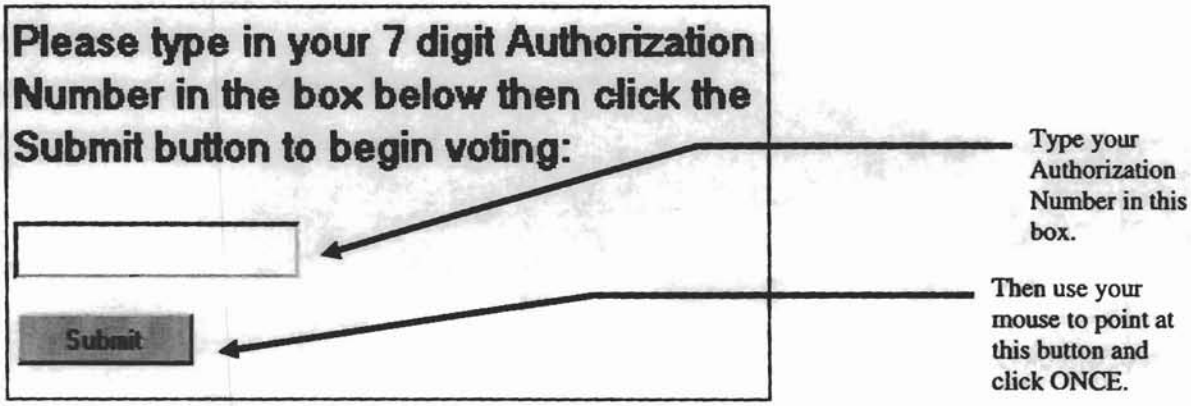
When you arrive at the voting area Saturday morning, proceed to your Area representative for check in. Upon inspection of your credentials, you will be given a color-coded slip of paper containing a voting Authorization Number. The computer program uses this secret number to prevent vote tampering and ensure accuracy of the system. The Authorization Number is given to you at random. There is no link between your number and your identity. The ballot you cast is authorized, yet anonymous.

IMPORTANT: Each Authorization Number is good for only ONE ballot. The computer is programmed to enforce this rule. If you are eligible for more than one vote, you must receive more than one Authorization Number. Contact an election official if you have questions regarding this.

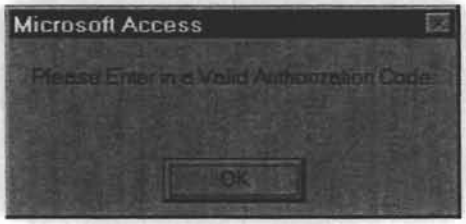
Once you have your Authorization Number(s), you will be escorted to a voting terminal to cast your ballot(s).

Step Two: The Voting Terminal

At the voting terminal, you will see the opening screen:

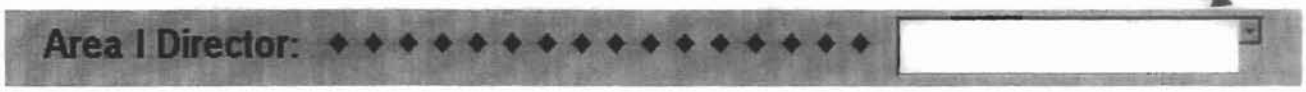


If you enter an invalid number, the system will not let you continue. You will see the following pop-up box:



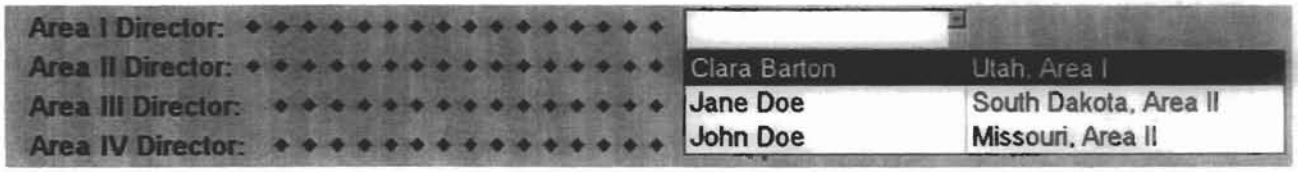
If you entered a valid Authorization Number, then the Official Ballot screen will appear automatically. Here is a portion of that screen:

Click ONCE on this arrow to see the candidates names.



Once you click the arrow, you will see the name, Area and jurisdiction of each candidate. The candidates are listed in the order published in this *Business Book* and as nominated from the floor:

Once the drop-down list of names appears, simply move the mouse up or down to highlight your choice, then click ONCE to select your candidate.



Once you click to select a candidate, you may move on to the next office OR click the arrow again to re-visit your choice. *Make sure to vote for all offices you wish.* Once your ballot is complete, you may click the Finish Voting button to cast your vote:

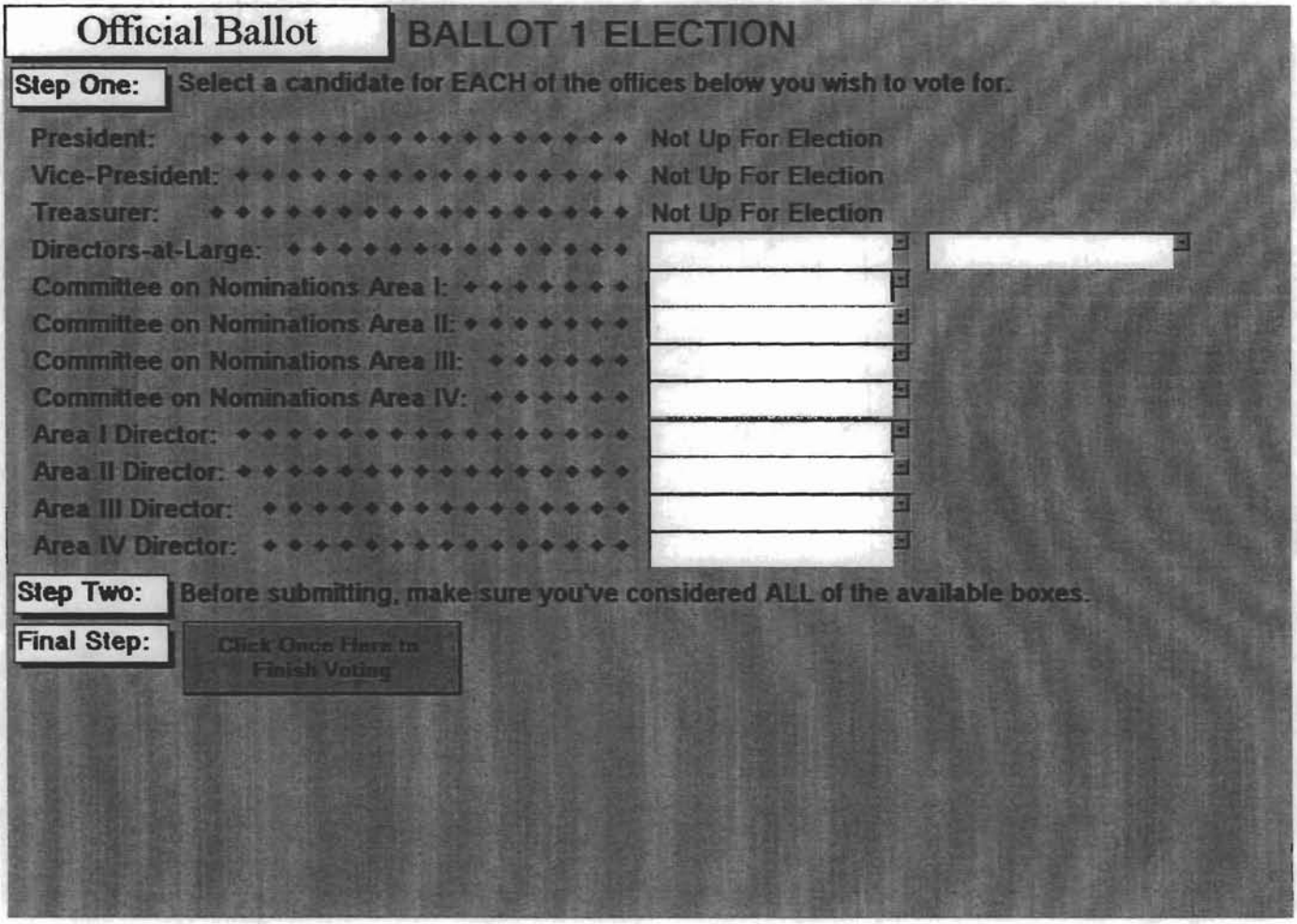
Step Three: Check Out

Proceed to the table by the exit door to check out and RETURN YOUR AUTHORIZATION NUMBER.

YOU'RE DONE!

Attachment D

Sample Ballot



Report of the President

Joey Ridenour, MN, RN; President
Executive Director, Arizona State Board of Nursing

On behalf of the Board of Directors and staff of the National Council, it is my privilege to welcome you to the 21st Annual Meeting of the National Council of State Boards of Nursing. I encourage you to listen, probe, debate and become engaged in National Council's most pressing issues and in the various activities that will take place during this year's meeting.

As evidenced by the reports in the 1999 *Business Book* and the agenda outlined for the week, volunteers and staff members of National Council have had both a challenging and productive year. Twenty-five committees and special task forces, involving 134 volunteers have accomplished the work outlined in this *Business Book* (see the list behind the Board of Directors' report, Tab 6, page 9). Each of you is valued for your hard work, knowledge and commitment to making a difference in regulation.

Members of the Board of Directors spent countless hours in preparing for and participating in approximately 13 Board Meetings (including meetings by telephone conference), Area Meetings, Leadership Retreats and have represented National Council at approximately 25 meetings and activities of other organizations. Their commitment to National Council's mission, their courage to ask the difficult questions and to carefully assess the issues have helped preclude problems, and have allowed the National Council to seize opportunities.

We are delighted to have recruited Eloise Cathcart as the third Executive Director for National Council during its 21st year. Eloise's leadership skills and expertise have already made a mark on National Council, and I am confident she will continue to be an innovative leader as we enter the new millennium. During the past four months, Eloise and I have conducted liaison meetings with major organizations such as the American Organization of Operating Room Nurses, Division of Nursing of the Department of Health & Human Services, U. S. Public Health Services, the American Nurses Credentialing Center, and the American Nurses Association. We have also had the pleasure of meeting with the Executive Officers and staff in our visits to six boards of nursing—Colorado, Louisiana (both the RN and PN boards), Minnesota, New York and Ohio. We value these Member Board visits for the opportunity they offer to keep communication open, to identify areas of common interest and concern, and to clarify information.

As President of the National Council, representing the organization, I have also been a speaker at several meetings—the American Nurses Credentialing Center Institute for Research Education & Consultation (IREC) Omni Conference, National Council's Continued Competence Roundtable, and the Council of Licensure & Enforcement & Regulation (CLEAR) National Summit on State Regulation of Health Professions in the 21st Century. Beyond sharing viewpoints of nursing regulation, meetings such as these foster the dialogue important for continuing collaboration.

The National Council's Strategic Plan adopted by the Delegate Assembly in 1998 has innovative learning as its foundation and has been the organizing framework for the Board's work during and between meetings. At this meeting, there will be opportunities to make decisions about several strategic initiatives. I strongly believe innovative learning must replace maintenance learning (seeking to preserve the status quo) and shock learning (reacting to changes without planning) for those of us who wish to be leaders in regulation. Some ways in which the principles of innovative learning have been put into practice over the last 12 months are:

1. Anticipation: being active and imaginative rather than passive and habitual in the way we offer the next generation of entry-level nurse licensure testing.
2. Learning to listen to others: recognizing patterns and using synthesis in identifying new concepts such as the regulatory outcomes project.
3. Participation: shaping events rather than being shaped by them through development of strategies such as the mutual recognition master plan for nursing regulation.
4. New Information Systems: having decisions based on organized information systems that lead boards of nursing to ask the right questions and to systematically integrate information into their decision making, such as Nur*sys*.

I am proud of our accomplishments reported in this *Business Book* and it has been a pleasure to reflect on the work of this forward-looking and successful organization. Although we have found a number of challenges, I am convinced that our strength lies in unified, coordinated action to be able to advance optimal health outcomes by leading in health care regulation across all boundaries. I also want to congratulate the states that now have the interstate compact signed into law—Arkansas, Maryland and Utah and those near adoption as we go to print—North Carolina, Texas and Wisconsin.

I hope you will join me in focusing on National Council's mission *"to lead in nursing regulation by assisting Member Boards, collectively and individually, to promote safe and effective nursing practice in the interest of protecting the public"* as we conduct the business of this year's Delegate Assembly. Together, we will innovate regulation for the new millennium.

Report of the Board of Directors

Board Members
Joey Ridenour, AZ, President
Margaret Howard, NJ, Vice-President
Barbara Morvant, LA-RN, Treasurer
Dorothy Fulton, AK, Area I Director
Lorinda Inman, IA, Area II Director
Julia Gould, GA-RN, Area III Director
Anna Yoder, MA, Area IV Director
Kathy Apple, NV, Director-at-Large
Cindy VanWingerden, VI, Director-at-Large

Staff
Eloise B. Cathcart, MSN, RN, *Executive Director*

During the course of the past year, the Board of Directors has overseen the implementation of the Strategic Plan which was adopted by the 1998 Delegate Assembly. Attachment A of this report highlights the achievements that were made toward the plan's stated outcomes. Attachment B recognizes the many individuals who have participated in accomplishing the strategic initiatives of the National Council over the past year. Attachment C is a summary of the 1998 Delegate Assembly actions and subsequent implementation. In addition, the Board of Directors makes the following recommendations to the 1999 Delegate Assembly.

Recommendations to the Delegate Assembly

1. **That the Auditor's report be adopted.** ***(A copy of the audit can be found behind Tab 8, page 9.)***

Rationale

The Board of Directors engages an audit firm to conduct an annual review of financial records of the National Council. As a part of its fiduciary responsibility to the Member Boards, the Board, in concert with the Finance Committee, reviews this report and directs staff to respond to concerns raised in the management letter. The Board recommends the acceptance of this audit in acknowledgment of its accountability to the delegates and in the interest of maintaining open communication about the financial status of the National Council.

Fiscal Impact

None.

2. **That National Council discontinue development activities related to computerized clinical simulation testing (CST®) being considered as a possible component of the NCLEX-RN® examination.**

Rationale

At its May 1999 meeting, the Board of Directors reviewed comprehensive information from multiple sources about the CST project. Based on its careful consideration of reports from the Finance Committee, Examination Committee, and CST Task Force, and its evaluation of the organization's fiscal resources and program priorities, the Board of Directors determined that the most responsible and prudent action was to suspend CST project activities and to bring the question of the future of CST to the Delegate Assembly for a decision at this time. This Board action is not inconsistent with last year's Delegate Assembly direction to continue the CST pilot study and bring a report back to the Delegate Assembly *no later* than August 2000.

On the basis of its review of the issues addressed in the Finance Committee, Examination Committee, and CST Task Force reports (provided to the Board in May 1999), the Board of Directors believes that ample evidence has been developed to suggest that it is not viable for the National Council to implement CST, as it has been operationalized, as a potential component of the NCLEX-RN examination. Also, based on the committee reports, its consideration of Member Board concerns raised at the Area Meetings, and its fiduciary responsibility to the organization, the Board of Directors believes that the appropriate action which provides for the best

stewardship of organizational resources would be to end the CST project and discontinue investing National Council resources in CST at this time.

Copies of the Finance Committee, Examination Committee, and CST Task Force reports that were referenced by the Board of Directors at its May 1999 meeting can be found behind Tab 3, starting on page 5.

Fiscal Impact

The fiscal impact for discontinuing the CST project at the 1999 Delegate Assembly is estimated to be approximately $650,000, which will be saved from the FY99 and FY00 budgets. These savings have been estimated to account for all outstanding payments to NBME and outstanding costs to discontinue the CST project. It is important to realize that these savings are related *only* to this phase of the CST pilot study project. If the CST project were to continue, additional significant fiscal resources would need to be budgeted to finance future work.

Comments on Recommendations from Standing Committees

1. The Board supports the recommendation of the Nursing Practice and Education Committee for the adoption of the proposed uniform core licensure requirements for initial licensure of RNs and LPN/VNs and supports the recommendation that states move toward incorporation of the uniform core licensure requirements at the state level.

Meeting Dates

- August 9, 1998 *(post-Delegate Assembly meeting)*
- August 27-29, 1998
- October 12-14, 1998
- November 4-5, 1998 *(fall meeting)*
- November 6, 1998 *(Board retreat)*
- February 3-5, 1999 *(winter meeting)*
- March 9, 1999 *(telephone conference call)*
- March 17, 1999 *(telephone conference call)*
- May 5-7, 1999 *(spring meeting)*
- June 2, 1999 *(telephone conference call)*
- June 24-25, 1999 *(summer meeting)*
- July 25, 1999 *(pre-Delegate Assembly meeting)*

Attachments

Attachment A

Strategic Plan Progress Report to the 1999 Annual Meeting

Highlights of Activity for Fiscal Year 1999

"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."

"The role of the National Council is to serve as a consultant, liaison, advocate, and researcher to Member Boards, and as an education and information resource to the public and policy makers."

Vision: "The National Council of State Boards of Nursing will advance optimal health outcomes by leading in health care regulation worldwide."

Strategic Initiative: 1
Nurse Competence
The National Council will assist Member Boards in their role in the evaluation of initial and ongoing nurse competence.

Outcome: 1 "State-of-the-art" entry-level nurse licensure assessment.

The Board continued its oversight of the NCLEX® examination to ensure that it remains a state-of-the-art nurse licensure assessment examination of distinction. Contractual matters with The Chauncey Group focused on development of MBOS (Member Board Operating System) as a Web-based system and quality improvement of the digital photograph. Significant improvements were made to the process of recruiting item writers and item reviewers, including capitalizing on Web technology to offer applications. Publications about the NCLEX examination were revised and widely disseminated, and efforts are underway to improve the NCLEX® Program Reports subscription publication. The Examination Committee is exploring new technology avenues for the future NCLEX examination. Proposed item types include free-text entry, numeric entry, order matching, zoning, and shading portions of graphics. Computer mouse utilization is necessary to enable any of the new item types, and the Examination Committee approved exploration of a mouse as a candidate interface for the NCLEX examination of the future. More information will be shared during the Examination Committee's forum.

Outcome: 2 Resources to support the regulatory discipline, remediation, and alternative processes.

The most important development in this area involves the National Council assuming the agent role for Member Boards in meeting their mandate to report to the HIPDB (see Tab 10). Additionally, a name change was made to National Council's disciplinary data bank (DDB): it is now called the Disciplinary Tracking System and will be incorporated within Nursys. Data entry and monthly reports were kept on schedule throughout the year.

Outcome: 3 Approaches and resources for evaluating ongoing competence of nursing personnel.

The Continued Competence Subcommittee planned and conducted a Continued Competence Roundtable on April 30; twenty-six representatives of 20 organizations attended. Work is underway with a subgroup of the Interprofessional Workgroup on Health Professions Regulation to develop elements for an interprofessional competence model.

Strategic Initiative: 2
Regulatory Outcomes
The National Council will coordinate the identification of effective regulatory outcomes and assist Member Boards to implement and evaluate strategies for sound regulation.

Outcome: 1 An articulated relationship demonstrating the benefits of nursing regulation for the public health, safety and welfare.

The Phase I report for the Commitment to Excellence Project was completed by the Urban Institute and distributed to Member Boards. A search for external funding is underway, as is planning and work toward Phases II and III (see Tab 9).

Outcome: 2 Resources and tools to facilitate Member Boards' performance enhancement initiatives.

The support of Member Board activities continues to be a priority for the Board of Directors. In addition to planning and hosting the Area Meetings and the Annual Meeting, Resource Network funds supported activities for three boards of nursing and an orientation session was conducted for seven new Member Board executive officers.

Outcome: 3 Uniform requirements/standards for nursing regulation.

The Board received the report of the Nursing Practice and Education Committee and supports the committee's recommendation for uniform core licensure requirements for initial licensure of RNs and LPN/VNs (see Tab 11).

Outcome: 4 Educational offerings and resources for Member Boards.

The Institute for the Promotion of Regulatory Excellence Task Force planned and offered a number of educational offerings this year, including the 1999 Regulatory Day, the eight concurrent educational sessions offered in conjunction with the Annual Meeting, and two optional day-long educational programs on education and discipline issues. Other meetings included a fall leadership conference, a Continued Competence Roundtable, and numerous committee meetings.

Strategic Initiative: 3
Changing Practice Settings
The National Council will analyze the changing practice environment to assist in identifying state and national regulatory implications and to develop strategies to impact public policy.

Outcome: 1 Systematic assessment and evaluation of the environment impacting nursing practice and nursing regulation.

Over 4,100 pieces of legislation were reviewed for potential regulatory impact, with inclusion of over 870 bills from the 1999 state legislative sessions published in Policy Currents, which was distributed bi-weekly to Member Boards. The National Council participated in three national telemedicine conferences and dialogued with 10 federal agencies, particularly in regard to mutual recognition for nursing regulation.

Outcome: 2 Leadership to influence health care and regulatory policy.

The Board assures that the National Council is recognized as a leader in the areas of health care and regulatory policy. This occurs through participation in national and international conferences, widespread dissemination of publications via print and electronic media, capitalizing on national exhibiting opportunities, and conducting numerous liaison and collaborative meetings with various health care organizations. New documents are regularly added to National Council's public Web site, which receives approximately 7,000 hits per month. A major redesign of the public Web site was completed, thereby enhancing accessibility to information, providing multiple search functions, and allowing easier access to archived documents and to useful external Web resources. Advisement of the National Council is frequently sought, and the Board places great value on activities that assure National Council's leadership role in regulatory and policy issues.

Outcome: 3 Approaches and strategies to respond effectively to critical issues and trends impacting nursing regulation.

Through National Council involvement in several regulatory forums (FARB, CLEAR, IWHPR, etc.), as well as participation in meetings with major nursing organizations, the Board is able to keep abreast of initiatives that impact nursing regulation. Aided by this information, the Board exercises its responsibility to determine priorities of the work of the National Council to respond to critical issues and trends. This year, focus was given to matters such as facilitating practice across state boundaries, increasing access to safe nursing care by advanced practice registered nurses, and exploring the use of technology to enhance the processes of nursing regulation.

Outcome: 4 Implementation of the mutual recognition model of nursing regulation.

The Board has provided oversight to the development of this regulatory model. As of June 24, 1999, four states have signed the interstate compact into law. The Board has carefully studied several policy issues related to this innovative approach for nursing regulation.

Outcome: 5 Approaches and resources to assist Member Boards in the regulation of advanced practice registered nurses.

Under the Board's direction, the National Council has taken a leadership role in bringing together the advanced practice registered nurse (APRN) organizations to successfully collaborate on the draft APRN uniform core licensure requirements. The APRN Task Force prepared the draft Uniform Licensure/Authority to Practice Requirements for review and discussion by the membership at the Annual Meeting (see Tab 12). Additionally, the National Council received and distributed to Member Boards copies of the final report for the Family Nurse Practitioner Advanced Pharmacology Curriculum and Regulatory Criteria Project completed in September 1997.

Outcome: 6 Approaches and resources to assist Member Boards in addressing issues related to assistive personnel.

The Board continues to fully support the National Nurse Aide Assessment Program (NNAAP) by continuing its contract with Assessment Systems, Inc., (see Tab 14, page 27) and sponsoring the 10th annual Nurse Aide and UAP Conference.

Strategic Initiative: 4
Data and Databases
The National Council will provide information systems and data to facilitate regulatory decisions.

Outcome: 1 A comprehensive nurse database.

Work on development of the Nursys system continues. The Board remains very involved in the selection of vendors and continues to carefully monitor all phases of development. Information about Nursys will be presented during a forum.

Outcome: 2 An enhanced technical infrastructure between and among Member Boards, National Council and service providers.

The Board approved additional monies to purchase and provide a state-of-the-art technical infrastructure for our electronic network. All National Council PCs, including those ordered as replacements for the Member Board computers, were upgraded to Pentium and Y2K compliance. Speed and response time were improved by the installation of new servers and a higher-speed connection to the Internet. Full system-wide security was retained, and a technical backup, recovery and library system to support the entire National Council network was configured and installed.

Outcome: 3 Regulatory information for Member Boards, other governmental entities, health care organizations, health care consumers, and others.

A number of research reports were completed and reported, including aggregate statistics summarizing socio-demographic characteristics of newly licensed RNs and LPN/VNs, the 1997 Licensure and Exam Statistics, the Quarterly Job Analysis Studies, the Nurse Aide Job Analysis Study, current NCLEX-RN and NCLEX-PN passing rate statistics, and abstracts of the role delineation study and the unlicensed assistive personnel study. Updates for the 1998 Profiles of Member Boards are currently being compiled. "A Study of the Effectiveness of Nurse Disciplinary Actions by Boards of Nursing"(funded by HRSA, DHHS) was completed and distributed to Member Boards. A searchable database containing Member Board-generated e-mail surveys was placed on NCNET, and the Research Section of the public Web site was enhanced with additional information about studies, data, and other Web-based research resources.

Strategic Initiative: 5
Congruence Between Education & Practice
The National Council will assist Member Boards to evaluate and implement their role with nursing education programs to bring congruence between graduate competence and the requirements of the practice environment.

Outcome: 1 Identified employer expectations of entry-level nurses.

The Board continues to explore ways to assess and respond to employer expectations of entry-level nurses. Some joint work with JCAHO (Joint Commission on Accreditation of Healthcare Organizations) was initiated.

Outcome: 2 Collaboration among representatives of nursing education, practice and regulation.

As an example of collaboration, with the City of Hope Medical Center, a spring conference was conducted on the end-of-life care project and related educational needs. A grant from the Robert Wood Johnson Foundation funded attendance for one representative from each Member Board.

Outcome: 3 A [Delegate Assembly] position on the role of Member Boards in nursing education.

The Board received the report of the Subcommittee on Nursing Education regarding draft model standards for nursing education. Work is scheduled to continue in FY00, and input will be sought from Member Boards over the next few months.

Strategic Initiative: 6
Organizational Capacity
The National Council will have the organizational structure and capacity to lead in regulation.

Outcome: 1 A sound organizational governance and management infrastructure to advance the National Council's mission and vision.

The Board appointed a new Executive Director, and a restructuring of the National Council was implemented. Through the Finance Committee, the Board continues to monitor the finances of the organization, which continue to be strong. (Detailed information about National Council's finances will be presented during the Finance Committee Forum.) Many volunteers fully participated in the work of the National Council; there were 25 committees and task forces involving 134 volunteers. An excellent slate of candidates has been prepared by the Committee on Nominations. The Board continues to carefully monitor the evolution of the Special Services Division as a potential revenue source of the National Council.

Outcome: 2 A planning process which promotes Member Board satisfaction with National Council products and services.

The Board valued the participation of Member Boards in the Trend Analysis Study that identified health care and regulatory environment trends and issues, as well as identified implications for Member Boards and the National Council. The Board relies heavily on the results of the study to inform many of its decisions. Additionally, the President and Executive Director facilitated an open discussion time with Member Board executive officers at each Area Meeting.

Outcome: 3 Technology enhancement for regulatory activities.

A major technical initiative is the development of Nursys as a comprehensive data system to serve the expanding and complex needs of nursing regulation. Nursys will allow National Council to assume the agent role, thus facilitating the work of Member Boards to respond to federal reporting mandates.

Attachment B

1998-1999 Committees

APRN Task Force
Katherine Thomas, TX-RN, *Chair*
Nancy Allen, UT
Dale Gordon, ME
Mary Ann Rosencrans, OH

Board Staff Education Network
Patricia McKillip, KS, *Chair*
Eileen Gloor, IA
Carol Osman, NC
Dorothy Pacyna, CT
Cynthia Purvis, SC

Commitment to Excellence Project Technical Working Group
JoAnn Allison, NH
Susan Brank, CA-RN
Patrice Greenawalt, OK
Georgia Manning, AR
Jodi Power, VA
Anne Ringquist, MN
Debra Scott, NV
Bernadette Sutherland, KY
Gerry Sweeten, FL
Emmaline Woodson, MD

Committee on Nominations
Monica Collins, ME, *Chair*
Linda Roberts-Betsch, GA-RN
Barbara Stamp, OH
June Sturm-Roller, CO

Computerized Clinical Simulation Testing (CST®) Task Force
Debra Brady, NM, *Chair*
Deborah Feldman, MD
Peggy Hawkins, NE
Helen Taggart, GA-RN
Jacqueline Waggoner, IL

DDB Advisory Panel
Nancy Twigg, AZ, *Chair*
Carolyn Bryan, ND*
Kathryn Schwed, NJ
Sheree Zbylot, MS

Examination Committee
Lynn Norman, AL, *Chair*
M. Christine Alichnie, PA
Teresa Bello-Jones, CA-VN
Cora Clay, TX-VN
Madelon Cook, OR
Teofila Cruz, GU
Sheila Exstrom, NE
Rula Harb, MA
Sandra MacKenzie, MN
Carol McGuire, KY
Anita Ristau, VT
Lori Scheidt, MO

Examination Committee Item Review Subcommittee
JoAnn Allison, NH
Charlene Carafelli, OH
Jill Degregorio, RI
Nancy Durrett, VA
Analyn Frasure, ID
Jackie Murphree, AR
Thomas Neumann, WI
Mary Ellen O'Hurley, CT
Carol Parsons Miller, WV-PN
Cynthia Purvis, SC
Louise Shores, OR
Ann Shuman, CA-VN

Finance Committee
Barbara Morvant, LA-RN, *Chair*
Lanette Anderson, WV-PN
Sandra Evans, ID
Doris Nuttelman, NH
Ruth R. Stiehl, FL

Information Systems User Group
Susan Boone, OH
Shirley Brekken, MN
Michael Coleman, NC
Mark Majek, TX-RN
Milene Sower, NY

Institute for the Promotion of Regulatory Excellence Task Force

Ruth Ann Terry, CA-RN, *Chair*
Jean Fergusson, PA
Carrie Harris, FL
Margaret Kotek, MN

Mutual Recognition Interim Compact Administrators Group

Kathy Apple, NV
Iva Boardman, DE
Shirley Brekken, MN
Donna Dorsey, MD
Sandra Evans, ID
Faith Fields, AR
Marcia K. Flesner, MO
Lorinda Inman, IA
Polly Johnson, NC
Charlene Kelly, NE
Elizabeth Lund, TN
Patricia Lynch Polansky, NJ
Kimberly Nania, WI
Laura Poe, UT
Marcia Rachel, MS
Joey Ridenour, AZ
Mary Strange, TX-VN
Katherine Thomas, TX-RN
Diana Vander Woude, SD

Mutual Recognition Interim Compact Administrators Group Subcommittee—Rules

Faith Fields, AR
Nathan Goldman, KY
Charlene Kelly, NE
Katherine Thomas, TX-RN
Janet Walsh, AZ

Mutual Recognition Interim Compact Administrators Group Subcommittee—Structure

Iva Boardman, DE
Shirley Brekken, MN
Donna Dorsey, MD
Lorinda Inman, IA
Polly Johnson, NC
Elizabeth Lund, TN
Laura Poe, UT
Sharon Weisenbeck, KY

Mutual Recognition Discipline Work Group #2

Iva Boardman, DE
Gary Duke, CA-RN
Thania Elliott, LA-RN
Jeanne Giese, WA
Diane Glynn, KS
Judith Grybowski, VI
Sandra Johanson, KY

Mutual Recognition Master Plan Coordinating Group

Shirley Brekken, MN, *Chair*
Kathy Apple, NV (*Board liaison*)
Iva Boardman, DE
Joan Bouchard, OR*
Lorinda Inman, IA (*Board liaison*)
Elizabeth Lund, TN
Laura Poe, UT
Anna Yoder, MA (*Board liaison*)

Mutual RecognitionTrial by Distance Planning Work Group

Iva Boardman, DE
Roger Brink, NE
Bruce Douglas, CO
Howard Kramer, NC
Rene Panelli, MN
Randolph Reaves, AL

Nursing Practice & Education (NP&E) Committee

Jan Zubieni, CO, *Chair*
Nancy Bafundo, CT
Gregory Howard, AL
Kenneth Lowrance, TX-RN
Linda Seppanen, MN

NP&E Continued Competence Subcommittee

Bette Lindberg, MA, *Chair*
Cookie Bible, NV
Ann Ferguson, OK
Betty Hanna, MN

NP&E Subcommittee on Education

Helen Zsohar, UT, *Chair*
Eileen Gloor, IA
Judith Mayer, MD
Linda Roberts-Betsch, GA-RN

Phase II User Group (Nursys)
Debbie Jones, AR
Lynn Kirk-Flury, MD
Mark Majek, TX-RN
Donna Mooney, NC
Thomas Neumann, WI
Rita Thalken, NE

Policy Futures Panel
Advisory Committee for Commitment to Excellence Project
Diana Vander Woude, SD, *Chair*
Joan Bouchard, OR*
Judi Crume, AL*
Donna Dorsey, MD
Marcia Rachel, MS
Joyce Schowalter, MN

Research Advisory Panel
Mary Patricia Curtis, MS, *Chair*
Mary Jo Gorney-Moreno, CA-RN
Charlene Kelly, NE
Milene Sower, NY

Resolutions Committee
Carol Osman, NC, *Chair*
Myra Broadway, ME
Marcia K. Flesner, MO
Doris Nuttelman, NH
Valisa Saunders, HI

Trend Analysis Study Focus Group
Sandra Bane, IA
Patricia Beverage, NC
Jane Conroy, KS
Susan Davis, KY
Charlie Jones Dickson, AL
Dan Duggan, NY
Jule Hallerdin, MD
Shirlene Harris, AR
Margaret Hourigan, ME
Charles Moseley, ID
Thomas Neumann, WI
Patricia Lynch Polansky, NJ
Carol Swink, OK
Linda Todd, MS
Linda Wagner, OH

**Indicates members who served partial terms*

Attachment C

Summary of 1998 Delegate Assembly Actions and Subsequent Implementation

The 1998 Delegate Assembly adopted the following motions. Follow-up activities in response to these motions are described.

1. **Adopted the proposed revisions of the NCLEX-PN® *Test Plan.***

   The test plan was published and disseminated to Member Boards. An announcement was published in *Issues* (Volume 19, Number 3), a press release was mailed to all schools of nursing, and information was posted on the Web.

2. **Adopted a policy recommendation to Member Boards that criminal background checks be conducted on applicants for nursing licensure. This policy would be incorporated in the uniform licensure requirements and the *Model Nursing Practice Act* and *Model Nursing Administrative Rules.***

   Criminal background checks were incorporated in the proposed uniform core licensure requirements that will be considered by the 1999 Delegate Assembly. The licensure requirements section of the *Model Nursing Practice Act* and *Model Nursing Administrative Rules* will not be revised until after more work on mutual recognition is completed. Criminal background checks will be included in those sections of the models at a future date.

3. **Approved the position paper, developed by the Nursing Program Accreditation/Approval Subcommittee of the Nursing Practice and Education Committee, related to approval of nursing education programs by boards of nursing.**

   The position paper was printed and distributed to all Member Boards. A copy was placed on the National Council's Web site and an excerpt of the paper was published in *Issues.*

4. **Adopted a resolution to (1) continue to monitor the current HCFA rule-making on APRN proposals related to the states' authority to regulate; (2) communicate these HCFA proposals to Member Boards, requesting their response on practice and consumer impact; and (3) communicate the regulatory perspective directly to HCFA.**

   Monitoring of HCFA regulations related to APRNs continues. A copy of the regulations was distributed to Member Boards following the 1998 Delegate Assembly.

5. **Accepted the Auditor's Report for the period beginning October 1, 1996, through September 30, 1997.**

   The accepted Auditor's Report was published in the Annual Report.

6. **Approved revised wording to Bylaw Article VII, Section 3, to read: "The Delegate Assembly, the legislative body of the National Council, shall provide direction for the National Council through adoption of the mission, strategic initiatives and outcomes, position statements, and actions at any Annual Meeting or special session."**

   All National Council documents have been revised to so reflect the motion, including the bylaws.

7. **Adopted the new strategic initiatives and outcomes.**

   The new strategic initiatives have been published in appropriate organizational documents. The Board of Directors used the strategic initiatives and outcomes as the framework to establish the activities and to allocate the necessary organizational resources for FY99 (see page 3 in this Tab).

8. **Adopted the recommendation that the National Council continue with the research and development of computerized clinical simulation testing as a component of the NCLEX-RN® examination with a final report to the Delegate Assembly no later than 2000.**

   Research and development have actively continued. A recommendation is being presented to the 1999 Delegate Assembly for consideration. (In addition to the Board's report behind Tab 6, more information about CST® can be found behind Tabs 3, 13 and 14.)

9. **Adopted a motion to endorse the practice that nursing personnel clearly display on their employment identification badges their licensing credential in order to protect the public's right to know the licensure status of nursing care personnel.**

   The motion was published in the news release identifying the actions of the 1998 Delegate Assembly and also published in *Issues.*

10. **Reaffirmed the National Council's commitment to continue dialogue with professional consumer organizations to address concerns about mutual recognition through the interstate compact.**

    The National Council participated in multiple national and federal activities to collaborate and build coalitions in relation to mutual recognition.

Notes

Notes

Forum: Business Opportunities

Thursday, July 29
11:00 a.m. – 12:00 p.m.
CLOSED SESSION

Friday, July 30
3:00 p.m. – 4:00 p.m.
CLOSED SESSION

Saturday, July 31
2:00 p.m. – 5:00 p.m.
CLOSED SESSION

What is a closed session?
A ***Closed Session*** at National Council's Annual Meeting is defined as a session that is open to delegates and Member Board representatives only. Facilitators will staff the entrances to the meeting room to assure that only authorized meeting attendees are permitted inside.

Information regarding these closed sessions was mailed to Member Boards in June and is not included in this publication.

All delegates and Member Board representatives are strongly encouraged to attend every closed session.

Notes

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Notes

Notes

Forum: Finance Committee

Report of the Finance Committee

Committee Members

Barbara Morvant, LA-RN, Area III, *Treasurer and Chair*
Lanette Anderson, WV-PN, Area II
Sandra Evans, ID, Area I
Doris Nuttelman, NH, Area IV
Ruth Stiehl, FL, Area III

Staff

Eloise Cathcart, MSN, RN, *Executive Director (beginning January 1999)*
Jennifer Bosma, PhD, CAE, *Executive Director (until November 1998)*
Thomas Vicek, MBA, CPA, *Director of Administrative Services*

Relationship to Strategic Plan

Strategic Initiative 6.....*The National Council will have the organizational structure and capacity to lead in regulation.*
Outcome 1.....*Maintain a sound resource management system for the National Council.*

Recommendations to the Board of Directors

1. **Made recommendations regarding the fiscal impact of proposed activities.**

2. **Recommended the initial FY99 operating and capital expenditure budgets and several mid-year budget adjustments. (Copy of operating budget is Attachment A.)**

3. **Recommended that the Special Services Division (SSD) be continued as it is presently structured with no additional infusion of capital until the Delegate Assembly evaluation in 2000.**

4. **Recommended the CST® project be discontinued without completion of the pilot study.**

Highlights of Activities

- Reviewed quarterly financial statements and recommended their approval to the Board of Directors.

- Reviewed the FY99 operating and capital expenditure budget requests and recommended their approval to the Board of Directors.

- Assumed SSD financial oversight responsibility from Board of Directors and monitored activities on a project-by-project basis.

- Reviewed the current status and financial projections for the CST project.

- Reviewed and analyzed several large Nur*sys* and mutual recognition expenditures.

- Met with the auditors from Ernst & Young, and reviewed the audited fiscal 1999 financial statements (Attachment B) and management letter.

- Monitored insurance coverage, the candidate projection study, all expenditures over $15,000 and all financial policies. Met with investment consultant on a quarterly basis to monitor investment performance.

Meeting Dates

- August 19, 1998
- October 16, 1998
- January 26, 1999
- May 4, 1999
- June 23, 1999

Attachments

Attachment A

FY99 Budget by Organization Plan, Strategic Initiatives and Outcomes

FY99 Budget

Strategic Initiative #1: The National Council will assist Member Boards in their role in the evaluation of initial and ongoing nurse competence.

1. "State-of-the-art" entry-level nurse licensure assessment.

NCLEX® Examination Revenue	(15,207,300)
Salaries, Benefits, & Taxes	1,142,945
NCLEX Examination Processing Costs	10,775,500
Other Direct Expenses	896,555
Allocation of Administrative Costs	323,593
Total	***(2,068,707)***

2. Resources to support the regulatory discipline, remediation, and alternative processes.

All Other Revenue	(2,000)
Salaries, Benefits, & Taxes	96,947
Other Direct Expenses	19,885
Allocation of Administrative Costs	30,061
Total	***144,893***

3. Approaches and resources for evaluating ongoing competence of nursing personnel.

Salaries, Benefits, & Taxes	65,930
Other Direct Expenses	31,360
Allocation of Administrative Costs	21,157
Total	***118,447***
Strategic Initiative #1: TOTAL	***(1,805,367)***

Strategic Initiative #2: The National Council will coordinate the identification of effective regulatory outcomes and assist Member Boards to implement and evaluate strategies for sound regulation.

1. An articulated relationship demonstrating the benefits of nursing regulation for the public health, safety and welfare.

Salaries, Benefits, & Taxes	120,259
Professional/Contractual	168,991
Other Direct Expenses	25,910
Allocation of Administrative Costs	39,805
Total	***354,965***

	FY99 Budget
2. Resources and tools to facilitate Member Boards' performance enhancement initiatives.	
Meetings Revenue	(146,692)
Salaries, Benefits, & Taxes	103,837
Other Direct Expenses	277,745
Allocation of Administrative Costs	32,657
Total	***267,547***
3. Uniform requirements/standards for nursing regulation.	
Salaries, Benefits, & Taxes	8,827
Other Direct Expenses	16,680
Allocation of Administrative Costs	2,851
Total	***28,358***
4. Educational offerings and resources for Member Boards.	
Salaries, Benefits, & Taxes	55,192
Other Direct Expenses	16,330
Allocation of Administrative Costs	17,390
Total	***88,912***
Strategic Initiative #2: TOTAL	***739,783***

Strategic Initiative #3: The National Council will analyze the changing practice environment to assist in identifying state and national regulatory implications and to develop strategies to impact public policy.

1. Systematic assessment and evaluation of the environment impacting nursing practice and nursing regulation.	
Salaries, Benefits, & Taxes	4,414
Other Direct Expenses	45,597
Allocation of Administrative Costs	21,188
Total	***71,199***
2. Leadership to influence health care and regulatory policy.	
Publications/Multimedia Revenue	(140,540)
Salaries, Benefits, & Taxes	262,986
Other Direct Expenses	345,550
Allocation of Administrative Costs	84,376
Total	***552,372***
3. Approaches and strategies to respond effectively to critical issues and trends impacting nursing regulation.	
Salaries, Benefits, & Taxes	39,312
Other Direct Expenses	14,050
Allocation of Administrative Costs	12,719
Total	***66,081***

FY99 Budget

4. Implementation of the mutual recognition model of nursing regulation.

Salaries, Benefits, & Taxes	303,497
Other Direct Expenses	237,310
Allocation of Administrative Costs	98,187
Total	***638,994***

5. Approaches and resources to assist Member Boards in the regulation of advanced practice registered nurses.

Salaries, Benefits, & Taxes	29,950
Other Direct Expenses	68,005
Allocation of Administrative Costs	9,530
Total	***107,485***

6. Approaches and resources to assist Member Boards in addressing issues related to assistive personnel.

Royalty Revenue	*(326,000)*
Salaries, Benefits, & Taxes	6,484
Other Direct Expenses	24,620
Allocation of Administrative Costs	2,159
Total	***(292,737)***
Strategic Initiative #3: TOTAL	***1,143,395***

Strategic Initiative #4: The National Council will provide information systems and data to facilitate regulatory decisions.

1. A comprehensive nurse database.

Nur*sys* Revenue	0
Salaries, Benefits, & Taxes	227,102
Nur*sys* Direct Expenses	965,583
Allocation of Administrative Costs	98,178
Total	***1,290,863***

2. An enhanced technical infrastructure between and among Member Boards, National Council and service providers.

Salaries, Benefits, & Taxes	88,381
Other Direct Expenses	16,863
Telephone & Communications	110,000
Equipment Maintenance & Rental	56,000
Allocation of Administrative Costs	28,413
Total	***299,657***

FY99 Budget

3. Regulatory information for Member Boards, other governmental entities, health care organizations, health care consumers, and others.

Salaries, Benefits, & Taxes	246,165
Other Direct Expenses	60,747
Allocation of Administrative Costs	77,904
Total	***384,816***
Strategic Initiative #4: TOTAL	***1,975,336***

Strategic Initiative #5: The National Council will assist Member Boards to evaluate and implement their role with nursing education programs to bring congruence between graduate competence and the requirements of the practice environment.

1.Identified employer expectations of entry-level nurses.

Salaries, Benefits, & Taxes	20,234
Other Direct Expenses	12,240
Allocation of Administrative Costs	6,461
Total	***38,935***

2. Collaboration among representatives of nursing education, practice and regulation.

Salaries, Benefits, & Taxes	9,402
Other Direct Expenses	24,050
Allocation of Administrative Costs	3,055
Total	***36,507***

3. A Delegate Assembly position on the role of Member Boards in nursing education.

Salaries, Benefits, & Taxes	42,511
Allocation of Administrative Costs	13,548
Total	***56,059***
Strategic Initiative #5: TOTAL	***131,500***

FY99 Budget

Strategic Initiative #6: The National Council will have the organizational structure and capacity to lead in regulation.

1. A sound organizational governance and management infrastructure to advance the National Council's mission and vision.

Special Services Division Revenue	(1,119,347)
Investment Revenue	(526,000)
Membership Revenue	(183,000)
Salaries, Benefits, & Taxes	1,211,390
Other Direct Expenses	1,025,831
Allocation of Administrative Costs	331,510
Total	***740,384***

2. A planning process which promotes Member Board satisfaction with National Council products and services.

Salaries, Benefits, & Taxes	48,447
Other Direct Expenses	111,955
Allocation of Administrative Costs	15,424
Total	***175,826***

3. Technology enhancement for regulatory activities.

Salaries, Benefits, & Taxes	5,203
Other Direct Expenses	0
Allocation of Administrative Costs	1,742
Total	***6,945***
Strategic Initiative #6: TOTAL	***923,155***
Total organization contingency fund	***120,000***
Grand total strategic initiatives #1 - #6 plus contingency fund	***3,227,802***

SUMMARY

Total Revenue	($17,650,879)
Less: Total Expenditures	$20,878,681
Net (Revenue)/Expenditures	$3,227,802

Planned Deficit Budget

The FY99 deficit was planned for as early as 1992, when the candidate fee for FY94 through FY99 was set. Significant surpluses were planned for in the early years of that period, so that normally increased costs in the later years could be provided for. Further, the need for surpluses in the early years of the FY94 through FY99 period to offset deficits in the later years of that period increased as the number of NCLEX® examination candidates decreased and the National Council took on additional projects such as Nur*sys* and mutual recognition for nursing regulation.

The National Council is projected to return to annual operating surpluses in FY00 through FY02 as a result of the additional revenue generated by that period's candidate fee, which was set by the 1997 Delegate Assembly.

Attachment B

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 statements of financial position of National Council of State Boards of Nursing, Inc. as of September 30, 1998 and 1997, and the related statements of activities and cash flows for the years 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 audits.

We conducted our audits 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 audits provide 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, 1998 and 1997, the changes in its net assets, and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Ernst & Young, LLP
December 4, 1999

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

	September 30	
	1998	**1997**
Assets		
Current assets:		
Cash and cash equivalents	**$ 1,157,623**	$ 1,471,674
Accounts receivable	**495,740**	576,731
Examination fees due from Member Boards	**–**	236,880
Accrued interest, prepaid expenses, and other	**528,931**	418,509
Total current assets	**2,182,294**	2,703,794
Investments, at fair value	**11,932,040**	12,538,020
Cash held for others	**475,334**	349,441
Property and equipment:		
Furniture, fixtures, and leasehold improvements	**259,998**	259,998
Equipment and computer software	**2,956,582**	1,464,172
	3,216,580	1,724,170
Less: Accumulated depreciation	**(1,547,218)**	(1,257,202)
	1,669,362	466,968
Total assets	**$16,259,030**	$16,058,223
Liabilities and net assets		
Current liabilities:		
Accounts payable	**$ 2,419,578**	$ 1,957,859
Accrued salaries and payroll taxes	**502,063**	376,384
Total current liabilities	**2,921,641**	2,334,243
Deferred revenue – Examination fees collected in advance (net of prepaid processing fees of $3,413,782 in 1998 and $2,894,408 in 1997)	**1,431,586**	1,213,784
Liability for cash held for others	**475,334**	349,441
Unrestricted net assets:		
Board-designated	**1,336,991**	2,231,629
Other	**10,093,478**	9,929,126
	11,430,469	12,160,755
Total liabilities and net assets	**$16,259,030**	$16,058,223

See notes to financial statements.

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

	Year ended September 30	
	1998	**1997**
Revenues		
Examination fees	**$14,780,259**	$15,539,538
Grant revenue	**7,632**	265,124
Net investment income	**1,439,168**	1,509,123
Membership fees	**183,000**	183,000
Royalty revenue	**450,000**	450,000
Other income	**566,225**	505,309
	17,426,284	18,452,094
Expenses		
Program services:		
Licensure and credentialing	**12,837,865**	13,351,611
Nursing practice	**373,129**	261,075
Nursing education	**161,766**	85,941
Information	**1,899,701**	1,586,835
Special services division	**514,338**	546,354
Organizational	**917,778**	679,148
Total program services	**16,704,577**	16,510,964
Supporting services:		
Management and general	**1,451,993**	1,253,205
Total supporting services	**1,451,993**	1,253,205
Total expenses	**18,156,570**	17,764,169
Increase (decrease) in unrestricted net assets	**(730,286)**	687,925
Net assets, beginning of year	**12,160,755**	11,472,830
Net assets, end of year	**$11,430,469**	$12,160,755

See notes to financial statements.

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

	Year ended September 30	
	1998	**1997**
Operating activities		
Increase (decrease) in net assets	**$ (730,286)**	$ 687,925
Adjustments to reconcile revenue increase in net assets to net cash provided by operating activities:		
Depreciation	**290,017**	207,512
Realized and unrealized gain on investments	**(692,566)**	(701,157)
Changes in operating assets and liabilities:		
Accounts receivable and examination fees due from Member Boards	**317,871**	106,734
Accrued interest, prepaid expenses, inventories, and other	**(206,548)**	219,258
Accounts payable	**587,612**	(307,629)
Accrued salaries and payroll taxes	**125,679**	38,869
Deferred revenue, net	**217,802**	151,918
Net cash provided by (used in) operating activities	**(90,419)**	403,430
Investing activities		
Decrease in investments, net	**1,268,778**	294,501
Net additions to property and equipment	**(1,492,410)**	(241,298)
Net cash provided by (used in) investing activities	**(223,632)**	53,203
Increase (decrease) in cash and cash equivalents	**(314,051)**	456,633
Cash and cash equivalents at beginning of year	**1,471,674**	1,015,041
Cash and cash equivalents at end of year	**$1,157,623**	$1,471,674

See notes to financial statements.

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

September 30, 1998 and 1997

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

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 the expenses 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 was fully received by January 31, 1997. Of this amount, the National Council received $137,145 in fiscal year 1997.

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 $229,904 and $223,555 for the years ended September 30, 1998 and 1997, respectively.

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 a computerized clinical simulation testing (CST®), nursing information system (Nur*sys*), 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, 1998 and 1997:

	1998		1997	
	Cost	Market Value	Cost	Market Value
U.S. government and government-backed obligations	$ 3,851,287	$ 4,368,180	$ 5,735,648	$ 5,680,327
Corporate securities	5,436,939	5,656,399	5,112,028	5,572,246
Other	1,554,919	1,907,461	1,044,893	1,285,447
	$10,843,145	$11,932,040	$11,892,569	$12,538,020

Net investment income consists of the following for the years ended September 30, 1998 and 1997:

	1998	1997
	Unrestricted	Unrestricted
Dividends and interest	$ 746,602	$ 807,966
Net realized and unrealized gains	692,566	701,157
Total net investment income	$1,439,168	$1,509,123

4. Commitments

The National Council leases office space under an operating lease arrangement and subleases storage space under an operating sublease agreement.

Future noncancelable rental commitments as of September 30, 1998, are as follows:

1999	**$300,177**
2000	**304,409**
2001	**308,754**
2002	**314,934**
2003 and thereafter	**510,803**

Rent expense for 1998 and 1997 under these leases was $293,520 and $257,664, respectively.

5. Year 2000 Computer Conversion (Unaudited)

The National Council, along with most organizations, has determined that it will be required to modify or replace certain portions of its software so that its computer systems will function properly with respect to dates in the year 2000 and thereafter. The National Council will utilize both internal and external resources to replace and test the software of Year 2000 modifications. The estimated cost of the project will be funded through operating cash flows and is not expected to have a material effect on the results of operations.

Notes

Notes

Forum: Commitment to Excellence Project

Commitment to Public Protection Through Excellence in Nursing Regulation Project

Advisory Committee Members
Diana Vander Woude, SD, Area II, *Chair*
Joan Bouchard, OR, Area I
Donna Dorsey, MD, Area IV
Marcia Rachel, MS, Area III
Joyce Schowalter, MN, Area II

Technical Working Group
JoAnn Allison, NH, Area IV
Susan Brank, CA-RN, Area I
Patrice Greenawalt, OK, Area III
Georgia Manning, AR, Area III
Jodi Power, VA, Area III
Anne Ringquist, MN, Area II
Debra Scott, NV, Area I
Bernadette Southerland, KY, Area III
Gerry Sweeten, FL, Area III
Emmaline Woodson, MD, Area IV

Staff
Carolyn J. Yocom, PhD, RN, FAAN, *Director of Research Services*

Relationship to Strategic Plan
Strategic Initiative 2.....*The National Council will coordinate the identification of effective regulatory outcomes and assist Member Boards to implement and evaluate strategies for sound regulation.*
Outcome 1.....*An articulated relationship demonstrating the benefits of nursing regulation for the public health, safety and welfare.*

Background
Initiated in March 1998, the ultimate goal of this project is to establish the processes essential for providing boards of nursing with the necessary, ongoing support and assistance that will permit them to strengthen the quality of the regulatory services they provide in support of their mandate to protect the public's health and safety. This three-phase project is directed towards the development of a performance measurement system that incorporates data collection from internal and external sources and the use of benchmarking strategies and best practices identification. It is anticipated that it will facilitate ongoing performance outcome evaluation and its incorporation within boards' strategic planning and quality improvement processes.

Project Description
The first phase of the project, which was completed in December 1998, focused on validation of the expected roles/functions of an effective nursing regulatory board based on the perspectives of multiple stakeholders (e.g., consumers of nursing services, employers, educators, nurses, legislators, etc.). The objectives of the second and third phases of this 30-month project are to develop: (1) a set of feasible procedures that individual boards can use regularly (at least annually) to track their performance; (2) a process for obtaining comparable annual data on board performance, especially service outcomes, that enable comparisons to be made across states and that can be used to identify best practices that other state boards can adapt as appropriate; and (3) an educational component for boards

of nursing that focuses on the complementary nature of performance outcome measurement and strategic planning activities.

The project is being implemented with the expert assistance of the Urban Institute. The Institute is a nonprofit policy research organization established in Washington, D.C., in 1968 to investigate social and economic problems confronting the U.S. and the government policies and programs designed to alleviate them. Through its work, the Institute has become nationally known and respected as an objective and nonpartisan source of information and analysis for informed policy deliberation and debate. The Institute's objectives are to sharpen thinking about societal problems and efforts to solve them, improve government decisions and their implementation, and increase citizen's awareness about important public choices. Through work that includes broad conceptual studies, program evaluations and administrative and technical assistance, Institute researchers and consultants make data and findings available to the public and to public officials concerned with formulating and implementing more efficient and effective government policy. Senior-level staff members working on the project are Elaine Morley, Harry Hatry and Randall Bovbjerg.

Two volunteer groups, the Advisory Committee and the Technical Working Group, have active roles in this project. The roles of the *Advisory Committee* are to:

- Select Technical Working Group participants and pilot states.
- Select replacements for the above, if needed; and select additional participants for either group, as appropriate.
- Provide guidance regarding structure and roles of the Technical Working Group.
- Review and provide feedback on key draft materials (e.g., indicators and their definitions).
- Develop an approval process for the final selection of indicators and data collection procedures to be used in Phase Three, for across-board comparative data collection and analysis activities.
- Communicate with Member Boards about the project and solicit their cooperation and participation.

The roles of the *Technical Advisory Group* are to:

- Select a set of performance indicators (using the candidate indicators developed during Phase One as a starting point) for which data will be collected by states participating in Phase Three. The selected indicators will include outcome, output and efficiency indicators.
- Identify "breakout categories" by which indicator data should be disaggregated and reported to enhance their usefulness. For example, indicators related to licensing may be broken out by type of license, such as initial licensure, renewal, or endorsement; indicators related to complaint handling or discipline may be broken out by type/severity of complaint.
- Identify explanatory factors for which information should be collected to provide potential explanations for variations in indicator data among boards. Examples of potential explanatory factors include: board structure, number of staff, number of licensees, average length of nursing experience of licensees.
- Develop clear definitions for each indicator, breakout category and explanatory factor to facilitate accurate provision of data by individual Member Boards and consistency of data submitted across boards.
- Establish data collection procedures for indicators, particularly those for which data are not routinely collected, to facilitate accurate provision of data by individual boards and consistency of data submitted across boards. The group will identify stakeholder groups to be surveyed and the questions to be included in surveys.

Phase One: March 1998 – December 1998

Phase One focused on identification of the distinct roles and responsibilities of a board of nursing and, secondly, the identification of "candidate" performance indicators. This was accomplished by gathering and analyzing input provided by representatives of multiple stakeholders obtained from focus groups, individual interviews and a review of governmental and secondary source documents. Participants included representatives of boards of nursing (members and staff), employers, nurses (LPN/VNs, RNs and APRNs), consumers of nursing services, nurse educators, representatives of LPN/VN and RN nursing organizations, and representatives of executive and legislative branches of government.

There was little disagreement among participants regarding what should be the appropriate roles for boards of nursing. Those most widely accepted were:

- Establishing/interpreting the legal scope of practice of various levels of licensees
- Issuing licenses to qualified individuals

- Assessing/ensuring continued competency of nurses
- Investigating complaints against licensees and imposing appropriate discipline
- Establishing rehabilitation options, as an alternative to disciplinary action, for impaired licensees
- Communicating with/informing constituencies: nurses, employers and the general public

While there was substantial support for board of nursing involvement in regulation/approval of nursing education programs, there was lack of agreement on the degree of involvement. Additional suggested board roles included:

- Expanding their regulatory scope to cover additional nursing personnel, i.e., assistive personnel
- Establishing a regulatory or quasi-regulatory relationship with nurse employers
- Acquiring, analyzing and disseminating information related to nursing and health care (i.e., information about the environment in which nurses practice and patient outcome of nursing care)

Another key outcome of Phase One was the identification of a set of "candidate" performance indicators, including output, outcome and efficiency indicators for use as a starting point for Phase Two of the project.

Phase Two: January 1999 – September 1999

Starting with the "candidate" performance indicators, data collection procedures, and breakout categories identified in Phase One, the Technical Working Group will select the set of performance indicators to be pilot tested, and develop comprehensive definitions for each data element needed to generate those performance indicators. This will encompass a variety of data including: physical outputs, "intermediate" outcomes, "end" outcomes, and indicators of efficiency based on inputs and processes used. Their deliberations will yield four things: (a) identification of a series of outcome and efficiency indicators; (b) initial suggestions as to the data sources, and for performance indicators for which data are not currently collected, suggested data collection procedures; (c) identification of breakout categories for each outcome indicator; and (d) identification of descriptive/explanatory factors (such as characteristics of the board, number of licensees in the state) for which data should be sought to promote better understanding of each state's performance data.

The objective is to select indicators and definitions that are likely to be acceptable and feasible for at least annual collection by most, if not all, Member Boards -- which then would be the basis for comparative data analysis across the boards. The findings and recommendations of the working group sessions will be disseminated to the Advisory Committee and all state boards of nursing for their review and comment. Revisions will be made to indicators or definitions based on those comments.

Phase Three: October 1999 – June 2001

Phase Three consists of three key activities: (1) a pilot test by 13 Member Boards to evaluate the feasibility of and the procedural steps involved in data collection; (2) a large-scale testing of data collection, analysis and reporting procedures; and (3) Member Board training regarding performance outcome measurement and its relationship to strategic planning activities. Each of these will be described briefly.

Pilot testing. The Advisory Committee has selected, from among volunteers, fourteen Member Boards to participate in the pilot test. The participating boards are: Kentucky, Louisiana-RN, Maryland, Missouri, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Puerto Rico, Tennessee, West Virginia-PN and Texas-RN. Each board participating in the pilot test will be asked to provide the data on each data element needed to generate the performance indicators. The National Council and Urban Institute will be responsible for developing and disseminating the data collection forms along with detailed definitions of each data element (as developed with the Technical Working Group). National Council and the Urban Institute will also be responsible for collecting that data, processing it, and analyzing it. This task will begin in October 1999 and continue for approximately six months (March 2000). Based on findings from the pilot test, the Technical Working Group, the Advisory Committee, National Council, and the Urban Institute will modify the process and document a revised set of performance indicators, their definitions, and data collection procedures to be used on a nationwide basis. This process will begin in January 2000 and be completed by April 2000.

Full trial of the data collection procedures. After data collection procedures have been finalized, the Advisory Committee and National Council will request data from all Member Boards. Boards will be provided with a revised data collection form to be completed for submission to National Council. Submission of the data will be voluntary. We do not expect that all state boards will participate, at least not in the first years of the effort. Our initial target is participation of 50 percent of the 61 state boards in this nationwide trial. The data collection, data cleaning, and data analysis will be undertaken by National Council and the Urban Institute under the guidance of the steering

committee. This task will begin in May 2000 and continue until February 2001. Data cleaning and preliminary data analysis will begin during October 2000 and continue through May 2001. The final report will be completed during June 2001.

Member Board Education. The Urban Institute and National Council will provide, using a "train-the-trainer" approach, training in performance measurement and strategic planning procedures. The purpose is to train persons who will subsequently be available to train and/or assist individual state boards of nursing in these activities. The focus of the training will be both on the technical procedures and on ways in which the information can be used by state boards of nursing. Initial training will be held in approximately August or September 2000.

Forum Presentation

During the 1999 Annual Meeting forum, information will be provided regarding the current status of the project, types and examples of performance indicators to be included in the pilot study and examples of data reports and their potential usage. An opportunity will also be provided for questions.

Forum: Agent Role

HIPDB/NPDB Agent Role Forum - Background

The National Council of State Boards of Nursing has explored the feasibility of serving as the reporting agent for Member Boards to both the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB). Having the National Council as an agent would mean that states could continue to report to the DDB without interfacing directly with the federal agencies. The National Council would serve as a conduit so that the appropriate information is sent on to the federal data bank, but would also be authorized (through individual contractual agreements with each Member Board) to use the information in the National Council's new nurse license information system, Nursys.

To facilitate implementation, the agent role was divided into three parts:

a) Historical (legacy) reporting to the HIPDB and NPDB – *historical data is information about discipline actions taken since the legislation that created the HIPDB (August 1996) and the official opening of the NPDB (January 1992) to the present.*

b) Ongoing reporting to the HIPDB and NPDB – *ongoing reporting refers to the mandatory reporting required of all licensing boards that will begin with the opening of the HIPDB (current projected opening date is October 1, 1999).*

c) Query service for the HIPDB and NPDB – *licensing boards will be authorized to submit queries, or inquiries, about individuals to both the HIPDB and NPDB, for a fee. Queries may be done either directly by the authorized entity or through an authorized agent.*

In June 1999, Member Boards received a request from the Health Resources and Services Administration (HRSA) to select a time schedule for reporting historical data to the HIPDB/NPDB. During a subsequent conference call, the National Council Board of Directors determined that the National Council would be available to serve as an agent for reporting historical data (legacy reports) for boards of nursing.

On June 25, 1999, the Board of Directors met with Dr. Vivian Chen of the Health Resources and Services Administration. At that time:

- The Board reaffirmed that national council will serve as an agent to assist Member Boards in reporting historical (legacy) data. **The reporting of historical data will be a benefit of membership with no additional cost to Member Boards.** Staff and legal counsel were directed to develop an agreement between National Council and Member Boards to address historical data reporting. The agreement will be sent out for Member Board review and signing immediately after the 1999 Annual Meeting.

- The Board continues to explore the feasibility of serving as the ongoing agent for Member Boards reporting to the HIPDB/NPDB. Staff was directed to prepare an implementation plan, to include detailed fiscal (including possible charges to Member Boards), legal, policy, technical and human resources impact for the Board's use in making a decision regarding the ongoing agent role. The Boards will also address at that time whether national council will be an agent just for licensed nurses, or will also be an agent for other categories of personnel regulated by boards of nursing (e.g., nurse aides, psychiatric technicians).

- The options provided on the HRSA notice pertain to what time span of data is planned to be reported in preparation for HIPDB
  - ⇒ OPTION 1 is the data required for HIPDB (August 21, 1996, forward)
  - ⇒ OPTION 2 is the data required for HIPDB and NPDB (January 1992 forward)

  The National Council can support either option.

- The following timeline will assist Member Boards in anticipating activities related to the HIPDB:
  - ⇒ July 1, 1999 – requested notification date for how boards plan to report historical data (choice of option)

- ⇒ Mid-July – distribution of registration packets (to include an information book, background legislation, instructions for certification as a reporting entity, how to designate an agent for reporting and/or querying)
- ⇒ August 30, 1999 – **final date** for submitting to HRSA plans for reporting historical data
- ⇒ October 1, 1999 – **final date** submitting historical data using the NPDB elements

Electronic reporting to the HIPDB and NPDB will be required. National Council will continue to accept written reports for the time being. National Council's goal is also an all-electronic system. Member Boards should anticipate the future implementation of all electronic reporting. This date is under consideration but has not been selected.

In June 1999, *Legacy Reports* containing each Member Board's historical data from January 1992 were sent to all Member Boards to assist them in reviewing the individuals previously reported to the Disciplinary Data Bank (DDB). In addition to identifying missing historical reports, this also provides an opportunity to assure completeness, accuracy, and currency of data for Nu*rsys*.

The current DDB reporting screens include most of the NPDB elements. The advantage to member Boards to met the earlier reporting dates is the ability to provide HIPDB historical reports using NPDB elements. HIPDB historical reports submitted after October 1, 1999, would be expected to provide all HIPDB elements.

Attachments

*Following Attachment A are a number of documents prepared by Dr. Vivian Chen and HRSA staff and distributed to the National Council Board of Directors on June 25, 1999.

Attachment A

Comparison of Elements
Current NPDB and Expected HIPDB Elements

NPDB Mandatory Reporting Elements	Expected Mandatory Reporting Elements for HIPDB
▪ Practitioner name	▪ Practitioner name
▪ ----------	▪ Organization name
▪ ----------	▪ Organization type
▪ Work address	▪ Home address/Address of record
▪ Date of birth	▪ Date of birth
▪ ----------	▪ Social Security number
▪ Professional school attended and year of graduation	▪ Name of <u>each</u> professional school attended and year of graduation
▪ License number, field of licensure, name of State/Territory which issued the license	▪ License number, field of licensure, name of State/Territory which issued the license
▪ Description of acts or omissions or other reasons for action taken	▪ Description of the acts or omissions or other reasons for the action taken
▪ Description of the action	▪ Basis for Action Code
▪ Date of action	▪ Date actions was taken
▪ Effective date	▪ Effective date
▪ Duration	▪ Length
▪ ----------	▪ Amount of any monetary penalty
▪ ----------	▪ Whether the action is on appeal
▪ Classification of the action in accordance with a reporting code adopted by the secretary	▪ Classification of the action in accordance with a reporting code adopted by the secretary
▪ Gender	▪ Gender
▪ ----------	▪ Occupation
▪ ----------	▪ National Provider Identifier (NPI) (when issued by HCFA)
▪ ----------	▪ If deceased, date of death
▪ ----------	▪ If action is based on professional competence conduct
▪ Name of program/agency that took the adverse action	▪ Name of program/agency that took the adverse action
▪ ----------	▪ Physician specialty
Permissive Elements for NPDB	**Permissive Elements for HIPDB**
▪ Other name used	▪ Other name(s) used
▪ Home address	▪ Other addresses (work, etc.)
▪ Social Security number	▪ (see above)
▪ Organization name	▪ (see above)
▪ DEA#	▪ Federal license, certification or registration number(s), such as a DEA registration number and Medicare provider number
▪ ----------	▪ Federal Employer Identification Number (for individuals who possess one)
▪ ----------	▪ Date of appeal
▪ ----------	▪ If deceased
▪ ----------	▪ Name(s) of any health care entity in which the subject is affiliated or associated
▪ ----------	▪ Address of each associated or affiliated health entity
▪ ----------	▪ Nature of subject's relationship with each associated or affiliated health care entity
▪ ----------	▪ Authorized Agent ID#
▪ ----------	▪ Is subject automatically reinstated after adverse action is completed Y/N

Mandatory elements must be reported to NPDB/HIPDB; Permissive elements may be reported to NPDB/HIPDB.

Comparison of Elements
Current NPDB and Expected HIPDB Elements

Both NPDB and HIPDB require the following reporting entity information:

- Name and address of the reporting entity and the name of the agency taking action
- The name, title and telephone number of the responsible official submitting the report on behalf of the reporting entity

NPDB requires also requires additional reporting entity information (HIPDB will probably have similar fields)

- Data Bank ID (would be assigned)
- Type of Report (initial report, correction or addition, revision to action, or void previous report)
- Type of Adverse Action (would be licensure action)

For ongoing reporting, Member Boards will be expected to submit ONLY ONE REPORT to HRSA. That report must contain all mandatory fields for both the NPDB and HIPDB. The reports should also contain available information for the permissive fields for each data bank. The data bank vendor will be responsible for distributing information appropriately.

The following information was prepared by Dr. Vivian Chen and HRSA staff and distributed to the National Council Board of Directors on June 25, 1999.

National Council of
State Boards of Nursing

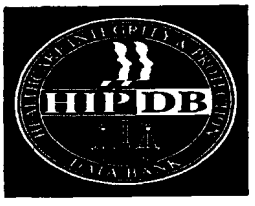
June 25, 1999

Vivian Chen, Sc.D., M.S.W.

DIVISION OF QUALITY ASSURANCE

- *Health Care Quality Improvement Act*
- *1921 of the Social Security Act (section 5 of MMPPPA)*
- *1128E of the Social Security Act (section 221 of HIPAA)*

Healthcare Integrity and Protection Data Bank



Health Insurance Portability and Accountability Act (P.L. 104- 191)

Final Adverse Actions that will be Reported

This does not include settlements in which no findings of liability have been made.

- HEALTH RELATED CRIMINAL CONVICTIONS
- HEALTH RELATED CIVIL JUDGMENTS
- EXCLUSION FROM FEDERAL OR STATE HEALTH CARE PROGRAMS
- OTHER ADJUDICATED ACTIONS

Health Insurance Portability and Accountability Act (P.L. 104- 191)

Final Adverse Actions that will be Reported

- LICENSING AND CERTIFICATION ACTIONS
  - *The actual loss of a license, right to apply, or renew a license*
  - *Revocation or Suspension (Length of the Action)*
  - *Reprimand or Censure*
  - *Probation*
  - *Voluntary Surrender*

[1128E and Section 5 Requirements]

Health Insurance Portability and Accountability Act (P.L. 104- 191)

Mandated Data Elements

- SUBJECT'S NAME
- SUBJECT'S TAX IDENTIFICATION NUMBER (TIN)
- NAME OF ANY HEALTH CARE ENTITIES ASSOCIATED WITH THE SUBJECT
- NATURE AND STATUS
- BASIS (INCLUDING A DESCRIPTION OF ACTS OR OMISSIONS AND INJURIES)
- OTHER INFORMATION DEFINED

Health Insurance Portability and Accountability Act (P.L. 104- 191)

Who will be Reported?

- Health Care Providers
- Health Care Suppliers
- Health Care Practitioners

Health Insurance Portability and Accountability Act (P.L. 104- 191)

Who can Query?

- Federal and State Government Agencies
- Health Plans
- Health Providers, suppliers and practitioners (self-query only)

Health Insurance Portability and Accountability Act (P.L. 104- 191)

Other Important Provisions

- Reporter's corrections Disclosure
- User Fees
- Civil Liability Protection
- NPDB Coordination

Health Insurance Portability and Accountability Act (P.L. 104- 191)

Other Important Provisions (continued)

- *Protection of Privacy*
- *Regular reports*
- *Dispute Procedures*

HIPDB STATUS

- STATUTORY REQUIREMENTS
- NPRM COMMENTS
  - 117 COMMENTS
  - FINAL RULE
- NEW MANDATORY REPORTING REQUIREMENTS

HIPDB STATUS (CONT.)

- SYSTEMS REQUIREMENTS
  - INTERNET AND BROWSER
  - ELECTRONIC PAYMENTS
  - SINGLE REPORTING AND QUERYING (IQRS)
- USE OF AUTHORIZED AGENTS
- PROPOSED SCHEDULE

Authorized Agents

- Must Be Registered
- Entity Must Authorize the Agent
- Important Provisions
  - Confidentiality
  - Liability
- Entity Retains Responsibility to Report
- Payment Options

REFERENCE SITES

- WEBSITES:
- www.hrsa.dhhs.gov/bhpr/dqa
- www.npdb.com
- www.npdb-hipdb.com (after 7/1/99)
- HELPLINE: 1 800 767-6732
  (1 800 SOS-NPDB)

NPDB/HIPDB DIFFERENCES

- LICENSURE
  - NPDB Physicians/Dentists
  - HIPDB All licensed practitioners, providers and suppliers
- CLINICAL PRIVILEGES
  - NPDB ONLY

NPDB/HIPDB DIFFERENCES

- MEDICAL MALPRACTICE PAYMENTS
  - NPDB ONLY
- PROFESSIONAL SOCIETY MEMBERSHIP
  - NPDB ONLY

NPDB/HIPDB DIFFERENCES

- CRIMINAL CONVICTIONS AND CIVIL JUDGMENTS
  - HIPDB ONLY
- OTHER ADJUDICATED ACTIONS
  - HIPDB ONLY

NPDB/HIPDB DIFFERENCES

- MEDICARE/MEDICAID EXCLUSIONS

NPDB-ALL LICENSED PRACTITIONERS

HIPDB - ALL LICENSED PRACTITIONERS, PROVIDERS AND SUPPLIERS

NPDB/HIPDB DIFFERENCES

- PENALTIES

NPDB - CMP up to $11,000/instance
(Reporting and/or Violation of Confidentiality provisions)

HIPDB - CMP up to $25,000/instance
Publication of Name for failure

NPDB AT A GLANCE

The National Practitioner Data Bank (NPDB) is a central repository of information on physicians, dentists, and, in some cases, other health care practitioners. It contains reports of medical malpractice payments, adverse licensure actions, adverse clinical privilege actions, and adverse professional society membership actions. Information reported to the NPDB is available to hospitals, other health care entities that provide health care services and have a formal peer review process, professional societies, State licensing boards, Plaintiff's attorneys and [illegible] plaintiffs or plaintiffs representing themselves under limited circumstances, researchers (statistical data only), and health care practitioners (self-query only).

Section 5 (b) of the *Medicare and Medicaid Patient and Program Protection Act of 1987, as amended by the Omnibus Budget Reconciliation Act of 1990* (Section 1921 of the Social Security Act), was enacted to provide protection to program beneficiaries from unfit health care practitioners and to improve the anti-fraud provisions of the Medicare and State health care programs. Section 1921 requires each State to adopt a system of reporting certain adverse licensure actions and any negative action or finding that a State licensing authority, peer review organization, or private accreditation entity has concluded against a health care practitioner or health care entity. Section 5 also permits additional entities, such as agencies administering Federal health care programs, State agencies administering or supervising State health care programs, State Medicaid fraud control units, utilization and quality control peer review organizations, and certain law enforcement officials access to Section 5 data through the NPDB.

HIPDB AT A GLANCE

The Healthcare Integrity and Protection Data Bank (HIPDB) is a national health care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions taken against health care providers, suppliers, or practitioners. It contains the following types of information: (1) civil judgments against a health care provider, supplier, or practitioner in Federal or State courts related to the delivery of a health care item or service; (2) Federal or State criminal convictions against a health care provider, supplier, or practitioner related to the delivery of a health care item or service; (3) actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, or practitioners; (4) exclusion of a health care provider, supplier, or practitioner from participation in Federal or State health care programs; and (5) any other adjudicated actions or decisions that the Secretary establishes by regulations. Information reported to the HIPDB is available to Federal and State government agencies, health plans, researchers (statistical data only), and health care providers, suppliers, and practitioners (self-query only).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration
National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

NPDB/HIPDB LEGISLATIVE COMPARISON CHART

TITLE IV

The National Practitioner Data Bank was established under title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986.*

♦ WHO REPORTS?

- ❑ Medical malpractice payers
- ❑ Boards of Medical/Dental Examiners
- ❑ Hospitals
- ❑ Other health care entities
- ❑ Professional societies with formal peer review

♦ WHAT INFORMATION IS AVAILABLE?

- ❑ Medical malpractice payments (all health care practitioners)
- ❑ Adverse licensure actions (physicians/dentists)
  - -- revocation, suspension, reprimand, censure probation, surrender
- ❑ Adverse clinical privilege actions (physicians/dentists)
- ❑ Adverse professional society membership actions (physicians/dentists)

♦ WHO CAN QUERY?

- ❑ Hospitals
- ❑ Other health care entities
- ❑ Professional societies with formal peer review
- ❑ Boards of Medical/Dental Examiners/Other health care practitioner State licensing boards
- ❑ Plaintiff's attorney/pro se plaintiff/plaintiffs representing themselves (limited circumstances)
- ❑ Health care practitioners (self-query)
- ❑ Researchers (statistical data only)

SECTION 1921 4/1/99

Section 1921 of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1990.

♦ WHO REPORTS?

- ❑ Health care practitioner State licensing boards
- ❑ Health care entity State licensing boards
- ❑ Peer Review Organizations
- ❑ Private Accreditation Organizations

♦ WHAT INFORMATION IS AVAILABLE?

- ❑ Any adverse licensure actions (practitioners/entities)
  - -- revocation, reprimand, suspension (including length), censure, probation
  - -- any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction
  - -- any other loss of the license
- ❑ Any negative action or finding that a State licensing authority, peer review organization, or private accreditation organization has concluded against a health care practitioner or entity

♦ WHO CAN QUERY?

- ❑ Hospitals and other health care entities (Title IV)
- ❑ Health care practitioner/entity licensing boards
- ❑ Agencies administering Federal health care programs, or their contractors
- ❑ State agencies administering State health care programs
- ❑ State Medicaid fraud control units
- ❑ Peer Review Organizations
- ❑ U.S. Comptroller General
- ❑ U.S. Attorney General and other law enforcement officials
- ❑ Health care practitioners/entities (self-query)
- ❑ Researchers (statistical data only)

SECTION 1128E

The Healthcare Integrity and Protection Data Bank was established under section 1128E of the Social Security Act.

♦ WHO REPORTS?

- ❑ Federal and State Government agencies
- ❑ Health plans

♦ WHAT INFORMATION IS AVAILABLE?

- ❑ Licensing and certification actions (practitioners, providers, and suppliers)
  - -- revocation, reprimand, suspension (including length), censure, probation
  - -- any other loss of license, or right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by voluntary surrender, non-renewability, or otherwise
  - -- any other negative action or finding by a Federal or State licensing and certification agency that is publicly available information
- ❑ Civil judgments (practitioners, providers, and suppliers)
- ❑ Criminal convictions (practitioners, providers, and suppliers)
- ❑ Exclusions from Federal or State health care programs (practitioners, providers, and suppliers)
- ❑ Other adjudicated actions or decisions (practitioners, providers, and suppliers)

♦ WHO CAN QUERY?

- ❑ Federal and State Government agencies
- ❑ Health plans
- ❑ Health care practitioners/providers/suppliers (self-query)
- ❑ Researchers (statistical data only)

COMPARISON OF TITLE IV, SECTION 1921, AND 1128E BASIC REQUIREMENTS

WHO REPORTS?

TITLE IV
National Practitioner Data Bank

- Medical malpractice payers
- Boards of Medical/Dental Examiners, Other State Licensing Boards
- Professional Societies with formal peer review
- Hospitals and Health Care Entities

SECTION 1921 (Social Security Act)

- Health Care Professional State Licensing Boards
- Entity State Licensing Boards
- Peer Review Organizations/ Private Accreditation Entity

1128E (FADC)

- Government Agency
  -Dept. of Justice
  -DHHS
  -Any other Federal Agency that administers or provides payment of health care
  -State law enforcement agencies
  -State Medicaid fraud control units
  -Federal/State agencies responsible for licensure/certification of health care providers, suppliers and practitioners
- Health Plans

WHAT INFORMATION?

TITLE IV
National Practitioner Data Bank

- Medical malpractice payments
- Adverse Licensure actions (physicians/dentists)
  -revocation - suspension
  -reprimand - censure
  -probation - surrender
- Adverse clinical privilege action (physicians/dentists)
- Adverse professional society membership actions (physicians/dentists)

SECTION 1921 (Social Security Act)

- Any adverse action, including:
  -revocation
  -suspension (and length)
  -reprimand
  -censure
  -probation
- Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction
- Any other loss of the license of the practitioner or entity
- Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity

1128E (FADC)

- Licensing and certification actions taken against health care providers, suppliers, and practitioners, including
  -revocation -reprimand
  -censure -probation
  -suspension (length)
- Any other loss of license, or right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by voluntary surrender, non-renewability, or otherwise
- Any other negative action or finding by such Federal or State agency that is publicly available information
- Civil judgments
- Criminal convictions
- Exclusion from Fed. or State health care program
- Other adjudicated action or decision

WHO CAN QUERY?

TITLE IV
National Practitioner Data Bank

- Hospitals
- Other Health Care Entities
- Plaintiff's Attorney
- Practitioner (self query)
- Researcher
- Boards of Medical/Dental Examiners/Other Health Care Practitioner State Licensing Boards

SECTION 1921 (Social Security Act)

- Health Care Practitioner State Licensing Boards
- Health Care Entity State Licensing Boards
- Agencies Administering Federal Health Care Programs
- Certain Peer Review Organizations
- State Agencies Administering State Health Care Programs
- State Medicaid Fraud Units
- Hospitals and Other Health Care Entities (Title IV)
- U.S. Comptroller General
- U.S. Attorney General and Other Law Enforcement
- Health Care Practitioners (self-query
- Health Care Entities (self-query)

1128E (FADC)

- Federal and State Government Agencies
- Health Plans
- Health Care Provider (self query)
- Health Care Supplier (self query)
- Health Care Practitioner (self query)

MANDATORY ELEMENTS for ADVERSE ACTION REPORT

May 4,1999

Italicized elements are NEW elements for NPDB

Section A. Registered Reporting Authority
Reporting entity Name and Address
Data Bank ID
Password
Type of Report

Section B. Subject Identification
Type of Subject

B1. Individual Subjects
Name; home address or address or record
City; State; ZIP code; Country, if not USA
Organization Name
Type of Organization
Sex
Date of birth
If deceased the Date of Death
Occupation/Field of Licensure
State License Number
State(s) of Licensure
Physician Specialty
Professional School Attended
Graduation Year
Social Security Number(s) —
National Provider Identifier (when available)

B2. Organization Subject
Organization Name
Business Address; City; State; ZIP; Country, if not USA
Taxpayer Identification Number(s)
Type of Organization
State License Number
State of Licensure
Do you provide health care services and follow a formal peer review process?
National Provider Number (when available)

Section C. Adverse Action or Finding Information
Type of Adverse Action *New Codes*
Name of Program/Agency that took the Adverse Action
Adverse Action Classification Code (from a list)
Basis for Action Classification (NPDB collected this only the coding system has changed)

Date Action was taken
Date Action became Effective
Length of Action
Total Amount of Monetary Penalty, Fine and/or Restitution
Narrative Description of Act(s) or Omission(s) or other Reasons for Action
Is this Action based on the subject's professional competence or conduct, which adversely affected or could have affects the health or welfare of a patient.
Action on Appeal; Date of Appeal

C2. Negative Finding Information
Type of Negative Finding
Negative finding classification code (from a list)
Basis for finding classification (from a list)
Date of finding
Name of program/Agency that authorized the PRO review
Narrative description of Act(s) or Omission(s) or other reason that led to the finding.

Section D. Reporting Entity Certification
Name of authorized submitter
Title of authorized submitter
Telephone Number
Signature date

NPDB DIFFERENCES

Organization Name
  Mandatory (it was optional)
Sex
  Name of field changed from Gender to Sex (remains mandatory)
Work Address
  Optional (it was mandatory)
Home Address
  Mandatory (title of field changed to Home Address/Address of Record)
  (Home address was optional)
Social Security Number
  Mandatory (it was optional)

OPTIONAL DATA ELEMENTS

Section A. Registered Reporting Authority
Authorized Agent Identification Number

B1. Individual Subjects
Other Name(s) Used

Other Address; City; State; ZIP; Country, if not USA
Deceased
Federal Employer Identification Number(s) FEIN
Drug Enforcement Administration (DEA) Number(s)
Unique Physician Identification Number(s) (UPIN)
Medicare Provider/Supplier Identification Number(s)
Medicaid Provider Identification Number(s) State(s)
Name of Health Care Entity with which subject is Affiliated/Associated
Address of Affiliate/Associate; City; State; Zip; Country, if not USA
Nature of Subject's Relationship to Affiliate/Associate

B2. Organization Subject
Other Organization Name(s) Used
Other Address Used; City; State; ZIP; Country, if not USA
Name(s) and title(s) of Principal Officer(s) and Owner(s)
Drug Enforcement Administration (DEA) Number(s)
Unique Physician Identification Number(s) (UPIN)
Medicare Provider/Supplier Identification Number(s)
Medicaid Provider Identification Number(s) State(s)
Name of Health Care Entity with which subject is Affiliated/Associated
Address of Affiliate/Associate; City; State; Zip; Country, if not USA
Nature of Subject's Relationship to Affiliate/Associate

Section C. Adverse Action or Finding Information
Is subject automatically reinstated after Adverse Action period is completed?

Comparison of NPDB (current) and HIPDB Reporting Requirements

Type of Action	NPDB	HIPDB
Licensure	Physicians/Dentists	All licensed health care practitioners, providers, suppliers
Clinical Privileges (including panel membership)	Physicians/Dentists Voluntary reporting on other licensed practitioners	Not collected
Professional Society Membership	Physicians/Dentists Voluntary reporting on other licensed practitioners	Not collected
Medicare/Medicaid Exclusions	All licensed practitioners	All licensed practitioners, providers, suppliers
Medical Malpractice Payments	All licensed practitioners	Not collected
Criminal Convictions (health care related)	Not collected	All licensed practitioners, providers, suppliers
Civil Judgments (health care related)	Not collected (except malpractice)	All licensed practitioners, providers, suppliers
Other Adjudicated Actions (health care related)	Not collected	All licensed practitioners, providers, suppliers

Comparison of NPDB (current) and HIPDB Reporters and Queriers

NPDB	HIPDB
Mandated reporters:	
Medical malpractice payers	Health Plans
Hospitals	Federal Agencies
Other health care entities (including managed care)	State Agencies
State Medical and Dental Boards	
Professional Societies	
HHS Office of Inspector General (Exclusions)	
Mandated Queriers:	
Hospitals	None
Voluntary Queriers:	
Other health care entities (including managed care)	Health Plans
State Medical and Dental Boards	Federal Agencies
Other State Practitioner Licensing Boards	State Agencies
Professional Societies	

Comparison of NPDB and HIPDB Penalties

NPDB

Failure to report a medical malpractice payment	Civil money penalty of up to $11,000 for each instance
Violation of confidentiality provisions	Civil money penalty of up to $11,000 for each instance
Failure to report an adverse licensure action	After opportunity to correct, designation of another entity to report
Failure to report multiple clinical privileging or professional society actions	After opportunity to correct, potential loss of immunity

HIPDB

Health Plan	Civil money penalty of up to $25,000 for each instance
Federal Agency	Publication of name
State Agency	Publication of name

System requirements for the HIPDB

The Healthcare Integrity and Protection Data Bank (HIPDB) Web Server uses the latest in security technology along with various implementation measures to provide a secure environment for data storage and retrieval. The system is designed to ensure that only eligible users may access the Data Bank and that unauthorized access from the internet is prevented. HIPDB users must enter a username/password to login. This Data Bank Identification Number and Password are created by the contractor and are required for reporting and or querying. Each successful login to the HIPDB web site is granted a session key, which is used only during that login session. The session key expires after a period of inactivity to protect the system from users who leave their workstations unattended without logging off the system.

The following requirements are suggested to properly access the system:

- Explorer 4.0 or later or Netscape 4.0 or later
- Modem 33.6 Kb
- Pentium Processor

Fact Sheet
Healthcare Integrity and Protection Data Bank

Background

The Secretary of the U.S. Department of Health and Human Services, acting through the Office of Inspector General (OIG) and the United States Attorney General, were directed by the *Health Insurance Portability and Accountability Act of 1996*, Section 221(a), Public Law 104-191, (the Act) to create the Healthcare Integrity and Protection Data Bank (HIPDB) to combat fraud and abuse in health insurance and health care delivery. Until this time, there has not been a comprehensive source of adverse action information on health care providers, suppliers, and practitioners. The HIPDB will become operational upon the publication of the final rule (estimated to be September 1999).

Health care fraud burdens the Nation with enormous financial costs and threatens health care quality and patient safety. Estimates of annual losses due to health care fraud range from 3 to 10 percent of all health care expenditures--between $30 billion and $100 billion based on estimated 1995 expenditures of more than $1 trillion.

HIPDB at a Glance

The Healthcare Integrity and Protection Data Bank (HIPDB) is a national health care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions taken against health care providers, suppliers, or practitioners.

The HIPDB contains the following types of information:

(1) civil judgments against health care providers, suppliers, or practitioners in Federal or State court related to the delivery of a health care item or service;

(2) Federal or State criminal convictions against health care providers, suppliers, or practitioners related to the delivery of a health care item or service;

(3) actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, or practitioners;

(4) exclusions of health care providers, suppliers, or practitioners from participation in Federal or State health care programs; and

(5) any other adjudicated actions or decisions against health care providers, suppliers, or practitioners that the Secretary establishes by regulations.

Settlements in which no findings or admissions of liability have been made will

not be reported to the HIPDB.

Notice of Proposed Rulemaking

The Notice of Proposed Rulemaking (NPRM) for the HIPDB was published October 30, 1998 in the Federal Register, Volume 63, Number 210. A copy of this NPRM may be found at **www.hrsa.dhhs.gov/bhpr/dqa.** We expect the final rule to contain some changes that may affect an organization's eligibility to query and/or reporting requirements for the HIPDB.

If you register before the final rule you will be notified when the final rule is published. It is recommended that entities review the final rule before querying and reporting. Based on **statutory language**, eligible parties (*see Reporting to the HIPDB*) can begin to register now.

Interpretation of HIPDB Information

HIPDB is primarily a flagging system which may serve as an alert to users indicating that a comprehensive review of the practitioner, provider, or supplier's past actions may be prudent. The HIPDB is intended to augment, not replace, traditional forms of review and investigation, serving as an important supplement to a comprehensive and careful review of practitioner, provider, or supplier's past actions.

As a nationwide flagging system, the HIPDB provides another resource to assist Federal and State agencies, State licensing boards, and health plans in conducting extensive, independent investigations of the qualifications of the health care practitioners, providers or suppliers, whom they seek to license, hire or credential, or with whom they seek to contract or affiliate.

HIPDB information is intended for use in combination with information from other sources when making determinations on employment, contracting, certification, licensure decisions, or other affiliations. Therefore, the information in the HIPDB should serve only to alert Federal or State agencies and health plans that there **may** be a problem with a particular practitioner, provider, or supplier. HIPDB information should always be considered together with other relevant data when evaluating a healthcare practitioner, provider, or supplier.

Confidentiality of HIPDB Information

Information reported to the HIPDB is considered confidential and cannot be disclosed except as specified in the final rule. The Act requires that HIPDB information be provided and utilized in a highly proprietary manner that appropriately protects the confidentiality of the information. Persons and entities receiving information from the HIPDB, either directly or from another party, must use it solely with respect to the purpose for which it was provided.

Appropriate uses of the information include the prevention of fraud and abuse activities and improving the quality of patient care. As mandated by the Act, the HIPDB will not contain any individually identifiable patient names or records.

These same disclosure rules apply when an entity designates an Authorized Agent *(see Authorized Agent section)* to handle HIPDB queries and/or reports. In this case, both the entity and the agent are required to maintain confidentiality in accordance with the HIPDB final rule.

The Privacy Act of 1974, 5 USC 552a, as amended, protects the contents of Federal systems of records such as those contained in the HIPDB, from disclosure, unless the disclosure is for a routine use of the system of records as published annually in the *Federal Register*. The published routine uses of HIPDB information will not allow for disclosure of information to the general public.

Eligible Entities

Entities entitled to participate in the HIPDB are defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 and in the HIPDB final rule. Eligible entities are responsible for meeting specific reporting and/or querying requirements. Qualified entities must register with the HIPDB in order to query and/or report.

Eligible entities, as defined in the NPRM **include** *but are not limited to* the following:

1). Federal and State Governmental Agencies:

- Department of Justice
- Department of Health and Human Services
- Any other Federal or State agency that either administers or provides payment for the delivery of health care services, such as the Department of Defense and the Department of Veterans Affairs.
- State law enforcement agencies
- State Medicaid Fraud Control Units
- Other Federal and State agencies responsible for the licensing and certification of health care providers, practitioners, and suppliers.

2) Health Plans:

1) A policy of health insurance;
2) A contract of a service benefit organization;
3) A membership agreement with a health maintenance organization or other prepaid health plan;
4) A plan, program, agreement or other mechanism established, maintained or made available by a self insured employer or group of self insured employers, a practitioner, provider or supplier group, third party administrator, integrated health care delivery system, employee welfare association, public service group or organization or professional association; and
5) An insurance company, insurance service, or insurance organization licensed to engage in the business of selling health care insurance in a State and which is subject to State law that regulates health insurance.

Authorized Agents

An outside organization that queries and/or reports to the HIPDB on an entity's behalf is referred to as an Authorized Agent. In most cases, an Authorized Agent is an independent contractor used for centralized credentialing, such as a county medical society or Credentials Verification Organization (CVO).

Before an Authorized Agent may submit queries on behalf of an entity, the entity must designate the Authorized Agent to query the HIPDB on its behalf by completing the appropriate form and sending it to the HIPDB.

Querying the HIPDB

Eligible persons, entities, and agents may obtain information from the HIPDB by submitting a request as outlined in the informational sheet, *How to Report and Query*. The Act exempts Federal agencies from these fees.

The Act, specifies that information from the HIPDB will be available to:

- **Federal and State government agencies**
- **Health plans**
- **Health care providers, practitioners, or suppliers through a self query**

Currently there are no mandatory querying requirements associated with the HIPDB.

Examples of appropriate queries include: A managed care organization queries to inquire about a physicians assistant for affiliation in their network; a health care organization queries concerning a durable medical equipment company's record prior to purchasing wheelchairs for their nursing home facilities; an individual practitioner supplier, or provider self queries for licensure in another State.

HIPDB information *will not* be available to the general public. However, a person or entity may request aggregate information that does not identify any particular patient, health care provider, supplier or practitioner. *Examples of appropriate use of aggregate data include:* researchers use the aggregate data to identify the number of practitioners excluded from the Medicare and Medicaid programs. Similarly, a health plan uses the aggregate data to develop outcome measures in their efforts to monitor and improve quality of care.

Fees

As required by the Act, query fees will be imposed on all individuals and entities requesting information from the HIPDB, with the exception of Federal agencies.

Fees for querying the HIPDB will be based on the cost of processing requests and providing information to eligible entities and individuals. The exact amount of the fee will be published in the *Federal Register* and posted at www.npdb-hipdb.com

Reporting to HIPDB

Health plans and Federal and State governmental agencies are required to report the following reportable actions to the HIPDB.

Reports must be submitted to the HIPDB by whichever is later of the following:

- **within 30 days from the date the final adverse action was taken;**
- **by the date when the reporting entity became aware of the final adverse action; or**
- **by the close of the entity's next monthly reporting cycle, whichever is later.**

Corrections or additions must be reported within 60 calendar days of discovery. HIPDB reporters must report revisions to action or notice of appeals within 30 calendar days after the reporting entity learns of such revision or appeal.

Reportable Actions

1. Federal and State licensure or certification agencies must report final adverse actions (as described in 45 CFR Part 61) when taken against a health care provider, supplier or practitioner.

Examples of this type of report would include: revocation of a nursing license by a State Board of Nursing; voluntary surrender by an HMO of its State license; an FDA certification action against a mammography screening facility; a HCFA certification action against a clinical laboratory under the Clinical Laboratory Improvement Act (CLIA).

2. Federal and State law enforcement and investigative agencies must report criminal convictions against a health care provider, supplier or practitioner related to the delivery of a health care item or service.

Examples of this type of report would include: a criminal conviction against a physician for defrauding Medicare or a criminal conviction against a medical supply company for defrauding a State Medicaid program..

3. Federal and State law enforcement and investigative agencies and health plans must report civil judgments related to the delivery of a health care item or service (except those resulting from medical malpractice).

Examples of this type of report would include: a judgment won by a health plan against a chiropractor for false billing or a judgement in State court against a durable medical equipment supplier for falsifying claims.

4. Federal and State government agencies must report health care providers, suppliers, or practitioners excluded from participating in Federal or State health care programs.

Examples of this type of report would include: Federal exclusion from Medicare reimbursement and State exclusion from Medicaid reimbursement.

5. Federal and State governmental agencies and health plans must report other adjudicated actions or decisions related to the delivery of a health care item or service (excluding clinical privileging actions taken against health care practitioners) against a health care provider, supplier, or practitioner. *Other adjudicated actions or decisions* means a formal or official final actions:
1) taken against a health care provider, supplier, or practitioner by a Federal or State Governmental agency or a health plan;
2) which include the existence of a due process mechanism, and;
3) are based on acts or omissions that affect or could affect the delivery or payment of a health care item or service.
Possible examples of this type of report (if the above criteria were met) include: a personnel action against a nurse by a HMO, or a personnel action against a physical therapist by a Veterans hospital.

Disputing a HIPDB report

The Act provides a mechanism for those who dispute a report in the HIPDB. The dispute process will afford the subject an opportunity to bring relevant factual information, including reversals of criminal convictions by an appeals court, to the attention of the reporter. If the reporter does not revise the information within 30 calendar days, the subject of the report can request that the Secretary of HHS review the matter.

The subject of a report may dispute *only the factual accuracy* of the information contained in the HIPDB report. The Secretary will not review issues regarding the merits of the case, or the due process that the subject received.

After review, the Secretary will take an appropriate action such as remove the dispute status, correct the information, leave the information unchanged, void the report from the HIPDB, and/or add a statement to the report.

Immunity for Reporting to the HIPDB

The immunity provisions of the Act protect individuals and entities from being held liable in civil actions for reports made to the HIPDB unless they have knowledge of the falsity of the information contained in the report.

Failure to Report

Any health plan that fails to report information on an adverse action required to be reported to HIPDB shall be subject to a civil money penalty of up to $25,000 for each such adverse action not reported.

The Secretary shall provide for a publication of a public report that identifies those government agencies that have failed to report information on adverse actions as required.

Further questions?

Contact the HIPDB Help Line
1-800-767-6732
or
www. npdb-hipdb.com

The ***HIPDB Help Line staff*** and ***Web Site*** will assist users with information regarding HIPDB policies and procedures such as Electronic Funds Transfer account registration, Agent designation, and will help to answer technical questions. Assistance will also be provided for submitting complete and accurate reports or queries and entity registration.

Neither the Help Line staff nor the HIPDB Web Site will accept changes to reports or disputes; provide legal interpretations of the statute or regulations; or provide information on individual practitioners.

The Healthcare Integrity and Protection Data Bank *Help Line* is open and staffed with Information Specialists weekdays, except Federal holidays, between 8:30 a.m. and 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time.

Forum: Nursing Practice and Education Committee

Report of the Nursing Practice and Education Committee

Committee Members

Jan Zubieni, CO, Area I, *Chair*
Nancy Bafundo, CT, Area IV
Gregory Howard, AL, Area III
Kenneth Lowrance, TX-RN, Area III
Linda Seppanen, MN, Area II

Staff

Ruth Elliott, EdD, RN, *Director for Practice and Education (through April 1999)*
Vickie Sheets, JD, RN, *Director of Policy and Credentialing*

Relationship to Strategic Plan

Strategic Initiative 1 ..... *The National Council will assist Member Boards in their role in the evaluation of initial and ongoing competence.*
Outcome 2 ..... *Resources to support the regulatory discipline, remediation, and alternative processes.*
Outcome 3 ..... *Approaches and resources for evaluating ongoing competence of nursing personnel.*

Recommendations to the Delegate Assembly

1. **Adopt the proposed uniform core licensure requirements for initial licensure of RNs and LPN/VNs and recommend that states move toward incorporation of the uniform core licensure requirements at the state level.**

Rationale

While it was determined that mutual recognition could be implemented without uniform core licensure requirements, their development has continued to be a priority. Uniform core licensure requirements will promote consistency and a general understanding of the objective of nursing regulation while facilitating accessibility of care by easing nursing practice across state lines. The proposed requirements have been developed after careful study of individual state and territorial licensure requirements, delineated in information prepared for the Mutual Recognition Task Force and the publication *Profiles of Member Boards*, continuous feedback of earlier drafts and the results of a recent survey of Member Boards regarding current requirements and the rationale for those requirements.

Background

The Nursing Practice and Education (NP&E) Committee has been working for two years to develop *Uniform Core Licensure Requirements* to present for consideration by the National Council Delegate Assembly. The work has included reviewing current nursing licensure requirements, projecting future needs, presenting preliminary work at Area Meetings, and soliciting feedback regarding the work in progress. The committee also looked at how other professions approach licensure requirements.

Review of comments following last year's Annual Meeting regarding the draft requirements led the committee to question whether the draft requirements developed in 1998 needed greater specificity in some areas. Accordingly, a range of requirements was articulated for each component, from the broadest, most general approach to the most specific and restrictive, with several layers of specificity in between. A survey of Member Boards focused on the rationale for requirements and asked the question, "Why?" The work culminated in the development of a set of proposed uniform core licensure requirements for RNs and LPN/VNs. An executive summary of the requirements and a supporting paper is found under Attachment A to this report.

Highlights of Activities

- **The NP&E Committee Coordination Role**

The National Council bylaws create the Nursing Practice and Education Committee as a standing committee of the organization, comprised of at least one member from each Area. The bylaws charge the Nursing Practice and Education Committee to provide general oversight of nursing practice and education regulatory issues by coordinating related subcommittees. This year, the Nursing Practice and Education Committee has coordinated the Subcommittee on Education and the Continued Competence Subcommittee.

The NP&E Committee reviewed the draft model statutory and administrative rule language related to nursing education program approval that had been developed by the Subcommittee on Education and provided feedback regarding those rules. The subcommittee requests comments on the draft. The draft model language and a feedback form are found under Attachment B.

The NP&E Committee was closely involved in the work of the Continued Competence Subcommittee as it explored collaboration with the American Nurses Credentialing Center (ANCC) and other certifying organizations. Nursing Practice and Education Committee representatives attended the December 1998 Competence Conference sponsored by ANCC. The subcommittee's highlight of the year was the Continued Competence Roundtable held April 30, 1999, in Chicago. Twenty organizations participated in a collegial dialogue regarding the issues presented in the challenge of maintaining competence over the course of a career. Identified next steps include development of uniform language regarding competence definition, and development of survey questions to be used to solicit feedback from nurses providing direct patient care regarding competence activities. A list of roundtable participants is found under Attachment C.

The Continued Competence Subcommittee also continued development of the *Continued Competence Accountability Profile (CCAP).* CCAP information packets were distributed to Member Boards and other organizations. Those entities interested in participating in pilot implementations of CCAP were recruited to demonstrate CCAP for a variety of uses. Although many entities have expressed interest in CCAP, only four have registered as pilot projects. Those include two boards of nursing and two schools of nursing. Continued Competence Subcommittee members presented CCAP and used case studies to demonstrate its application at the 1999 Regulatory Day of Dialogue in each Area.

- **Additional NP&E Committee Activities**
  - Reviewed a variety of background articles related to nursing practice and regulation
  - Reviewed and analyzed Recommendation #10 of *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* (the second Pew Report on Health Care Workforce Regulation)
  - Reviewed the trend analysis study results with National Council's Director of Research Services
  - Provided input regarding future research projects
  - Began a discussion of the regulatory implications of systems review and individual accountability
  - Advised staff regarding content for the *1999 Dialogue on Discipline* (held in conjunction with Annual Meeting)
  - Identified topics and possible authors for the 1999 nursing practice and education edition of *Issues*

Future Activities

- Continue Nursing Practice and Education Coordination Role
- Other topics assigned by the Board of Directors

Meeting Dates

- September 28-30, 1998 *(joint meeting with subcommittees)*
- January 29-30, 1999
- May 17-18, 1999

Attachments

Attachment A

Proposed Uniform Core Licensure Requirements
Executive Summary

Professional licensure requirements assure that the individuals who are granted the authority to practice nursing have demonstrated specified educational, examination and behavioral requirements. The purpose of developing uniform core licensure requirements is to assure mobility of licensed nurses while maintaining licensure standards critical to protect the public health, safety and welfare. In light of concerns that licensure sometimes erects unnecessary barriers, National Council's Nursing Practice and Education (NP&E) Committee viewed public protection to include adequate access to nursing services. Facilitating nurse mobility assures that health care consumers have access to nursing services and that these providers are qualified according to consistent standards regardless of where in the country the consumer lives.

Committee Premises

1. It is critical to focus on what the public needs rather than what states are currently doing.
2. It is desirable to divide the huge challenge of uniform licensure requirements into manageable portions.
3. It is crucial to avoid simply choosing the least common denominator.
4. It is important to avoid redundancy in the requirements.
5. It is important that the committee has defined "core" to mean minimum and essential.
6. It is essential that Member Boards continue to be responsible for verification that individual licensure applicants meet these uniform requirements.
7. It is assumed that boards that approve the Uniform Core Licensure Requirements will accept any reasonable approach selected by a board of nursing for conducting verification of these requirements.
8. The underlying goal is to promote public safety in the least restrictive manner.

Framework for Licensure Requirements

The National Council's definition of competence is *the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the nurse's practice role, within the context of public health, welfare and safety.* The proposed *Uniform Core Licensure Requirements* are organized using the competence framework developed by the 1996 Continued Competence Subcommittee, which included the following components:

- ***Competence Development*** - the method by which a nurse gains nursing knowledge, skills and abilities
- ***Competence Assessment*** - the means by which a nurse's knowledge, skills and abilities are validated
- ***Competence Conduct*** - refers to health and conduct expectations, including assurance that licensees possess the functional abilities to perform the essential functions of the nursing role

The NP&E Committee is aware that the proposed requirements are going to cause everyone some discomfort and that the proposed uniform core licensure requirements would require legislation in most states. The committee stresses again their definition of core – the essential requirements needed for initial entry into nursing practice. The committee did not focus on what is easy for boards to do or what is the least risky for boards, but rather emphasized what was best for the public good. For those individuals chafing at giving up time-honored traditions, the committee poses a pivotal question: *Do you really think nursing is that much different, that much safer on your side of the state boundary line?* It is critical to focus on what are the minimal, essential requirements for licensure, and achieve public protection through the least restrictive means. The proposed *Uniform Core Requirements* are summarized on the following page. Please see the full paper for the rationale for the proposed requirements and a discussion of how the committee developed these recommendations.

Summary of Proposed Requirements

I. Requirements Related to Competence Development

Registered Nurses (RN)

NURSING EDUCATION –

Graduation from or verification of completion and eligibility for graduation from state-approved registered nursing program.

NURSING EDUCATION – FOREIGN-EDUCATED CANDIDATES

Graduation from nursing program comparable to U.S. state-approved RN nursing programs as verified by credentials review agency.

Licensed Practical/Vocational Nurses

NURSING EDUCATION –

Graduation from or verification of completion and eligibility for graduation from state-approved practical nursing program.

NURSING EDUCATION – FOREIGN-EDUCATED CANDIDATES

Graduation from nursing program comparable to U.S. state-approved LPN/VN nursing programs as verified by credentials review agency.

II. Requirements Related to Competence Assessment

Registered Nurses (RN)

ASSESSMENT – U.S. CANDIDATES

Nursing Knowledge, Skills and Abilities

NCLEX-RN® examination, unlimited attempts

ASSESSMENT – FOREIGN-EDUCATED CANDIDATES

Review Process

CGFNS certificate or equivalent credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English.

Nursing Knowledge, Skills and Abilities

NCLEX-RN® examination, unlimited attempts

Licensed Practical/Vocational Nurses

ASSESSMENT – U.S. CANDIDATES

Nursing Knowledge, Skills and Abilities

NCLEX-PN® examination, unlimited attempts

ASSESSMENT – FOREIGN-EDUCATED CANDIDATES – LPN/VN

Review Process

Credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English.

Nursing Knowledge, Skills and Abilities

NCLEX-PN® examination, unlimited attempts

III. Requirements Related to Competence Conduct

Registered Nurses (RN)

CRIMINAL CONVICTIONS

Self report regarding all felony convictions and all plea agreements and misdemeanor conviction of lesser-included offenses arising from felony arrests. Local/state and federal background checks using current technology (i.e., fingerprinting) to validate self-reports.

CHEMICAL DEPENDENCY

Self report regarding any drug-related behavior that affects the candidate's ability to provide safe and effective nursing care.

FUNCTIONAL ABILITIES

Self report regarding any functional ability deficit that would require accommodation to perform essential nursing functions.

Licensed Practical/Vocational Nurses

CRIMINAL CONVICTIONS

Self report regarding all felony convictions and all plea agreements and misdemeanor conviction of lesser-included offenses arising from felony arrests. Local/state and federal background checks using current technology (i.e., fingerprinting) to validate self-reports.

CHEMICAL DEPENDENCY

Self report regarding any drug-related behavior that affects the candidate's ability to provide safe and effective nursing care.

FUNCTIONAL ABILITIES

Self report regarding any functional ability deficit that would require accommodation to perform essential nursing functions.

Proposed Uniform Core Licensure Requirements
A Supporting Paper

Background

Professional licensure requirements assure that the individuals who are granted the authority to practice nursing have demonstrated specified educational, examination and behavioral requirements. National Council's Nursing Practice and Education (NP&E) Committee has been working for two years to develop *Uniform Core Licensure Requirements* to present to the National Council Delegate Assembly for consideration. The work has included reviewing current nursing licensure requirements, projecting future needs, presenting preliminary work at Area Meetings, and soliciting feedback regarding the work in progress. The committee also looked at how other professions approach licensure requirements.

The committee believes that increased consistency in licensure requirements is an appropriate direction for regulation in a rapidly shrinking world. The opportunities for sharing of information and resources via communication and travel have produced an evolution of nursing practice standards from local practices that varied greatly to standards that are much more alike than different in all the regions of the nation. A national nursing licensing examination available for all jurisdictions has been in place for years and other nursing licensure requirements can also be more consistent from state to state. Uniform requirements would be less confusing for patients, nurses, other health team members and third party payors as well as legislators and policy makers. The committee also recognizes that adoption of core licensure requirements will assist the implementation of the mutual recognition compact by diminishing concerns over disparate qualifications for licensure in compact states.

The committee defined core licensure requirements for initial entry into the nursing profession as those minimum requirements that are essential to promote public protection. The purpose of developing uniform core licensure requirements is to assure mobility of licensed nurses while maintaining licensure standards critical to protect the public health, safety and welfare. In light of concerns that licensure sometimes erects unnecessary barriers, the committee viewed public protection to include adequate access to nursing services. Facilitating nurse mobility assures that health care consumers have access to nursing services and that these providers are qualified according to consistent standards regardless of where in the country the consumer lives.

Committee Premises

1. It is critical to focus on what the public needs rather than what states are currently doing. The committee respects the history and tradition in the jurisdictions, but was prepared to propose change to promote more consistent public policy.

2. It is desirable to divide the huge challenge of uniform licensure requirements into manageable portions. The committee began with uniform core requirements for initial licensure. Once agreement is reached on initial requirements, the committee plans to move forward with uniform requirements for licensure endorsement, renewal and reinstatement.

3. It is crucial to avoid simply choosing the least common denominator. The elements selected for inclusion in the uniform core requirements must provide the most rational approach for assuring public safety as well as nurse mobility.

4. It is important to avoid redundancy in the requirements. If an element was subsumed in another requirement, the committee kept it in the latter. Examples: high school graduation and completion of nursing education programs; English proficiency and meeting requirements of the *Immigration Reform and Responsibility Act of 1996.*

5. It is important that the committee has defined "core" to mean minimum and essential. States may choose to add certain requirements for their own licenses, e.g., to meet specific social legislative mandates in a jurisdiction.

6. It is essential that Member Boards continue to be responsible for verification that individual licensure applicants meet these uniform requirements.

7. It is assumed that boards that approve the Uniform Core Licensure Requirements will accept any reasonable approach selected by a board of nursing for conducting verification of these requirements.

8. It bears repeating that the committee's underlying goal is to promote public safety in the least restrictive manner.

The National Council's definition of competence is *the application of knowledge and the interpersonal, decision-making, and psychomotor skills expected for the nurse's practice role, within the context of public health, welfare and safety.* The proposed *Uniform Core Licensure Requirements* are organized using the competence framework developed by the 1996 Continued Competence Subcommittee, which included the following components:

- ***Competence Development*** - the method by which a nurse gains nursing knowledge, skills and abilities
- ***Competence Assessment*** - the means by which a nurse's knowledge, skills and abilities are validated
- ***Competence Conduct*** - refers to health and conduct expectations, including assurance that licensees possess the functional abilities to perform the essential functions of the nursing role

Proposed Uniform Core Licensure Requirements

I. Competence Development

CORE REQUIREMENT	RATIONALE
NURSING EDUCATION – REGISTERED NURSES (RN) Graduation from or verification of completion and eligibility for graduation from state-approved registered nursing program.	*The development of nursing competence begins in formal nursing education programs. Note that preparatory requirements, such as high school graduation, are not specified in the core requirements. Many nursing programs require high school graduation or GED, so repeating the requirement at the point of licensure is redundant. For those situations when students have not graduated from high school, successful completion of a higher education program demonstrates that the licensure candidate has equivalent knowledge and skills.*
NURSING EDUCATION – LICENSED PRACTICAL/VOCATIONAL NURSES (LPN/VN) Graduation from or verification of completion and eligibility for graduation from state-approved practical nursing program.	*Nursing program completion means fulfillment of all the requirements of and to be eligible for graduation, but not necessarily to have graduated from a nursing education program approved by the board of nursing (or other governmental entity, as applicable in the school's state). This educational requirement is drafted to provide access to licensure and flexibility for those students who complete program requirements at different times of the year.* *State-approved registered nursing programs are all types of programs designed to prepare individuals for initial entry into practice and RN licensure, including diploma, associate degree, baccalaureate, generic master's and nursing doctoral programs. All state-approved nursing programs, including NY Regents for RN, 91C Army Program for LPN/VN, or other state-approved external programs, are included. Portions of RN programs (often combined with PN/VN Role Delineation/ Socialization courses) that are determined to meet the requirements for practical/vocational nursing education, and are approved by a state board of nursing, are also included.*

NURSING EDUCATION – FOREIGN-EDUCATED CANDIDATES – RN

Graduation from nursing program comparable to U.S. state-approved RN nursing programs as verified by credentials review agency.

NURSING EDUCATION – FOREIGN-EDUCATED CANDIDATES – LPN/VN

Graduation from nursing program comparable to U.S. state-approved LPN/VN nursing programs as verified by credentials review agency.

All applicants must demonstrate that they meet comparable educational requirements. The Commission on Graduates of Foreign Nursing Schools (CGFNS) (for RN) or other credential review agencies provide a more standardized and consistent review to assure that foreign education programs are comparable to U.S. state-approved RN nursing programs. Individual boards of nursing may not deal with foreign credentials on a regular basis, and may not have consistent opportunities to maintain contacts and knowledge of foreign programs.

II. Competence Assessment

CORE REQUIREMENT	RATIONALE
ASSESSMENT **U.S. CANDIDATES – RN** Nursing Knowledge, Skills and Abilities NCLEX-RN® examination, unlimited attempts	*The NCLEX-RN® examination measures the competencies needed to practice safely and effectively as a newly licensed entry-level RN. This examination is used by boards of nursing throughout the United States and its territories to assist in making licensure decisions. The NCLEX-RN examination is based on an incumbent job analysis of newly licensed entry-level RNs. This analysis addresses critical nursing activities, the frequency of performance and their impact on client safety. The job analysis is the foundation for development of a test plan that assures that each unique NCLEX-RN examination reflects the knowledge, skills and abilities essential for the registered nurse to meet the needs of clients requiring the promotion, maintenance and restoration of health. If the criterion-referenced examination functions as designed, repeat candidates will not be exposed to the same items again. The NCLEX® examination has been developed to measure entry-level knowledge. The burden is upon the candidate to pass this criterion-referenced examination, and the decision rests with the candidate to discern any need for additional education or training to prepare for the examination. Thus, unlimited attempts within NCLEX® examination policies are included in the core requirements.*

CORE REQUIREMENT	RATIONALE
ASSESSMENT **U.S. CANDIDATES – LPN/VN** Nursing Knowledge, Skills and Abilities NCLEX-PN® examination, unlimited attempts	*The NCLEX-PN® examination measures the competencies needed to practice safely and effectively as a newly licensed entry-level LPN/VN. This examination is used by boards of nursing throughout the United States and its territories to assist in making licensure decisions. The NCLEX-PN examination is based on an incumbent job analysis of newly licensed entry-level LPN/VNs. This analysis addresses critical nursing activities, the frequency of performance and their impact on client safety. The job analysis is the foundation for development of a test plan that assures that each unique NCLEX-PN examination reflects the knowledge, skills and abilities essential for the practical/vocational nurse to meet the needs of clients requiring the promotion, maintenance and restoration of health.*
ASSESSMENT – FOREIGN-EDUCATED CANDIDATES – RN Review Process CGFNS certificate or equivalent credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English.	*CGFNS provides a certification program, which includes evaluation of English proficiency, and an examination designed to predict success on the NCLEX-RN® examination. The CGFNS certificate program, which is available only for RN candidates, is well established and is currently required by 42 boards of nursing. Other agencies that provide equivalent credentialing review as well as evaluation of English proficiency may be used. These requirements are consistent with the Immigration Reform and Responsibility Act of 1996.*
Nursing Knowledge, Skills and Abilities NCLEX-RN® examination, unlimited attempts	*Same requirement as for U.S.-educated candidates.*
ASSESSMENT – FOREIGN-EDUCATED CANDIDATES – LPN/VN Review Process Credentials review that includes verification of the candidate's education, training, experience and licensure with respect to the statutory and regulatory requirements for the nursing profession, as well as oral and written competence in English.	*CGFNS does not currently provide an LPN/VN certification. Credentials review should include evaluation of English proficiency. These requirements are consistent with the Immigration Reform and Responsibility Act of 1996.*
Nursing Knowledge, Skills and Abilities NCLEX-PN® examination, unlimited attempts	*Same requirement as for U.S.-educated candidates.*

III. Competence Conduct

CORE REQUIREMENT	RATIONALE
CRIMINAL CONVICTIONS – RN and LPN/VN Self report regarding all felony convictions and all plea agreements and misdemeanor conviction of lesser-included offenses arising from felony arrests. Local/state and federal background checks using current technology (i.e., fingerprinting) to validate self-reports.	*Crimes that have a potential impact on the ability to practice a profession safely or predict how the nurse might treat vulnerable clients in his or her care should be considered as part of a licensing decision. They are indicative of that aspect of competence conduct composed of affective or behavioral elements. They may also reflect inadequate critical thinking skills and poor judgment. A felony conviction is a significant event. With the common use of plea bargains, the behavior underlying a misdemeanor should also be scrutinized on behalf of those vulnerable persons who are recipients of nursing care. It is the responsibility of the board of nursing to use the conviction history (including plea agreements) in decision making regarding competence conduct and licensure.* *The inclusion of criminal background checks as part of uniform core licensure requirements provides validation of candidate self report and is consistent with the policy recommendation by the 1998 National Council Delegate Assembly to conduct criminal background checks on candidates for nursing licensure.*
CHEMICAL DEPENDENCY – RN and LPN/VN Self report regarding any drug-related behavior that affects the candidate's ability to provide safe and effective nursing care. ***Sample Application Questions*** • *Do you currently engage in drug-related behavior including the use of mood-altering drugs/substances and/or alcohol that affect your ability to perform the essential nursing functions? Yes or No* • *Have you, in the last _____, engaged in drug-related behavior including the use of mood-altering drugs/substances and/or alcohol that affected your ability to perform the essential nursing functions? Yes or No* • *Have you, in the last _____, been the subject of a chemical dependency intervention or participated in chemical dependency treatment/ rehabilitation? Yes or No* *Please explain any yes responses.*	*Questions asked on a licensure application address whether the candidate is currently using, or in the recent past has used mood-altering drugs and substances, including alcohol, that would affect the candidate's ability to provide safe and effective nursing care. Questions also address whether a candidate has recently undergone chemical dependency treatment. Self-reports are accepted, with opportunity for the board to ask for additional documentation and/or treatment records.* *The use of mood altering drugs and substances potentially impacts all four functional ability categories (see section on functional abilities below). In addition, denial of impairment is a frequent characteristic of individuals who are chemically dependent. Asking chemical use questions is proactive, attempting to identify the need for intervention and treatment rather than wait for a problem to occur. Asking the questions promotes increased awareness of competence conduct, and prompts candidate self-assessment. Recovering nurses need to think about the relationship between recovery and the accessibility of drugs in the work setting, and consider whether or not some type of accommodation (e.g., limitation of environment, shift or scope) might be needed to protect both client safety and the nurse's recovery. Documenting responses to these questions creates a paper trail. The questions are asked of everyone. If a serious problem is identified, the burden rests with the candidate to prove that all licensure requirements are met.*

CORE REQUIREMENT	RATIONALE
	Individuals currently using illegal drugs are not protected under the Americans with Disabilities Act (ADA). The time period that would be considered current drug use is subject to interpretation. The time period should focus on whether a condition or a history of a condition creates a significant ongoing likelihood that the individual's ability to practice safely is affected. Individuals who have enrolled in or completed rehabilitation programs are protected by the ADA, but still must be able to perform the essential functions of the nursing role.
FUNCTIONAL ABILITIES – RN and LPN/VN Self report regarding any functional ability deficit that would require accommodation to perform essential nursing functions. ***Sample Application Questions*** *Do you currently have any mental or physical condition that affects your capacity in any of the following functional ability categories that affects your ability to practice nursing and/or requires accommodation to allow you to perform essential nursing functions?* • *Physical (gross and fine motor, physical endurance, physical strength, mobility) (Yes or No)* • *Sensory (visual, tactile, olfactory, hearing) (Yes or No)* • *Cognitive (reading, arithmetic, analytical and critical thinking) (Yes or No)* • *Interactive (interpersonal, communicative) (Yes or No)* *If yes to one or more, please describe the nature of the mental or physical condition, the manner in which it affects your ability to practice safely, and the type of accommodation needed.* *Were accommodations in the nursing educational program necessary for you to complete nursing requirements? If yes, identify the accommodations.*	*Functional abilities are non-domain specific abilities, i.e., those physical and mental activities and attributes needed by a nurse to practice safely in terms of essential nursing functions, with or without accommodations. The use of refined and precise questions on the licensure application can provide information about whether and how an applicant's functional abilities deficits affect nursing practice and the accommodations needed to allow the nurse to perform essential nursing functions. The licensure application questions focus on how current mental and/or physical conditions affect the nurse's ability to practice nursing safely, as well as accommodations required in the recent past that may need to be continued. Self-reports would be the minimum acceptable mechanism for obtaining information regarding a candidate's functional abilities, with opportunity for the board to ask for additional documentation of accommodations.* *As a behavioral component of competence, it is appropriate to address functional abilities as a part of the licensure application process. It is proactive, attempting to identify the need for accommodations rather than wait for a problem to occur (better for patients, better for nurses). Asking the questions promotes increased awareness of competence conduct, and prompts candidate self-assessment. Documenting responses to these questions creates a paper trail. The questions are asked of everyone. If a serious problem is identified, the burden rests with the candidate to prove that all requirements for licensure are met.*

Licensure Decision Making

Competence Development and Competence Assessment

Once a board determines what is to be the content for licensure requirements, the board delegates to board staff the day-to-day processing activities in most jurisdictions. The great majority of candidates either meet the competence development requirements or they do not. There are few cases that require a case-by-case review by the board. Similarly, for competence assessment, candidates either pass the examination, or they do not.

Competence Conduct

Competence conduct decisions are less straightforward. The boards are dependent on application questions and the honesty and integrity of candidates to respond truthfully to the questions. With the exception of criminal background checks, the NP&E Committee could not identify a means to verify responses to competence conduct questions on licensure applications. The committee members were concerned that in boards asking questions, honest candidates could be given extra scrutiny while less than candid or dishonest individuals could slip through without review. The points raised during the debate about application questions is summarized below:

To Question ...

- Attempts to identify potential problems and deal with proactively, rather than wait for harm to occur
- Promotes self awareness and prompts self assessment in the candidates
- Implements a uniform approach to candidates by asking questions of all
- Facilitates implementation of board decision-making since it is easier for a board to deny licensure than to remove a license once granted (shift of burden of proof)
- Creates a paper trail regarding responses to the questions at the time of licensing if grounds for discipline were to be identified at a later time
- Increases potential for ADA challenge

Or Not to Question

- Avoids potential liability for board if it receives negative information about a candidate and does nothing
- Avoids being harder on honest applicants than those in denial or who lie
- Creates less work, consumes fewer resources
- Avoids ADA challenges – levels "the playing field" and allows an individual to implement self limits; board becomes involved only if actual problem identified
- Implements a uniform approach to all candidates by not asking anyone

The NP&E Committee recognized that *to question* creates risk. But it is a proactive approach that attempts to identify problems before harm occurs. On its face, *not to question* seems to avoid significant risk for the board. But the committee members realized that since we live in a litigious society, a board could just as easily be sued for not doing an adequate review of individuals if a patient were subsequently harmed because of a nurse's incompetence. The committee believed that being proactive was preferable to being challenged for not doing enough. In addition, legal counsel advised that this emphasis on current status and the resulting effects on practice would likely be viewed more positively under the ADA than focusing on the nature of a disability and an individual's history.

Criminal Convictions

Individuals with a history of criminal conviction require case-by-case review by most boards. However, some boards have moved away from this approach for evaluating criminal convictions by establishing specific parameters regarding criminal convictions. The Nursing Practice and Education Committee reviewed the work of the 1998 Discipline Resources Subcommittee, and recommends for implementation of the uniform core requirements that the decision-making parameter for criminal convictions consists of a time-limited bar from licensure for candidates with a history of felony conviction. Since most recidivism occurs in the first three years following incarceration, setting at least a three-year interval between the completion of the felony sentence and the application for licensure provides a safety cushion for the public. The individual could use this time interval to get his/her life back together following the felony conviction. The board would still conduct a case-by-case review after the three-year period so that the board can evaluate not only the nature and context of the crime, but also the rehabilitation efforts, the time elapsed, continued competence issues and other factors at the time of licensure. The board has the discretion to deny licensure if there is evidence that the individual would not be able to practice safely and effectively.

The NP&E Committee also advises that misdemeanors be evaluated on a case-by-case basis. While many misdemeanors are minor in nature and would not preclude licensure, some misdemeanors are bargained down from original felony charges. The underlying behavior may be as bad as some felony convictions. The board should use its discretion wisely, dismissing minor scraps or mishaps and focusing on more serious cases involving conduct reflecting a potential to harm vulnerable patients.

The time-limited bar approach is currently being used in Kentucky and Arizona. The policy recommendation to verify the candidate's responses to questions about prior criminal convictions through background checks was approved by National Council's 1998 Delegate Assembly.

Chemical Dependency and Drug-related Behavior

Drug-related behavior that affects the candidate's ability to provide safe and effective nursing care is another area of competence conduct that is difficult to identify and assess. The sample questions suggested in the proposed uniform licensure requirements are time limited and focus on how resulting behavior would affect an individual's ability to perform the essential nursing functions.

Functional Abilities

Perhaps the most challenging competence conduct evaluation that a board undertakes relates to functional abilities, the physical and mental activities and attributes needed by a nurse to practice, with or without accommodations, the essential nursing functions. The NP&E Committee recommends asking application questions related to the different categories of functional abilities – physical, sensory, cognitive and interactive. These identified categories are based on previous research conducted by the National Council. And again, emphasis in the questions is on the implications for nursing practice.

Discussion

Consistency and uniformity in standards and licensing requirements make sense. The world is a very different place than the world where administrative agencies and professional licensing were created. Communication and travel that used to require days and weeks now requires seconds, minutes and hours. There is now little regional variation in the practice of the nursing profession. Boards are truly more alike than different in their licensure requirements. Increased mobility of nurses, while creating regulatory challenges, has also created wonderful opportunities to improve the public's access to nursing care. And the public does expect access to safe, competent nurses.

In late April-May of 1999, the NP&E Committee conducted a survey of current licensure requirements among Member Boards. The most critical questions on the survey related to rationale – the "why" for specific elements of licensing requirements being in place. However, some respondents did not articulate rationale, and others addressed the "how" rather than the "why" for different elements. An interesting observation made during review of the survey responses is that while a board might have one or two elements that were outliers to the majority of boards, no board had only the most restrictive or only the least restrictive licensing requirements. The committee believes that this reflects the impact of board experience on regulatory activities. Certain elements become a focus, an issue, or a cause because of a difficult case, a particular interested legislator, or a specific board member's agenda. In other words, the committee believes that outliers are more likely to reflect that board's history and tradition than rational inquiry and decision-making.

The NP&E Committee is aware that the proposed requirements are going to cause everyone some discomfort. Some will wonder why high school education was not required; more may be concerned that completion and eligibility for graduation from a state-approved nursing program is accepted. But the committee believes that completion of the required study is the essence of competence development. If a state determines that a portion of RN education or the 91C army program provides appropriate competence development to sit for the RN and PN examinations respectively, then that state's judgment and experience is to be trusted.

Competence conduct provides special challenges. The committee believes that boards have a responsibility to be proactive, to ask the questions and to follow up by requesting additional information when needed regarding criminal convictions, drug-related behaviors and functional abilities. Some aspects of competence conduct are invisible, not easily detected by the employer or client. To those who would allow individuals a chance to self-limit first, and involve the board only if subsequent problems are identified later, the committee asks, what is best for the public?

Asking the questions promotes awareness among candidates. The message to nursing employers is not that the boards are dealing with competence conduct so employers do not have to address it, but rather that competence conduct is critical to public safety, so must be addressed by both the board and the employer. Assuring competence is a joint responsibility between the board, the individual nurse, and the nursing employer. Each has an important role to play.

People often think that uniform requirements are a good idea until they are asked to change some of their elements. When people truly compromise, no one person gets exactly what he or she wants, because compromise is an agreement reached by mutual concessions. A compromise is an arrangement for settling (or preventing) a dispute on equitable terms that each position may not love but can live with. There have been effective compromises that have lasted for years (e.g., most elements of the United States Constitution). There have been inequitable compromises that rightfully have not stood (e.g., the Constitution allowed regional slavery in the United States until adoption of the Thirteenth Amendment). The best compromise is not the lowest common denominator, but something between, something intermediate, a true blending of qualities.

The committee is aware that the proposed uniform core licensure requirements would require legislation in most states. This is not surprising in light of the discussion in the preceding paragraph. The committee stresses again their definition of core – the minimum, essential requirements needed for initial entry into nursing practice. The committee did not focus on what is easy for boards to do or what is the least risky for boards, but rather emphasized what was best for the public good. For those individuals chafing at giving up time-honored traditions, the committee poses a pivotal question: *Do you really think nursing is that much different, that much safer on your side of the state boundary line?*

Conclusion

There are three things needed to achieve uniform core licensure requirements in the United States:

- Willingness to place emphasis on the public good
- Willingness to compromise
- Willingness to trust sister boards

In these crazy times, it is tempting to hang on to tradition and history, "the way we have always done it." Boards of nursing take their responsibility very seriously. For a board that has a more restrictive element, it is difficult to give up some aspect of control, to trust another board's experience and judgment. But it is critical to focus on what are the minimal, essential requirements for licensure, and achieve public protection through the least restrictive means. The NP&E Committee respectfully recommends that the Delegate Assembly adopt the proposed uniform core licensure requirements and promote their implementation by the Member Boards.

Attachment B

Proposed Education Content for Model Nursing Practice Act and Model Nursing Administrative Rules

Background

When the National Council of State Boards of Nursing was created in the late 1970s, one of the first projects undertaken by the new organization was the development of the National Council's *Model Nursing Practice Act* and *Model Nursing Administrative Rules.* Under a grant from the Kellogg Foundations, these documents were developed and approved; the model act in 1982 and the model rules in 1983. Subsequent review and revision of the documents took place at five-year intervals.

The 1997 Models Revision 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. The subcommittee determined that an exploration of the context within which the models would be used and identification of concepts related to both process and outcomes would be informative. Their goal was to make the models current, relevant, flexible, and ***used.*** The subcommittee also conceived an innovative format approach - an electronic loose-leaf notebook. The major conceptual areas identified for inclusion in the models include:

- *Powers and Authority of the Board*
- *Education Program Approval*
- *Licensure*
- *Discipline*
- *Exemptions/Exceptions*
- *Special Topics*

It was expected that the work on multistate regulation and mutual recognition would result in revisions in the *Model Nursing Practice Act* and *Model Nursing Administrative Rules.* Work proceeded on review of education program approval, sections of the models less apt to be reflected by a change in regulatory approach.

Nursing Education Program Approval

Boards of nursing originated for the purpose of regulating nursing education programs. The role of the board was to provide standards for nursing education and to protect the public from poorly prepared nurses. However, in the last few years, there has been much discussion regarding the current role of boards of nursing in the regulation of nursing education programs. Discussion has centered on issues of board staff resources, impact of multiple agencies accrediting education programs, and identification of the unique role of the board of nursing in the regulation of nursing education.

For the last two years, the NP&E Subcommittee on Education has worked on developing model language for nursing education program approval. The work of the subcommittee included review of previous National Council position papers, and analysis of the criteria of a variety of current works regarding education priorities and standards. Resources included the Commission on Collegiate Nursing Education (CCNE) Accreditation Standards and the National League for Nursing Accrediting Commission Interpretive Guidelines for Standards and Criteria. In addition, the subcommittee conducted 1997 and 1998 Member Board surveys. Following a thorough review of all standards, a list of 17 common criteria was compiled in the form of a working template against which the rules and regulations of all jurisdictions for which documents were available to National Council were compared. The following unique roles of boards of nursing in relation to nursing education programs were identified:

- *Granting initial approval of basic nursing education programs*
- *Monitoring and sanctioning programs at risk by means of statutory authority*
- *Demonstrating greater awareness of statewide nursing education needs*
- *Participating in standard setting for basic nursing education programs*

These regulatory activities were used as the framework for development of nursing education program approval content for the *Model Nursing Practice Act* and *Model Nursing Administrative Rules.*

Purpose of Nursing Education Approval Models

The purpose of the regulation of nursing regulation is to assure that the public is protected from the unauthorized, unqualified practice of nursing. Toward this end, 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 for Nursing Education Approval Models

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;
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.

Powers and Authority

The board is authorized to make, adopt, amend, repeal and enforce such administrative rules, as it deems necessary for the proper administration and enforcement of this Act, and to protect the public health, safety and welfare. Relevant to nursing education program approval, this includes the authority to develop and enforce standards for nursing education and practice; collect and analyze data regarding nursing education, nursing practice and nursing resources; and provide consultation and conduct conferences, forums, studies and research on nursing education and practice.

Critical Concepts for the Regulation of Nursing Education

Process – Nursing education provides access to:

- knowledge and principles;
- skill development, including critical thinking;
- opportunities to apply knowledge, skills, abilities (KSAs) and decision making;
- opportunities for values clarification, role modeling and the development of professional accountability and competence; and
- clinical opportunities to apply what has been learned.

Outcomes - Nursing education produces graduates whom:

- possess nursing knowledge, skills and abilities (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.

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Proposed Education Content for *Model Nursing Practice Act*

Article VII. Approval of Nursing Education Programs.

Section 1. Approval Standards. The Board shall, by administrative rules, set standards for the establishment and conduct of nursing education programs, ~~including all clinical facilities used for learning experiences,~~ leading to state authorization to practice, and shall ~~survey and~~ approve such programs which meet the requirements of the Act and the Board administrative rules. Subsequent to Board review the Board of Nursing will provide a written report to the nursing education program identifying compliance with standards supporting documentation and relevant recommendation. In all cases, the Administrator of the program shall submit a written response to the Board of Nursing for any identified recommendations for corrective action for a specific period.

Comment: ~~The Board of Nursing, in order to safeguard public health, safety and welfare, should approve the establishment and conduct of nursing education programs. The Board should establish standards for, and approve educational programs preparing persons for, the practice of nursing at the undergraduate and graduate levels. What constitutes sufficient preparation for the practice of nursing should be decided by the Board of Nursing.~~ Graduation from an approved nursing education program is a criterion for state authorization to practice in every jurisdiction. This requirement is integral to the Board of Nursing mandate to safeguard public health, safety and welfare.

Rationale for change:
- *To meet evolving health care needs, nursing education programs are focusing on more community-based clinical experiences for students that do not fit into traditional clinical settings. Nursing programs should be allowed flexibility in determining settings that meet specific learning needs and promote diversity in education.*
- *Boards of nursing have an obligation to provide timely and appropriate feedback to nursing education programs regarding the meeting of approval standards as established by the board.*

Section 2. Initial Approval Required. An educational institution within this State desiring to conduct a nursing education program shall apply to the Board and submit evidence that its nursing program is able to meet the standards established by the Board. If, upon investigation, the Board finds that the program meets the established standards for nursing education programs, it shall approve the applicant program.

Comment: There is generally accepted agreement that Boards of Nursing have current awareness of nursing education program needs that vary by state and community. (No change has been made in the model language, but a comment has been added to this section.)

Section 3. ~~Periodic Evaluation of Nursing Programs~~ Continuing Approval Required. The Board shall periodically, as established by Board rules, evaluate approved nursing education programs ~~and shall publish a list of approved programs~~. An educational institution within this State seeking ~~to conduct a~~ continuing approval of a nursing education program shall ~~apply~~ submit to the Board ~~and submit~~ periodic evidence that its nursing program ~~is able to~~ meets the standards established by the Board which may include recognition of national nursing accreditation.

Comment: Approval of nursing education programs continues to be the responsibility of Boards of Nursing to safeguard public health, safety, and welfare. The Board may conduct the review or designate some other mechanism. (A comment has been added to this section.)

Rationale for change:
Periodic review of the nursing education program is related to continuing approval. Parallel structure is maintained with a change in the section heading.

Section 4. Denial or Withdrawal of Approval. The Board may deny or withdraw approval or take such action as deemed necessary when nursing education programs fail to meet the standards established by the Board, provided that all such actions shall be in accordance with this State's Administrative Procedures Act and/or the Administrative Rules of the Board. A process of appeal and reinstatement shall be delineated in Board rules.

Comment: ~~Boards of Nursing may wish to utilize an intermediate approval status, such as conditional approval, for educational programs that do not fully meet approval standards. This status~~ Approval denotes that certain conditions must be met within a designated time period in order for the program to be fully approved. Failure to do so could result in denial or withdrawal of approval. The Board must provide the program due process prior to denial or withdrawal of approval.

Conditional approval generally allows educational programs to continue operation while they correct deficiencies and work towards meeting the conditions for full approval. The graduates of conditionally approved programs should be eligible to take the licensing examinations and, upon passing the examination, become licensed. (No change has been made in the model language, but the comment has been revised for this section.)

Rationale for change:
Even a program that is conditionally approved is still an approved program.

~~**Section 5. Reinstatement of Approval.** The Board shall reinstate approval of a nursing education program upon submission of satisfactory evidence that its program meets the standards established by the Board.~~

~~**Section 6. Provisional Approval.** Provisional approval of new programs may be granted pending the licensure results of the first graduating class.~~

Section 5. Dissemination of Approval Status. The Board shall widely disseminate a list of the approval status of nursing education programs within its jurisdiction.

Comment: The dissemination of information is consistent with the Board's accountability for safeguarding public health, safety, and welfare.

Rationale for Change:
The dissemination of information about approved programs is a separate issue than the requirement for continuing approval and should be listed separately.

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Proposed Education Content for *Model Nursing Administrative Rules*

Chapter 5-Nursing Education: Model Nursing Administrative Rules

Guiding principles for nursing administrative rules:

1. Promote public safety in an ever-changing health care environment and in innovative nursing education;
2. Emphasize outcomes evaluation and quality improvement in nursing education;
3. Incorporate current standards of practice into nursing education programs;
4. Maintain processes that are cost-effective and cost-accountable;
5. Maintain accountability to the consumers of nursing education programs;
6. Encourage nursing education programs to develop graduates who are effective RNs or LPN/ VNs committed to life-long learning.

***Standard 1* – The purpose and outcomes of the nursing program shall be consistent with the Nursing Practice Act, Board Administrative Rules, and other relevant state statutes.**

Documentation of Compliance Evidence that:

1) Describes the consistency between the purpose and outcomes of the nursing program and the state's Nursing Practice Act, Board Administrative Rules, and other relevant statutes.
2) Provides clear and convincing written rationale for any inconsistency between the purpose and outcomes of the nursing program and the Board Administrative Rules.

Rationale:
Boards of nursing maintain statutory accountability for all nursing programs leading to licensure. The purpose and outcomes of the nursing education program must be in compliance with laws of the state that govern nursing education and practice to assure that the public is protected from the unauthorized, unqualified practice of nursing.

***Standard 2* – The purpose and outcomes of the nursing program shall be consistent with generally accepted standards of nursing practice for the graduates of the type of nursing program offered.**

Documentation of Compliance Evidence that:

1) Identifies the standards of nursing practice being used by the nursing program.
2) Describes the congruence between the purpose and outcomes of the nursing program and the program's identified standards of practice.

Rationale:
Nursing education programs prepare the practitioners of the future. Current standards of nursing practice provide a benchmark for guiding the curriculum and outcomes of nursing education programs.

Standard 3 – The purpose and outcomes of the program shall incorporate the needs, expectations, and direct input of consumers.

Documentation of Compliance Evidence that:

1) Provides a written description of the nursing program's consumers, including cultural, racial, ethnic, and socioeconomic variables and health trends within the community served.
2) Describes how the purpose and outcomes incorporate the needs and expectations of the nursing program's identified consumers.
3) Describes how consumers actively participate in quality improvement of the nursing program.

Rationale:
Consumers, whether students, faculty or the public have a vested interest in the purpose and outcomes of the nursing education program.

***Standard 4* – The nursing program shall implement a comprehensive, systematic plan for ongoing evaluation that is based on program outcomes and incorporates quality improvement.**

Documentation of Compliance Evidence that:
1) Provides a written comprehensive systematic evaluation plan addressing all components of the nursing program.
2) Describes a plan which involves the nursing program's consumers.
3) Describes how program improvement is attained with the use of attrition and graduation rates, NCLEX® examination results, and employer and consumer satisfaction with graduates of the program.
4) Demonstrates that the results of program evaluation influence curriculum revision in meeting emerging health care needs.

Rationale:
The effectiveness, efficiency and acceptability of the nursing education program must be measured on an ongoing basis and used as the foundation for revision and quality improvement of the program. Demonstration of outcomes of evaluation are necessary to meet existing and emerging health care needs.

***Standard 5* – Faculty and students shall participate in program planning, implementation, evaluation, and quality improvement.**

Documentation of Compliance Evidence that:
1) Describes how ongoing decision-making reflects the participation of faculty and students in the planning, implementation, and evaluation and quality improvement of the nursing program.
2) Describes how the written curriculum plan, developed by the faculty, reflects the purpose and outcomes of the nursing program.

Rationale:
Faculty and students must be actively involved in all phases of the nursing education program.

Standard 6 - The curriculum shall provide diverse learning experiences consistent with program outcomes and quality improvement.

Documentation of Compliance Evidence that:
1) Demonstrates use of a variety of academic and clinical learning experiences with culturally diverse clients across the life span.
2) Illustrates how curriculum content and learning experiences address disease prevention; health promotion, maintenance and restoration; and end of life care.
3) Illustrates how innovation in teaching/learning methodologies reflects current and future health care practices.
4) Illustrates how clinical practice settings used in the nursing program represent the continuum of health care delivery.

Rationale:
Health care needs are constantly evolving and nursing education programs must be proactive in preparing students to function in current and future health care arenas. Students must be prepared to work with patients and clients along the life continuum and health/illness continuum.

Standard 7 - The fiscal, human, physical and learning resources support program outcomes and quality improvement.

Documentation of Compliance Evidence that:

1) Describes how the parent institution and nursing program provide and support an environment for quality improvement.
2) Reports budget history and projections for funding sources that support the program's needs for human, physical and learning resources.
3) Describes how the fiscal, human, physical and learning resources are reviewed, revised and improved as needed.
4) Reports that the practice settings for student experiences are approved by their applicable agencies.
5) Includes current written agreements between the parent institution and practice setting that address responsibilities of both parties.

Rationale:
Programs must demonstrate adequate support to provide quality education and experiences.

Standard 8 - The nursing program administrator shall be a professionally and academically qualified registered nurse with institutional authority and administrative responsibility for the program.

Documentation of Compliance Evidence that:

1) The chief nursing administrator holds a current unencumbered RN license that meets the requirement of the state.
2) The chief nursing administrator, for programs preparing for RN licensure, has an earned doctorate, an earned graduate degree in nursing, at least one-year experience in client care, and at least one-year experience teaching in a nursing program.
3) The chief nursing administrator, for programs preparing for PN/VN licensure, has an earned graduate degree in nursing, at least one-year experience in client care, and at least one-year experience teaching in a nursing program.
4) Shows the chief nursing administrator has expertise appropriate to his/her responsibilities and maintains such expertise.
6) Describes how the institution's chief nursing administrator has institutional authority and administrative responsibility for the program.

Rationale:
A chief nursing administrator requires sufficient education and experience to accomplish the responsibilities of the position, including development and maintenance of an environment conducive to the teaching/learning process and other leadership activities.

Standard 9 - Professionally and academically qualified nurse faculty are sufficient in number and expertise to accomplish program outcomes and quality improvement.

Documentation of Compliance Evidence that:

1) Each nurse faculty member holds a current unencumbered RN license which meets the requirement of the state.
2) Each nurse faculty member, for programs preparing for RN licensure, holds at least an earned graduate degree in nursing.
3) Each nurse faculty member, for programs preparing for PN/VN licensure, holds at least an earned baccalaureate degree in nursing.
4) Describes how the number and expertise of faculty are based on the nursing program's purpose and outcomes, number and level of students, acuity levels of clients, and characteristics of practice settings for student experiences.
5) Full- and part-time faculty have academic and clinical expertise appropriate to their teaching responsibilities and maintains such expertise.

Rationale:
A nursing faculty requires sufficient education and experience to develop and implement the purpose, philosophy, objectives, and curriculum of the nursing education program.

Standard 10 – Information communicated by the nursing program shall be fair, accurate, inclusive and consistent.

Documentation of Compliance Evidence that:

1) Describes how the approval status of the nursing program is communicated by the program to the public.
2) Describes how the policies affecting students are available to the public.
3) Describes the written academic policies, developed by the faculty, that promote student accountability for learning, progression and graduation.

Rationale:
Dissemination of accurate and objective information is consistent with the board's accountability for safeguarding public health, safety, and welfare.

Attachment C

List of Participating Organizations at the Continued Competence Roundtable – April 30, 1999

The Continued Competence Subcommittee and representatives of the Nursing Practice and Education Committee hosted an invitational roundtable to discuss issues of continued competence. National Council representatives were very pleased with the thoughtful dialogue that took place. The participating organizations are listed below. The participants identified the need to continue work on this important topic. Development of uniform language and development of ways to obtain input from nurses regarding competency issues were identified as the next steps. A follow-up meeting of the participating organizations was tentatively scheduled to be held in connection with the American Nurses Credentialing Center Competence Conference in November 1999.

American Academy of Nursing
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American College of Nurse Midwives
American Nurses Association
American Nurses Credentialing Center
Association of Operating Room Nurses
Certification Board Perioperative Nursing
Commission on Graduates of Foreign Nursing Schools
Emergency Nurses Association
Federation of State Boards of Physical Therapy (representing the Interprofessional Work Group)
National Association for Practical Nurse Education
National Association of School Nurses
National Certification Board of Pediatric Nurse Practitioners and Nurses
National Council of State Boards of Nursing
National League for Nursing
Nursing Organization Liaison Forum
U.S. Public Health Service
Wisconsin Board of Nursing

Notes

Notes

Forum: APRN Task Force

Report of the APRN Task Force

APRN Task Force Members

Katherine Thomas, TX-RN, Area III, *Chair*
Nancy Allen, UT, Area I
Dale Gordon, ME, Area IV
Mary Ann Rosencrans, OH, Area II

Staff

Eloise Cathcart, MSN, RN, *Executive Director*
Suzie Williamson, MPH, RN, *(Former) Director of Credentialing and Practice*

Relationship to Strategic Plan

Strategic Initiative 3.....*The National Council will analyze the changing practice environment to assist in identifying state and national regulatory implications and to develop strategies to impact public policy.*

Outcome 5.....*Approaches and resources to assist Member Boards in the regulation of advanced practice registered nurses.*

Recommendations to the Board of Directors

No recommendations.

Background

The RN/LPN Nurse Licensure Compact did not include APRNs because of the wide variety of recognition/licensure requirements from state to state. The National Council recognized the importance of including APRNs in multistate regulation because of the importance of this role in the continuum of nursing practice. APRNs are increasingly engaged in multistate practice. Like other nurses, APRNs are employees of staffing agencies, managed care organizations and integrated delivery systems that require physical travel across state lines or practice by telecommunications technology. In September 1997, the Board of Directors directed the APRN Task Force to study the issues surrounding implementation of a mutual recognition model of regulation for advanced practice registered nurses and develop strategy to be brought to the Delegate Assembly.

Highlights of Activities

- **Purpose**

This report is intended to identify uniform requirements for state authorization to practice as an Advanced Practice Registered Nurse (APRN) (see Attachment A). Standardization of requirements allows states to make changes in state laws and regulations to facilitate interstate practice.

- **Process**

The APRN Task Force developed a scattergram of requirements of APRN recognition in each jurisdiction. Analysis supported the original assumptions that significant differences existed between states. Further, within states, variation existed between categories of APRNs (i.e., CRNAs had different requirements than CNMs). The APRN Task Force developed a model based on the establishment of uniform requirements that would be compatible with the current mutual recognition model. The APRN Task Force believed that, in the face of the impact of significant regulatory change, inclusion of APRN professional organizations in the development of these requirements was essential.

■ **Meetings**

Representatives from APRN professional groups including accrediting and certifying bodies, specialty organizations and general nursing organizations were invited to participate in a series of meetings for the purpose of developing uniform requirements. A list of the participating organizations is attached (Attachment B). Five meetings were held between December 1997 and December 1998, in Chicago, San Diego and Washington, DC. During this time, drafts of the uniform requirements were shared with Member Boards for their comment. A forum was held during the 1998 Delegate Assembly to present the draft requirements and receive comment. The participating organizations agreed to include criteria when through a consensus model. However, when agreement could not be reached, the decision was made to include certain criteria when a majority of participants agreed; this was defined as sense of the group.

■ **Outcome**

Participants agreed that the development of uniform requirements was valuable in promoting consistent regulation between states. Their approval, however, does not necessarily imply endorsement of the mutual recognition model.

■ **Future Directions**

The APRN Task Force envisions several uses of the Uniform APRN Licensure/Authority to Practice Requirements document. These uses include providing a guideline for standardization of educational preparation and development of rules and regulations by Member Boards. The requirements also promote the recognition of emerging roles. Mechanisms to implement mutual recognition for APRNs can be defined in the future.

■ **APRN Task Force Recommendations**

The APRN Task Force is bringing the final Uniform APRN Licensure/Authority to Practice Requirements documents to the 1999 Annual Meeting for discussion. The forum is scheduled for Thursday, July 29, at 3:30 p.m. Member Boards are encouraged to attend.

■ **Acronyms**

AACN	American Association of Colleges of Nursing
ABNS	American Board of Nursing Specialties
CCNE	Commission on Collegiate Nursing Education
CNM	Certified Nurse Midwife
NCCA	National Commission for Certifying Agencies
NLNAC	National League for Nursing Accrediting Commission
NONPF	National Organization of Nurse Practitioner Faculties

■ **Definitions**

Accrediting Body—An organization which establishes and maintains standards for professional nursing programs and recognizes those programs that meet these standards.

APRNs—Advanced practice registered nurses, including certified nurse midwives (CNMs), certified nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs) and nurse practitioners (NPs).

Certifying Body—A non-governmental agency that validates by examination based on pre-determined standards and individual nurse's qualifications and knowledge for practice in a defined functional or clinical area of nursing.

Certification Maintenance Program—A program designed by a certifying body to assure ongoing competence for advanced practice.

Certificate Program—A non-graduate level program designed to prepare advanced practice registered nurses.

External Review Process—A review process by an accrediting body to assure appropriate standards are met.

Provisional Authority—Temporary legal authority to practice granted by a board of nursing pending completion of all requirements for full authority.

Meeting Dates

- November 10–12, 1997
- February 4–6, 1998
- May 4–6, 1998
- September 28, 1998
- September 29, 1998 *(Roundtable)*
- November 30–December 2, 1998
- December 1, 1998 *(Roundtable)*
- February 25–26, 1999
- May 17–19, 1999
- May 18, 1999 *(Roundtable)*

Recommendations to the Board of Directors

No recommendations.

Attachments

Attachment A

Uniform APRN Licensure/Authority to Practice Requirements

Advance Practice Registered Nurse Task Force

Uniform APRN Licensure/Authority to Practice Requirements[1]

June 1999

DRAFT

Proposed Language	Comments/Clarification
APRN Uniform Requirements – Initial/U.S.-Educated	
1. Licensed RN (unencumbered)	1. APRN Organizations-Consensus[2] 2. Intent is this does not apply to provisional authority for new graduates pending examination. The APRN Task Force felt an untested new graduate should not have multistate practice privilege. States can grant authority to practice within the state, but the multistate privileges would not apply.
2. Graduated from or completed a graduate level APRN program accredited by a national accrediting body.	1. APRN Organizations-Sense of group[2] –all but CNMs support this requirement. 2. The compact rules can address the criteria for recognition of accrediting bodies. 3. Historically, the lack of accreditation for NP and CNS programs has been a concern for Member Boards. We anticipate CCNE and NLNAC will address these matters in the near future. Both organizations are considering including NONPF *National Task Force Criteria* and AACN *Essentials of Master's Education*, which address the inclusion of pharmacotherapeutics in the curriculum. 4. The intent of the wording "or completed a graduate level APRN program" is to recognize post-graduate programs designed to prepare advanced practice registered nurses.
3. Currently certified by national certifying body in the APRN specialty appropriate to educational preparation	1. APRN Organizations-Consensus 2. Compact rules can address recognition of certifying bodies through an external review process. Examples of external review accreditation programs for certification include NCCA and ABNS. 3. National Council will continue to monitor compliance of certifying bodies with accreditation criteria.

4. For applicants for whom there is no appropriate certifying exam available, participating states will develop an alternate mechanism to assure initial competence.	1. APRN Organizations-Consensus 2. Participating states will develop a mechanism for approval of applicants for whom a certifying examination has not been developed. The compact rules will set out uniform criteria to develop various mechanisms to assure initial competence. Defining the criteria in the compact rules will provide a uniformity deemed essential. Examples of uniform criteria might include supervised practice for a period of time or verification of competency by a preceptor. 3. The intent is to have a viable regulatory mechanism for recognition and allow for emerging new APRN roles for which certifying examinations are not yet available. Example is the Perinatal NP.
APRN Uniform Requirements–Renewal	
1a. Maintain national certification in the appropriate APRN specialty through an ongoing certification maintenance program of a nationally recognized certifying body, **OR**	1. APRN Organizations-Consensus 2. Even if certifying body does not require participation in a competence maintenance program, participation will be required.
1b. Applicants for whom no recognized certification is available must participate in a competence maintenance program.	1. APRN Organizations-Consensus 2. For APRNs who do not have a recognized APRN Certification examination available, requirements to assure continued competence can be left to the states. Criteria for competence maintenance would be developed in compact rules (see initial/U.S. educated, #4 above).
APRN Uniform Requirements – Foreign Educated	
1. Same as U.S.-educated/initial criteria, except the APRN educational program must meet criteria for accreditation equivalent to that of a national accrediting body.	1. APRN Organizations-Consensus 2. Foreign-educated nurses can be recognized if they meet the following criteria: (a) Licensed RN (unencumbered). (b) Graduated from or completed a graduate level APRN program accredited by a national accrediting body. In lieu of a U.S. national accrediting body approval, states could determine equivalency of the foreign program to U.S.-accredited programs based on criteria established in the compact rules. It is anticipated that the compact rules will address specific criteria to be used by the states in determining equivalency of foreign programs with CCNE and NLNAC accreditation. (c) Currently certified by a national certifying body in the APRN specialty appropriate to educational preparation. (d) For applicants for whom there is no appropriate certifying examination available, states will have a mechanism to assure initial competence. (See initial/U.S.-educated, #4) 3. National Council will continue to monitor international collaboration efforts among certifying bodies and the accreditors of certifying bodies.

APRN Uniform Requirements–Endorsement	
1. Licensed as RN (unencumbered), **AND** 2. APRN licensure/authority to practice unencumbered in another jurisdiction, **AND** 3. Currently certified by a national certifying body in the APRN specialty appropriate to the educational preparation or authorized to practice as an APRN in another jurisdiction through a mechanism to ensure initial competence when no appropriate certification exam is available, **AND** 4a. Meets educational requirements for initial licensure/authorization to practice **OR** 4b. Demonstrates successful completion of approved APRN certificate program prior to 2003.	1. APRN Organizations-Consensus on 1-4a. No agreement on 4b; dates suggested ranged from 2000-2007. 2. The intent is to permit grandparenting of currently recognized APRNs. The date 2003 was chosen by the APRN Task Force when consensus could not be reached among the APRN organizations. The APRN Task Force chose 2003 because: students enrolled in an educational program need time to complete the program; programs need time to move from certificate to graduate level; and the time should be sufficient for individuals to be given notification of grandparenting. 3. Compact states can grandparent APRNs endorsing from another state even though the endorsee does not meet the 2003 criteria as long as the endorsee met another jurisdiction's requirements prior to 2003. Requirements 4a and 4b provide grandparenting for APRNs who have been legally recognized and are practicing safely in a jurisdiction prior to 2003.
APRN Uniform Requirements–Re-entry into Practice	
None.	Extensive discussion took place with the APRN organizations about re-entry requirements. The conclusion was that few individuals might wish to re-enter advanced practice and the variety of mechanisms used by the states might identify an effective re-entry process for the future.

[1]**The mechanism of legal recognition** can be any of the various ones used by states to authorize advanced practice, e.g., certificate of authority, licensure or recognition.

[2]**Consensus and Sense of Group**

Consensus means that all APRN organizations agreed. Sense of the Group means a majority of the APRN organizations agreed.

Several meetings took place from December 1997 to December 1998 with the APRN professional and certifying organizations to develop the draft Uniform Licensure/Authority to Practice Requirements. The term "consensus" and "sense of the group" relate specifically to the outcomes of those discussions.

Edited 6/14/99

Attachment B

List of Participating Organizations in APRN Roundtable—May 18, 1999

- American Academy of Nurse Practitioners (AANP)
- American Academy of Nurse Practitioners Certification Program (AANPCP)
- American Association of Colleges of Nursing (AACN)
- American Association of Nurse Anesthetists (AANA)
- American Board of Nursing Specialties (ABNS)
- American College of Nurse Midwives (ACNM)
- American College of Nurse Practitioners (ACNP)
- American Nurses Association (ANA)
- American Organization of Nurse Executives (AONE)
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
- National Alliance of Nurse Practitioners (NANP)
- National Association of Clinical Nurse Specialists (NACNS)
- National Association of Neonatal Nurses (NANN)
- National Association of Nurse Practitioners in Reproductive Health (NANPRH)
- National Association of Pediatric Nurse Associates and Practitioners (NAPNAP)
- The National Certification Board of Pediatric Nurse Practitioners and Nurses (NCBPNP/N)
- National Certification Corporation for the Obstetric, Gynecologic & Neonatal Nursing Specialties (NCC)
- National League for Nursing Accrediting Commission (NLNAC)
- National Organization of Nurse Practitioner Faculties (NONPF)

Attachment C

Organizations Participating in Development of APRN Licensure/Authority to Practice Requirements

- American Academy of Nurse Practitioners (AANP)
- American Academy of Nurse Practitioners Certification Program (AANPCP)
- American Association of Colleges of Nursing (AACN)
- American Association of Nurse Anesthetists (AANA)
- American Board of Nursing Specialties (ABNS)
- American College of Nurse Midwives (ACNM)
- American College of Nurse Practitioners (ACNP)
- American Nurses Association (ANA)
- American Nurses Credentialing Center (ANCC)
- American Organization of Nurse Executives (AONE)
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
- Council on Certification of Nurse Anesthetists (CCNA)
- Council on Accreditation of Nurse Anesthetists (CANA)
- National Alliance of Nurse Practitioners (NANP)
- National Association of Clinical Nurse Specialists (NACNS)
- National Association of Neonatal Nurses (NANN)
- National Association of Nurse Practitioners in Reproductive Health (NANPRH)
- National Association of Pediatric Nurse Associates and Practitioners (NAPNAP)
- The National Certification Board of Pediatric Nurse Practitioners and Nurses (NCBPNP/N)
- National Certification Corporation for the Obstetric, Gynecologic & Neonatal Nursing Specialties (NCC)
- National League for Nursing Accrediting Commission (NLNAC)
- National Organization of Nurse Practitioner Faculties (NONPF)
- Sharp and Associates

Notes

Notes

Forum: CST® Project

Report of the CST® Task Force

CST Task Force Members
Debra Brady, NM, Area I, *Chair*
Deborah Feldman, MD, Area IV
Peggy Hawkins, NE, Area II
Helen Taggart, GA-RN, Area III
Jackie Waggoner, IL, Area II

Staff
Anna Bersky, PhD, RN, *CST® Project Director*
June Krawczak, EdD, RN, *CST® Project Associate*
Lorraine Kenny, RN, *CST® Research Study Coordinator*

Attachments

Attachment A

Update on the FY99 CST® Project Activities

August 1998: Delegate Assembly adopted a motion to continue with the research and development of CST® as a component of the NCLEX-RN® examination with a final report to the Delegate Assembly no later than 2000.

November 1998: Board of Directors approved extension of pilot study data collection from January 1 to July 31, 1999.

November 1998: Key Validation

- *Initiated process of textbook documentation of key content*
- *Completed validation of programmed keys including review and determination of disposition of unanticipated actions and misfit items*

January 1999: Completed seven new cases utilizing new and more efficient case development approach.

January 1999: Joint meeting of CST Task Force and Examination Committee.

February 1999: Board of Directors adopted a motion to postpone further exploration of Member Board use of CST for applications other than initial licensure until after the completion of the pilot study regarding the use of CST as a component of the NCLEX-RN exam.

April 1999: Completed first set of expert rating meetings for investigation of regression-based scoring. This would have to be repeated for the purpose of cross validation, should the project continue.

April 1999: Completed six new scoring keys utilizing new and more efficient scoring key development process.

April 1999: Joint meeting of CST Task Force and Examination Committee.

May 1999: Completed 10 case disguises.

May 1999: Revised draft of CST questions and comments.

June 1999: Completed Phase III of the NBME contract for work on CST.

Pilot Study Participant Status Update (numbers tested vs. goals) as of June 1, 1999

Category	Tested through 12/98	Tested 1/99 through 6/7/99	Scheduled as of 6/7/99	Tested through 7/99	Goal
Foreign Educated	117	60	3		150
Experienced Nurses	180	9	6		200
Neophytes (students)	191				100
New Graduates	513	508	105		1000
Total	1001				1450

Attachment B

Final Report: Initial Evaluation of Member Board Use of CST® for RN Education and Assessment

Introduction

Computerized Clinical Simulation Testing (CST®) is a new testing methodology designed to assess the application of the registered nurse's (RN's) independent clinical decision-making to the management of client care. CST is being developed and researched by the National Council of State Boards of Nursing for potential use in the National Council Licensure Examination for Registered Nurses (NCLEX-RN® examination). In conjunction with the pilot study, the National Council is also conducting an investigation of Member Board (MB) use of CST for RN continuing education and evaluation. The applications investigated were: RN continuing education; assessment of RNs re-entering practice; assessment for continued competence; and a component of the assessment of RNs being disciplined.

Description of CST

The purpose of CST is to evaluate competence in application of the clinical decision-making process to the management of client care. It differs from a multiple-choice question test in that it does not present questions with a list of answer options.

The CST system operates in a Windows environment. In CST, the examinee is first presented with an introduction to a patient situation including a brief description of the current client situation, including the case day, time and location. Following the introduction, the examinee advances to the client care screen. From this screen, the user can either open components of the client's chart for review or specify, through free-text entry, desired nursing activities to implement for the patient or the family/significant other. Examinees are free to perform any nursing actions, in any sequence, and at any time they desire. Other than reviewing components of the chart, all nursing actions (assessment, diagnosis, intervention and consultation) are initiated through free-text entry. When a specified action is confirmed by the examinee, a client response is received and simulated time moves forward. Once confirmed by the examinee, the nursing action is recorded and cannot be retracted, and simulated time advances. As the examinee proceeds through a case, the client's condition changes in response to nursing action (or non-action) and the unfolding of the underlying health problem. No testing cues in the form of questions with answer options are provided.

Evidence of competence in clinical decision-making is demonstrated by specifying assessment, diagnosis, intervention and evaluation actions for a client during an unprompted, time sensitive, dynamic scenario. Inference about examinee ability to analyze and interpret client data can be made based upon the appropriateness, as well as the timing and sequencing of assessment, diagnostic and intervention actions. While the full scope of nursing actions is available in CST, it is not designed to test fine details of factual knowledge (e.g., identification of specific low sodium foods; steps in a procedure), ability to teach, psychomotor skills, communication or interpersonal skills, delegation or supervision, or ethical or moral behaviors. The scope of nursing actions available in CST, and its unprompted, dynamic and temporal nature, contributes to the realism of the testing environment.

Summary: Member Board Evaluations

The purpose of the Member Board investigation of CST as a potential tool for RN continuing education and/or assessment is to evaluate the feasibility of its use for each application. For each application explored by Member Boards, the study addressed: administration issues (logistics, scheduling, resources needed); performance evaluation issues (methods of evaluation of performance, use of performance information, resources needed); appropriateness of cases and scoring keys for each application; and participant (Member Boards' and study subjects') feedback regarding experience with CST.

Participation in the study of Member Board use of CST was open to all Member Boards. In spring 1997, the National Council's Board of Directors selected, from board of nursing applicants, the National Council jurisdictions to participate in the study. The selected jurisdictions included: AZ, CO, DE, MS, OK, OR, WA and WV-RN. Upon execution of a CST license agreement, software agreement and participation agreement, each participating Member Board received a software package consisting of a brief orientation guide and six case scenarios with end-of-case feedback. An instruction manual and scoring keys for each of the six cases was also provided to each Member Board. Training in the use of the software and scoring of performance records were provided by National Council staff. Selected jurisdictions have had CST software available for their use during FY98 and FY99.

Following a brief summary of the study results of seven participating Member Boards are the full reports of each individual Member Board.

Applications Explored by Participant Member Boards. The following table presents a summary of the applications explored across the participating Member Boards.

	Applications Explored			
Jurisdictions	CE	Re-entry	Discipline	Continued Competence
AZ	X	X		
CO	X			
MS			X	
OK		X		X
OR		X		
WA				X
WV-RN	X			

Study Participants. The study participants included 103 nurses with an age range of 25 to 76 and a mean age of 45 (SD=10). The number of years of clinical nursing practice of participants ranged from one to 44 years with an average of 16 years.

Orientation. Most participants reported spending about one hour in an orientation that included the use of the orientation manual, demonstration by board staff and working through one practice case. Four boards reported that one practice case seemed adequate for an optimal orientation while three boards reported the need for two to four practice cases to provide an optimal orientation. Results of the 1991 study of CST (N=263 study participants) suggested that two to three practice cases are needed for optimal orientation.

Evaluation of Participant Performance. Four Member Boards reported that participant performance records were scored using varying approaches. Boards that scored performance records reported that it took about 30 minutes. Three participant jurisdictions reported that performances were not scored but that the end-of-case feedback was used and found to be informative.

Participant Feedback: Appropriateness/Relevancy, Realism, User Friendliness, and Advantages and Disadvantages of CST.

- **Appropriateness/Relevancy of CST to Application Explored:**
  Approximately: 2 percent reported that it was not relevant; 28 percent reported that it was somewhat relevant; 70 percent reported that it was moderately to very relevant.

- **Realism:**
  Patient presentation: Approximately: 2 percent reported that these were not at all realistic; 14 percent reported these were somewhat realistic; 84 percent reported these were moderately to very realistic.
  Patient response to treatment: Approximately: 2 percent reported these were not realistic; 18 percent reported these were somewhat realistic; 78 percent reported these were moderately to very realistic.
  Nursing care options: Approximately: 4 percent reported these were not realistic; 25 percent reported these were somewhat realistic; 69 percent reported these were moderately to very realistic.
  Opportunity to demonstrate clinical decision-making: Approximately: 5 percent reported not at all; 56 percent reported some opportunity; 39 percent reported very to extremely good opportunity.

Rate CST as a measure of clinical decision-making: Approximately: 28 percent reported not a good measure; 42 percent reported fairly good measure; 30 percent reported very to extremely good measure.

- **User Friendliness:**
  Difficulty with computer recognition of free-text: Approximately: 34 percent reported frequent difficulty; 58 percent reported some difficulty; 8 percent reported no difficulty.
  Difficulty with review of patient chart: Approximately: 8 percent reported frequent difficulty; 23 percent reported some difficulty; 68 percent reported no difficulty.
  Difficulty advancing the clock: Approximately: 10 percent reported frequent difficulty; 16 percent reported some difficulty; 74 percent reported no difficulty.

- **Difficulty/challenge presented:**
  Approximately: 6 percent reported it much too easy; 82 percent reported appropriate level of difficulty/challenge; 7 percent reported much too difficult.

- **Advantages of CST:** Participant comments regarding the advantages of CST were:
  - Opportunity for critical thinking and/or exploring various decisions
  - Realistic cases
  - User friendly
  - End-of-case feedback
  - Costs associated with nursing care provided during the case
  - Potentially valuable tool for assessing continued competence or use as diagnostic tool
  - Potentially valuable educational tool

- **Disadvantages of CST:** Participant comments regarding the disadvantages of CST were:
  - Lack of user friendliness
    - Difficulty with use of free-text entry
    - Need to request each vital sign with a separate free-text entry
    - Difficulty advancing the clock
  - Time consuming to administer and score by board of nursing staff: need large-scale computer administration and scoring; need to determine psychometric soundness and legal defensibility
  - Difficult for those with limited computer skills
  - Lack of audio/visual component
  - Need more diverse case pool

Conclusions. After careful review and consideration of the Member Board reports, the CST Task Force felt that while there is indication that CST may be useful for a number of applications other than initial licensure, problems identified by the boards included: orientation to software; need for additional cases; need for administration of CST at a test center or location other than board of nursing office; and need for automated psychometrically sound scoring. Given that many of these issues are being explored during the CST Pilot Study, at its February 1999 meeting, upon a recommendation of the CST Task Force, the Board of Directors moved to postpone further exploration of Member Board use of CST for applications other than initial licensure until after the completion of the pilot study regarding the use as a component of the NCLEX-RN examination. Further, a motion was passed to direct that those Member Boards currently using CST for applications other than initial licensure and wishing to continue to use CST, be permitted to continue its use until August 2000, with the understanding that CST staff support of this project will end as of August 1999.

Attachment C

CST® Final Report: Member Board Use of CST® for RN Education and Assessment

Arizona State Board of Nursing

A. *Application Explored*

Our purpose was to explore the effectiveness of continuing education and re-entry courses in different populations. We wanted to determine what effect time away from patient care has on decision-making competency and look at the differences in CST® scores of nurses who are currently involved in direct patient care versus nurses who are not directly involved in direct patient care, or who have not been employed in nursing for a defined number of years.

B. *Subjects*

1. Recruitment
   Recruitment of nurses was done through the Board Newsletter, via talking with nurses at Nurses' Day at the Legislature, and by requesting Board Consultants to participate in CST testing.
2. Description of Subjects
   Of our 20 participants, four were involved in direct patient care, five were involved in patient care less than 20 percent of the time, nine were professional staff at the Arizona State Board of Nursing (ASBN) and two nurses had been out of nursing for more than five years. All nurses who participated were from the Phoenix or Tucson metropolitan area.

C. *Orientation/Administration*

1. The orientation to CST consisted of the orientation manual provided by the CST Task Force and the on-line orientation. Depending on the stress level of some participants, we provided additional one-on-one instructions to supplement information provided in the orientation manual. The average time spent on orientation was 44 minutes, with times ranging from 20 minutes to 180 minutes. The average time spent on the case was 41 minutes, with times ranging 15 minutes to 160 minutes. Due to time constraints, the majority of participants completed only one case study. **Seventy-six percent** of the participants rated the orientation manual as somewhat helpful or helpful and provided comments to improve the orientation process. **Eighty-three percent** of the participants rated the on-line orientation as somewhat helpful or helpful.

D. *Evaluation of Participant Performance*

1. A committee of four persons found the evaluation or grading of the transaction logs to be very subjective. On the scale of 2 (low) to 9 (high), we had no one achieve an 8-9 rating. Four persons rated a 7, three persons a 6 and three persons a 5. Fourteen logs were given a 4 or less rating. We estimated that **42 percent** of the participants passed, **22 percent** indicated they felt they had not done well on CST, and **67 percent** felt they had only done fairly well. The average scores by participating groups were:
   - Nurse Practice Consultant—3.72
   - Nurses with less than 20 percent of direct patient care—3.4
   - Nurses out of nursing more than five years—1.00
   - Direct patient care—0.75

E. *Appropriateness of CST to Application Being Explored*

1. Realism and appropriateness of content
   Sixty-one percent of the participants felt the cases, in terms of patient presentations, were moderately realistic to very realistic.

2. Ability of participants to apply clinical decision making process
   The participant's confidence level in CST's ability to measure participant's clinical decision-making process was low. Seventy-eight percent indicated that they felt it was only a fairly good measurement or not a good measurement at all.
3. Advantages
   - The opportunity for critical thinking, the variety of cases, and matching the diagnosis with interventions required. **Seventy-six percent** felt the level of difficulty in case presentation was appropriate.
   - The case-end feedback was a positive aspect, as participants found it helpful to frame their competence, know where to improve, and to learn more about the diagnosis and the treatment. **Sixty-two percent** found the case-end feedback moderately helpful to very helpful.
   - The knowledge of the cost of nursing care was consistently viewed with intrigue and interest.
   - The potential for being a valuable tool in assessing continuing competency. **Seventy-six percent** felt the case format provided them was a somewhat realistic opportunity to demonstrate their application of the clinical decision-making process.
4. Disadvantages
   Inability to input desired nursing activities for computer acceptance was the most frequently cited frustration. **Fifty-nine percent** indicted they frequently or always had problems with computer recognition of their activity. Comments such as "I couldn't get it to understand my desired action," or "Nurses use verbs so much and nouns are what the program accepts," were frequently heard.

   Another disadvantage was the repetition of entry related to like activities, and the inability to allow the user to select more than one option at a time. Some felt that frequently changing screens to add like activities caused the participants to lose their train of thought. The most frequently cited example was vital signs.

   Directions to initiate nursing activities were not easy to understand. Some found the screen designs difficult to follow when attempting to initiate nursing activities and decision-making regarding the next step. Some completed the orientation, got to the Nursing Activity screen and said, " Now what do I do?" One person stated, "It is not real life to go on duty and have to review the entire chart of a patient before beginning care." **Forty-one percent** indicated they had trouble reviewing a patient's chart. Another individual commented, "If I had bought a program like this, I would have requested a refund."

   Lack of user friendliness. **Eighty-nine percent** of participants rated their proficiency of using CST as moderate to low and **78 percent** felt CST was not at all or only somewhat user friendly. One participant wrote, "I found the program to bog down the process of taking the exam. I can only imagine a candidate sitting for the exam with the same level of anxiety and being faced with the frustrating nature of it." Another stated that the complexity of the computer techniques made it difficult to focus on patient problems.

   Principles of advancing the clock were not consistently understood. **Eighty-nine percent** stated that they did not have trouble advancing the clock, however, participants did not always demonstrate an understanding of the need to advance the clock as part of their nursing activities.

F. *Recommendation for Future Use for Applications Explored*

1. Is it feasible?
   Our administration site for CST was located at Arizona State Board of Nursing Office.

   The site coordinator and another Nurse Practice Consultant were responsible to make packets for the participant to complete (included forms and evaluations from NCSBN), set up times for the participant to come and take CST, orient them to CST upon arrival to test and review the transaction log with them when they were finished.

   A committee consisting of the executive director, site coordinator, the nurse practice consultant and a doctorally prepared nurse from another agency reviewed and scored the transaction logs.

It is estimated that the site coordinator spent approximately 150 hours on the CST project ($3,900). The time of the Executive Director, the Nurse Practice Consultant who helped administer CST, and the Nurse Practice Consultants who took CST equates to an additional 50 hours ($1,250).

2. Do you recommend the use of CST for the application explored?

We continue to feel there is definite need for a mechanism to measure continued competency, but the participants gave a low rating on their confidence level in CST's ability to measure their clinical decision-making process. Seventy-eight percent indicated they felt it was only a fairly good measurement or not a good measurement to all.

Recommendations we are suggesting to help participants gain more confidence in CST include:

a) Improve CST orientation with a focus on advancing the clock and expanded instructions. The orientation should be no more than one hour in length.
b) Develop a post-orientation evaluation that measures if the test participant has an adequate understanding of the computer application.
c) Allow for a "practice case" study prior to testing.
d) Modify the computer language to accept commonly used verbs.
e) Bundle like nursing activities to allow multiple activities to be done with a single entry.
f) Add a nursing kardex for a point of reference regarding activities of care.
g) Improve user friendliness through decreasing the use of the keyboard, increasing the use of the mouse of making CST more interactive through CD-ROM, tutorial approach.

2a) Could you continue to administer CST as you have done in the study?

Because of the high investigative workload at ASBN at this time we would not be able to continue administering CST. Furthermore, it may be more appropriate to have a private agency administer CST since participants could have a fear of coming to "the Board" for testing. It would seem that it would be best if the regulatory agency would not be administering continuing competency testing.

2b) Does the case pool meet your need?

In order for continued competency to be measured, it is felt it would be good to have the participant complete at least four cases. Since nursing is becoming more specialized, the participant would definitely want to test in their area of specialty, e.g., Med/Surg, OB, Pediatrics, etc., or the setting they are most prepared to work in e.g., Home Health, Long Term Care, etc. It seems that it would be optimal to have at least six to eight cases per specialty so that the participant could "practice on one to two cases" prior to testing on four cases.

2c) Other perceived needs of Member Boards.

Developing an on-line tutorial, as well as a video, to preview CST, would be most helpful.

3a) Major impediments that participants identified were:

See section E. 4.

Colorado Board of Nursing

Application Being Explored:

The Colorado Board of Nursing proposal selected by National Council State Boards of Nursing was to examine the use of Computerized Clinical Simulation Testing (CST®) as a component of evaluation for registered nurses who have been disciplined. The purpose of this pilot study was to explore the effect of a critical thinking course in nurses who have been disciplined by the Colorado State Board of Nursing for substandard care. The research questions in this study were:

1. What is the effect of a critical thinking/decision-making course on disciplined nurses' clinical decision making as measured by CST?
2. What are the effects of a combination of educational content specific courses related to the disciplined nurses' substandard care complaints and a critical thinking course on disciplined nurses' clinical decision making as measured by CST?

Design

The pilot study was designed to include three groups.

Group 1, the control group, would complete the CST before attending the Board-directed, content-specific CE that relates to the disciplined nurses' area of substandard practice. Three months after completing the CE, the disciplined nurses would again complete the CST.

Group 2 would complete CST before attending the Board-directed critical thinking course. Three months after completing the CE, disciplined nurses would again complete the CST.

Group 3 would complete CST before attending the Board-directed critical thinking course and the content-specific CE that relate to the disciplined nurses' area of substandard practice. Three months after completing the CE, disciplined nurses will again complete the CST.

Unfortunately, a number of limitations precluded the Colorado Board from implementing the pilot study as designed. Please see Section F, submitted in December for further comments. Ten subjects did complete Board-directed, content-specific CE prior to CST. Data regarding the time-frame between completion of CE and CST were not collected. Three subjects had not completed Board-directed CE at the time the CST was administered. Two subjects were not required to complete content-specific CE.

Subjects

Recruitment

The consultant reviewed the files of all registered nurses with current, signed stipulations related to substandard care. The use of drugs or alcohol precluded participation, as did non-compliance. Those nurses in substantial compliance with their stipulation were invited to participate in the study. A total of 43 nurses received invitations to participate. Twenty-eight responded to the invitation. Six chose not to participate, two of whom would be unable to come to Denver. One person would be completing probation before the study would be completed. The other three did not provide a reason.

Description of Participants

a) Number of Subjects
Fifteen subjects and seven alternates were selected.

b) Demographics
Gender:

FEMALE	MALE
13	2

Primary Language/Ethnicity (self described)

English, not of Hispanic origin	White
15	15

Age:

<30	30-34	35-39	40-44	45-49	50-55	> 55
0	1	2	3	6	2	1

Years in Nursing Practice

0-4	5-9	10-14	15-19	20-24	25-29	>30
0	4	4	2	3	0	2

Basic Nursing Education

Diploma	Associate Degree	Baccalaureate Degree
1	8	6

Practice Setting

Inpatient/Med-Surg	Long Term Care	OB	OR	Other (includes Critical Care)
6	3	2	1	2

Orientation/Administration

Most effective orientation:

Several methods were used to orient subjects to the CST. All participants received a copy of the orientation manual and the PowerPoint orientation printout prior to their scheduled test date. They were instructed to review it prior to the day of their testing. Upon arrival at the testing site, the materials were collected and questions were answered.

The first three subjects indicated that they felt prepared to begin the CST based on the written materials they had reviewed. All of these subjects seemed to have difficulty navigating the cases and generally did not implement target behaviors. The consultant then decided to use one of the cases as an orientation case and walk the subjects through the process. This seemed to facilitate more subjects actually implementing care for case clients.

Logistics and average amount of time for orientation

Subjects were directed to come to the Board office at a specified time. An orientation checklist was utilized for consistency in orienting subjects. Identification was checked, questions answered and an informed consent signed by each subject. The National Council participant questionnaire was administered. The office with the computer with the CST cases was reserved for all of the scheduled administration times. The Program Administrator who had initiated the process for participation by Colorado was no longer on Board. The CST cases had been installed on her computer. This actually facilitated the testing process. There were no time conflicts.

The orientation, including administration of a practice case, took between 45 and 60 minutes.

Logistics, personnel and average amount of time for administration

Logistics for administration were the same as logistics for orientation. The consultant remained available in close proximity to the subject, though not in the same office. None of the subjects chose to have the office door closed. This allowed the consultant to spot check the progress of the subject without being overbearing.

The personnel involved in the administration was the consultant. The office receptionist also interacted with the subjects solely to greet them upon their arrival at the office.

Administration for each case took about one hour. There did not seem to be any difference in administration time between the first few subjects who had not done a practice case and those who did utilize a practice case.

An additional fifteen minutes was utilized to complete the evaluation forms for the CST Task Force.

Evaluation of Participant Performance

Scoring process use

The consultant utilized the scoring key for each case as provided. At the completion of each CST, a Transaction List (TL) was generated that was compared to the scoring key provided. In all cases, individual judgment on the part of the consultant was utilized to give the subjects the benefit of the doubt in borderline situations. The consultant always used the scoring key in making those decisions.

Effectiveness of scoring keys/scoring process

In a few of the cases Colorado utilized, the consultant disagreed with several of the priorities indicated by the scoring keys. However, to maintain consistency and objectivity, they were utilized to score all subjects. It would appear that the CST program should be able to score the subjects based on the keys. The process itself was easy. The only problem encountered was that the directions for filling TLs deleted the lists for the first few subjects. The consultant had reviewed the TL on screen and was able to evaluate performance based on observation but was unable to further evaluate and document scores.

Sharing of evaluation data with participants or others

On-screen reviews were done with each subject. The consultant answered questions generated by the subjects based on the on-screen comments. Most of the subjects reviewed all of the data provided. Most subjects commented that they liked the process and felt it was a good learning experience. All completed the evaluation forms provided and were open with their responses. All subjects felt the process was non-threatening.

Evaluation data were shared with Board staff and members in far more detail than with subjects. Since the validity of the application was being explored, the consultant felt that it would be misleading to assume that a low score was an indication of unsafe practice. Review of the TLs did indicate to the consultant that most of subjects who did not perform nursing activities in a systematic, organized manner did not score in the passing range. This may be an indication of altered critical thinking/decision making skills.

How evaluation data might be used

In the judgment of the consultant, CST would be appropriate to evaluate the need for critical thinking/decision-making education versus content-specific education for nurses being disciplined. The consultant thinks that continuing the study of the application would be beneficial in making long term decisions regarding the application of CST.

Appropriateness of CST to Application Being Explored

Realism and appropriateness of content and level of difficulty of scenarios and scoring keys to application being explored

All subjects, Board staff and the consultant who reviewed them judged the scenarios realistic. The scenarios Colorado received were either medical situations or maternal/newborn. The outpatient and home care cases focused on coping and patient teaching of adults. One of the medical-surgical cases was a teenager whose primary needs were psychosocial. None of the scenarios incorporated caring for a postoperative client or a pediatric patient. We did not receive any scenarios dealing with the long-term care setting. Three scenarios depicted acute care emergency situations, two of which were the maternal/newborn cases, the third was a client on a telemetry unit.

Most of the subjects participating in our study practice in the acute medical-surgical setting. It was difficult to select varied scenarios for them to work through due to the limited cases available to us. The consultant felt that several of the cases were almost "cookbook" in nature. There is a very definite sequence of actions for a nurse to take for a patient experiencing chest pain, a laboring patient with increasing blood pressure, or a newborn that is becoming more lethargic and not eating.

The scoring keys for the last three scenarios described above were appropriate. The other three scenarios provided for more individualization of interventions for the client as identified by the subjects. However, the scoring key did not allow for that. Perhaps the psychosocial problems demonstrated by those clients are the highest priority problems. Several subjects and the consultant disagreed.

Ability of participants to apply the clinical decision-making process to management of cases

Subjects repeatedly stated that although they understood how to work their way through the cases, it was cumbersome to have to select individual parameters when groups or bundled interventions would be more appropriate. For example, all of our subjects wanted to be able to perform vital signs without having to select each part separately. Subjects who wanted to do a head-to-toe assessment of the clients at the start of the case made the same comment. Subjects stated that by the time they entered all of their selections for an assessment, they forgot why they were assessing. The other complaint that was consistently voiced was that it was difficult to figure out how to tell the computer what it was that they wanted to do.

The consultant is an educator and felt that nurses who did not use North American Nursing Diagnosis Association (NANDA) terminology on a regular basis might have difficulty navigating the nursing activities section of the programs. It is impossible to determine whether the difficulties encountered by the subjects was one of clinical decision-making or program navigation.

Advantages

Advantages of the CST include: the realism of the cases, perceived as non-threatening by subjects; could be cost-effective diagnostic tool in determining areas for CE; reliability of the scenarios for data collection; ability to repeat scenarios for pre- and post-testing of subjects; and the potential for developing even more realistic cases with real action and sound.

Disadvantages

Disadvantages of the CST include: lack of current technology regarding audiovisual components for the program; cumbersome nature of the program; lack of variety of scenarios received by Colorado; and the inability to test more that one subject at a time in Colorado.

Recommendation for Future Use for Application(s) Explored

1. Is it feasible? Resources used.
   a) The CST was installed on the computer of the Program Administrator. Her private office became the testing station for administration of the test. The privacy and ability to control noise and light was an advantage to the participants. Due to personnel changes early in the implementation phase, the computer was always available for scheduled testing. Had the Program Administrator remained on board, coordination of scheduling may have become an issue.

      A consultant who was hired specifically for this project administered the project. The consultant is a master's prepared RN with an education background. Office support was provided for clerical assistance by current office staff. Costs for office space, computer time, utilities etc. have not been calculated. Eighty hours were needed for planning, recruitment, administration and evaluation of the participants CST by the consultant. Additional hours for completion of the final report will be included in the final report under section C.

      COST: $ 4,300

      Communication with potential participants, and notification of selection required word processing, postage and telephone expenses.

      COST: 200

   b) Total Cost: $ 4,500

2. Do you recommend the use of CST for the application(s) explored? YES

   The original proposal submitted by Colorado indicated a desire to use the CST to evaluate decision making/critical thinking of nurses being disciplined and included a critical thinking course for some of the study participants. Due to a number of constraints, the education piece was not implemented. The CST was administered to participants being disciplined for substandard care. The CST scores indicated that more than half of the participants did not include target behaviors in their simulations. Whether this was due to the orientation, the cases, or the behaviors of the nurses, it would appear that further use of the CST could provide additional data.

   a) Colorado could continue to use the CST as was done during the study. It would be more beneficial however to use the CST as part of a diagnostic tool to determine what, if any, education might be of benefit to participants. This was the original intent of the Colorado proposal and should be further explored.

      Additionally, it became apparent that the original orientation to the CST was not adequate to ensure that the participants understood how to implement care. Even after using one of the cases as part of a live orientation, many participants had difficulty. One case may not reflect the ability of a nurse to provide care, which includes the target behaviors. We would recommend that participants complete at least two cases.

   b) The current case pool provided to Colorado is not adequate. In fact, the case selection was disappointing. More acute medical surgical nursing and at least two long-term care, pediatrics and psychiatric nursing cases would have been helpful.

   c) The size of the study thus far implemented is small. It would be advantageous to increase the study size. Providing a mechanism to administer the cases to participants as part of their stipulations to help identify appropriate course work to overcome deficiencies would also be helpful.

d) The CST concept is wonderful. Technology has advanced dramatically recently. Motion video and sound would enhance the CST tremendously. There is no reason why participants cannot see the client, hear breath sounds or whatever, and progress through a case in a much more realistic manner.

There also needs to be a documentation piece in the cases. A number of participants in the study were being disciplined for failure to document. The CST does not require this behavior.

Implementation of orders including medication administration needs to be integrated into the cases.

Lastly, a cross-reference of terms might be helpful for those unfamiliar with the taxonomy used in the cases. Some study participants became frustrated figuring out how to get to the nursing activity they wanted to implement.

It would also be helpful to have clustered behaviors. Measuring vital signs, measuring intake and output, and head-to-toe assessment are examples of clustered selections instead of separate actions as they now exist.

Mississippi Board of Nursing

A. *Application Being Explored*

The Mississippi Board of Nursing explored the use of CST as an evaluation/assessment tool for registered nurses who had been reported for practice-related violations of the Nursing Practice Law. Participation was either voluntary (for those involving no formal disciplinary action) or mandatory (for those involving formal disciplinary action).

B. *Subjects*

1. Recruitment

Disciplinary participants were recommended by Board disciplinary staff if it was determined that the violation was strictly practice-related. Non-disciplinary participants were requested to participate following the decision to close an investigation with no formal action. Closure of their case was not dependent upon their participation in the CST project.

2. Description of Subjects

a) Number of subjects

b) Demographics

Eight registered nurses participated in the project. The average age was 43.3 years (Range = 26 - 60 years), and the average number of years of experience as a registered nurse was 12.9 years (Range = 2 - 30 years). Twenty-five percent were African American, with the other 75 percent being white. Regarding entry-level RN education, 25 percent held an Associate Degree in Nursing and 75 percent held a Baccalaureate Degree in Nursing. Two participants were either enrolled in or had completed a master's degree in non-nursing.

Although participants used computers on a somewhat infrequent basis, they generally believed their computer skills to be average.

C. *Orientation/Administration*

1. Most Effective Orientation

2. Logistics and Average Amount of Time for Orientation

3. Logistics, Personnel and Average Amount of Time for Administration

All participants had the manual available to them and were assisted by the same Board RN employee as they worked through the same on-line orientation case. General orientation time ranged from 10 minutes to 60 minutes (Mean = 34.3 minutes) and participants spent an additional 20 to 105 minutes (Mean = 44.3 minutes) to review the orientation case. Involvement by the staff members ranged from very little to very much per participant, depending on the comfort level the participant had with the technology and the reason for which they were participating.

D. *Evaluation of Participant Performance*

1. Scoring or Evaluation Processes Used

2. Effectiveness of Scoring Keys/Scoring Processes

3. Sharing of Evaluation Data with Participants or Others

4. How Evaluation Data Might be Used

Actual scoring of responses was not performed. Instead, the Board staff member observed the participants during the orientation case and reviewed the case-end feedback with each participant following the testing session. Rather than a numerical score, the Board was interested in trends and patterns that presented themselves. For example, one participant had been identified by the employer as being deficient in decision-making skills, problem-solving skills and prioritization skills. A review of this participant's responses and a follow-up discussion with her confirmed this information and identified other areas of concern. This information was shared with the employer and participant and a plan of correction was developed.

E. *Appropriateness of CST to Application Being Explored*

1. Realism and Appropriateness of Content and Level of Difficulty of Scenarios and Scoring Keys to Application Being Explored

For most participants, the expected responses were at a lower level than were the entered responses. As a result, participants frequently needed to re-enter their responses in a more simple format that communicated knowledge and decision-making closer to that of an entry-level RN instead of an experienced RN.

2. Ability of Participants to Apply the Clinical Decision-Making Process to Management of Cases

Most participants could apply the clinical decision-making process to the management of cases but, as previously mentioned, were forced to break down their process into simpler steps in order to have their responses recognized by the program. Participants felt their entries seemed redundant and some believed there were limited options/responses related to management in general.

3. Advantages

The advantages were that participants could identify the cases as being realistic. The case-end feedback was perceived as an excellent summary of related information, a focused critique of the participants' responses and a revealing comparison of the participants' responses with those of the experts.

4. Disadvantages

A disadvantage of using CST with experienced RNs is that since the data and scenarios in CST target entry-level knowledge and behavior, experienced RNs were forced to consciously break down all decisions into multiple simple steps. This was frustrating for some participants and may have interfered with their ability to display their time and ability level.

F. *Recommendation for Future Use for Application(s) Explored*

1. Is it feasible? Resources Used.

   a) All CST sessions took place in a private office at the agency. Because a limited number of participants were involved, the executive director was the administrator/coordinator for all sessions in order to promote consistency.

   b) If used for practice-related categories of disciplinary cases, a testing technician (or equivalent) could be used to administer the test on a part time (1/3 time) basis. However, an RN staff member would need to meet with the participants to discuss their situation. This might require 1/4 time. Estimated cost per year for personnel: $40,000 - $45,000. Estimated cost of room, overhead per year (assuming testing would occur 30 days per year): $2,500. Miscellaneous costs: $500 per year.

2. Do You Recommend the Use of CST for the Application(s) Explored?

   Because of the intense one-on-one time required when working with practice-related disciplines, I would not recommend using CST for this purpose.

3. If You Do Not Recommend the Use of CST,

   a) What are the major impediments?

      The time and level of personnel needed to administer and evaluate the test and needed to interact with the nurse following administration.

   b) Would you perceive it as useful in the future?

      Probably not for this purpose.

   c) Other comments.

      I believe the technology itself and the awkwardness of some of the operational aspects interferes with the participant's ability to fully demonstrate what needs to be demonstrated. When combined with observation and evaluation of hands-on care and real-life on-your-feet decision-making, much can be revealed about the nurse's ability to function safely.

Oklahoma Board of Nursing

A. *Application Being Tested*

The applications being tested are continued competence demonstration and re-entry into practice.

B. *Subjects*

1. Subjects were recruited by placing a call for volunteers in the Board's newsletter and announcements at various meetings.

2. Application being tested

Continued competence demonstration	17
Re-entry into practice	8
Total	25

Area of practice

Education	7
Clinical nursing	18
Total	25

C. *Orientation/Administration*

Participants were given a brief verbal technical orientation, the instruction manual and instructed to use the initial scenario to acquaint themselves with the program. Technical assistance was immediately available throughout the test period. Tests were not timed. The testing periods ranged from 1 ½ to 5 hours.

D. *Evaluation of Participant Performance*

Each exam was scored by three different Board staff registered nurses. While scoring keys were helpful, the process was very time-consuming. Evaluation data were not shared with participants due to the time lapse between writing the exam and the evaluation being available. Evaluation data would be very helpful if immediate feedback is given.

E. *Appropriateness of CST to Application Being Explored*

The cases are realistic and the content is appropriate for entry-level practitioners. Most of the participants were able to apply the decision-making process appropriately. It was felt that some of the participants did not make a serious effort to demonstrate effective decision-making.

Advantages of CST are seen as (1) relatively user friendly; (2) cases are realistic and familiar to every nurse; (3) gives an opportunity for exploring various decisions; and (4) has potential as a learning methodology as well as identifying learning needs.

Disadvantages are (1) time-consuming to administer and score; (2) time-consuming for participant to write exam; (3) may be anxiety provoking for persons unfamiliar with computer technology; (4) may be threatening to nurses being expected to demonstrate their competence; and (5) legal defensibility.

F. *Recommendation for Future Use for Application(s) Explored*

1. Is it feasible? Resources used.

CST was administered in the Board office on a computer reserved for this project. One clerical staff person was assigned to schedule appointments, orient participants and maintain records. This required approximately one hour per participant, although this time could be decreased without

loss of integrity. Overall costs to the Board were minimal (less than $500) due to using existing equipment and staff. It is definitely feasible for implementation.

2. Do you recommend the use of CST for the application(s) being explored?

Applications explored were the use of CST for evaluation of ongoing continued competence and re-entry. CST is recommended for both categories. We had hoped to explore CST's use with nurses involved in the disciplinary process but were unable to recruit volunteers from this group for the pilot. However, the Board believes CST would be very useful and expect to utilize CST as a part of the assessment phase with this group.

(a) Could you continue to administer CST as you have done during the study? If not, how would you recommend it be administered?

If CST becomes a reality, the Board would want to consider contracting with a test center due to the volume of tests that would be administered.

(b) Does the current case pool meet your needs or would you need other cases?

There would need to be additional case scenarios developed particularly in the areas of legal/ethical issues.

(c) Other perceived needs?

Guidelines for scoring the tests were somewhat difficult to utilize. Perhaps efficiency and speed would come with practice. We are currently in the process of scoring the tests by three different RNs in the Board office. So far, there has been surprising consistency between the scorers.

(d) Other comments.

The Board appreciates the opportunity to be involved in this study. We will continue administering the test until March 1, 1999. The Board supports the continued development and future implementation of CST.

Oregon State Board of Nursing

A. *Application being explored*

Oregon's participation in the pilot study of the CST involved RNs who did not meet the practice requirement for licensure/renewal of license, and who were therefore required to complete a re-entry program. The pilot questions included: Could the CST be used in lieu of a re-entry program requirement? What criteria might be applied to such an alternative (e.g., length of time out of practice)? If CST is not sufficient in lieu of the program, how might it be used in conjunction with the program?

B. *Subjects*

1. Recruitment
2. Description – Number and Demographics

Seven subjects were recruited from groups of re-entry applicants enrolled in programs local to the Portland area. The coordinator's inability to take the CST to groups of participants in other parts of the state severely limited the recruitment potential. Participants were not only asked to voluntarily give time to take the test, but also had to travel to the board office to do so.

Subjects, with an average age of 43.6 years, reported an average of 7.4 years of experience as an RN. Educational preparation included associate degree, diploma, baccalaureate and master's degrees. Subjects rated computer skills as fair to very good. Five of the subjects were enrolled in an Internet re-entry course and informally reported that development of computer skills was an associated benefit.

C. *Orientation/Administration*

Subjects were oriented (as a group when possible) by an online demonstration using the post MI case. Subjects were actively involved in the demonstration by discussion and decision about information to review and nursing actions to take. Orientation sessions, approximately an hour in length, were lively and subjects seemed to enjoy the participation. Subjects were given a copy of the orientation manual and CST Participants' Checklist to use for reference as needed. With the online demonstration as the primary orientation, subjects were able to complete the test independently. Administration time varied from 45 to 90 minutes.

D. *Evaluation of Participant Performance*

1. Scoring or evaluation processes used
2. Effectiveness of scoring keys/scoring processes
3. Sharing of evaluation data with participants or others
4. How evaluation data might be used

End of case feedback was an extremely useful tool for the pilot subjects. Each subject was able to have immediate information and reinforcement regarding performance on the examination. Beyond that feedback, examination results were not scored. Two factors contributed to the decision not to score the examination results: 1) time for orientation to the scoring manual as well as actual scoring was not sufficient for the task, and 2) the relatively subjective nature of the scoring process (without training and inter-rater reliability) was discouraging. The resulting cost/benefit ratio did not support a decision to complete this activity.

E. *Appropriateness of CST to Application Being Explored*

CST is user friendly and, at least in a group setting, generates an enthusiastic response and enjoyment from nurses. It has extremely high potential for use as a learning experience for individuals or groups, especially when the end of case feedback is included.

When such systems are in place, a control study using pre- and post-CST testing would help to determine circumstances in which the CST might be relied on for a licensure decision.

The major current benefit of CST for the re-entry application is its potential as a teaching tool. Cases could be used effectively by individuals or groups, with end-of-case feedback and/or group debriefing. The test may be useful as an alternative to a long and expensive re-entry program at a later point in time, but only when 1) the scoring reliability has been perfected, 2) systems for administration of the test are widely available, and 3) studies have been done that correlate scores with competence to practice.

F. *Recommendations for Future Use for Application(s) Explored*

1. Is it feasible? Resources used
   a) Describe administrative site, personnel types, time, and materials used and provide
   b) Estimate of overall cost to administer.

The CST program was available at the Board office in Portland, Oregon. Re-entry students were located throughout the state. Those who were willing to do the test were required to travel to Portland. This served as a major deterrent to recruitment of subjects. Orientation required from one to two hours, and depending on the number of cases, the test itself could take from two to four hours. The volunteer subject was required to commit essentially a full day to the activity, especially if traveling from any distance. Travel from some locations would have required an overnight stay. An additional deterrent was the fact that we were able to offer no meaningful incentives for participation.

Administration site. A small interview room was designated for the CST pilot project. The computer, which contained the program, was kept there and the pilot coordinator had priority use of the room. While the site was far from ideal, it was sufficient for the small number of subjects we were able to recruit.

Personnel types. The education consultant served as pilot coordinator and primary staff person for the project. Duties included security for the system, recruitment activities, orientation of subjects, administration of the test, maintenance of records and preparation of reports. The information management specialist provided computer support service.

Time. Time needs occurred in three primary areas: recruitment of subjects, orientation and administration of tests, and record/report preparation. Recruitment activities (writing letters, phone communication and speaking to groups of re-entry students) required approximately 15 hours; orientation and administration required approximately 18 hours, and records/reports (including preparation for the panel presentation at the annual meeting) has required to date approximately 16 hours. Time was a major deterrent to the project. For example, more time for recruitment may have increased the number of subjects by a few, thereby increasing the time required for the other aspects. Since it was not possible to be relieved of any other responsibilities to engage in the project, the coordinator soon reached her maximum capability in terms of time.

Materials used. The Oregon State Board of Nursing (OSBN) purchased a new computer system in order to provide optimum equipment for the project. Other than that, the resources required for the project were daily operational items such as telephone, e-mail, copier and so forth. The major materials used for the project were the software and forms provided by the National Council.

Estimate of overall cost.

As described above, the two major areas of cost were the purchase of a computer system for the project and time – primarily of the project coordinator. Assuming the upgraded computer would subsequently be assigned to other uses, for the time it was dedicated to the pilot study the cost estimate is $140. Based on the approximate hours reported above, the personnel cost estimate is $1,600 for a total estimate of cost of $1,740.

2. Do you recommend the use of CST for the application(s) explored? If yes:
   a) Could you continue to administer CST as you have done during the study? If not how would you recommend it be administered?

b) Does the current case pool meet your needs or would you need other cases? If you need other cases, what type cases and how many would you need?
c) Other perceived needs of Member Board regarding the use of CST
d) Other comments

Recommendation. There is good potential for use of CST as a competency measure in lieu of or in addition to re-entry course requirements if two major problems can be overcome. First, a highly reliable scoring system, including correlation of scores and competency, must be developed in order to assure that licensure renewal decisions are correlated with reasonable assurance of competency to practice. Second (and only if the first can be done), a delivery system for the administration of the test must be reasonably accessible to the applicant. Since the pilot project did not have either of these essential components in place, its relative lack of success in terms of number of subjects should not be interpreted negatively in terms of the possibilities for use of CST for re-entry purposes.

Continued administration. No, it would not be feasible to continue to administer the test as was done during the study. First, there is neither time nor space to accommodate such a program. Second, and more important, it would be a major drawback to its potential benefits to have the test available in only one location within the state. We suggest the use of testing centers, such as Sylvan, combined with a system of scoring that is much more reliable and valid than could be provided in this office.

Case pool. If the issues identified above were resolved, and CST were established as a tool for assessment of competency for re-entry, more cases would be needed. The six cases now available to us would become generally known and "stale." In addition, new cases would need to be protected by a security system. The nature of the current cases, and the range of clinical situations they cover, would be appropriate to use for re-entry purposes. Because of the importance of a licensure decision, the test we rely on for that decision must be reliable, valid and secure. If a decision is made not to proceed with development of CST for competency testing, then the currently available cases would have excellent potential as a teaching tool within re-entry programs. For this use, it would need to be locally available to re-entry programs.

Washington State Board of Nursing

Recommendations for future use for application of CST explored in Washington State:

1. Initially, Washington had planned to explore three applications of the CST: re-entry into practice following completion of a refresher course, administration to those in the disciplinary process and for continued competency. It proved to be impossible to recruit volunteers for any application except continued competency and even that was a challenge. The CST does not appear to be feasible for the application tested.

    a) Two administration sites are being used, one in Eastern Washington and one in Western Washington. Both sites are housed in computer labs in schools of nursing that participated in the student project.

    The program manager for nursing education was responsible for testing the volunteers. Each volunteer took three to four hours to complete from three to six of the scenarios. Occasionally it was possible to schedule more than one volunteer for a testing session and that was a time-saver.

    All materials used were provided by the National Council.

    b) Estimated cost to administer is $130 (minimum) per administration. This is with the computer lab time being donated. Also there has been no charge from the schools for the paper used in printing the transaction reports.

2. I do not recommend use of the CST for the application explored unless it is refined.

    a) I could not continue to administer the CST as I have done. The time commitment is too great. I would recommend that the test be administered at an NCLEX® testing site.

    b) The current case pool does not meet the needs. Further cases would need to be recruited. I would have liked to have tested nurses returning to the work force and would have liked to have recruited graduates of the Regents program, but did not think of that until after the project started.

    c) The Washington State Nursing Commission would need additional staff to continue using the CST and that is not an option.

3. As stated before, I do not recommend use of the CST.

    a) Major impediments to the use of the CST include:
        1) Scenarios and the data banks need refinement.
        2) Nurses rely heavily on all senses in practice and there is no way to substitute words to substitute for this.
        3) Time commitment of staff to administer the CST.
        4) Reliability of computers in "borrowed" labs is sometimes lacking.
        5) Cannot continue to expect schools to donate the use of the computer labs indefinitely.

    b) The CST may be useful in the future; however, I think there may be other less expensive and less labor intensive ways of monitoring competency.

West Virginia Board of Nursing

The West Virginia Board of Examiners for Registered Professional Nurses began participation in the pilot study of Computerized Clinical Simulation Testing (CST®) in April of 1998. West Virginia's focus for this study is CST use for purposes of continuing education. CST was identified by this Board as an opportunity to participate in research relative to the evaluation of competence in application of the clinical decision-making process to the management of client care for the registered professional nurse since West Virginia's mandatory continuing education rule became effective January 1, 1997. Those participating in this study expressed appreciation for having been part of the CST study.

Recruitment, Description, and Orientation of Subjects

Orientation to the study occurred in April and recruitment began in early May. Announcement of CST occurred during Board meetings and regional council/association meetings. The CST study was announced in the RN Newsletter (Board publication), to West Virginia schools of nursing, and regional acute care centers. Faculty from schools of nursing were a great support in encouraging participation in this study.

Seventeen participants completed the study. Of these participants, the average age was 37 with an average of 11.4 years of experience. Twelve of the 17 participants were currently in direct patient care. Most participants use computers one to three times a week to daily with an overall rating on computer skills as "good." In evaluating their experience, most felt they did not perform well and had a low level of proficiency in using the software.

Orientation

Participants in this study began orientation by receiving the orientation manual for review prior to their scheduled time. At the Board office, they reviewed the orientation manual, on-line presentation, and then received individual or group instruction by staff. The individual or group instruction provided an opportunity to go through a sample case in order to visualize screens and demonstrate the ability to move from one area to another. Participants indicated that including individual instruction and demonstration during the orientation helped to reduce apprehension.

The average orientation time was 20.9 minutes. Review of CST orientation cases was an average of 20.1 minutes. The average administration time, which included orientation and one case, was 72 minutes.

Eleven out of 17 felt confident in their ability to carry out free-text activities. Fifteen out of 17 were confident in reviewing the "patient's chart." Eleven felt confident in "advancing the clock in simulated case time." Only eight of the 17 participants felt confident in suspending/stopping requests to "advance the clock in simulated case time." Ten participants felt confident in "selecting more than one Nursing diagnosis/problem" and indicating "etiology for diagnoses."

Evaluation and Appropriateness of CST to Continuing Education

Participants expressed a positive experience and made several recommendations to enhance the simulation experience. Case presentations were viewed as well-written and relevant to practice. Many participants indicated they preferred CST to a multiple-choice test. CST was seen as a good teaching tool and offers the opportunity for independent decision-making. Most participants felt the case-end feedback was very comprehensive and informative.

Participants with moderate computer skills indicated a positive experience with the simulation and that it was user friendly. Participants with limited computer experience focused on technical aspects of the simulation rather than the case scenario. Many of the free-text nursing activities entered were not recognized by the simulation. Repetitive entry of like activities was a concern to many participants. Location of the study was seen as a limitation. Having only one available study location limited recruitment and participation opportunities for many interested registered nurses in the state.

Recommendation for Future Use of CST to Continuing Education

This pilot study was administered at the office of the West Virginia Board of Examiners for Registered Professional Nurses. Personnel involved in this study included the executive secretary, assistant executive secretary, education secretary, and the computer operations coordinator. The estimated costs to administer would be personnel costs for the time administered, installation of software and program maintenance, materials, and supplies. Most personnel and participants felt that a site other than the Board office would provide a more comfortable environment. The Board office is truly not a place most nurses would choose to go and visit. Multiple sites would offer better access and probably would increase the number of participants.

The current case study pool is very diverse. A greater selection of case studies would provide those participants interested in specific areas an opportunity to obtain more continuing education. According to participants, any and all areas would be of interest, particularly community based studies. A more detailed orientation and instruction time would allow for a more positive experience for participants with minimal computer skills. Free-text expansion and reduction of repetitive entries of like activities was also recommended by participants.

Attachment D

Examination Committee & CST® Task Force Questions Related to CST®

Issues	When	Comments
I. Psychometric Validity/Measurement		
A. General Validity Issues		
1. What does CST® measure and what will it contribute to licensure decisions?		
a. What does CST measure? Can CST measure the affective domain? Is CST measuring higher cognitive levels? Exactly what traits does CST measure? (DA) What is (should be) the definition of entry-level clinical decision-making? (1/99) Is CST measuring critical thinking? (1/99) How is critical thinking defined? What model is used? (DA) It has been repeatedly stated that CST tests analysis. Analysis is not necessarily critical thinking. Are we confusing the taxonomy with critical thinking? (DA) Don't graduates have to make clinical decisions at some level? What cues do they recognize? (1/99)	Now	*Computerized Clinical Simulated Testing (CST®)* is designed to measure application of the clinical decision-making process. *CST records* when and what assessments and interventions an examinee initiates through free-text entry during a dynamic, time-based client simulation. Based on the actions, as well as the timing and sequence of actions, measures related to examinee management processes can be inferred and estimated. Results of the pilot study will include descriptive information that may or may not support the degree to which CST measures clinical decision-making. All study participants will answer survey questions related to the extent to which they were able to apply/demonstrate their decision-making skills during CST.
b. What will CST add to the licensure decision? How will we know whether the use of this technology will enhance our decisions regarding licensure? How will CST better measure an applicant's ability to practice safely? (1/99) Does CST contribute to evidence about who is competent to practice safe and effective nursing? (CST RP 4)	2000	Will have descriptive information in 2000 that may or may not support.
2. CST Case/Exam Validity, Realism, and Development		
a. Can we develop cases that are valid and realistic? Face Validity?	Now & 2000	Case authors write cases that are based on real-life experiences. Expert opinion as well as resources (including approved texts and journals) are used to document CST case content. Additionally, descriptive data obtained from study participants' answers to survey questions about realism in CST will be summarized as part of the final report on CST.
b. Does each CST case offer participants the opportunity to demonstrate their competence in application of the clinical decision-making process to management of the client? (CST RP 1)	2000	

c. Does each CST exam offer participants the opportunity to demonstrate their competence in application of the clinical decision-making process to the management of a series of clients? (CST RP 2)	2000	
d. Does the clinical situation depicted in a CST case reflect "real-life" situations encountered by nurses? (CST RP 1a)	Now	First, case authors write cases based on real-life experiences. Data that will address this issue will be provided by the answers to survey questions completed by all pilot study participants. Participants are asked to rate the extent to which the cases and the opportunities for initiating nursing activities seem realistic. The lack of multiple case management and the clock advance mechanism have been noted as possible limitations to the realistic nature of the simulation.
e. To what extent can client-management activities used in real-life client encounters be performed in CST? (CST RP1b)	2000	
f. Is it possible to "game" CST cases? (1/99)	2000	Will look at data to evaluate this but may take more time to identify the possibilities. Will require additional research beyond pilot study to investigate any possible CST gaming scenarios.
g. Does the CST methodology "drive" the content? (1/99)	Now	There are known limitations to the content that can be tested. CST does not measure the why and how of nursing actions. For example, CST can record if and when during a case an examinee performs a pulse oximetry as well as its relationship to the performance of other nursing activities. **Depending on the appropriateness and timing and sequencing of the action, inferences about examinee rationale can be made, however, CST cannot directly evaluate examinee rationale or whether the examinee knows how to perform the procedure.**
h. What evidence exists to suggest that higher scores on CST = better performance in the clinical setting? Can studies be done to compare CST results with employer evaluation? Faculty see students in very controlled settings. (DA)	Now	For actual licensure exam, can't get employer evaluations for those who fail licensure exam.
i. What is the case development and documentation process? (TP)	Now	*Guidelines for CST case and examination form development were approved for the pilot study by the joint CSTTF/EC Work Group*
3. CST Scoring Validity and Development		
a. How do we score? Can we score CST reliably and validly? (1/99)	2000	
b. Are CST case scoring keys a valid representation of optimal client management? Do they reflect currently accepted standards of practice? (CST RP 1c)	Now & 2000	The validation of the scoring item content is based on expert opinion as well as through the use of approved texts and journals. *The joint CSTTF/EC Work Group approved guidelines for scoring key development and validation for scoring key content.*

c. What measurement approaches (scoring system?) to evaluating participant performance on a case provide valid information about nursing competence in application of the clinical decision-making process? (CST RP 1d)	Now & 2000	Evaluating two different approaches (Rasch based and regression based).
d. Does the automated scoring system produce participant measures that are consistent with expert ratings of participant transaction lists (record of actions taken by a participant during a CST case)? (CST RP 1e)	2000	
e. Is scoring key development/validation repeatable? (1/99)	2000	
f. What is the scoring key development and documentation process? (TP)	Now	*The joint CSTTF/EC Work Group approved guidelines for scoring key development and validation for scoring key content.* The current process for scoring key development involves four different expert panels. One group develops the programmed key, second performs key validation, third rates performance records, fourth sets standard.
B. Comparing CST with the current NCLEX-RN examination?		
1. Do CST and multiple choice question (MCQ) testing methodologies measure different components of nursing competence? (CST RP 4a)	Now & 2000	*Data received in 2000 may or may not be able to answer whether or not CST and MCQs measure the same or different components of nursing competency.*
2. What evidence exists to suggest that CAT does not adequately evaluate competence? (DA)	Now	*There is no research or evidence to suggest that CAT does not adequately evaluate competence.*
3. Why are we connecting CST to NCLEX at this point if we are not sure exactly what it tests and how much it adds to validity? (DA)	Now	CST is under investigation—no decision has been made regarding its potential use for NCLEX
4. Is there cueing in CST? Or, how does cueing in CST differ from cueing in MCQs? (1/99)	Now	Differences of opinion exist between EC and CSTTF on this issue. EC believes cueing does exist. The EC is of the opinion that after the original free-text answer is typed, the alphabetically matched words that are displayed for clarification, selection and confirmation present an environment where correct answers can be ascertained from the list of distracters presented. In effect these lists of words provide "cues" for correct answers much like distracters in a MCQ test. *Additionally the EC believes that information, such as doctor's orders, may serve as cues.* **The CST Task Force believes that the cueing that exists in CST closely approximates the cueing that exists in real life situations. For example, the cues in CST found in the history and physical and doctor's orders in the patient's chart and the changes in patient condition over time and in relation to nursing actions are like real life cues.** Further, the CSTTF explains free-text entry of nursing actions in CST as follows: CST presents no questions with an associated list of answer options. CST permits the initiation of nursing actions through free-text entry. In order to accomplish this,

		computer intelligence has been built and structured so that the computer can recognize what examinees intend to do. The intelligence built for CST is a list of 1,250 unique nursing actions (parent terms). These nursing actions are associated with over 45,000 synonyms that have been structured to recognize examinee free-text entry (for example, the system will recognize either the free-text entry of "assess urine" or "urine, assess"). Once free-text is entered into the nursing activity box the computer searches for an alphabetical match to the examinee request and a list of alphabetically matched words is presented for clarification, selection, and confirmation. It should be noted that the examinee never knows whether anything he/she types in, or anything that appears in a list for clarification and selection, is an action that is on the scoring key. This is in contrast to the type of cueing that occurs in the MCQ examination. In the MCQ exam, the examinee knows that for every question encountered, one of the four options presented is correct. In CST any action initiated and confirmed during a particular case could be an inappropriate, risky or flag action for which they could be penalized. Thus, CST permits the capture of behaviors, both positive and negative, that examinees initiate throughout the time-based simulation as they manage the care of the client.
C. Scoring and Measurement		
1. How will we know what the pilot test measures, what it tests, and what it did? (1/99)	2000	
2. What is the relationship between participant ability measures across cases? (CST RP 2a)	2000	
3. Do participant ability measures from cases representing similar clinical practice areas (e.g., med-surg, peds, ob, psych, etc.) correlate more highly than measures from cases representing different content areas? (CST RP 2b)	2000	
4. Do participant ability measures from cases in which there are a preponderance of either assessment or intervention item types correlate more highly with other cases that have a preponderance of the same item type, than with measures from cases that have a preponderance of the other type or a more equal distribution of item types? (CST RP 2c)	2000	
5. What approaches to combining information across cases provide valid information about nursing competence in application of the clinical-decision making process? (CST RP 2d)	2000	
6. What is the reliability of each examination form? How many cases are needed to get a reliable estimate of participant performance across cases? (CST RP 2e)	2000	
7. At what level of measurement (e.g., items, sub-scores, cases or examination) are pass/fail standards best determined for individual cases and for a combination of cases? (CST RP 3)	2000	

8. What difference, if any, is there between individual case scoring keys developed by two independent groups? What is the difference in the measures they produce? (CST RP 1f)	2000	
9. Do participants who are expected to have "more" clinical decision-making ability (based on their having more nursing experience and/or more education) perform better on CST than those expected to have "less" clinical decision-making ability? (CST RP 4b)	2000	
10. Is performance on CST related to extraneous factors, such as computer experience, keyboard experience, practice with CST or demographic characteristics? (CST RP 4c)	Now & 2000	Based on previous research findings it is known that most examinees who participated in that study reported feeling comfortable using CST after having taken two to three practice cases. Further information about this, as well as data related to computer experience and demographics, *will be asked of examinees* during the pilot study. To mitigate effects of extraneous factors the *National Board of Medical Examiners (NBME)* sends to each candidate a CD with a simulation tutorial and practice cases. Costs, effectiveness and possible reduction of liability associated with this approach are not yet known at this time.
11. How will we control for the warm-up and fatigue effects in the Pilot test? (1/99)	2000	
12. How will we control for the inconsistencies in instructions given to the different participants? (1/99)	2000	
13. How will the fact that there are pre-graduation students taking the pilot affect the results? Not just how many classes they've had to-date in their program, but what core coursework are they missing? (1/99)	2000	
D. Standard Setting		
1. If the conclusion was that CST determined clinical decision-making at entry level, will we be able to set a standard? (1/99) 2. At what level of measurement (i.e., items, sub-scores, cases or examinees) are pass/fail standards best determined for individual cases and for a combination of cases? (CST RP 3)	2000	
E. Combining CST with the NCLEX examination		
1. How will pass/fail decisions be made using both exams? (1/99) What are the implications of using various approaches to combining CST and MCQ test results for determining eligibility for nursing licensure? (CST RP 5)	2000	
2. Will the NCLEX examination failure rate increase? (10/98)	Now & 2000	Yes, it will increase. It is difficult, however, to predict how much until the pilot study data analysis is complete.
3. What if the candidate passes the NCLEX portion and fails the CST or vice versa? (1/99)	2000	
4. Which way of combining CST with MCQ performance is most consistent with judges' decisions? (CST RP 5b)	2000	
II. Pilot Study		
A. Participants/Sample issues		
1. Is there a minimum number of participants that will be needed for statistical reasons? (1/99)	Now	The required sample size of 1,450 examinees, including 1,000 new graduates, must be met by July 31, 1999.

2. What happens if the pilot doesn't get the minimum number of participants needed? (e.g., loss of participants because of unusable data). (1/99)	Now	The required sample size of 1,450 examinees, including 1,000 new graduates, must be met by July 31, 1999. As of May 10, 1999, 1,384 examinees have tested, including 852 new graduates.
3. When do we quit collecting data and make a recommendation to BOD, if we do not get sample size? June BOD meeting? (1/99)	Now	See May 1999 Board (BOD) Agenda Item 6.1.1h.
4. Will we still have a representative group after participants whose data are "unusable/unfound" are removed from the sample? (1/99)	August 1999	
5. Can the project timelines be met? Will there be enough information for a 2000 Delegate Assembly decision? (10/98)	Now	Depending on any change in research priorities not all concerns raised by EC can be evaluated in the current project timeline. Some issues will not be resolved. For example: 1.) will have to further investigate standard setting since the pilot standard is not based on live exam and have no basis for comparison; 2.) may want to further investigate new case and scoring key development process that have been explored but not yet evaluated.
III. Operational Issues		
A. Can CST be operationalized for a large candidate population? (1/99)		
1. Technical Issues a. What processes in the operation can be automated—vs. "individual processes?" (TP)	2000	May need further investigation in a Beta test prior to implementation
b. Will there be critical errors System shutdowns when candidate fails? Candidate fails on-screen? What constitutes a crash/system failure? (1/99)	2000	May need further investigation in a Beta test prior to implementation
2. Case Development and Case Pool needs		
a. Can we (NC) program cases? (1/99)	Now	NC has not tried this process but CST staff observed this process at NBME. The authoring tools appear to be quite user friendly and the ability to do in-house programming could greatly enhance the efficiency of the case development process. However, NBME has not yet provided an estimate for orienting NC staff to this process.
b. Will there be case enhancements (i.e., A/V, multi-case management, delegation)? (1/99)	Now	Not planned at this time. A/V enhancement can be easily integrated into the CST cases as was demonstrated during the 1991 CST Pilot Study. It was not possible to test this methodology during the current study because of Sylvan limitations for administering CST with motion sequences. While possible in a technical sense, any changes from the current method of administration (i.e., A/V, multi-case management, delegation) will require additional scoring research that is not currently stipulated as part of the research plan.

c. How long does it take to develop a case? (1/99)	Now	With current development model, NC + NBME time = approx. 80 hrs/case. This current model involves a lot of duplication of work between NC and NBME staff. If NC did in-house programming, once they become efficient, anticipate significant reduction in time.
d. How many cases are needed in the pool? (and how many needed to score?) (1/99)	Now & 2000	Currently estimate is approximately 250.
e. How will items be coded? Searches for outdated concepts, etc.? Currency reviews? (1/99)	Now	Use four year cycle for review and reviews would be done using the linked databases that underlie CST.
f. How will we handle Item/Case Exposure? Will case disguise techniques be used? (1/99)	Now	By having adequate case pool and case disguise (two to three disguises/case).
g. How will we handle the increased level of security needed for case development? (1/99)	2000	
B. Examinee training Issues		
1. How do we cope with/implement a system that requires computer literacy—computer skills? (1/99) Will there need to be a lengthy training period for orienting candidates to CST? (1/99)	2000	Transition plan would address this.
C. Time Issues		
1. How much time is needed for testing of candidates using CST? (1/99)	Now & 2000	Based on NBME research and NC experience in 1991, for eight cases, up to four hours plus orientation time could be required for CST. If this is the scenario adopted, a four-hour time requirement can only be accommodated through an additional day of testing, thus necessitating a return to multi-day testing format for NCLEX. **However, depending on the current pilot study findings and on the way that CST and CAT might be combined, the exact amount of total testing time is difficult to predict at this time. Additionally, orientation time is difficult to predict at this time since, for the pilot study, subjects are required to become oriented prior to the testing session.**
2. How much time needs to be added to the total test time to allow for pre-testing of cases? (How much pre-testing is needed? What will be the minimum sample size?) (1/99)	2000	
3. How quickly can CST candidates' performance be determined and communicated to Member Boards? (1/99)	2000	
D. Cost Issues		
1. What are the human and fiscal resources required to support case/examination development? (1/99) What is the projected implementation cost? (1/99) What are the operational costs? (1/99) What is the projected cost for developing the number of cases needed for implementation? (1/99) What will be the projected cost to maintain the database and cases? (1/99)	Now	See May 1999 Board Agenda Item 6.1.1h.
2. What are the projected costs to purchase/change the contract with NBME, etc.?	Now	See May 1999 Board Agenda Item 6.1.1h.
3. If we buy NBME out, what will it cost to develop and/or continue to support the purchased software? (1/99)	Now	See May 1999 Board Agenda Item 6.1.1h.
4. What will be the cost to the candidate? (1/99)	Now	See May 1999 Board Agenda Item 6.1.1h.

5. Can the National Council afford the time and money to implement CST? (1/99)	Now	See May 1999 Board Agenda Item 6.1.1h.
6. Does the benefit justify the cost in a cost/benefit analysis of CST compared to the current NCLEX examination? (1/99)	Now	See May 1999 Board Agenda Item 6.1.1h.
7. What is the plan for National Council staffing and budgeting? (TP)	2000	
E. Vendor Issues		
1. What will be the criteria in conducting NBME contract evaluations? (TP)	2000	
2. Will we develop a CST Vendor selection/Contract negotiation process in the search for other vendors? (TP)	Now	Can't do CST as it is with another vendor due to NBME contract unless that vendor works for NC.
3. Will we develop a RFP process and documents for development and administration? (TP)	2000	
4. Can we develop a workable plan for interface of CST and NCLEX vendors? (TP)	2000	
F. Timeline for Implementation		
1. What is the projected CST implementation timeline? (TP)	Now	5-8 years anticipated.
2. Should there be a CST Beta Test prior to implementation? When would it occur?(1/99)	Now	Probably need a beta test prior to implementation.
G. Unprotected groups		
1. What are the operational issues for CST in relation to ADA (i.e., Software training, reading load, obtaining qualified readers)? (1/99)	2000	How CST responds to ADA concerns has yet to be determined.
2. What are the CST policies and procedures (i.e., readability, sensitivity DIF) (TP)	2000	Need to be developed to fit as closely to current NCLEX standards as possible.
H. MB Issues		
1. What is the plan for National Council committee structures? (TP)	Now	Policy
2. How will the exploration of changes needed for CST in MB exam activities, policies, and procedures take place? (e.g., registration, etc.) (TP)	2000	Policy
3. How will the exploration of changes needed for CST in MB laws and regulations take place? (TP)	2000	Policy
4. Is there a design for ongoing CST data flow to National Council? If so, what? (TP)	Now & 2000	
5. How would the addition of CST affect the operational processes for delivering NCLEX-RN examination results to candidates and boards? (1/99)	2000	
6. What if Member Boards do not like the results after we begin implementation? (1/99)	Now	Policy
I. Post implementation plans for ongoing CST R&D		
1. Is there a design for CST cycle research? If so, what? (TP)	2000	
2. What is the plan for developing ongoing development and evaluation mechanisms for CST? (TP)	2000	
IV. Political Issues		
A. Can/Will CST be used for LPN/VN's?		
1. Is CST applicable to LPN practice? (1/99)	Now	Current model is not designed for LPN/VN practice. An evaluation of CST would have to be performed to determine its appropriateness for LPN/VN practice, or model changes that would have to be made. A research study would then need to be conducted with this target population.
2. How will we reconcile implementing for RNs and not PNs? Should we not do parallel implementations? (1/99)	2000	Policy decision and would need R&D for PN version.

B. Vendor Concerns		
1. Relationship with NBME a. What can be done about NBME as the sole source test vendor since the software is proprietary? (1/99) b. Have other vendors been explored re: software development? (1/99) c. Are there perceived ramifications from our contractual relationship with NBME, such as physicians owning the software, and that they may not be inclined to support variations for the NCLEX examination? (1/99) d. What will be the BON and public (nurse, educator, etc.) perception to our being in a contractual (close? subordinate?) relationship with NBME? (1/99) e. Will NBME and a test administration service be able to deliver the exam per NC needs?	Now	Need input from legal and from membership
C. 1998 Delegate Assembly Perceptions about CST		
1. A concern has been raised that at Delegate Assembly 1998, the delegates did not get the "whole picture" when they made the decision to go ahead with the CST Pilot Study; there is some perception that other important projects may have been placed on hold because of the money spent on CST. (10/98)	Now	
V. Keeping up with technology		
A. Will the CST technology be "outdated" before implementation? Before our questions get answered? (1/99)	Now	Hard to evaluate as no comparable exams have been identified.
B. With voice activation and virtual reality in existence is CST already obsolete?	Now	Hard to evaluate as neither of these technologies are currently being developed as high stakes testing methodologies.
C. What are the known technological limitations to delivery of the exam? (1/99)	Now and TP	At this point, test administration center not able to deliver exam with motion sequences. Beta test will probably be needed to further evaluate the delivery system.
VI. Board of Nursing Use of CST for Applications other than NCLEX		
A. What is happening with the eight boards of nursing that are using CST for other purposes such as continued competence, continued education and discipline?	Now	Boards of nursing (BONs) have completed their evaluations. Final reports will be disseminated at 1999 Delegate Assembly (DA).
B. Will any of this information be useful to the EC/CSTTF in helping them to address issues related to CST as a potential component of the NCLEX-RN® examination? (10/98)	Now	BONs have identified a number of CST orientation and CST functional issues that need to be addressed. An outline of these will be included in their final reports to the 1999 DA.
VII. Other		
A. When and how do we communicate concerns to the BOD and Delegate Assembly, i.e., June BOD meeting? (1/99)	Now	See May 1999 Board Agenda Item 6.1.1h.

Notes

Notes

Forum: Examination Committee

Report of the Examination Committee

Committee Members

Lynn Norman, AL, Area III, *Chair*
Christine Alichnie, PA, Area IV
Teresa Bello-Jones, CA-VN, Area I
Cora Clay, TX-VN, Area III
Madelon Cook, OR, Area I
Teofila Cruz, Guam, Area I
Sheila Exstrom, NE, Area II
Rula Harb, MA, Area IV
Sandra MacKenzie, MN, Area II
Carol McGuire, KY, Area III
Anita Ristau, VT, Area IV
Lori Scheidt, MO, Area II

Item Review Subcommittee Members

JoAnn Allison, NH, Area IV
Charlene Carafelli, OH, Area II
Jill Degregorio, RI, Area IV
Nancy Durrett, VA, Area III
Analyn Frasure, ID, Area I
Carol Parsons Miller, WV-PN, Area II
Jackie Murphee, AR, Area III
Cynthia (Pat) Purvis, SC, Area III
Tom Neumann, WI, Area II
Mary Ellen O'Hurley, CT, Area IV
Louise Shores, OR, Area I
Ann Shuman, CA-VN, Area I

Staff

Patricia Brown, MS, RN, CCRN, *NCLEX® Content Associate*
Liz Farwell, MS, RN, *NCLEX® Volunteer Coordinator*
Barbara Halsey, MBA, *NCLEX® Administration Manager*
Amy Langen, *Testing Administrative Coordinator*
Kathy Potvin, *NCLEX® Administrative Assistant*
Casey Marks, *Acting Psychometrician*
Anne Wendt, PhD, RN, *NCLEX® Content Manager*
Anthony Zara, PhD, *Senior Director, Testing and Research*
Chief Operating Officer, SSD

Relationship to Strategic Plan

Strategic Initiative 1.....*The National Council will assist Member Boards in their role in the evaluation of initial and ongoing nurse competence.*
Outcome 1.....*"State-of-the-art" entry-level nurse licensure assessment.*

Recommendations to the Delegate Assembly

None.

Background

As one of the three standing committees of the National Council, the Examination Committee, coupled with the Item Review Subcommittee, which was created in 1997 to assist the Examination Committee in the item review process, represents almost half of the boards of nursing. The Examination Committee's charge is to provide a "state of the art" entry-level nurse licensure assessment. In order to do this, the committee has monitored and maintained the current NCLEX® examination to ensure that it meets the high standards of the testing and measurement industry, investigated future enhancements to the NCLEX examination, and monitored all aspects of examination administration. In addition, the committee oversees the activities of the Item Review Subcommittee, which evaluates the pretested master pool items for inclusion in the item pool. All of these activities continue to produce a psychometrically sound and legally defensible examination. The highlights of the Examination Committee and Item Review Subcommittee's activities are listed below.

Highlights of Activities

Monitor and Maintain the NCLEX® Examination

- **Developed and Monitored NCLEX® Examination Policies and Procedures**

The committee evaluated the effectiveness of all Board of Directors-approved examination related policies and procedures, as well as the Examination Committee's policies and procedures, and the *NCLEX® Examination Manual for Member Boards*. Revisions were made in pertinent procedures to reflect processes changed and refined during the fifth year of NCLEX examinations being administered via computerized adaptive testing.

- **Conducted Committee Item Review Sessions**

In the interest of maintaining consistency in the manner in which NCLEX examination items are reviewed before becoming operational, the committee: 1) reviewed new items only after the items had been tried out with accompanying statistics, 2) required that at least two Examination Committee members lead each Item Review Subcommittee meeting, and 3) made the final decisions addressing revisions to coding, Operational Definitions, Detailed Test Plans, and Guidelines for Currency Review. Under the direction of the Examination Committee, 1) RN and PN pretest questions were reviewed (see chart on next page) and 2) this year, Master Pool review groups for both the NCLEX-RN® and NCLEX-PN® examinations reviewed Master Pool Items. The Item Review Subcommittee will evaluate these items for inclusion in the Item Pool during FY99. Items from the NCLEX-PN examination were closely monitored for adherence to the *1999 NCLEX-PN® Test Plan*, effective April 1999. The responsibility of reviewing real examinations for face validity and providing a detailed report to the Examination Committee was assigned to the Item Review Subcommittee this year. The Item Review Subcommittee's assistance continues to reduce the heavy item review workload, facilitating the efforts of the Examination Committee in the item review process.

- **Examination Committee Item Review Subcommittee Sessions**

During three separate sessions between April 1998 and March 1999, members of the Examination Committee Item Review Subcommittee reviewed real examinations for face validity and pretest items. Of the 1,007 NCLEX-RN® pretest items which met statistical criteria and were reviewed by the committee, 970 (96.3%) were approved. Of the 1,208 NCLEX-PN® pretest items which met statistical criteria and were reviewed by the committee, 1,155 (95.6%) were approved for inclusion in the Item Pools.

- **Monitored Item Production**

The Chauncey Group's item development plan to meet the contractual goal of having three operational item pools is progressing. The Examination Committee is investigating how to best utilize a third item pool. The increased number of item writing sessions has produced more items than available pretest slots using the current Chauncey Group technology for maximizing pretest pools. The Chauncey Group technology for utilizing pretest slots has not been fully optimized and staff are working on improvements. The Examination Committee has been emphasizing to the test service the importance of writing items that address the higher levels of cognitive processing such as application and analysis, and an increase in those items has resulted.

■ **Evaluated Item Development Process and Progress**

The Examination Committee evaluated Chauncey-conducted item writing and item review sessions. Committee representatives attended and monitored the item development sessions whenever possible in order to provide feedback to the committee and to Chauncey.

RN ITEM DEVELOPMENT PRODUCTIVITY COMPARISON

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed	Items Approved	Survival Rate
April 95 - March 96	6	74	1,791	6	1,523	1,355	89%
April 96 - March 97	10	134	3,815	11	3,225	2,952	92%
April 97 - March 98	8	90	2,929	11	3,326	3,252	97.7%
April 98 - March 99	5	73	2,060	4	1,414	1,378	97.4%

LPN/VN ITEM DEVELOPMENT PRODUCTIVITY COMPARISON

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed	Items Approved	Survival Rate
April 95 - March 96	6	52	1,564	5	1,112	1,026	92%
April 96 - March 97	8	92	2,503	8	2,417	2,001	83%
April 97 - March 98	7	83	2,362	7	2,439	2,419	99%
April 98 - March 99	4	56	1,636	5	1,520	1,499	98.6%

■ **Monitored Implementation of 1998 *NCLEX-RN® Test Plan*, 1999 *NCLEX-PN® Test Plan* and Passing Standard**

The committee evaluated test performance of the NCLEX-RN examination in light of the new passing standard and test plan that were implemented April 1, 1998. In particular, the committee reviewed passing rate information for various subgroups during different testing intervals throughout the year to ensure that the change in passing standard and test plan produced the intended outcomes on the performance of the test.

■ **Revised and Approved *Detailed Test Plan for the NCLEX-PN® Examination***

To facilitate the item development process and assist candidates preparing for the NCLEX examination, the committee revised and approved the *Detailed Test Plan for the NCLEX-PN® Examination* (previously known as *Guidelines for NCLEX-PN® Item Writers*).

■ **Revised the NCLEX-PN® Candidate Diagnostic Profile**

The committee reviewed the format of the NCLEX-PN Candidate Diagnostic Profile and modified it in a way to be very similar with the new NCLEX-RN Candidate Diagnostic Profile that was implemented last year. In particular, the format in which candidate performance on the 10 content areas of the examination is conveyed has been changed. Graphical representation of content area performance has been changed to textual description, and this information has been moved from the front to the back side of the diagnostic profile.

■ **Responded to Member Board Inquiries Regarding the NCLEX® Examination**

As part of its activities, the committee responded to Member Boards' questions and concerns regarding NCLEX examination items and simulated examinations, particularly by conducting reviews of RN and PN items that were designated by Member Boards as inconsistent with jurisdiction statutes and/or not reflective of entry-level practice. Between April 1998 and March 1999, the Examination Committee reviewed eight NCLEX-RN examination items that were submitted by Member Boards. Six of these items were retained for future use and two items were pretest items that did not meet our statistical criteria; thus these items were held for revision. There were 20 NCLEX-PN examination items submitted for review. Fifteen items were retained and five items were pretest items that did not meet our statistical criteria; thus these items were held for revision.

- **Reviewed RN Job Analysis Updates**

At each scheduled meeting, the Examination Committee received updates from National Council's research department on the quarterly mini-job analysis studies and provided feedback to the research department. A four-member workgroup from the Examination Committee attended a National Council-hosted summit on state-of-the-art job analysis methods and issues and is working with the research department on the current RN job analysis study. The work group provided the research department with recommendations.

- **Monitored Examination Analyses**

The committee evaluated the statistical performance of the NCLEX examinations by reviewing reports on item and candidate performance. These reports included such elements as; item exposure rates, overlap among the items seen by different candidates, non-test-plan content coverage, questioned items, precision of competence estimates and pass/fail decisions, and passing rates and examination completion rates for many subgroups of candidates. All evidence in these reports indicates that the NCLEX examinations are running within defined parameters and are operating as psychometrically sound instruments, meeting National Council and industry-wide quality standards. See Attachment A for the test service reports, which provide more detail concerning these issues.

- **Monitored the Development of Operational Item Pools**

The committee monitored the process for the annual configuration and implementation of two parallel RN and PN item pools. To inform the configuration of item pools, the committee selected the variables from the RN and PN test plans and the NCLEX Item Coding and Tracking data base (NICT), which were used to create the pools. In addition, criteria that could be used for sculpting the item pools (the process by which an operational pool is assembled for efficient CAT performance; pools are sculpted every six months) were identified and weighted for pool sculpting. The committee reviewed pool configuration and face validity reports in order to monitor the pool configuration and sculpting process.

The committee determined that both the RN and PN pools should continue to be rotated semi-annually from April 1999 through March 2000, as they were during the previous years of CAT administration of the NCLEX examination.

- **Development of Third Operational Item Pool**

The committee continued work on the development of a third operational pool. Of particular psychometric interest at this time is whether two or three pool rotations are required per year to afford more testing opportunities to candidates. Reports and simulated tests have been requested from the test service to compare the quality of tests drawn from two "deep" pools verses three "shallow" pools. Results of these simulations will provide guidance as to the best possible way of integrating more operational items into the current testing format.

Investigated Enhancements for Future NCLEX Examinations

- **"Next Generation" NCLEX Examination**

At its October meeting, the committee developed an initial plan for addressing the organizational plan tactic concerning "the next generation NCLEX examination." The plan includes a pilot test of innovative items in 1999 via the Internet, initially using subjects recommended by Member Boards. These innovative item types are being developed under the direction of the Examination Committee. Staff will develop item types that take advantage of current technology to assess the competencies of entry-level nurse candidates. These new item types may also invoke different levels of cognitive processing not being assessed with the current text-based multiple-choice questions.

For this pilot study, approximately 20 RN and 20 PN test questions will be developed using formats currently not included in the NCLEX examination but currently in use in other testing programs. Proposed formats may include essay (or free-text entry), zone (where portions of a graphic are selected), order match (which could be used to identify steps in a procedure), numeric entry (for calculations), and shading (for selecting an area on a graphic). The questions will be targeted for the entry-level RN and PN candidates and will be designed to be compatible with the current test plans.

It is anticipated that a final report will be brought to the 2000 Delegate Assembly.

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

Since 1997, several members of the Examination Committee have met with members of the CST Task Force to develop examination-related policies and procedures for the CST pilot study, to learn more about CST and provide feedback to the Examination Committee, and to attend CST development meetings.

This year, the Examination Committee met as a whole to discuss key issues related to CST. At their first formal joint meeting this year, the Examination Committee participated in a mock CST scoring key development session. The purpose of this participation was to inform the Examination Committee about the specific content measurement aspects of CST in a hands-on and direct way. At the conclusion of the joint meeting, a multi-page list of questions and concerns was generated by the group regarding different aspects of the CST project (see Tab 13, page 29 in this *Business Book*). The Examination Committee expressed concern at the number and magnitude of important issues that were still "unknown" at this date in the project's life span. Although the Examination Committee attempted to focus its questions on the content measurement of CST, there were very important operational, cost, and political issues that the Examination Committee believed should be addressed with the Board of Directors. The substantive issues of concern to the committee are (1) psychometric validity/measurement issues, (2) operational issues and costs, and (3) political issues. A more detailed report of these issues was provided to the Board of Directors in May. Essentially the report is Attachment B, beginning on page 21 behind this report.

■ **Global Characteristics**

At its October meeting, the Examination Committee developed an initial plan for identifying global characteristics of entry-level nurse candidates that are important from a regulatory perspective. The plan included receiving input from National Council committees and panels as they met throughout the year at the National Council headquarters and from Area Meeting attendees. Once input from nursing regulation experts is received, a list of characteristics will be generated and Member Board representatives will be asked to prioritize this list. The Examination Committee will review and refine the list and present a report of its findings to the Delegate Assembly in 2000.

Monitored All Aspects of Examination Administration

■ **Directed Efforts to Enhance and Transition the Member Board Office System (MBOS) to Y2K Compliance and to a Web-based System**

Beginning in August 1998, an enhanced version of MBOS (3.31) and Expedite was mailed to Member Boards for installation. The Examination Committee also worked with Chauncey to implement MBOS Y2K compliance changes in April 1999 (version 3.32). An Advisory Group was appointed to assist Chauncey in the development of the Web-based MBOS. The Kentucky, Maryland, Minnesota, Mississippi, Missouri, and Ohio boards of nursing are participating in testing aspects of the system as they are designed, and providing feedback to Chauncey. National Council's testing and information technology departments are also testing the Web-based system. All Member Boards will be asked to participate in a testing period during the summer of 1999. The targeted implementation date for the MBOS Web-based system is October 1, 1999.

■ **Monitored Procedures for Candidate Tracking; Candidate Matching Algorithm**

The Examination Committee continued to monitor the status and effectiveness of the candidate matching algorithm. Chauncey conducts a weekly scan of the database, using additional matching criteria, to detect records received during the past week that appear to match a previously received record, yet did not combine during initial processing. Any suspect cases are resolved by staff. In addition, an annual full database scan was conducted in April 1999. The annual scan detected eight instances of duplicated records (i.e., records for the same person who tested more than once and who was treated by the system as two separate individuals). Chauncey examines the reasons for records failing to cumulate. In each case identified, the cause was related to the accuracy and completeness of the data provided. The scan results serve as a reminder of the importance of each board of nursing carefully checking candidate records for accuracy at the time of eligibility declaration. Cumulated records are required in order to properly enforce the waiting period between examinations and to provide blocking files of previously seen items.

- **Monitored Electronic Irregularity Reports and Site Compliance**

The Examination Committee reviewed summary reports on electronic irregularity reports (EIRs) and carefully identified and monitored any trends pointing to specific hardware, software, image capture or scheduling problems. The committee continued to review site compliance reports filed by Member Boards and National Council staff to determine compliance with existing policies, procedures, and security requirements at all Sylvan Technology Centers and Educational Testing Service institutional testing centers. Reported violations of policies, procedures, or security measures require follow-up and resolution by Sylvan or Chauncey. Resolution is monitored by the Examination Committee and National Council staff. The committee requested action be taken at nine testing centers found to have been constructed without meeting all previously existing requirements for proctor visibility. Four of these nine centers have completed modifications, four are in progress, and one center was closed to NCLEX examination administration. In the coming year, Sylvan has proposed sending a representative from the facilities department to each testing center twice per year to check and maintain equipment and/or perform scheduled hardware upgrades. A site compliance checklist will be completed at the time of the visit. In addition, Sylvan re-instituted the concept of Regional Managers who will oversee the testing centers. Seven Regional Managers will provide additional staff training and monitoring of activities in the testing center network. The committee and staff are hopeful these two enhancements will improve the quality of services provided to candidates at the testing centers and ensure centers are configured to meet all NCLEX examination requirements.

- **Monitored the Security of the NCLEX Examination Administrations and Item Pools**

The Examination Committee also monitored investigations of potential security breaches, reviewed final reports from the ETS Office of Test Security and made determinations and recommendations as to the security of the NCLEX examination administrations and item pools. Although there were several security incidents during the past year, no incident was determined to compromise the NCLEX examination item pools. The Examination Committee will be presenting additional information on security at its forum during the Annual Meeting (a closed session scheduled for Friday, July 30, at 8:30-9:00 a.m.).

- **Compliance with the 30/45-Day Scheduling Rule**

The Examination Committee, Board of Directors and National Council staff monitor compliance with the 30/45-day scheduling rule. From April 1998 through April 1999, seven candidates were unable to be offered an appointment within the compliant period. Sylvan continues the practice of notifying the National Council when centers are operating close to capacity. In addition, when centers are operating close to capacity, Sylvan contacts center staff to open additional hours or days, if at all possible. In some markets, temporary testing centers may be set up to handle overflow. Temporary testing centers do not administer the NCLEX examination until receiving special approval from the National Council. Currently, only one temporary testing center is used to administer the NCLEX examination and will be replaced with a permanent center by the end of September 1999.

- **Monitored Compliance with the Americans with Disabilities Act (ADA)**

All Member Board- and National Council-approved requests for ADA modifications are routed to a Special Conditions Coordinator at the Sylvan Candidate Services Call Center (CSCC) to help ensure candidates are scheduled in a timely manner and that all approved accommodations are provided. Sylvan continues to request assistance from Member Boards in providing lists of approved readers.

Future Activities

- There has been real progress toward the development of three operational NCLEX-RN and NCLEX-PN examination item pools, with a substantial number of new items being generated at the higher cognitive levels of application and analysis. The committee continues to monitor progress and work with National Council staff and Chauncey and Sylvan to investigate the best utilization of the three operational item pools.

- The Examination Committee approved the implementation of a mouse interface for the NCLEX examinations. This action increases the possibilities for the creation of "next generation" NCLEX items, which the National Council staff and test services are actively pursuing. In addition, the committee approved the use of a drop-down calculator for possible use in the NCLEX examination in conjunction with implementation of the mouse interface. A mouse interface for the NCLEX examination will not be implemented prior to April 1, 2000.

- In the future, committee members have requested that Sylvan provide data on quality assurance measures which provide an accurate view of the testing experience for NCLEX examination candidates. Sylvan's revised Quality Assurance Program and center performance improvement plan will be reviewed by the committee in the fall of 1999 to determine if it will meet the monitoring needs of the program. Examination Committee members will continue to request that the test services provide the creative solutions/resolutions to meet the daily challenges and opportunities related to the administration of the NCLEX examination.

- In FY2000, the committee will review the results of the 1999 RN Job Analysis study and evaluate the *NCLEX-RN® Test Plan.* The committee will also provide a report to the 2000 Delegate Assembly on global characteristics of entry-level nurse candidates that are important to assess from a regulatory perspective.

Meeting Dates

- October 5-7, 1998
- October 8-10, 1998 *(Item Review Subcommittee)*
- November 30, 1998 *(telephone conference call)*
- December 2-6, 1998 *(Item Review Subcommittee)*
- January 26-28, 1999
- January 28-29, 1999 *(joint meeting with the CST Task Force)*
- February 11, 1999 *(telephone conference call)*
- April 26-28, 1999
- April 27, 1999 *(joint meeting with the CST Task Force)*
- May 4, 1999 *(telephone conference call)*
- May 25, 1999 *(telephone conference call with the CST Task Force)*
- June 15-18, 1999 *(Item Review Subcommittee)*
- July 13-17, 1999 *(Item Review Subcommittee)*
- August 3, 1999 *(telephone conference call)*

Attachments

Attachment A

Annual Report of The Chauncey Group International and Sylvan Prometric

Highlights of Activities

■ **Telephone Activity in NCLEX® Examination Operations**

For the quarter ending March 1999, NCLEX® examination customer service staff at The Chauncey Group International answered 34,600 phone calls, which is a twelve-percent increase from the same quarter last year. Telephone registrations accounted for 5,384 calls during that time, which is a five percent decrease from the same period last year. Overall, activity on the candidate 800-number inquiry line has experienced a small increase this year. From the time the inquiry line was opened in February 1994, NCLEX examination customer service staff have answered more than 724,000 candidate calls.

■ **Staff and Workload in NCLEX® Examination Operations**

As we enter our sixth year of production, the incoming workload for NCLEX® Operations is stable and predictable. By using agency staff, our Operations group expands and shrinks to accommodate the changing requirements of our workload. By the end of 1998, more than 867,700 test sessions have been delivered to NCLEX examination candidates since the start of CAT testing in 1994. The Operations group has processed 598,000 scannable registration forms, 127,000 telephone registrations and 185,000 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 period, we expect that eight full-time agency workers will be answering calls and performing the required daily clerical support functions.

Seven Chauncey staff members 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 of nursing 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, collect customer satisfaction survey data, and prepare yearly program publications.

Registration and Testing Activities by Calendar Year						
Registration Type	**1994**	**1995**	**1996**	**1997**	**1998**	**Total**
Scanned Registration	122,493	122,814	116,575	113,871	122,449	598,202
Telephone Registration	22,745	26,136	26,281	25,233	26,436	126,831
Electronic Registration	38,435	42,531	41,549	39,894	22,605	185,014
Other Registrations	3,017	3,322	3,541	2,475	2,859	15,214
Total Registrations	186,690	194,803	187,946	181,473	174,349	925,261
Test Sessions	155,111	189,057	181,726	174,793	167,068	867,755

■ **Customer Satisfaction Survey**

Each quarter, to measure the effectiveness of our customer service, a random sample of NCLEX examination candidates using the NCLEX® 800 Registration/Inquiry phone number is sent a Customer Satisfaction Survey. The intention of this survey is to measure the perceptions of our services, to identify areas of weakness based on respondents' written comments, and to 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 1999, each survey question has received a 95% or greater positive response from candidates who returned the survey. Individual comments express satisfaction with the telephone registration service and the professionalism of the staff.

■ **NCLEX® Program Reports**

Five annual cycles of the *NCLEX® Program Reports* have been produced and distributed to educational program subscribers. 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, and candidate performance on Categories of Human Functioning, Categories of Health Alterations, a Wellness/Illness Continuum, Stages of Maturity, and by 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 thirteen-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 very 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	1997-1998
RN Educational Programs	572	657	656	670
PN Educational Programs	177	209	186	183

Test Development Activities

■ **Item Writing Workshops**

For the NCLEX-RN® examination, there were five item writing workshops held between April 1, 1998, and March 31, 1999. A total of 73 item writers, representing all four major practice areas, developed 2,060 items. For the NCLEX-PN® examination, four sessions were held with a total of 56 item writers producing 1,636 items.

Members of the Chauncey test development staff conducted the sessions. Item writers represented all four National Council geographic regions at each workshop. Members (or their designees) of the National Council Examination Committee and National Council staff also audited several of the workshops.

■ **Item Review Workshops**

The four NCLEX-RN® Item Review Panels that met between April 1, 1998, and March 31, 1999, approved 1,378 (97.4%) of the 1,414 items reviewed, while the five NCLEX-PN® Item Review Panels that met between April 1, 1998, and March 31, 1999, approved 1,499 (98.6%) of the 1,520 items reviewed. All of the meetings were held in Princeton. Each Item Review Panel consisted of participants who represented each of the four National Council geographic areas. Examination Committee members (or their designees) and National Council staff also audited these meetings.

■ **Item Review at the Examination Committee**

Over the past few years, our test development process has been successful in producing a larger volume of items and targeting those items to meet test plan and difficulty level requirements. Item production has surpassed the maximum size of tryout slots, which is dependent upon candidate volume. In the past year, there has been a decrease in predicted candidate volumes, which has resulted in lower sample sizes per item. There were 2,274 NCLEX-RN items pre-tested. Of the 1,007 NCLEX-RN pre-test items that met statistical criteria, 970 items (96.3%) were approved by the Examination Committee for inclusion into the item pools. There were 2,228 NCLEX-PN items pre-tested. Of the 1,208 NCLEX-PN pretest items that met statistical criteria, 1,155 items (95.6%) were approved by the Examination Committee for inclusion into the item pools. The low percentage approval rate reflects the decreased volumes of tryout items with adequate sample sizes. At the October 1998 meeting, the Examination Committee reviewed master pool items for currency. The committee approved a total of 106 (94%) of the 113 NCLEX-RN and 85 (92.4%) of the 92 NCLEX-PN examination items for continued use in the operational pools. At the December 1998 meeting, the Examination Committee reviewed real examinations from the April 1998 operational pool for face validity.

Targeting Item Difficulty

The Chauncey NCLEX examination test development team has been quite successful in improving its ability to target item difficulty for the NCLEX examination. Over the past few years, we have improved our test development process to target items that meet test plan and difficulty requirements. In addition, we have increased our focus on developing items that require higher cognitive thinking to answer. Several methods continue to be used including: discussing item difficulty at item writing and review sessions; discussing exemplars of difficult items; rewriting items that are based on appropriate content but which have not met NCLEX examination statistical criteria; and by providing National Council staff with recommendations for extending invitations to experienced item writers for returning to subsequent workshops.

Monitoring

The Chauncey test development team recognizes the importance of maintaining the currency of items over time. Ongoing monitoring of the CAT operational pools for both the NCLEX-RN and NCLEX-PN examinations for content, accuracy, currency, and appropriateness is done prior to release of the pools twice each year. Items that are flagged for content and sensitivity reasons are presented to the Examination Committee for disposition and removed from the master pool, when appropriate.

Chauncey, in collaboration with the National Council staff, has developed an extensive coding system, and all items in the NCLEX-RN and NCLEX-PN master pools have been coded according to several detailed content codes. This coding enables us to query the database for content that may be outdated or inaccurate.

Test development staff review the master pool of items on a rotational basis to re-validate items with current sources. These items are then reviewed by the Examination Committee with special emphasis on items that were flagged for accuracy or currency concerns. The Examination Committee makes a decision on the disposition of these items. Beginning in spring 1999, master pool items will be reviewed by a panel of item reviewers, prior to review by the Examination Committee.

Construction of 1999 Operational Pools

Prior to configuring the April 1999 item pools, a master pool of available items was evaluated. For the NCLEX-RN examination, the master pool consists of approximately 7,463 total items, an increase of 863 items from the previous year. For the NCLEX-PN examination, the master pool consists of approximately 5,551 total items, an increase of 1,001 items from the previous year.

Progress of Pools

At each meeting of the Examination Committee, Chauncey staff presents an item pool status report on both the NCLEX-RN and NCLEX-PN examination master pools and on the progress towards meeting the demands of the operational item pools. National Council and Chauncey staffs are constantly working together to evaluate the test development process and to propose modifications to the current procedures as needed.

Face Validity Reviews

The Chauncey test development staff routinely review actual and simulated examinations based on criteria established by the Examination Committee. In addition to reviewing test specification criteria, Chauncey staff review these examinations for additional criteria. The criteria, which were re-evaluated and changed by the Examination Committee over the past year, include documentation, cultural awareness, geriatrics, emergency procedures and the nursing process. The review also includes the identification of items based on similar content within an actual or simulated examination.

The actual and simulated candidate examinations reviewed for face validity are generated at five ability levels: low; moderate; borderline (pass/fail); moderately high; and high.

The face validity review of the simulated and actual examinations for the April and October 1998 operational pools indicated that there was some overlap of content areas which is most apparent in the longer examinations.

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 across non-NCLEX examination Chauncey staff. Using guidelines reviewed by the Examination Committee, the new items for the NCLEX examination item pools undergo a sensitivity review as they are processed during item development.

To address test-level concerns such as gender balance and juxtaposition of items, sensitivity reviews are done on a selection of the simulated examinations generated for the respective operational pools. The review of the 1998 operational pools indicated that the pools are generally in accordance with ETS sensitivity guidelines, which Chauncey uses.

■ NCLEX® Examination Differential Item Functioning (DIF) Review Panel Meetings

The NCLEX® Examination 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 test takers, one individual with a general linguistic background and one individual who is currently a licensed registered nurse.

DIF statistics are computed comparing the performance of males with females and of Whites with other ethnic/focal groups: Blacks, Hispanics, Asian Indians, Native Americans, and Pacific Islanders. Items containing moderate to large DIF are reviewed at a DIF Panel Meeting.

The sources of the items for review at the July 1998 meeting were the October 1997 operational pools and the October 1997 and January 1998 pretest pools. The panel reviewed a total of 97 RN and 100 PN items from the operational pools and 26 RN and 27 PN items from the pretest pools. The panel recommended the referral of 5 RN and 2 PN items from the operational pools to the Examination Committee for review and disposition.

The sources of the items for review at the February 1999 meeting were the April 1998 operational pools and the April 1998 and the July 1998 pretest pools. The panel reviewed a total of 114 RN and 107 PN items from the operational pools and 36 RN and 25 PN items from the pretest pools. The panel recommended the referral of 5 RN and 2 PN items from the operational pools for review and disposition by the Examination Committee.

The reasons for referral included access to facilities/services; childrearing practices; items about the view of self and personal space. The Examination Committee reviewed the items from the July 1998 DIF Review Panel at the October 1998 meeting and the items from the February 1999 DIF Review Panel at the April 1999 meeting. Items flagged by the DIF Review Panel were reviewed by the Examination Committee who decided whether to approve an item for reuse in the operational pools, put an item on hold for revision, or remove an item from the pool. Of the three RN items and two PN items referred to the Examination Committee by the DIF Review Panel, only one item was referred for revision. The remaining items were approved by the Examination Committee.

■ Readability Levels of Operational Pools

The Fry method of determining readability levels was used to calculate the reading levels of the operational pools for the NCLEX-RN and NCLEX-PN examinations for October 1998 and April 1999. This method calculates readability based on non-medical terminology. According to the Fry index, the estimated reading levels of the October 1998 and April 1999 RN operational pools are grade 8 and 7.8 respectively, and the estimated reading levels of the October 1998 and April 1999 PN operational pools are grade 7.1 and 6.6 respectively. These levels are below the National Council policy for a maximum reading level of tenth 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 newly developed items on-line that are in the pretest pools and/or simulated operational examinations for high, medium, and low achievers for both the NCLEX-RN and NCLEX-PN examinations.

In the fall of 1998, six Member Boards scheduled review sessions, while in the spring of 1999, 11 Member Boards have scheduled reviews.

All comments from a Member Board review 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

As projected in the 1998 report, Sylvan continues to expand the size of the testing network, although at a slower pace than in the past few years. As of May 6, 1999, the NCLEX examination is administered in 265 laboratories housing 2,830 workstations located in the United States and its territories. The current size of the network represents an increase of 431 workstations and 16 testing laboratories since the 1998 report. Moderate expansion of the

network will continue through 1999, and NCLEX examination candidates will continue to be able to choose from an increasing variety of test sites and testing hours.

■ **30/45-day compliance**

Sylvan maintained sufficient capacity on a site-by-site basis to adequately provide compliant seating to all candidates during the 1998 peak testing season for the NCLEX examinations. During the last year (April 1998 - April 1999), only seven NCLEX examination candidates were unable to be offered an appointment within the compliant period, which represents a significant reduction over previous years. Of the seven who were offered appointments outside of compliance, two were special accommodations candidates who had been approved to test in a separate room and also had extended testing or break time. Candidates who are not seated within the compliant period are sent a refund of their registration fee.

Sylvan continues to analyze center utilization levels to ensure we are able to meet the testing needs of all of our testing clients. We recently refined our processes to allow us to determine the number of blocks available to NCLEX examination candidates within the compliant period on a daily basis. Sites with less than 10 blocks available to NCLEX examination candidates within the next 30 days are reported to the National Council staff on a weekly basis.

Analysis of projected volumes show we still maintain sufficient capacity to provide compliant seating to candidates during the 1999 peak NCLEX examination testing season.

■ **Quality assurance update**

In early 1999, Sylvan created and began staffing a new Channel Services Department. This department consolidates and expands upon the functions of the previous Quality of Service and Channel Support Departments. Seven regional managers have been hired and are fully responsible for monitoring and enhancing the quality of services and operations at the sites they are responsible for. Regional managers provide training, ongoing support and follow up on issues raised by internal statistical measurement tools, Examinee Exit Evaluations, site visits and complaints. The previous Quality Assurance Plan has been analyzed and a new plan is currently being designed and implemented. Additional statistical tools not previously available are being incorporated into the plan to track network-wide trends. Individual incidents continue to be documented by Electronic Irregularity Reports (EIRs). Sylvan provides quarterly Quality Assurance Monitoring reports to the National Council's Examination Committee.

■ **Conversion of NCLEX® Test Center Administrator's Manual**

The NCLEX® Test Center Administrator's Manual used by Test Center Administrators (TCAs) when administering the NCLEX examination was revised and incorporated into Sylvan's standard Policies, Procedures and Practices Manual in late 1998. Incorporation of the NCLEX examination program into the standard manual makes locating critical information much easier for both center staff and SylvanAssist Hotline Support representatives as each client practice is organized in the same way. Additionally, all information contained in Sylvan's standard manual is available on-line. This permits test center staff and SylvanAssist representatives to easily locate required information by searching on key words such as "identification." Member Boards were sent copies of the Manual in January 1999 and will receive updates annually.

NCLEX Examination Operations

The operations in support of the NCLEX examination program functioned this past year much as they have in the prior year. The great majority of events occur correctly and on schedule. Occasionally when events do not proceed as planned, such as a server goes down or a file is delayed, Chauncey staff, with the assistance of our partners at Sylvan Prometric, make every attempt to resolve the situation promptly and deliver the required results as soon as possible. Events of note are described in detail in the following paragraphs.

■ **Photo images**

The quality of the photo images depends on many factors, such as, the lighting when the photo is taken, the skill of the person taking the photo, the dithering algorithm that converts a gray-scale image into black and white for printing, or the resolution of the printer. In October 1998, Chauncey implemented a procedure to print an enlarged and slightly clearer image for those reports containing an image that does not appear to be adequate for identifying the candidate. As a result of this enhancement, the frequency of calls from Member Boards for signature logs to assist in candidate identification has been significantly reduced.

- **MBOS, Expedite and Y2K**

This past year several significant steps were taken with MBOS and Expedite Manager (the PC software that transmits data to and from Chauncey) to update and bring them into compliance with Y2K requirements.

The first step was to install a Windows 95 version of Expedite Manager to replace the old DOS-based version. This step was phased in over many months to avoid saturating the MBOS Helpline, thus helping Chauncey to continue to provide a prompt response to calls for assistance. This new version of Expedite Manager was accompanied by an updated version of MBOS.

The second step involved a new version of MBOS that would create and accept Y2K compliant transaction records and produce the revised PN Diagnostic Profile. In order to implement this change, there was a one-week shut down of services to the Member Boards while all the old records were flushed out of the transmission queues and new software was installed at both the Member Boards and here at Chauncey. With the usual cheerful cooperation of the Member Board staffs, this conversion was accomplished with very little difficulty. The files that flow between the Member Boards and Chauncey and between MBOS and the Member Boards' internal systems are now Y2K compliant.

As part of the efforts to upgrade systems, Chauncey is developing a Web-based application of the MBOS software, which is targeted for implementation in October 1999. An Advisory Committee, which includes representatives from the Examination Committee, has been working with the application during the development process and has provided feedback to Chauncey staff about the application's functionality. All Member Boards will be provided with an opportunity to test the application in their offices prior to launching the new software.

- **NCLEX-PN® Diagnostic Profile**

A new test plan and passing standard went into effect for the NCLEX-PN examination on April 1, 1999. Simultaneously, a new NCLEX-PN® Candidate Diagnostic Profile was introduced which has been modeled closely on the NCLEX-RN® Candidate Diagnostic Profile which was introduced in April 1998. The new NCLEX-RN® Candidate Diagnostic Profile was very well received and provided a good model on which to design the NCLEX-PN® Candidate Diagnostic Profile.

Summary of NCLEX® examination results for the January through December 1998 testing period

Tables 1 and 3 provide a technical summary of the NCLEX examination results from January through December 1998. In addition, summaries for the January through December 1997 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 1998 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 multiple *Technical Reports* prepared by The Chauncey Group for the National Council of State Boards of Nursing.

The following bullet points are **candidate** highlights of the 1998 testing year for the **NCLEX-RN examination**.

- Overall, 116,713 RN candidates tested during 1998, compared to 121,912 during the 1997 testing year. This represents a decrease of 4.3 percent.
- 83,233 first-time, U.S.-educated candidates tested, compared to 89,580 for the 1997 testing year, representing a decrease of 7.1 percent.
- The 1998 average passing rate for the total group was slightly lower than in 1997. The overall passing rate was 71.8 percent in 1998 compared to 76.1 percent in 1997, and the reference group passing rate was slightly lower in 1998 than in 1997 (85.0 percent in 1998 compared to 87.7 percent in 1997). In April 1998, the passing standard for the NCLEX-RN examination was increased.
- Forty-eight percent of the total group and 51.1 percent of the reference group ended their tests after a minimum of 75 items were administered. This is slightly lower than the 1997 testing year in which 51.7 percent of the total group and 56.4 percent of the reference group took minimum length exams.

- The percentage of maximum length test takers was 14.2 percent for the total group and 12.8 percent for the reference group. This is slightly higher than last year's percentages (13.4 percent for the total group and 11.4 percent for the reference group).
- The average time needed to take the NCLEX-RN examination during the 1998 testing period was 2.32 hours (or two hours, 19 minutes) for the overall group, and 2.14 hours (or two hours, 8 minutes) for the reference group.
- 38.3 percent of the candidates took the mandatory break that occurs after two hours of testing, and approximately 3.9 percent of the candidates chose to take the optional break.
- Overall, 4.0 percent of the total group, and 2.6 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 1997 testing year.
- In general, the NCLEX-RN examination summary statistics for the 1998 testing period indicated patterns that were similar to those observed for the 1997 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 1998 testing year for the **NCLEX-RN examination.**

- The operational item statistics were consistent across the year and with the 1997 testing year. Point biserial correlations were generally in the range of 0.21 to 0.23 and model-data fit statistics were 0.05 to 0.08. Average item times were 60.3 to 64.0 seconds, indicating that candidates took slightly more than one minute, on average, to answer each question.
- Tryout item statistics indicated that 1,801 items were pretested during 1998. The number of tryout items flagged (44.1 percent) was slightly higher than last year (42.5 percent), but was well within the expected range of percentage of tryout items flagged. The number of approved pretest items decreased from 1,701 in 1997 to 1,006 in 1998.
- The mean B-Value of the RN tryout items for the 1998 year was -0.25, compared to -0.65 for the 1997 testing year.

The following bullet points are **candidate** highlights of the 1998 testing year for the **NCLEX-PN examination.**

- Overall, 50,230 PN candidates tested during 1998, compared to 52,687 during the 1997 testing year. This represents a decrease of 4.7 percent.
- 37,965 first-time, U.S.-educated candidates tested, compared to 40,659 for the 1997 testing year, representing a decrease of 6.6 percent.
- The 1998 average passing rate for the total group was slightly lower than in 1997. The overall passing rate was 77.9 percent in 1998 compared to 80.2 percent in 1997, while the reference group passing rate was slightly lower in 1998 than in 1997 (86.9 percent in 1998 compared to 88.4 percent in 1997).
- 54.4 percent of the total group and 57.9 percent of the reference group ended their tests after a minimum of 85 items were administered. This is slightly lower than the 1997 testing year in which 56.1 percent of the total group and 59.2 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 17.4 percent for the total group and 15.2 percent for the reference group. This is slightly higher than last year's percentages (16.8 percent for the total group and 14.6 percent for the reference group).
- The average time needed to take the NCLEX-PN examination during the 1998 testing period was 2.16 hours (or two hours, 9 minutes) for the overall group, and 2.00 hours for the reference group.
- 36.6 percent of the candidates took the mandatory break that occurs after two hours of testing, and approximately 1.9 percent of the candidates chose to take the optional break.
- Overall, 1.3 percent of the total group, and 0.6 percent of the reference group, ran out of time before completing the test. These percentages of candidates timing out are slightly higher than the 1997 testing year timing out percentages (0.8 percent for overall, 0.4 percent for reference group).
- In general, the NCLEX-PN examination summary statistics for the 1998 testing period indicated patterns that were similar to those observed for the 1997 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 1998 testing year for the **NCLEX-PN examination.**

- The operational item statistics were consistent across the year and with the 1997 testing year. Point biserial correlations were 0.22 to 0.23 and model-data fit statistics were -0.01 to 0.07. Average item times were 56.8 to 61.0 seconds, indicating that candidates took slightly less than one minute, on average, to answer each question.

- Tryout item statistics indicated that 1,548 items were pretested during 1998. The number of tryout items flagged (30.1 percent) was lower than last year (40.3 percent), but was well within the expected range of percentage of tryout items flagged. The number of approved pretest items decreased from 1,389 in 1997 to 1,082 in 1998.
- The mean B-Value of the PN tryout items for the 1998 year was -0.41, compared to -0.46 for the 1997 testing year. This continues the trend towards developing items of higher difficulty level.

References

Fry, E.B. (1972). Reading instruction for classroom and clinic. New York: McGraw-Hill.

Table 1
Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for the 1998 Testing Year

	Jan 98 - Mar 98		Apr 98 - Jun 98		Jul 98 - Sep 98		Oct 98 - Dec 98		Cumulative 1998	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	25,266	17,206	29,785	22,487	45,715	38,365	15,947	5,175	116,713	83,233
Percent Passing	73.5	88.2	74.3	88.0	75.7	83.4	53.5	73.0	71.8	85.0
Ave. # Items Taken	120.5	112.7	121.7	116.9	125.6	123.5	134.9	127.0	124.8	119.7
% Taking Min # Items	52.3	57.6	50.4	53.0	46.9	47.9	39.8	44.8	48.0	51.1
% Taking Max # Items	13.1	10.8	13.1	11.8	14.5	14.0	16.7	14.7	14.2	12.8
Ave. Test Time (Hrs)	2.29	2.06	2.24	2.06	2.29	2.20	2.60	2.35	2.32	2.14
% Taking Mand. Break	36.5	29.3	35.4	29.8	37.7	34.9	48.0	40.0	38.3	32.7
% Taking Opt. Break	3.7	2.2	3.5	2.1	3.5	2.8	6.0	3.8	3.9	2.6
% Timing Out	3.7	2.1	3.8	2.2	3.8	3.0	5.6	3.9	4.0	2.6

Table 2
Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for the 1997 Testing Year

	Jan 97 - Mar 97		Apr 97 - Jun 97		Jul 97 - Sep 97		Oct 97 - Dec 97		Cumulative 1997	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	24,948	17,544	31,913	23,809	49,948	42,488	15,103	5,739	121,912	89,580
Percent Passing	73.3	87.4	79.1	90.5	80.9	87.5	58.8	78.0	76.1	87.7
Ave. # Items Taken	122.3	115.1	116.4	109.2	118.2	114.6	135.7	125.2	120.7	113.9
% Taking Min # Items	50.6	55.5	55.0	60.3	53.1	55.6	42.2	48.6	51.7	56.4
% Taking Max # Items	13.8	11.7	11.8	9.8	12.7	11.8	18.3	14.6	13.4	11.4
Ave. Test Time (Hrs)	2.23	2.04	2.11	1.91	2.11	2.01	2.56	2.29	2.19	2.01
% Taking Mand. Break	35.7	29.2	31.7	24.8	31.9	28.4	46.3	37.1	34.4	28.2
% Taking Opt. Break	3.4	1.9	2.9	1.7	2.8	2.2	5.4	3.3	3.3	2.1
% Timing Out	3.5	2.1	3.0	1.7	2.7	2.0	5.3	4.1	3.3	2.1

Table 3
Longitudinal Technical Summary for the NCLEX-PN® Examination
Group Statistics for the 1998 Testing Year

PN	Jan 98 - Mar 98		Apr 98 - Jun 98		Jul 98 - Sep 98		Oct 98- Dec 98		Cumulative 1998	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	10,586	7,491	9,976	6,789	17,655	14,600	12,013	9,085	50,230	37,965
Percent Passing	75.3	85.9	75.2	86.2	82.4	88.8	76.0	85.4	77.9	86.9
Ave. # Items Taken	118.7	114.4	117.7	113.1	113.9	111.4	117.9	114.5	116.6	113.0
% Taking Min # Items	52.6	56.8	53.3	57.5	57.2	59.8	52.8	55.9	54.4	57.9
% Taking Max # Items	18.5	15.8	18.2	15.3	15.8	14.4	18.0	15.8	17.4	15.2
Ave. Test Time (Hrs)	2.21	2.04	2.20	2.01	2.04	1.92	2.24	2.09	2.16	2.00
% Taking Mand. Break	39.5	32.4	38.0	30.3	32.0	27.3	39.5	33.7	36.6	30.4
% Taking Opt. Break	2.0	1.0	2.2	30.3	1.5	0.7	2.1	1.3	1.9	6.2
% Timing Out	1.3	0.8	1.5	0.9	1.0	0.1	1.6	1.1	1.3	0.6

Table 4
Longitudinal Technical Summary for the NCLEX-PN® Examination
Group Statistics for the 1997 Testing Year

PN	Jan 97 - Mar 97		Apr 97 - Jun 97		Jul 97 - Sep 97		Oct 97- Dec 97		Cumulative 1997	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	11,120	8,192	10,717	7,491	18,695	15,606	12,155	9,370	52,687	40,659
Percent Passing	80.3	89.9	77.1	87.3	84.0	89.9	77.1	85.3	80.2	88.4
Ave. # Items Taken	115.0	110.4	116.9	113.2	112.8	110.3	118.0	115.0	115.3	111.9
% Taking Min # Items	56.9	61.4	54.5	57.7	58.9	61.0	52.3	55.3	56.1	59.2
% Taking Max # Items	16.9	13.9	18.0	15.7	15.2	13.6	18.2	16.2	16.8	14.6
Ave. Test Time (Hrs)	2.05	1.88	2.13	1.97	1.97	1.87	2.20	2.07	2.07	1.94
% Taking Mand. Break	33.1	26.2	36.9	30.3	30.2	25.8	38.7	33.3	34.1	28.4
% Taking Opt. Break	1.8	0.9	1.9	1.0	1.5	0.1	2.3	1.5	1.8	0.7
% Timing Out	1.1	0.4	1.1	0.6	0.1	0.1	1.4	0.9	0.8	0.4

Attachment B

Computerized Clinical Simulation Testing (CST®)

The Examination Committee (EC) held a one-time meeting with the CST Task Force (CSTTF) in 1995. At that meeting, the joint group identified characteristics of entry-level nurse candidates and the measurement methodologies that could be used to assess those characteristics (Exhibit A, page 24). As the CST project progressed, it was determined that Examination Committee input was needed for developing policies and procedures that CST would utilize in its large-scale pilot study. During 1997 and 1998, two to three representatives from the EC met with the CST Task Force as a work group to assist the CST Task Force and staff develop some of these examination-related policies and procedures, to learn more about CST and provide feedback to the EC, and to attend CST development meetings. In 1997-1999, EC representatives attended case development, scoring key development, key validation, and CST rating meetings in order to understand the complete scope of CST development.

In October 1998, the Examination Committee and the CST Task Force each worked to develop an appropriate division of the remaining CST project work and recommended a structure to the Board of Directors. In addition, the EC reiterated its commitment to involvement on the CST project. The Board determined the responsibilities of the Examination Committee and the CST Task Force at its November 1998 meeting: The EC will use the "CAT" development model for interface between EC and CSTTF; that the EC assume leadership for developing a preliminary transition plan; and that joint meetings should be used as much as possible.

At their first formal joint meeting in January 1999, the Examination Committee and the CST Task Force reviewed the Board's direction and further clarified their roles and responsibilities regarding the CST project. One of the other major activities of the meeting was for EC and CSTTF to participate in a mock scoring key development session. The purpose of this participation was to inform the EC about the specific content measurement aspects of CST in a hands-on and direct way. At the conclusion of the joint meeting, a multi-page list of questions and concerns was generated by the group regarding different aspects of the CST project (see Tab 13, page 29 of this *Business Book*). The EC voiced concern at the number and magnitude of important issues that were still "unknown" at this date in the project's life span. Although the EC attempted to focus its questions on the content measurement side of CST, there were very important operational, costs, and political issues that the EC believes should be addressed with the Board.

The substantive issues discussed are listed below, organized by (1) psychometric validity/measurement issues, (2) operational issues and costs; and (3) political issues.

Psychometric Validity/Measurement

1. What is CST measuring that is different from, and in addition to, the current NCLEX® examination?

   Based on information in the *CST Frequently Asked Questions* (CST FAQ) #1 and discussions with the CST Task Force and staff, the EC believes that CST attempts to measure the ability of the candidate to identify what nursing assessments and actions to take over time. This is accomplished using "free-text entry" to indicate the initial assessment and/or action in the management of a single client situation. The EC notes that, while no testing cues in the form of question or answer options are provided, a different form of cueing does exist in CST. That is, CST provides a list of activities from which candidates select what actions they desire rather than allow for total free-text entry.

   Thus, CST measures **what** broad assessments candidates' would like to make based on their selection of these assessments from a database list. Candidates then determine what broad actions to take based on selecting the action from a database list. The candidates must specify what they would do, but not **how** to make the assessments and not specifically **when or why** it is important to take the actions. The broad

specification of many of the possible activities and assessments does not allow sufficient demonstration of entry-level nursing competence, particularly for a high-stakes licensure examination. There seems to be a lack of breadth and depth in the competencies measured by CST; candidates only need provide an identification of what action or assessment is needed. As currently configured, CST seems able to tap candidate competence in determining the general assessments, interventions and reassessments in the management of a single client, but it does not address in-depth knowledge about the quality of assessments or interventions, or the rationale for each action. The EC is also unsure to what extent CST really taps much of the higher order thinking skills such as analysis, synthesis and evaluation. The EC notes that the current multiple-choice NCLEX-RN® examination also measures nursing assessments and actions that should be taken in caring for a client (without "free-text entry" and without the management of a single client over time).

In addition, the EC noted in its joint meeting with the CST Task Force, that problem identification/Nursing Diagnosis and efficiency information is being collected but is not utilized in the measurement of examinee performance at this time. There is no method currently under investigation for using this information within CST.

2. What characteristics of the entry-level nurse does the current NCLEX examination measure that CST does not measure?

   Based on Exhibit A, the *NCLEX-RN® Test Plan*, and information discussed at the joint CST meeting, CST, as it has been currently developed, does not assess the management of multiple clients, supervision of others providing care, ethical issues, legal issues, and documentation—all aspects of the Management of Care section of the *NCLEX-RN® Test Plan.* In addition, CST does not measure competencies related to how to perform procedures nor the use of therapeutic communication skills in caring for clients. CST does not assess many of the competencies necessary for caring for clients with psychosocial needs. Also, aspects of growth and development and physical assessment techniques are not captured by CST (e.g., the ways an assessment might need to be performed differently on a geriatric vs. pediatric client). Thus, there are some areas of health promotion and maintenance that cannot be measured by CST. In summary, there are large areas in the *NCLEX-RN® Test Plan* that are not and perhaps cannot be measured by CST at this time.

3. What are the psychometric issues that will need further exploration?

   Information will need to be collected regarding potential bias and sensitivity issues, readability level issues, performance issues relative to the complex nature of the CST software, and ADA accommodations. All of these issues will need to be researched by National Council because there are no other large-scale licensure programs using simulations which have procedures for addressing these psychometric concerns. Also, since the information developed through the pilot study was gathered using volunteers on CST assessments that had no consequences, some type of beta testing will be needed to develop more specific policy-related information about CST using a randomized subject design with CST.

Operational Issues and Costs

4. How long will the CST assessment need to be and what are the cost implications of this decision?

   Based on the CST FAQ #9 and #12, information contained in the Finance Committee report to the Board of Directors (May 1999 meeting), and the Board Report to the 1998 Delegate Assembly, an operational CST would likely need to be at least eight cases per candidate and require a lengthy tutorial. This equates to about five hours of testing at a minimum, requiring a second day of testing and at least a doubling of the candidate cost. Currents cost projections show that this project would cost approximately an additional $6 million and take more than five years for a full-scale implementation.

5. What are the implications of the current contract with NBME?

   Based on the Board's 1998 Delegate Assembly report and the Finance Committee Report, the EC notes that NBME is the only test service partner that will be permitted to work on CST-related issues. The Examination Committee is very concerned about this contracting arrangement, particularly in terms of being "locked-in" to using the NBME as a single-source vendor for the entire life span of CST.

6. What are some of the important transition issues related to implementing CST?

   In addition to the high cost of the project, the amount of volunteer and staff time needed to implement such a large undertaking should not be underestimated. The EC is concerned about the sufficiency of available volunteer hours, considering the other projects underway at the National Council. Furthermore, the drain of volunteer time needed to work on panels for the development of CST should not be underestimated in light of the need to use perhaps this same pool of volunteers for the NCLEX item development panels.

7. What are some of the concerns related to the CST software?

   The EC is concerned about the ability of the CST software to be future-focused (particularly with the NBME being the only possible software developers for the system). That is, CST is currently a text-only system and written descriptions of client problems seems likely to be technologically outdated by the time of a possible implementation. Although ostensibly designed to model realistic practice, there is artificiality to how nursing actions are "conducted" in CST that is quite different than practice (e.g., can't do a whole body skin assessment, but must specify by body part). Based on concerns reported by some Member Boards in their report on the use of CST for the 1998 Delegate Assembly, the CST software is not very intuitive and will require considerable candidate training, highlighting the potential danger of CST actually assessing software system manipulation knowledge rather than nursing competence. Also, the EC is concerned that there are issues related to the testing of foreign-educated and ADA candidates regarding computer literacy, ESL, opportunity to practice, and the required reading level.

Political Issues

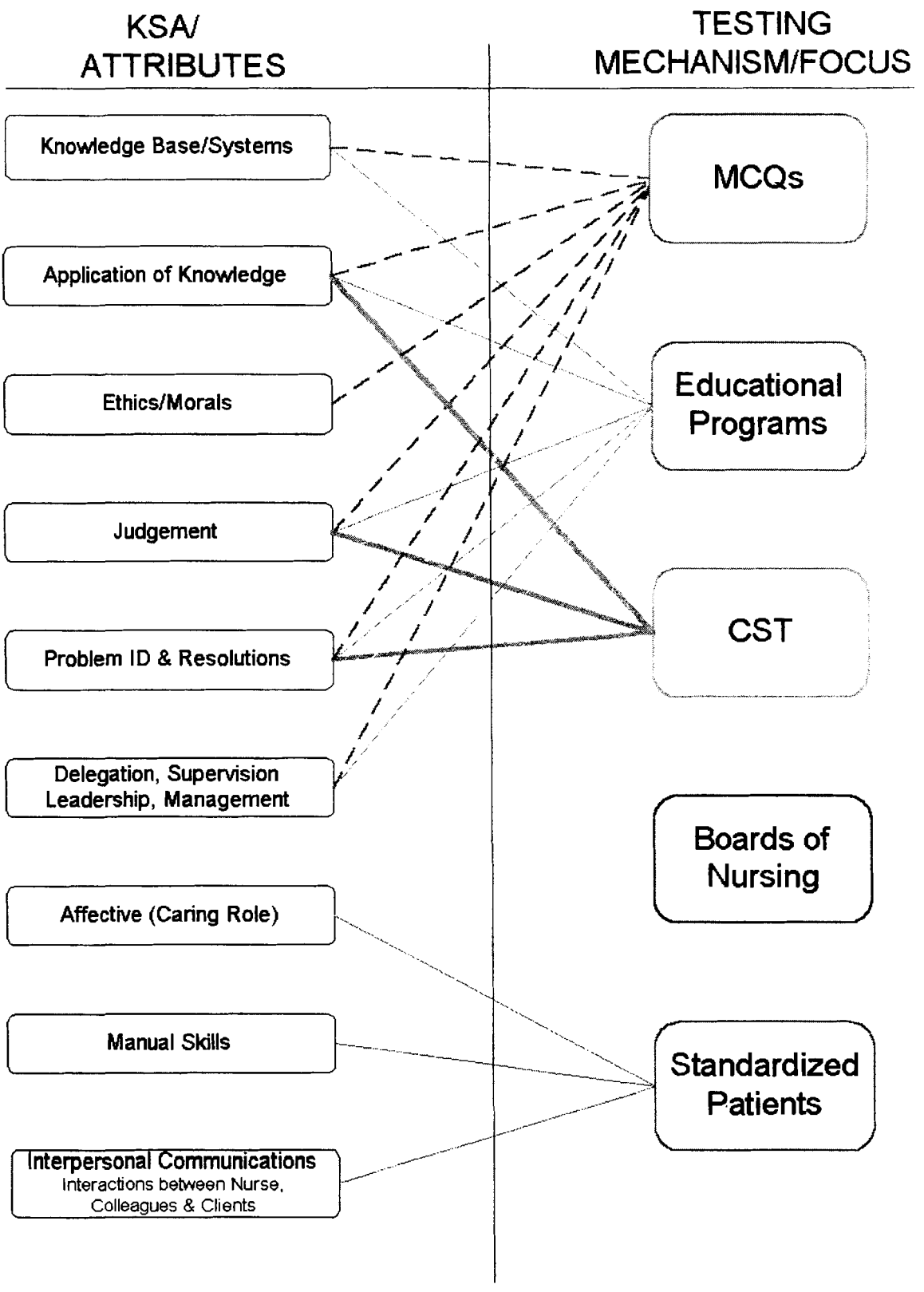
8. Can CST be used to measure LPN/VN competence?

   Based on the CST FAQ and Board report to the 1998 Delegate Assembly, CST is not appropriate to assess LPN/VN competence as it is currently designed. To create a CST model and cases that would be appropriate for LPN competence would require another significant research program at an unknown cost to the National Council. Since approximately 33% of the annual NCLEX volume is practical/vocational nurse candidates, the EC believes that there are unanswered issues related to this population's reaction to an implementation of CST for RNs prior to considering an investigation of CST for LPN/VNs. The EC believes that National Council should be mindful of sending a "hidden" message regarding the nature of LPN/VN practice, if it implements CST for RNs before even considering LPN/VN practice.

9. Should the Examination Committee's analysis and assessment to CST be presented to the Board at this time?

   The EC has struggled with its responsibility regarding involvement with CST since there is no formal mechanism for the committee to report its analysis of CST to the Board of Directors. In light of this, the committee is taking the initiative to share with the Board the information collected to date regarding CST and its assessments. Given its knowledge of entry-level licensure assessment and the real regulatory information needs of Member Boards, the EC voted unanimously to not support CST for an entry-level licensure implementation. There is currently sufficient evidence to know with a high certainty that CST will not be a viable element of the entry-level NCLEX-RN examination. There are a number of fundamentally important questions that are still open and will remain largely so even after the pilot study is complete.

Exhibit A


KSA/
ATTRIBUTES
TESTING
MECHANISM/FOCUS
Knowledge Base/Systems
Application of Knowledge
Ethics/Morals
Judgement
Problem ID & Resolutions
Delegation, Supervision
Leadership, Management
Affective (Caring Role)
Manual Skills
Interpersonal Communications
Interactions between Nurse,
Colleagues & Clients
MCQs
Educational
Programs
CST
Boards of
Nursing
Standardized
Patients

Have a question about the NCLEX® examination?

Staff from the National Council, Chauncey and Sylvan Prometric will be available during coffee breaks outside the Delegate Assembly meeting room to answer your questions. A table will be identified as the NCLEX examination table.

Thursday, July 29	Friday, July 30
10:30 – 11:00 a.m.	10:30 – 11:00 a.m
3:00 – 3:30 p.m.	

Want to have a special meeting to discuss an NCLEX examination issue?
Look for the *NCLEX Question Sign-Up Sheet* on the Message Board located near the registration desk. Please leave your name and information on how to contact you. Let us know if you wish to speak to staff from National Council, Chauncey or Sylvan, or any staff combination. Staff will contact you to arrange a time and place during the Annual Meeting in Atlanta.

What if we miss you during the meeting?
If we miss you during the Annual Meeting and you still have a question or comment you would like to share with the Examination Committee or staff, simply complete, detach and return this page to the National Council.

By MAIL: Attn: Barbara Halsey, 676 N. St, Clair Street, Suite # 550, Chicago, IL 60611
By FAX: Attn: Barbara Halsey, 312-787-6898

Name _____ Title _____

Jurisdiction _____ Phone Number _____

1998 Annual Report for the National Council of State Boards of Nursing, Inc.

Submitted by Assessment Systems, Inc.
June 1999

1998 Program Highlights

- A significant focus for ASI in 1998 was the implementation of the National Nurse Aide Assessment Program (NNAAP™) Written Examination in 30 client states and the continued development of phase two of the NNAAP™: the Skills Evaluation.

- The Written Examination rollout began in June and all states were converted to the new examination by October. The implementations were staggered for quality assurance, and the transition to the new examination was seamless. A comprehensive implementation of the NNAAP™ Skills Evaluation is in progress.

- 1998 was a successful year for nurse aide contract renewals. ASI maintained 100% contract retention, securing contract renewals for Alaska, Connecticut, Delaware, Idaho, Louisiana, Minnesota, Nevada, New Hampshire, North Dakota, Ohio, Rhode Island, and South Dakota.

National Nurse Aide Assessment Program (NNAAP™) Test Development Activities

Written Examination Activities:

- ASI concentrated on item pool maintenance activities in 1998. Item writing sessions were held in Denver in July and Orlando in August. Subject Matter Experts (SMEs) from seven client states participated in the Denver session, and SMEs from five client states participated in the Orlando session. Over 300 items were added to the NNAAP™ database as a result of these item writing sessions.

- After the item writing sessions were complete, the next phase of item pool maintenance involved item review. The item review session was held in Philadelphia in November, and SMEs from six client states participated. Nearly 300 newly written items were reviewed and will at some point appear as pretest items on a NNAAP™ Written Examination. Nearly 50 approved items were also reviewed for content and appropriateness.

- Item writing and review sessions are an essential part of the test development efforts necessary to maintain and grow the NNAAP™ item pool. ASI's next step will be to review the newly released *1998 Job Analysis: Nurse Aides Employed in Nursing Homes, Home Health Agencies, and Hospitals* performed by the National Council. ASI will work with SMEs to review the job analysis and ensure that the NNAAP™ is the most current and comprehensive examination available for nurse aide competency evaluation.

1999 Objectives for the Written Examination:

- ASI will rollout six new forms of the NNAAP™ Written Examination in late 1999 and will remove the six currently executing forms from service.

- A practice examination based on the NNAAP™ content outline and blueprint has been developed and will be available within the coming weeks. Nurse aide educators and employers in all client states will be notified when the practice examination is available. Individuals may download the practice examination from ASI's Web site (www.asisvcs.com) or may purchase the practice examination for a nominal fee.

Skills Evaluation Activities:

- ASI began Skills Evaluation development work October of 1997 with the Skills Development meeting. A cut score study for the Skills Evaluation was conducted in November of 1997, during which it was determined that each candidate will be tested on five skills and will be required to pass all five skills in order to pass the evaluation. With the initial stages of skills development well under way, ASI focused in 1998 on piloting the skills and determining the way in which the skills would be administered.

- Pilot testing the Skills Evaluation was of primary importance so that ASI could determine how the newly developed skills would function in practice. Pilot testing was held in Colorado and Florida in February 1999, and Ohio and Connecticut in March 1999. In each of these states, nurse aide candidates who were ready to take their competency evaluation were asked to participate in the pilot test. The skills were presented in a scenario-based format; that is, the skills in each scenario were designed to flow logically from one to the next in order to approximate a real-life care-giving situation. ASI's primary goals for the pilot were to ensure that the skills did flow in a logical pattern; to review administrative logistics; and to analyze the time it took for each candidate to complete each skill.

- ASI took the results of the pilot test to the Scenario Building Meeting in April, which was attended by SMEs from six client states. The group modified and enhanced the scenarios administered during the pilot tests, and the end result was a group of 29 scenarios. These scenarios will be used in a variety of combinations by ASI's client states in ways that best meet the needs of each client.

1999 Objectives for the Skills Evaluation:

- ASI will begin the Skills Evaluation rollout on June 7, 1999. As with the Written Examination, the Skills Evaluation rollout will be staggered over several months so that ASI can closely monitor the implementation in each state for quality assurance. By the end of 1999, phase two of the NNAAP™ rollout will be complete and client states will be administering both the Written Examination and the Skills Evaluation to their candidates.

- Comprehensive Nurse Aide Evaluator (NAE) training is essential to the objective and consistent administration of the Skills Evaluation. ASI held a train-the-trainer workshop in April in which subcontractors and lead evaluators participated. The new skills were demonstrated and discussed, and plans for the administration of the skills were finalized. The participants in the train-the-trainer workshop are now facilitating NAE training workshops across the country at fully equipped nursing facilities or nurse aide training programs. Hands-on training for all NAEs who will administer the evaluation has been planned, and NAE training has been conducted for Alaska, Connecticut, Maine, New Hampshire, South Carolina, and Washington state evaluators. ASI will monitor the workshops and will hold follow-up training sessions as necessary.

- Nurse Aide Candidate Handbooks will be revised to include information about the Skills Evaluation, and new NAE Manuals are being developed for the evaluators in each client state.

Marketing Activities

- ASI staff attended the 1998 National Nurse Aide/UAP Conference in Chicago, presented information about the NNAAP™ to conference participants, and held an open house reception and luncheon.

- ASI is actively speaking with Georgia, Tennessee, and Kentucky about their nurse aide programs. A presentation was given to the Tennessee Department of Education and Board of Nursing in March, and an initial meeting with the Kentucky Board of Nursing is scheduled for June 1999.

- ASI staff will attend the "Quality of Care in Nursing Homes: The Critical Role of the Nursing Assistant" conference sponsored by the American Society on Aging to be held in Philadelphia in July 1999.

Future Activities

- ASI will rollout six new forms of the NNAAP™ Written Examination in late 1999 and will remove the six currently executing forms from service.
- ASI will begin the Skills evaluation rollout in June 1999 on a staggered schedule.
- Staff will attend the 1999 National Nurse Aide/UAP conference in September.
- A practice examination based on the NNAAP™ content outline and blueprint has been developed and should be ready in late spring or early summer. Nurse aide educators and employers in all client states will be notified when the practice examination is available.
- Review the newly released *1998 Job Analysis: Nurse Aides Employed in Nursing Homes, Home Health Agencies, and Hospitals* performed by the National Council to ensure that the NNAAP™ is the most current and comprehensive examination available for nurse aide competency evaluation.

Notes

Notes

Forum: Mutual Recognition

Report of the Mutual Recognition Master Plan Coordinating Group

Committee Members

Shirley Brekken, MN, Area II, *Chair*
Kathy Apple, NV, Area I *(Board liaison)*
Iva Boardman, DE, Area IV
Joan Bouchard, OR, Area I *(until February 1999)*
Lorinda Inman, IA, Area II *(Board liaison)*
Elizabeth Lund, TN, Area III
Laura Poe, UT, Area I
Anna Yoder, MA, Area IV *(Board liaison)*

Staff

Eloise Cathcart, MSN, RN, *Executive Director*
Doris Nay, MA, RN, *Director of Member Board Relations*
Susan Williamson, MPH, RN, *(Former) Director of Credentialing and Practice*

Relationship to Strategic Plan

Strategic Initiative 3.....*The National Council will analyze the changing practice environment to assist in identifying state and national regulatory implications and to develop strategies to impact public policy.*
Outcome 4.....*Implementation of the mutual recognition model of nursing regulation.*

Recommendations to the Board of Directors

None.

Background

Following the Delegate Assembly in August 1998, the Board of Directors appointed the Mutual Recognition Master Plan Coordinating Group (MRMPCG). The Board of Directors and the MRMPCG met jointly for one day on August 29, 1998, to develop a national policy goal and to discuss responsibilities related to the plan.

The MRMPCG has fulfilled its role and responsibilities in relation to coordination and oversight of implementation of the Mutual Recognition Master Plan. The Master Plan was revised consistent with Board of Directors' actions in November 1998. It was updated in February 1999 to show progress in regard to implementation activities by lead volunteer groups and staff. An overall evaluation of the plan was conducted and revisions made at the May and June 1999 MRMPCG meeting.

Highlights of the Mutual Recognition Master Plan

- **Phase A. Member Board Operational Support**

An operational and fiscal tool was developed and distributed to Member Boards moving ahead with mutual recognition. The operational tool is based on the most commonly asked questions regarding operations and is available for distribution. Opportunities will be available at the 1999 Annual Meeting to facilitate opportunities for Member Boards to exchange strategies regarding implementation planning and actual experiences.

- **Phase B. Member Board Legislative Support**

The National Council's Board of Directors agreed to the non-substantive clarifications to the compact language in November 1998, following legal advise. Nineteen state boards of nursing report that they are currently moving ahead with mutual recognition. Legislative support activities have focused on assisting these states to move forward.

As of June 23, 1999, the states that have a signed interstate nurse licensure compact are: Arkansas, Maryland, Texas, and Utah.

Resource Network support has been provided upon request to Member Boards for attendance at the mutual recognition-related meetings. The legislative database for monitoring and tracking state mutual recognition legislation is in place and will support maintenance of information on mutual recognition at the state level. A tool of legal questions about compact implementation is available for distribution.

■ **Phase C. Member Board Discipline Process Support**

The Mutual Recognition Trial by Distance Planning Group, appointed by the Area Directors, met December 16-18, 1998, to build upon the foundation work begun by the MSR Discipline Comment/MSR Discipline Work Group #1 and the Mutual Recognition Discipline Work Group #2. Technical capabilities of distance technology applied to the discipline processes are being explored.

The Trial by Distance concept for "trying out" a discipline process for multistate cases was modified in response to advice from the Trial by Distance Planning Group. Originally, the plan was to demonstrate how concurrent hearings between involved states could be used for multistate cases. However, the Trial by Distance Planning Group advised focusing more on coordination and collaboration of investigation for multistate cases rather than trying to develop new concurrent administrative processes. Accordingly, the plan for the Trial by Distance was revised to focus on mock investigations rather than mock proceedings. Three states agreed to participate in the pilot demonstration, Utah, Texas-RN and Arkansas. An implementation plan and case studies were developed. Difficulties were encountered in scheduling the pilot, so rather than rush the process, it was decided to present the revised Trial by Distance plan for the mock investigations at the mutual recognition forum at the 1999 Delegate Assembly. This will allow opportunity for suggestions and feedback from the Member Boards. In addition, it has been suggested that additional states moving forward with legislation may also want to have the opportunity to participate in a Trial by Distance pilot. Repeating the pilot would provide opportunity for either validation of the process or identification of potential obstacles.

Development of a Mutual Recognition Discipline Process Resource is planned. This resource would pull together the work to date that has been done to support multistate discipline. It would include the proposed discipline process, challenging scenarios, discussion guides, suggested changes to State Nursing Practice Acts and Rules/Regulations, and sample language for use in consent agreements and stipulations.

■ **Phase D. Education and Information**

This phase was re-focused toward consumer and individual nurse public relations activities. Copy for an op-ed article and an advertisement for placement in newspapers in, at most, eight jurisdictions has been drafted and reviewed by designated Board members and administrative staff. A press release announcing the media campaign was placed on national newswire and sent to Member Boards. Additionally, National Council's Web site was regularly updated with a variety of informational articles and a chart recording legislative progress at the state level. Articles about mutual recognition were published in each edition of *Issues*, reaching more than 10,000 nationwide.

■ **E. Collaboration and Coalition Building**

National and federal activities to collaborate and build coalitions in relation to moving and achieving mutual recognition, in which the National Council participated through last fall, include:

- A two-day, face-to-face meeting with ANA to discuss the 14 points document of the ANA House of Delegates and to clarify National Council compact language.
- National Council prepared and distributed a *Response to ANA House of Delegates Regarding Concerns about Mutual Recognition and the Interstate Compact.*
- Participation in the state boards of nursing and nurses associations collegial meetings.
- A presentation and discussions at CLEAR about mutual recognition.
- An update on mutual recognition (with a focus on the impact of mutual recognition on immigration and international mobility) for the CGFNS strategic planning committee.
- Presentation for the Board of Trustees of the American Medical Association.
- Presentation for the national regulatory organization for speech, language and audiology therapists.
- Presentation at the Federal Joint Working Group on Telemedicine Meeting.
- Presentation at the Health Policy Conference for State Legislatures.

- Meeting for support with Kaiser.
- NFLPN Government Affairs luncheon/presentation on mutual recognition.

Information about national organizations' positions relative to mutual recognition and education tools on coalition building are being maintained and are available on National Council's Web site.

■ **Phase F. Compact Administration**

An interim structure for the operation of the Compact Administrators Group (CAG) prior to the year 2000 was developed. The group identified the following criteria to be used for attendance, voice, vote, and reporting out, to assure consistency and commitment of the interim group:

- Meetings are open to all Member Boards, and all attendees have voice in the meetings.
- Voting at such meetings would be the privilege of those who have a commitment of the board of nursing or the umbrella regulatory agency to move forward with mutual recognition in some official manner.
- All Member Boards will be kept informed of the proceedings of the Interim Compact Administrators Group (ICAG) meetings.

The ICAG prioritized a twofold purpose and established related subcommittees: one, to develop model rules for implementation of the compact; and two, to develop a governance structure for the compact administrator group. Draft model rules and regulations for the compact and draft bylaws for the Nurse Licensure Compact Administrators were distributed to Member Boards for review and comment. The *Nurse Licensure Compact Draft Model Rules and Regulations* and the draft *Nurse Licensure Compact Administrators Bylaws* prepared by the ICAG at its June 12-13, 1999, meeting can be found as Attachments A and B.

■ **Phase G. Information System for Mutual Recognition (Phase II)**

A user group (Phase II) has been appointed to identify the system requirements in Nur*sys* needed for implementation of mutual recognition. Individuals from states that have passed or are actively pursuing legislation are members of this group.

■ **Phase H. Project Administration**

This phase incorporates those coordination and management activities that National Council must accomplish to keep the implementation plan on track. Benchmarks for the success of mutual recognition have been established and are being monitored. The Board of Directors and the Interim Compact Administrators Group have dialogued regarding the relationship between the National Council and nurse licensure compact administrators.

A contract has been established with a grant-writing consultant, Robert J. Miller, to seek external funding for implementing portions of the Mutual Recognition Master Plan. Background materials have been submitted to the grant-writing consultant in regard to CAG support. No external funding has been acquired to date for any mutual recognition-related activities.

Attachments

Attachment A

Nurse Licensure Compact Draft Model Rules and Regulations

Article 6D and 8C of the Nurse Licensure Compact grant authority to the Compact Administrators to promulgate uniform rules to facilitate and coordinate implementation of the compact.

1. Definitions of terms in the compact

For the purpose of the compact:

a. **Board** means a state nurse licensing board.
b. **Final action** means imposition of disciplinary action or dismissal of a complaint.
c. **Information system** means the coordinated licensure information system.
d. **License** means the authority to practice nursing granted by the home state.
e. **Primary state of residence** means the state of a person's declared fixed permanent and principal home for legal purposes; domicile.
f. **Public** means any individual or entity other than a state nurse licensing board.

2. Issuance of a license from a compact state

For the purpose of this compact:

a. Primary state of residence shall be verified by evidence provided to the board.
Such evidence shall include at least one of the following:
   1. sworn affidavit, signed by the licensee, attesting to the licensee's primary state of residence
   2. driver's license with a home address.
   3. voter registration card displaying a home address.
   4. federal income tax return declaring the primary state of residence.
   (Statutory basis: Articles 2E, 4C, 4D)

b. In order to maintain authority to practice nursing when changing primary state of residence, the licensee shall apply for licensure in the new home state within 30 days of change in primary state of residence.
(Statutory basis: Articles 4B, 4C, 4D[1])

c. The former home state license becomes invalid thirty days after the licensee changes primary state of residence.
(Statutory basis: 4D[1])

3. Limitations on multistate licensure privilege

The board shall require all licensees becoming subject to disciplinary action that limits practice or requires monitoring to agree not to practice in any other party state during the term of the disciplinary action without prior authorization from such party states.
(Statutory basis: State statute)

4. Information system

a. Levels of access
   1. The public shall have access through the information system to nurse licensure information limited to: the nurse's name, jurisdiction(s) of licensure, license expiration date(s), licensure classifications(s) and status(es), emergency and final disciplinary actions and the status of multistate licensure privileges.

   2. Nonparty state nurse licensing boards shall have access to all information system data except current significant investigative information and other information as limited by state authority.

   3. Party state nurse licensing boards shall have access to all information system data.
   (Statutory basis: 7G)

b. The licensee shall have access to public information in the information system. Other data regarding the licensee shall be available to the licensee through the home state board in accordance with the home state's statutes. The licensee may request to review the data from the home state board. The burden of proof shall be upon the licensee to provide evidence that substantiates any claim or allegation that the data are inaccurate. The board shall verify and promptly correct inaccurate data through the information system.
(Statutory basis: 7G)

c. Denial of licensure shall be reported to the information system when based upon violation of state statute or regulation.
(Statutory basis: 7B)

d. The board shall report to the information system within five business days final action on disciplinary complaints and removal of licensure encumbrance.
(Statutory basis: 7B)

e. Current significant investigative information shall be deleted from the information system promptly upon report of final action.
(Statutory basis: 7B, 7F)

f. The information system shall promptly change the status of a license upon notification by the board.
(Statutory basis: 7F)

Revised June 13, 1999

Attachment B

Draft Nurse Licensure Compact Administrators Bylaws as of June 13, 1999

Article 1. Name
The name of this organization shall be the Nurse Licensure Compact Administrators (NLCA).

Article 2. Purpose and function
The purpose and function of the NLCA is to implement and maintain the Nurse Licensure Compact.

Article 3. Members
The compact administrator for each nurse licensure board of a party state is a member of the NLCA on the effective date of that state's legislation. Each nurse licensure board of a party state must notify the NLCA in writing of the name of the compact administrator and furnish a copy of the statute and compact regulations. An official roll of members shall be maintained.

Article 4. Officers
Members shall be eligible for election and may serve as officers as long as they are a compact administrator of a party state. The officers shall be the chair and vice-chair. The chair and vice-chair shall be elected from the members at the first meeting of the NLCA each year and each shall have a term of one year or until their successors are elected. No person shall serve more than three consecutive terms. No person may hold more than one elected office at one time. A vacancy in the office of chair shall be filled by the vice-chair. The Executive Committee shall fill a vice-chair vacancy by appointment. The person filling the vacancy shall serve until the first meeting of the next fiscal year. An officer may be removed by a two-thirds vote of the membership.

The responsibilities of the chair or vice-chair in the chair's absence shall be:
(a) Call meetings.
(b) Act as spokesperson for the organization.
(c) Preside over meetings of NLCA and Executive Committee and set agenda.
(d) Act as primary liaison to the National Council of State Boards of Nursing.

Article 5. Executive Committee
The Executive Committee shall consist of the NLCA as a committee of the whole. The Executive Committee shall:
(a) Approve budget, provide fiscal oversight and arrange for an annual audit;
(b) Contract for services and monitor contract compliance;
(c) Monitor member compliance with the compact, rules, policies, and procedures;
(d) Appoint ad hoc committees;
(e) Approve and maintain minutes;
(f) Appoint arbitrators for disputes arising from party states;
(g) Approve compact rule language for implementation by states;
(h) Acknowledge members and terminate membership privileges; and
(i) Perform other functions to effect the purpose of the NLCA.
(Legal counsel comment is forthcoming regarding termination of membership privileges.)

Article 6. Meetings
The NLCA shall meet at least once a year at a time and place as determined by the Executive Committee. Other meetings may be called at the request of a simple majority of the members. The quorum for conducting business at any meeting shall be at least one officer and a simple majority of the members. Members may be present physically

or electronically. 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.

All meetings shall be public with the following exceptions:

(a) Discussions regarding non-compliance of a party state.
(b) Executive sessions of the NLCA or Executive Committee or committees provided that the minutes reflect the purpose of and action taken in executive session.

(Legal counsel comment is forthcoming.)

Article 7. Fiscal

An annual fee shall be set by the NLCA and shall be payable each July 1. The fiscal year shall be October 1 through September 30. Any NLCA member whose fees remain unpaid after October 15 shall be reviewed and may be subject to removal of membership privileges. The financial records of the NLCA shall be audited annually and a report presented to the members.

Article 8. Privileges

Membership privileges shall include but are not limited to the right to vote as prescribed in these bylaws. Each member shall have one vote. A member may have another member vote on his/her behalf by a written authorization for proxy. *(Legal counsel comment is forthcoming regarding proxy voting and absentee voting.)*

Article 9. Removal and Reinstatement of Privileges

Any member who does not comply with the provisions of the bylaws and contracts of the NLCA shall be subject to immediate review by the Executive Committee and possible termination of privileges associated with membership. Any member who has had privileges terminated for nonpayment of fees shall be eligible for reinstatement of membership privileges upon payment of the current fee and any delinquent fees.

Article 10. Parliamentary Authority

The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the NLCA in all cases not provided for in the bylaws and any special rules of order adopted.

Article 11. Amendment of bylaws

Bylaws may be amended by two-thirds vote of the members present at any meeting, providing that copies of the proposed amendments have been presented in writing to the members 15 days prior to the meeting.

Revised June 12, 1999

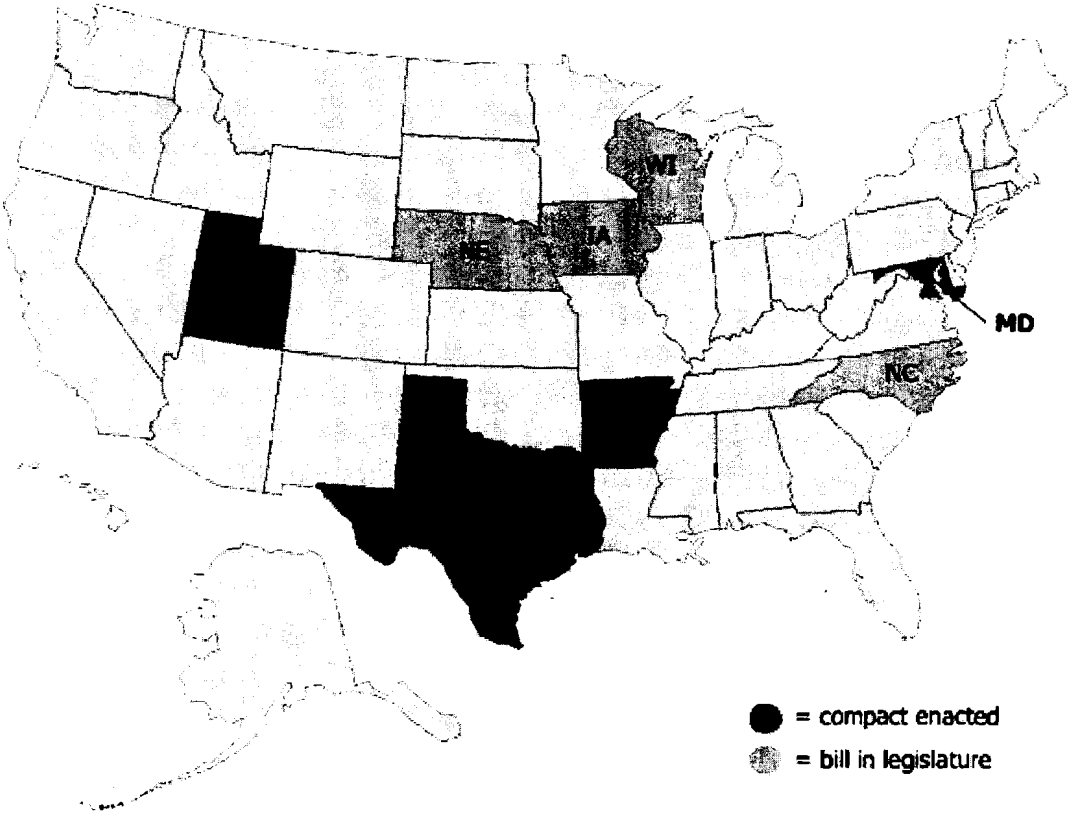
State Compact Bill Status

Page Last Updated 6/22/1999

The following table and map indicate the status of bills introduced in different states in order to enact the interstate nurse licensure compact. Dark-shaded, labeled states have enacted such legislation; lighter-shaded, labeled states have introduced legislation regarding the compact.

STATE	BILL #	STATUS	DATE OF LAST ACTION	EFFECT. DATE	BILL TEXT
Arkansas	S 28	Signed by Governor	2/24/1999	7/1/2000	[click]
Iowa	SSB 1145	In Senate Committee on State Government	2/23/1999	N/A	[click]
Maryland	H 429	Signed by Governor	4/27/1999	7/1/2000	[click]
Nebraska	L 523	Placed on General File	2/24/1999	N/A	[click]
North Carolina	S 194	Sent to Governor	6/22/1999	N/A	[click]
Texas	H 1342	Signed by Governor	6/19/1999	1/1/2000	[click]
Utah	S 146	Signed by Governor	3/14/1998	1/1/2000	[click]
Wisconsin	S 129	Senate Fiscal Estimate Received	5/20/1999	N/A	[click]
	A 305	Passed Assembly; to Senate Committee on Human Services and Aging	6/3/1999	N/A	[click]

Map of State Compact Bill Status



Notes

Notes

Forum: Nursys

Report of the Information Systems User Group

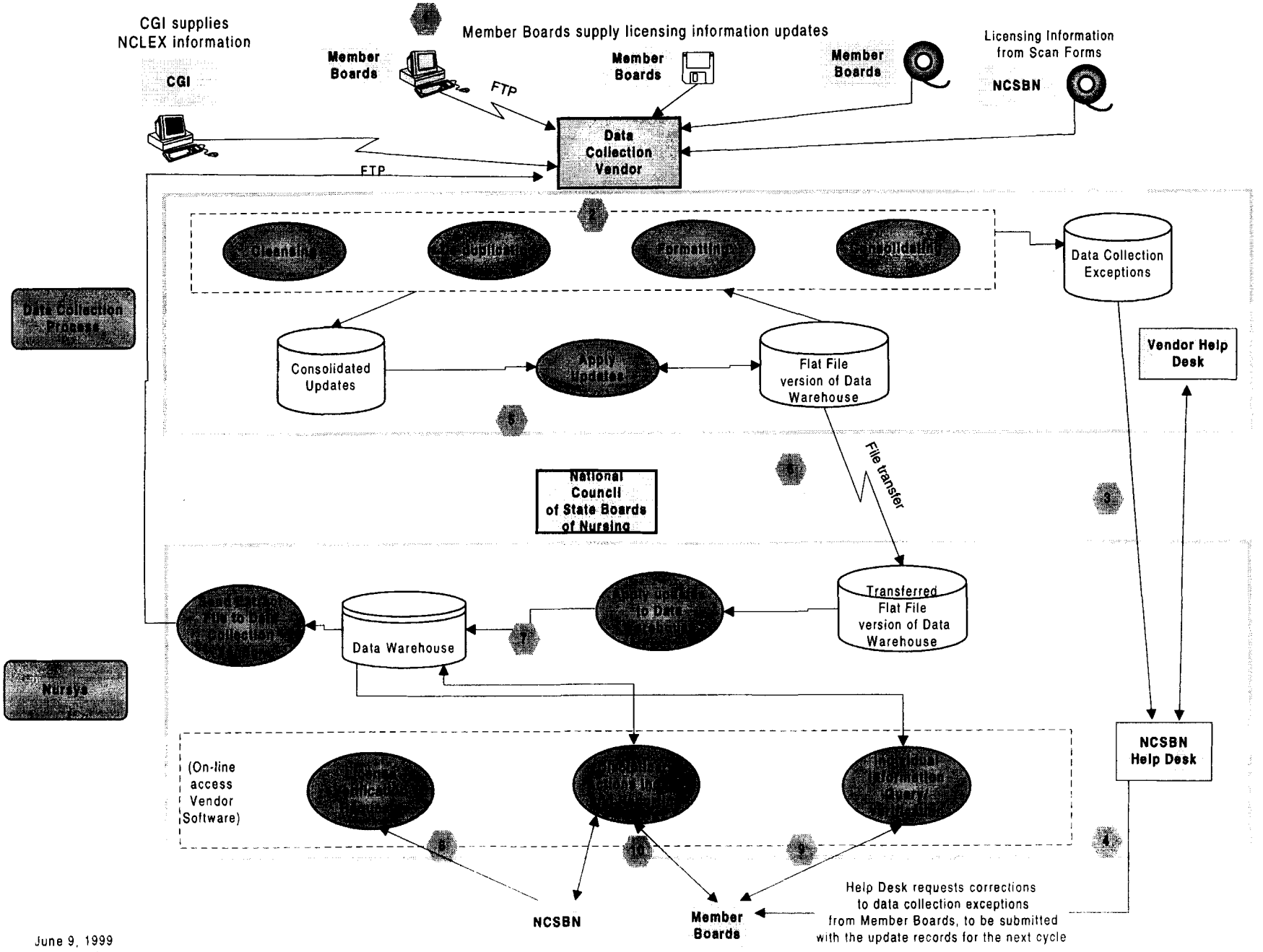
Committee Members
Susan Boone, OH, Area II
Shirley Brekken, MN, Area II
Michael Coleman, NC, Area III
Mark Majek, TX-RN, Area III
Milene Sower, NY, Area IV

Staff
Rich Albert, *Oracle DBA*
Chris Barden, *Software Trainer*
Sean Barden, *Programmer/Analyst*
Angela Diaz-Kay, *Director of Information Technology*
Craig Moore, MST, *Network Administrator*
Sandy Rhodes, *Support Specialist*
Wade Strawbridge, *Project Manager*

Vendors
Oracle Corporation, *Database Software*
Crockett and Associates, *Application Software*
InfoUSA, *Data Collection/Processing*
Sysix Technologies, *Hardware Distributor and Technical Services*

Relationship to Strategic Plan
Strategic Initiative 4.....*The National Council will provide information systems and data to facilitate regulatory decisions.*
Outcome 1.....*A comprehensive nurse database.*

Nursys Conceptual Design



June 9, 1999
Final Version 1

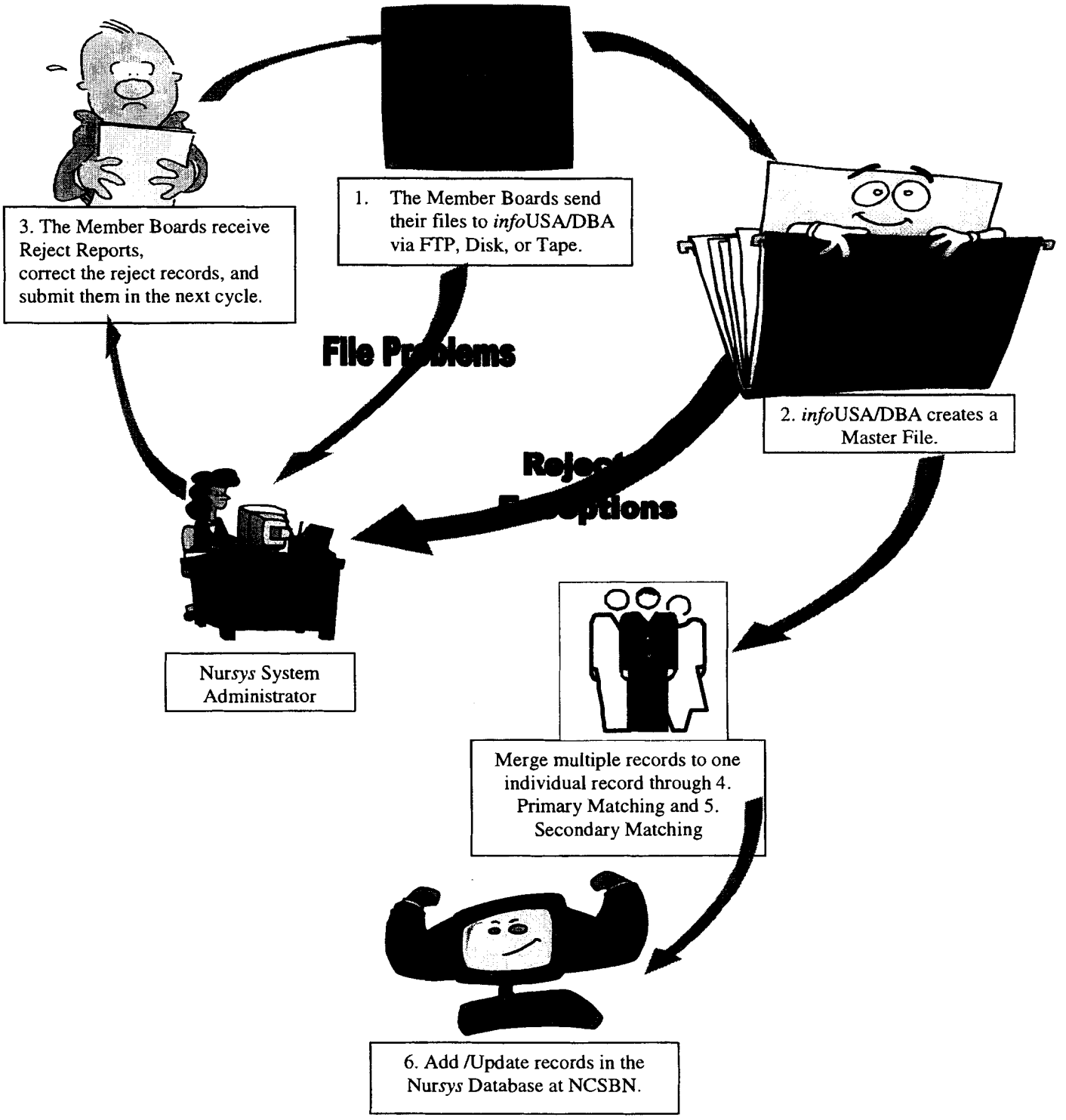
Nursys
Conceptual Design Overview

As a computer-based data warehouse providing a national resource of nurse licensing and disciplinary information as well as demographic characteristics of the nurse labor force, Nursys will require an integrated, tightly scheduled, and specifically sequenced set of processes, steps, and procedures. As such, multiple groups are involved in the process to focus on their respective responsibilities throughout the process. This is an overview of those processes and groups involved.

Conceptual Design Description

1. Data Suppliers will provide data to the Data Collection Vendor, *info*USA, in various formats and media. Data Suppliers will initially be the participating Member Boards and the extract file from the application. Later, the NCLEX information from CGI and the Scan Forms from National Council will also be submitted. Data will be collected on a scheduled basis and will include personal information, license description information, and educational information for licensees and applicants.
2. The collected data will then be processed by the Data Collection Vendor to cleanse, de-duplicate (both interstate and intrastate), format to a standard format utilized by Nursys, and consolidate data to relative individuals.
3. All data collection exceptions resulting from a cycle's processing will be reported to the National Council (NCSBN).
4. National Council will forward the exception to the original Data Supplier.
5. Once all data has been cleansed, de-duplicated, formatted, and consolidated, it will be applied as updates to a flat file version of the Data Warehouse. This version of the Data Warehouse will not contain disciplinary action information or verification request tracking information.
6. Once the update process has successfully completed, the Data Collector will transfer the flat file version of the Data Warehouse to National Council. National Council will ensure the receipt of this file and its soundness as input to the Data Warehouse update process.
7. National Council will execute the process to apply the flat file version to the Data Warehouse as updates. Disciplinary action information and verification request tracking information will be retained. Also, history will be generated based on the results of the updates.
8. License Verification Requests received by National Council will be processed into the system to track the receipt of the request.
9. Member Boards will query the Licensure Information for an applicant in order to verify the license(s) from participating Member Boards. Member Boards will be able to send a Speed Memo to the licensing Member Board(s) for any additional information they may need in order to verify the applicant, or for clarification on the information provided by the system.
10. Member Boards will be able to report Disciplinary Actions to Nursys to allow a central warehouse accessible by all Member Boards. This will also minimize errors in reporting and duplication of information.

Nursys Data Processing



Nursys Data Processing

1. Participating Member Boards download their new and/or changed data since the previous submission, and send it to *info*USA/DBA via FTP, Disk, or Tape. The Nur*sys* System Administrator is notified by the next day of any problems with the file and/or file information. The Nur*sys* System Administrator will notify the appropriate Member Board of the problem. If it is prior to the Submission Due Date, the Member Board can try to re-send the file.

2. The *info*USA/DBA converts all of the Member Board files to one Master File, by reformatting the fields on the input files to a common layout, editing any fields needing enhancements (i.e., dates), decoding values to common values (i.e., Female = F and Male = M), and applying the NCOA Addresses.

3. Any records with invalid/missing Required Fields (Last Name, First Name, License Number, License Types, or License Expiration Date) are rejected from further processing to an electronic Reject Report. Records with invalid/missing Secondary Match Fields are not rejected, but are written to an electronic Exception Report. The Nur*sys* System Administrator will FTP or e-mail the Reports to the appropriate Member Board.

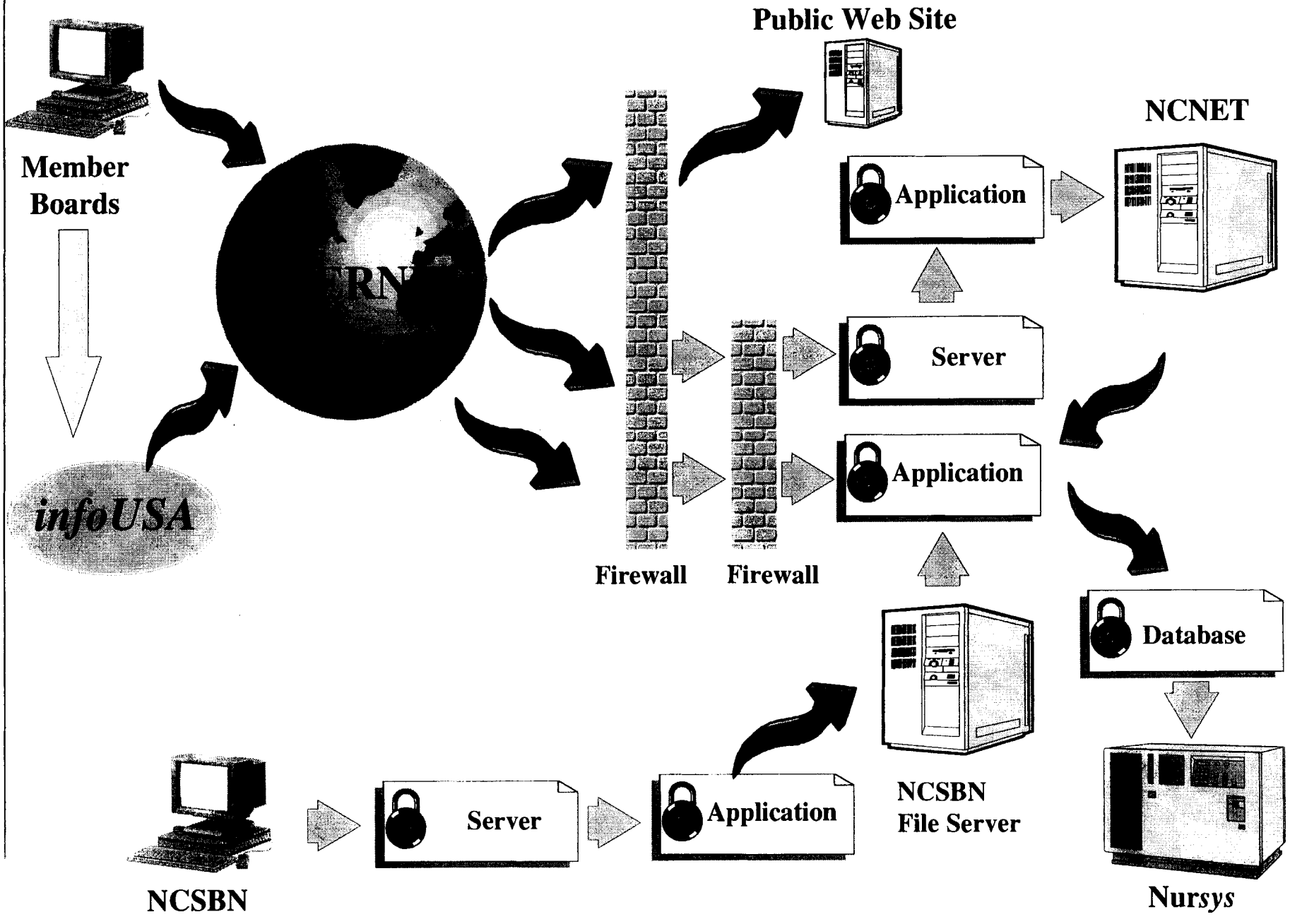
4. The records on the Master File with similar names and addresses are linked and further evaluated for Primary Matching, which is where records within the same jurisdiction are merged. Records are merged when they have:
   - the same social security number, and either the same date of birth or a blank date of birth
   - the same date of birth and either the same social security number or a blank social security number

5. Every record on the Master File is evaluated for Secondary Matching, which is where records across jurisdictions can be merged. So, the records' name and address is not included in the matching criteria. Instead all records are evaluated in the following three passes:
   1) Link records with the same social security number and with the same date of birth. If either is blank or not completely identical, the records are not linked.
   2) Link records with the same date of birth, maiden name, and year of graduation. (This pass is used to help link records that do not have a social security number.)
   3) Re-evaluates the records linked in passes 1 and 2 to make sure they should be merged.
      a) If the gender is different (one is Male and one is Female), the links are broken. If both genders are the same or blank, or if one gender is populated and one is blank, the records will remain linked.
      b) If records were linked into a group of records with different values for the social security number, all of the links between the records will be broken. If the social security numbers in the group are the same or blank, the records will remain linked.

   The records that are still linked are then merged.

6. The Master File is compared to the prior file, so only the records that were added or the records that have changed, are sent to National Council to be included in the Nur*sys* database.

Nursys Technical Specification Overview



Nursys Participation Request Form

Member Board Name: _____

Executive Director: _____

Member Board Contact Name for Nursys: _____

Position/Title: _____

Contact Phone Number: _____

Our board is interested in participation in the Nursys project. Participation will involve submission of our nurse licensing database, but we will be responsible for designating access to that data in compliance with our regulations.

We understand that submission of this request form is not a binding commitment on our part, and that we may withdraw participation at any time. If we do continue with the participation setup, we understand that system resources (including a technical contact person) will be required.

Our participation or non-participation does not impact our ability to use Nursys for license verifications. Participation will only allow other jurisdictions to verify licenses held in our jurisdiction, and will allow our local member board users to access data in our jurisdiction via the Nursys Web interface.

_____ _____

Signature of Executive Director Date

Nursys

Member Board User Access Request Form

Instructions:

1) Fill in all information in the boxes below.
2) In the User Authorization section, indicate whether you are adding or discontinuing authorization.
3) Check each authorization type you want to change. For example, if you want to add authorization for viewing history, check the 'Add authorization' and 'View History' boxes.

Member Board Name: ☐

Executive Director: ☐

Name of User Requesting Access to Nursys: ☐

Position/Title: ☐

User Telephone Number: ☐

User e-mail address: ☐

User Address: ☐

User Authorizations:

Adding User Authorization	☐	Removing User Authorization	☐
View Personal information (Includes personal, education and license information)	☐	**Add Personal, License, Education & Discipline Information**	☐
View Discipline information	☐	**Run Reports**	☐
View History	☐		
Perform Verification Acknowledgement	☐		

Signature of Executive Director _____ Date _____

Sample File Layout Submission/Data Dictionary

FIELD DESCRIPTION	FROM	TO	LENGTH
FILLER (DATA PROVIDED BY DATA COLLECTOR)	1	60	60
LAST NAME	71	120	50
FIRST NAME	121	150	30
MIDDLE NAME	151	180	30
NAME SUFFIX	181	190	10
MAIDEN NAME	191	240	50
MOTHER'S MAIDEN NAME	241	270	30
DATE OF BIRTH	271	278	8
GENDER	279	279	1
SOCIAL SECURITY NUMBER	280	288	9
ETHNIC INFORMATION	289	289	1
HOME TELEPHONE NUMBER	290	309	*20*
WORK TELEPHONE NUMBER	310	329	*20*
CURRENT MAILING ADDRESS: STREET ADDRESS	330	389	60
CURRENT MAILING ADDRESS: STREET/PO BOX	390	449	60
CURRENT MAILING ADDRESS: CITY	450	484	35
CURRENT MAILING ADDRESS: STATE/TERRITORY/PROVIDENCE	485	486	2
CURRENT MAILING ADDRESS: ZIP/POSTAL CODE	487	496	10
FILLER (DATA PROVIDED BY DATA COLLECTOR)	497	503	7
LICENSE NUMBER	504	518	15
LICENSE TYPE	519	520	2
ACTIVE STATUS	521	521	1
BASIS FOR LICENSURE	522	522	1
CURRENT LICENSE ISSUED DATE	523	530	8
CURRENT LICENSE EXPIRATION DATE	531	538	8
EDUCATION PROGRAM CODE	539	548	10

EDUCATION PROGRAM NAME	549	598	50
BASIC EDUCATION FOR INITIAL NURSING LICENSE IN THAT JURISDICTION	599	599	1
CITY OF EDUCATION	600	634	35
STATE OF EDUCATION	635	636	2
COUNTY OF EDUCATION	637	666	30
ZIP CODE OF EDUCATION	667	676	10
COUNTRY OF EDUCATION	677	706	30
GRADUATION DATE FROM NURSING PROGRAM	707	714	8
TYPE OF EXAMINATION	715	716	2
DATE OF EXAMINATION	717	724	8
INITIAL DATE OF LICENSURE IN THE LICENSING JURISDICTION	725	732	8
STATUS OF EXAM	733	733	1
STATE OF EXAM	734	735	2
LAST UPDATE DATE	736	743	8
DEATH STATUS	744	744	1
DATE OF DEATH	745	752	8
TAKEN NCLEX BEFORE	753	753	1
TAKEN NCLEX TO QUALIFY FOR THE SAME LICENSE	754	754	1
TAKEN NCLEX EXAM TO QUALIFY FOR A DIFFERENT LICENSE	755	755	1
ALIAS LAST NAME	756	805	50
ALIAS FIRST NAME	806	835	30
ALIAS MIDDLE NAME	836	865	30
DATE OF LICENSE STATUS CHANGE	866	873	8
FAX NUMBER	874	893	20
EMAIL ADDRESS	894	943	50
LEVEL OF HIGHER EDUCATION	944	944	1
SCORE1 OF EXAM	945	949	5
SCORE2 OF EXAM	950	954	5
SCORE3 OF EXAM	955	959	5
SCORE4 OF EXAM	960	964	5
SCORE5 OF EXAM	965	969	5
SCORE6 OF EXAM	970	974	5
SCORE7 OF EXAM	975	979	5
SCORE8 OF EXAM	980	984	5
SCORE9 OF EXAM	985	989	5
SCORE10 OF EXAM	990	994	5

LEVEL OF EDUCATION	995	996	2
ALIAS NAME2 FOR MISSOURI	997	1025	29
LICENSE DISCIPLINE FLAG	1026	1026	1
HAVE CGFNS CERTIFICATION	1027	1027	1
CGFNS CERTIFICATON NUMBER	1028	1034	7
FILLER	1035	1050	16

Nursys

LICENSE VERIFICATION REQUEST FORM

Notes to applicant:	1. See reverse side for instructions and for who needs to complete this form. 2. Forms with missing information or incorrect payment will be returned. 3. Complete this form in blue or black ink.

PERSONAL INFORMATION

Social Security #: _____ Date of Birth: _____ *mm/dd/yyyy*

First Name: _____ Last Name: _____

Maiden Name: _____ Middle Name: _____

Current Street Address: _____ Phone Number: _____

Address 2: _____

City: _____

State/Province: _____ Zip/Post Code: _____

Country (if not USA): _____

ENDORSEMENT INFORMATION

List the license types that you need verified:

License Type (check one)	Verification Fee (must be guaranteed funds)
LPN ☐	$15.00
RN ☐	$15.00
BOTH (LPN & RN) ☐	$30.00

*NOTE: Do **NOT** send cash, personal checks, business checks or traveler's checks*

LICENSE INFORMATION

List all licenses that you have ever held:

Jurisdiction	RN License #	PN License #

Mail To:
National Council of
State Boards of Nursing, Inc.
676 N. St. Clair Street, Suite 550
Chicago, IL 60611-2921

I, the above named individual, hereby apply for verification to the National Council of State Boards of Nursing to permit the National Council and/or its Member Boards to verify my licensure, educational, disciplinary and related information in NURSYS for the purposes of supporting my request for endorsement verification in the jurisdiction(s) listed above and any other states in which I have ever been licensed. I also confirm that the information I have submitted is true.

My application fee of $ _____ in guaranteed funds is attached.

_____ _____
Signature Date

For NCSBN use only:

Nursys

LICENSE VERIFICATION REQUEST FORM

INSTRUCTIONS FOR COMPLETION OF THIS FORM

1. This form should ONLY be completed if you were ever licensed in one or more of the following Jurisdictions,

Idaho (ID)
Kansas (KS)
Missouri (MO)
North Carolina (NC)
Ohio (OH)
Oregon (OR)
Texas (RN) (TX-RN)
Vermont (VT)

2. Please complete all sections of this form. Forms with missing information or incorrect payments will be returned.

3. All payments must be in guaranteed funds. For example, certified checks, cashier's checks, or money orders are accepted. Cash, personal checks, business checks, credit cards or traveler's checks are NOT accepted. Fees are non-refundable.

4. Please complete this form in blue or black ink.

5. Return this completed form to:

National Council of State Boards of Nursing, Inc.
676 North St. Clair Street, Suite 550
Chicago, IL 60611-2921

Nursys

Impact on Member Boards

Nursys[1] Features/Functions/ Tasks	Impact on Participating Member Board	Impact on Non-participating Member Board
Data Collection Process		
1. Submissions of Data	• Submits a file of updates to their licensing data for each cycle, according to the File Submission Schedule.	(None)
2. Records Rejected from Data Processing	• Correct the records in their Member Board's licensing system, and submit the corrected records in the next cycle with the updates.	(None)
Query Process		
1. View Individual Information	• Query the Nursys database for information. • View the personal information, license description information, education information, disciplinary action information, verification request tracking information, and historical information. • Screen-print the information.	• Query the Nursys database for information. • View the personal information, license description information, education information, disciplinary action information, verification request tracking information, and historical information. • Screen-print the information.
2. Request Additional Information	• Send requests, via Speed Memo, for additional information and/or clarification of information on another participating jurisdiction's licensee being verified. • Reply to requests for additional information and/or clarification of information on the jurisdiction's licensees being verified.	• Send requests, via Speed Memo, for additional information and/or clarification of information on a participating jurisdiction's licensee being verified.
Verification Process		
1. Distribution of Verification Request Forms for Nursys	• All Member Boards will be asked to distribute the Nursys Verification Request Form to all applicants requesting endorsement into their jurisdiction.	• All Member Boards will be asked to distribute the Nursys Verification Request Form to all applicants requesting endorsement into their jurisdiction.
2. Applicant is licensed in only non-participating jurisdictions	• Verify the Applicant by contacting the licensing jurisdiction(s). • The verification fee is sent to the verifying jurisdiction(s).	• Verify the Applicant by contacting the licensing jurisdiction(s). • The verification fee is sent to the verifying jurisdiction(s).

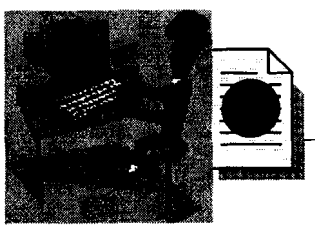
[1] In order to perform any of the Query, Verification, or Discipline Processes, the User logs in to the secured Nursys web-site via the Internet.

Nursys[2] Features/Functions/ Tasks	Impact on Participating Member Board	Impact on Non-participating Member Board
3. Applicant is licensed in a participating jurisdiction	• Verify the Applicant's license(s) in participating jurisdiction(s) by using Nursys within 60 days. • The verification fee is sent to National Council.	• Verify the Applicant's license(s) in participating jurisdiction(s) by using Nursys within 60 days. • The verification fee is sent to National Council.
4. Request for Extension	• Request that the Nursys System Administrator extend the expiration date an additional 30 days, if the verification is not complete and the 60 days have almost expired.	• Request that the Nursys System Administrator extend the expiration date an additional 30 days, if the verification is not complete and the 60 days have almost expired.
5. Acknowledge Verification	• Member Board's are requested to acknowledge that Nursys was used to verify the license, by using the Acknowledge Verification mechanism in Nursys.	• Member Board's are requested to acknowledge that Nursys was used to verify the license, by using the Acknowledge Verification mechanism in Nursys.
Discipline Process		
1. Add Discipline Information	• Enter Disciplinary Information directly into Nursys, for a license in your jurisdiction.	• Enter Disciplinary Information directly into Nursys, for a license in your jurisdiction.
2. Add Personal, Licensure, and/ or Education Information, if not found in Nursys, and add the Discipline Information	• Enter the Personal, Licensure, and/or Education, and Discipline Information directly into Nursys, for a license in your jurisdiction.	• Enter the Personal, Licensure, and/or Education, and Discipline Information directly into Nursys, for a license in your jurisdiction. • The Personal, Licensure, and/or Education Information will be flagged, until the Practice and Accountability Department has reviewed the information.
3. Modify Existing Discipline Details	• Modify Disciplinary Action and/or Violation information entered by the same jurisdiction.	• Modify Disciplinary Action and/or Violation information entered by the same jurisdiction.
4. Expunge Discipline	• Send a written request to the Practice and Accountability Department, or the System Administrator.	• Send a written request to the Practice and Accountability Department, or the System Administrator.

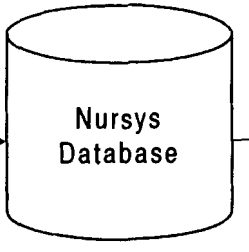
[2] In order to perform any of the Query, Verification, or Discipline Processes, the User logs in to the secured Nursys web-site via the Internet.

Nursys Web Print Engine

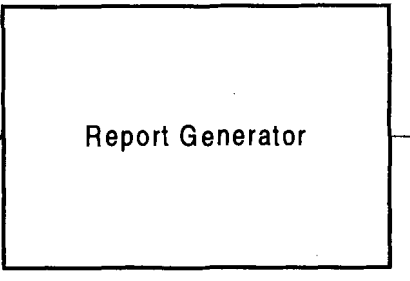
The Nursys Web Print Engine will provide the user with a web-based, asynchronous method of generating reports.
Simply, this application will provide a user a way to request a report, or have a series of reports generated automatically, in a batch fashion, to be printed by a user.



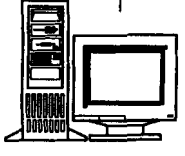
User at MB or NC requests a report, through Nursys website, to be generated



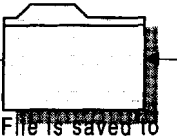
Data is obtained from database to populate report



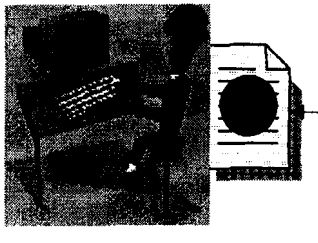
Report is generated and is saved as a wordprocessor file



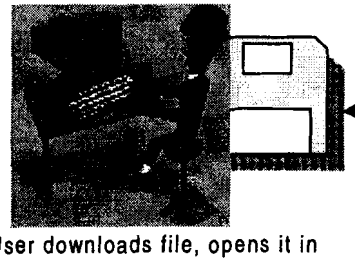
Server execute batch print job request(s) at specified times



File is saved to directory accessible from the web



User is notified on Nursys website that their report has been generated



User downloads file, opens it in Word, or WordPerfect, and prints it on their printer

Nursys

Verification Fee Model: One Fee per license type for a set time period

(unlimited Verifying Member Boards and unlimited applications for licensing within the set time period)

Nursys Collection of Fee	National Council	National Council rejects fee and request	National Council
$15 Verification Fee Payment	Applicant submits one fee regardless of how many participating verifying Member Boards	None	Applicant submits one fee regardless of how many participating verifying Member Boards
Service Provided for fee	To any Member Board (regardless of participating or non-participating)	None or incomplete information will be provided, at best, for non-participating Member Boards	Complete Information can be provided for participating Member Boards; Incomplete information will be provided, at best, for non-participating Member Boards
Efficiency	One stop shopping for both applicant and Member Boards	Applicant must contact Member Boards and pay multiple fees to acquire information	Minimal effort for applicant and Member Boards to obtain information from participating verifying Member Boards. Applicant must contact Member Boards and pay multiple fees to acquire information
Can request be nullified?	Not applicable	Not applicable	Not applicable
Can the fee be refunded?	No	Yes	No
Can Lockbox be used?	Yes	Yes	Yes
Will there be an 'Active Notification' to Member Boards?	No	Not Applicable	No
Will the request have an expiration date?	Yes	Not Applicable	Yes
Confusion Factor for the Applicant	Additional document to be filled out and submitted (Verification Request Form)	Yes - applicant must determine that National Council's service is not available. National Council must reject any erroneously submitted requests and fees.	Applicant must submit fee and request to National Council and to non-participating Member Boards.

Frequently Asked Questions About Nursys: 1999 Delegate Assembly Update

General Background

What is Nursys?

Nursys is a comprehensive electronic information system that includes the collection and warehousing of nurse licensing information and disciplinary actions as well as the general business applications and services associated with the use of the data warehouse. The term "Nursys" is a combination of 'Nurse' and 'System,' which provides a broad descriptor for the nurse data warehouse and the supporting business applications and services.

During the product's evolution, it has been called different names at different stages of development. For example, NIS was focused on the nurse data itself while ELVIS was focused on the software for a specific service using the nurse data. Nursys represents the next major step in the software development process and encompasses all of the elements of the system (i.e., the data, the collection processes and the supporting business processes).

What information will be available in Nursys?

The type of data that will be available in Nursys includes the following:

- *Personal Information*—a nurse's identity and specified residential/mailing addresses;
- *License Description Information*—information about an individual's nursing license;
- *Education Information*—information about an individual's education relative to nursing and a specific license;
- *Disciplinary Action Information*—information about disciplinary actions taken against and reported for an individual;
- *Verification Request and Fee Tracking Information*—information about the tracking of the receipt of verification requests and associated fee payments from an individual and the licensing Member Board's verification review process;
- *Historical Information*—any changes to the types of data mentioned above will cause the original information to be kept as history;
- *Source Information*—the source of each piece of data is tracked so that appropriate security measures can be enforced.

How will the data be used?

The data will be used to establish a data warehouse of unduplicated nurse license and disciplinary action information, which may be used by a Member Board to make licensing decisions.

How frequently will the information be updated?

Initially the updates will be submitted and processed monthly. More frequent updates will be established as data collection and processing become more efficient.

What services will be available through Nursys?

The first business application (Phase I) to be provided is electronic verification of nurse licensure and disciplinary action reporting. Upon completion of Phase I, Nursys will provide the ability to collect, track, report and verify nursing candidate information, licensing information, disciplinary actions and billing of license verification fees. The second stage (Phase II) will incorporate enhancements needed to support the mutual recognition of nurse licenses.

What is the difference between a participating and a non-participating Member Board?

A participating Member Board is one that supplies personal and license description information on applicants and licensees to the data collection process on a regular basis as additions and updates to the data warehouse. A non-participating Member Board is one that has not supplied personal and license description information to the data collection process although they may submit disciplinary data.

Is there a difference between Nursys services for participating Member Boards and non-participating Member Boards?

No. Participating and non-participating licensing boards have the same availability of services. However, the information needed for licensing an individual will not be found on Nursys if the verifying Member Board is not participating. The non-participating verifying Member Board may only provide information to the discipline module of Nursys and will therefore still be required to provide the licensing Member Boards with manual verifications. The advantage to the participating Member Board is reduced paper work, fee processing and a possible reduction in the number of temporary permits issued.

How will Nursys affect my office procedures?

There will be several ramifications of the Nursys implementation to all Member Boards, regardless of whether they are participating or not. All Member Boards will include the License Verification Request form in their packets sent to applicants, because other jurisdictions in which the applicant is licensed may require verification through Nursys. Also, for those jurisdictions that require use of Nursys for verifying licenses held in their jurisdictions, all other Member Boards will need to access their information via Nursys.

Cost Questions

Will there be a cost to Member Boards to use the services of Nursys?

No, there will not be a cost to Member Boards. The cost of license verification will be paid by the licensee.

How much will verification cost the licensee?

The cost of the electronic verification service to the licensee will be one $15 fee (subject to periodic review) per license type for a set 60-day time period. The number of states to be verified will be unlimited for each request within that time period.

Pilot

What is the 'pilot' phase?

The pilot phase includes volunteer Member Boards with access to the system prior to roll-out to all of the Member Boards. The pilot group will incorporate their data, clarify and/or define processes and procedures and identify any issues with the new system. The list of pilot sites and dates will be part of the final project plan.

Mutual Recognition

Is this system the same as the one to be used for mutual recognition?

Yes. Nursys will be the information system that will support the mutual recognition of nurse licenses. However, additional data and enhancements to business applications and services will be necessary to provide nurse licensure by mutual recognition functionality.

How does the Nursys Phase I time schedule affect Phase II?

The Phase II Information Systems User Group members have been selected and began meeting in June. This group will be responsible for the mutual recognition enhancements to Nursys, and mutual recognition requirements will be gathered at the same time that the Nursys system is being developed. Until such time as requirements are formulated for mutual recognition, the target date for completion is still January 1, 2000. Jurisdictions with mutual recognition legislative dates will be given priority for inclusion in Nursys following the pilot.

Vendor-Related Issues

Who are the vendors working on Nursys?

Crockett & Associates, Inc., a privately held firm located in Phoenix, Arizona. Crockett & Associates has a widespread background in the licensing software development arena, particularly in the area of nurse licensing. Crockett & Associates is providing its existing NURSE-TRACK software as the base for Nursys, and will be integrating the requirements for Nursys into the system. Crockett & Associates will work closely with National Council staff on development of the Web interface.

Database America, a wholly-owned subsidiary of *info*USA, Inc., headquartered in Montvale, New Jersey. Database America is a leading provider of data collection and processing services. Database America is the data collection vendor for Nursys, responsible for collecting, formatting, cleansing, and de-duplicating the personal, education, and licensure information stored in Nursys.

Oracle Corporation, the world's second largest software company, headquartered in Redwood Shores, California. Oracle is supplying the database in which the Nursys data will be stored.

Process Management Group, a privately held firm located in the Chicago area. Process Management Group is supplying a team of independent testers to verify the functionality of the software provided by the other vendors.

Why use a joint development approach?

A joint development approach will allow National Council to have input into how the application is developed and will leverage National Council staff's abilities while keeping costs under control. National Council has Web development and Oracle database resources in-house, and these resources will work with the application vendor to produce the Web application within the allocated budget and timeframe.

Since application vendors in the market already have licensing programs written, it makes sense for National Council to start with a vendor's existing system and hire the vendor to modify its system to meet the requirements for Nursys. The National Council staff needs to be included in the development so that they are familiar with the system and able to support it in the future.

What is the Independent Test Team, and why are they needed?

The Independent Test Team is a group of experienced testers from Process Management Group, Inc., who have quality assurance certifications from the Quality Assurance Institute. They are needed to verify that the vendors have delivered the system according to the requirements and to detect defects in the system prior to the software implementation.

Access & Security

How will Nursys be accessed?

Through the Internet using a secure, privileged access much like the Disciplinary Data Bank (DDB) is currently accessed. As part of Phase I, the existing DDB data will be converted into Nursys, and much of the existing DDB functionality will be integrated into Nursys.

How will the system be secured?

Different levels of security and access will be implemented for different functionality within Nursys. One of the first levels of security will be privileged access to the secured Internet Web site. Another level of security is the software interface (or application) between the user and the database. This will be accomplished using a combination of password protection and data privilege access. Additionally, only secured, privileged users will be granted access to the file server and database software.

Who (or what parties) will have access to information?

Initially, only Member Boards and National Council will have access to Nursys. Future development may include limited access by government agencies, by potential nurse employers, and by consumers.

What if I query Nursys and the information I need is not found?

There are at least four reasons why this might occur. They are:
Scenario 1—New license information could have been added to a Member Board's system in between update cycles for Nursys. Initially the data will be updated monthly so the information may not yet be available. For example, the nurse has been licensed in state 'A' and applies for licensure by endorsement to state 'B' in between monthly updates. The Member Board may choose to 'wait' until the next update cycle or the licensing Member Board may directly contact the verifying Member Board.

Scenario 2—Nursys may not contain certain types of data because all data involving the licensing of a nurse are not mandatory for the record to exist in Nursys. For example, if licensing state 'C' requires evidence of high school graduation, and if state 'D', the verifying board, does not provide such data, then state 'C' must use an alternate method to attain the high school information.

Scenario 3—The licensing information for a nurse from a participating Member Board was rejected during the data collection process. This could result when the data record that was submitted was somehow corrupted or mandatory data were incomplete. In either case the record is rejected and the Member Board is notified of the rejection. Again, the licensing Member Board may contact the verifying Member Board to request the information.

Scenario 4—The nurse is licensed in a non-participating state board. Any state board that is not participating in submitting data to the database may not have their licensing data in the data warehouse.

In each case, the Member Board will need to use an alternate method for contacting the verifying Member Board for the missing information.

Web Software

When will I be able to see the Nursys Web interface?

A SIG (Special Interest Group) meeting has been scheduled on Wednesday, July 28, 1999, at 4:00 PM. During this SIG, a demo of the Nursys Web interface will be presented.

What is the name of the Web site I will use for Nursys?

The Nursys Web interface will be a secured Web site accessible only to Member Board users who have submitted an access request form to National Council. The Web site users will logon to is www.nursys.org, or users may logon via NCNET.

Will all Member Boards be able to enter discipline data as they currently do in the DDB?

Yes. Screens will be provided for Member Boards to enter all of the necessary data (personal, education, license and discipline information) for licensees or applicants in their jurisdiction if the individual is not found in Nursys. If the Member Board is able to locate the individual in Nursys, then only discipline information will be added. National Council staff will also still be available to those Member Boards that use their services for the entry of discipline.

Will I be able to enter information for other nurses licensed in my jurisdiction (without entering discipline)?

No. Member Boards will only be able to directly enter information into the database if the individual has discipline that is also being entered. Data relating to individuals who do not have discipline will be added through a flat file of updates that is sent to the Data Collector each update cycle.

Will initial training be provided for the software?

Yes, National Council staff will provide training. This training will be hands-on and detailed. National Council has budgeted to provide training for one individual per Member Board. Requests for additional attendees at the Member Boards' expense will be further evaluated based on space and cost considerations. User manuals will also be provided, and are available on the Web interface.

Will subsequent training be provided?

Provisions for subsequent training is under review, and details will be posted at a later date.

How will security be handled on the Web interface?

The first layer of security will be the logon screen. Once the user gains access to the system, there will be two layers of security: 1) by Member Board; and 2) by function. Each user of the system will have an assigned jurisdiction, and will be able to perform only the actions provided for that jurisdiction. Each user will also have a level of functional security, which tells what functions this particular user is allowed to perform. For example, a user in North Carolina will have access to North Carolina's data, and will have access to data in other jurisdictions if the data are not restricted. The North Carolina user will also have access only to the functions to which the user is assigned. For example, if the North Carolina user was given access to read all information, then this user will not be able to update any data, even if it is North Carolina data.

Security will be administered by the Nur*sys* Administrator.

How will I know what other jurisdictions are participating, and how current their data are?

A list is available via the Web interface, as part of the information screens. This screen is updated for each update cycle, and lists each participating Member Board and the date of their last update.

Detailed Data Questions

When will my Member Board's data be included in Nur*sys*?

Member Boards' data will be added on a quarterly basis. A letter will be sent to each Member Board, including a Participation Request form, Data Submission Media form, and Data Restriction Requirements form as well as other information. These three forms are required for participation in Nur*sys*. The Participation Request form will require the signature of the Member Board's Executive Director. Since the custom data processing requirements for each Member Board may take customized coding, Member Boards will be scheduled to go live on Nur*sys* on a quarterly basis, with the Member Board giving National Council at least two months' notice of its interest in participation.

What if a mandatory data element is missing from a record?

If a mandatory data element is missing from a record, then that record will be rejected from inclusion in the database. The Member Board that submitted the record will be notified of the rejection.

What are the required data elements to enter a record into the Nur*sys* database?

There are six mandatory data elements required for a nurse record to be added to the database. These include:

- Last Name;
- First Name;
- License Number for each license;
- License Type;
- Expiration Date for each license;
- Update Date.

Basis for licensure is also required for on-line entries, and Update Date is required for data file submissions. These data elements were chosen as the minimum needed to create a record. Additional data will be requested and necessary to insure efficiency and completeness in verifying licensure.

Do you want all data records from my system every month?

No. The types of data records that would be included in the database would be those records that are related to licensed nurses regardless of status. Initially, when a Member Board first submits their data to the data collection process, all data records pertaining to licensed nurses would be sent. Thereafter, only updates to licensed nurses or newly licensed nurses would be submitted to the data collection process.

How is matching to occur?

Match criteria (rules for matching & merging data from multiple sources) were identified and developed in conjunction with the data collection vendor. The vendor was selected because of their expertise in the elimination of duplicate data to create clean databases. There are two phases for matching: primary and secondary matching. The primary matching process links records together for individuals with the same or similar name and address. If the linked records have the same Social Security number or date of birth, the records will be merged. This will primarily merge duplicate records from the same jurisdiction. All of the records will then go through secondary matching, which looks for matches by passing through the data three times. In the first pass, records with the same Social Security number and date of birth (regardless of their name and/or address) are linked. In the second pass, records with the same date of birth, maiden name, and year of graduation are linked. The records that were linked will be merged if they have the same gender, and there are not different Social Security numbers within the same group of linked records. This will primarily merge duplicate records from different jurisdictions. National Council can provide more detailed descriptions of the matching process if required.

What if the data are not in electronic form?

The system will be developed to receive and process only data that can be electronically transmitted (i.e., FTP, tape or disk). If the data are not in one of these media forms, the Member Board will need to convert the data to enable electronic transmission. Nur*sys* will accept data from a variety of media forms, including File Transfer Protocol (FTP), tape and disk. FTP is the recommended mode of transmission, as it is a fast and secure method of transmitting the data.

Will my Member Board's data need to be Year 2000 Compliant to be included in Nur*sys*?

Yes. New participating Member Boards will need to submit Year 2000 Compliant data. The purpose of this requirement is to ensure the accuracy of the data included in the data warehouse.

Notes

Notes

Forum: Resolutions Committee/New Business

Report of the Resolutions Committee/New Business

Committee Members

Carol Osman, NC, Area III, *Chair*
Myra Broadway, ME, Area IV
Marcia Flesner, MO, Area II
Valisa Saunders, HI, Area I
Doris Nuttelman, NH, Area IV, *Finance Committee Liaison*

Staff

Doris Nay, MA, RN, *Director of Member Board Relations*

Relationship to Strategic Plan

Strategic Initiative 6.....*The National Council will have the organizational structure and capacity to lead in regulation.*
Outcome 1.....*A sound organizational governance and management infrastructure to advance the National Council's mission and vision.*

Recommendations to the Delegate Assembly

1. **That the National Council of State Boards of Nursing explore the feasibility of development of an English Proficiency Examination in a health care context.**

Rationale

Ability to comprehend and speak the predominant language is an important component of licensure requirements. While there are English proficiency examinations currently in use to assist boards in licensure decisions, none are designed to measure the English proficiency levels for safe nursing practice.

Submitted by:

Oregon State Board of Nursing
Maryland Board of Nursing

Resolutions Committee Analysis

A. Consistency with National Council articles of incorporation, bylaws, mission, strategic initiatives and policies: *Consistent*
B. Relationship to ongoing programs: *Not in current Strategic Plan*
C. Duplication with other proposed motion/s: *No duplication*
D. Legal implications: *To be legally defensible, any English Proficiency Examination with a cut score will have to be supported by an adequate job analysis demonstrating that the level of English proficiency corresponding to the cut score is necessary for the safe and effective practice by entry-level nurses*
E. Financial impact: *Impact on National Council for FY00 is $39,680 (see fiscal impact statement included in Attachment A)*

2. **That the National Council of State Boards of Nursing conduct research to determine appropriate cut scores for currently available examinations to establish the relationship of the examination to competency in English proficiency needed for safe practice; and based on research findings, provide recommendations to Member Boards on standards for English proficiency requirements.**

Rationale

Ability to comprehend and speak the predominant language is an important component of licensure requirements. Additionally, there is no research to give guidance in establishing a required cut score for licensure.

Submitted by:
Oregon State Board of Nursing
Maryland Board of Nursing

Resolutions Committee Analysis

A. Consistency with National Council articles of incorporation, bylaws, mission, strategic initiatives and policies: *Consistent*
B. Relationship to ongoing programs: *Not in current Strategic Plan*
C. Duplication with other proposed motion/s: *No duplication*
D. Legal implications: *To be legally defensible, any English Proficiency Examination with a cut score will have to be supported by an adequate job analysis demonstrating that the level of English proficiency corresponding to the cut score is necessary for the safe and effective practice by entry-level nurses*
E. Financial impact: *Impact on National Council for FY00 is $60,760 (see fiscal impact statement included in Attachment B)*

Background

The background for motions #1 and #2 is identical. The rationale for both motions is similar but individualized to reflect the intent of each motion.

The Resolutions Committee held telephone conference calls on Wednesday, May 19, 1999, and Monday, May 24, 1999, to review the motions received. Following the policies and procedures established by the Board of Directors, the committee prepared the motions for inclusion in the *Business Book*. The committee will meet at 4:00 p.m. on Friday, July 30, 1999, to review any additional resolutions/motions received by 2:00 p.m. on Friday, July 30, 1999.

The Resolutions Committee used the following guide to analyze each of the motions submitted:

A. Determination of consistency with National Council articles of incorporation, bylaws, mission, strategic initiatives and policies:
   Non-consistent
   Consistent
B. Determination of relationship to ongoing programs:
   Not in current Strategic Plan *(see Tab 6, Attachment A)*
   In current Strategic Plan
C. Assessment for duplication with other proposed motion/s:
   No duplication
   Duplication
D. Legal implications:
   Implications identified
   None
E. Financial impact:
   Impact identified
   None

- **Resolutions Forum**

All resolutions received will be presented by the committee at the Resolutions Forum which will be held at 9:15 a.m. on Saturday, July 31, 1999.

Meeting Dates

- May 10, 1999, *(telephone conference call)*
- May 24, 1999, *(telephone conference call)*
- July, 30, 1999

Attachments

Attachment A

Motion #1 – To explore the feasibility of development of an English Proficiency Examination in a health care context

Background

Since June 1995, the Oregon State Board of Nursing (OSBN) has studied the issue of measures to determine if applicants for licensure have appropriate English language proficiency for competency in nursing practice. In the course of that study, the OSBN reached the following conclusions: 1) available examinations to measure English proficiency were developed for academic or business contexts; 2) no research findings are available to show the relationship between any particular examination and competency for nursing practice; and 3) there is need for development of an English proficiency examination in a health care context and research to show the relationship between nursing competency and scores on the examination.

From 1995 to 1997, the OSBN explored with staff at National Council and CGFNS the possibilities for development of a national English proficiency exam more appropriate for a nursing context than current exams that are written for academic or business contexts. CGFNS agreed to consider the issue. By summer 1997, CGFNS reported that their market studies and available venture capitol were not supportive of development of a health-related English proficiency examination. The passage of more stringent immigration laws in September 1996 was a factor in the decision to not proceed with test development.

An informal survey of states was conducted to determine if there were discernable shared standards either in the examination(s) or the cut scores required for English proficiency. Using information in National Council's *Profiles of Member Boards – 1996* and the survey results, it was determined that 45 jurisdictions report having a requirement for demonstration of English proficiency. Twenty-six of those jurisdictions responded to the survey. Tests used by the 26 responding states included: Commission on Graduates of Foreign Nursing Schools (CGFNS) exam, Test of English as a Foreign Language (TOEFL), Test of Spoken English (TSE), Test of Written English (TWE), and Michigan English Language Assessment Battery (MELAB). It is important to note that the English proficiency portion of the CGFNS exam is now TOEFL with a cut score of 540. The number of states using each of these tests, and the range of cut scores that are required, are presented in Table 1. The total number of "state boards using" is greater than 26 because some states reported using more than one test.

Table 1 Tests Used for English Proficiency by the Twenty-six Responding States, and the Range of Cut Scores Required for Licensure

Test:	# of state boards using:	Range of required scores:
CGFNS	24	"pass"
TOEFL	13	447 – 560
TSE	4	45 – 50
MELAB	2	75 – 80
TWE	1	no score given

Issue

Communication is a critical competency for safe nursing practice. Ability to comprehend and speak the predominant language is therefore an important component of licensure requirements. While there are English proficiency examinations currently in use to assist boards in licensure decisions, none are designed to measure the English proficiency levels for safe nursing practice.

Proposal
It is recommended that the National Council of State Boards of Nursing adopt the following:

That the National Council of State Boards of Nursing explore the feasibility of development of an English Proficiency Examination in a health care context.

Submitted by:
Oregon State Board of Nursing
Maryland Board of Nursing

National Council of State Boards of Nursing
Fiscal Impact Statement

FISCAL YEAR 2000

TITLE OF MOTION/RESOLUTION:
1. To explore the feasibility of development of an English Proficiency Examination in a health care context.

I. SUMMARY

	FY00	FY01	FY02
Revenue			
Out-of-Pocket Expense	*$39, 680		
Existing Staff Time Expense			
Net Revenue/(Expense)			

*(projected staff acquisition included in Out-of-Pocket expense)

II. PROJECTED DATES:

Beginning: 10/1/1999

Completion: 8/1/2000

SUBMITTED BY:
Oregon State Board of Nursing
Maryland Board of Nursing

Attachment B

Motion #2 – To conduct research to determine appropriate cut scores for currently available examinations to establish the relationship of the examination to competency in English proficiency needed for safe practice; and based on research findings, provide recommendations to Member Boards on standards for English proficiency requirements.

Background

Since June 1995, the Oregon State Board of Nursing (OSBN) has studied the issue of measures to determine if applicants for licensure have appropriate English language proficiency for competency in nursing practice. In the course of that study, the OSBN reached the following conclusions: 1) available examinations to measure English proficiency were developed for academic or business contexts; 2) no research findings are available to show the relationship between any particular examination and competency for nursing practice; and 3) there is need for development of an English proficiency examination in a health care context and research to show the relationship between nursing competency and scores on the examination.

From 1995 to 1997, the OSBN explored with staff at National Council and CGFNS the possibilities for development of a national English proficiency exam more appropriate for a nursing context than current exams that are written for academic or business contexts. CGFNS agreed to consider the issue. By summer 1997, CGFNS reported that their market studies and available venture capitol were not supportive of development of a health-related English proficiency examination. The passage of more stringent immigration laws in September 1996 was a factor in the decision to not proceed with test development.

An informal survey of states was conducted to determine if there were discernable shared standards either in the examination(s) or the cut scores required for English proficiency. Using information in National Council's *Profiles of Member Boards – 1996* and the survey results, it was determined that 45 jurisdictions report having a requirement for demonstration of English proficiency. Twenty-six of those jurisdictions responded to the survey. Tests used by the 26 responding states included: Commission on Graduates of Foreign Nursing Schools (CGFNS) exam, Test of English as a Foreign Language (TOEFL), Test of Spoken English (TSE), Test of Written English (TWE), and Michigan English Language Assessment Battery (MELAB). It is important to note that the English proficiency portion of the CGFNS exam is now TOEFL with a cut score of 540. The number of states using each of these tests, and the range of cut scores that are required, are presented in Table 1. The total number of "state boards using" is greater than 26 because some states reported using more than one test.

Table 1 Tests Used for English Proficiency by the Twenty-six Responding States, and the Range of Cut Scores Required for Licensure

Test:	# of state boards using:	Range of required scores:
CGFNS	24	"pass"
TOEFL	13	447 – 560
TSE	4	45 – 50
MELAB	2	75 – 80
TWE	1	no score given

Issue
Communication is a critical competency for safe nursing practice. Ability to comprehend and speak the predominant language is therefore an important component of licensure requirements. While there are English proficiency examinations currently in use to assist boards in licensure decisions, none are designed to measure the English proficiency levels for safe nursing practice. Additionally, there is no research to give guidance in establishing a required cut score for licensure.

Proposal
It is recommended that the National Council of State Boards of Nursing adopt the following:

That the National Council of State Boards of Nursing conduct research to determine appropriate cut scores for currently available examinations to establish the relationship of the examination to competency in English proficiency needed for safe practice; and based on research findings, provide recommendations to Member Boards on standards for English proficiency requirements.

Submitted by:
Oregon State Board of Nursing
Maryland Board of Nursing

National Council of State Boards of Nursing
Fiscal Impact Statement

FISCAL YEAR 2000

TITLE OF MOTION/RESOLUTION:

2. To conduct research to determine appropriate cut scores for currently available examinations to establish the relationship of the examination to competency in English proficiency needed for safe practice; and based on research findings, provide recommendations to Member Boards on standards for English proficiency requirements.

I. SUMMARY

	FY00	FY01	FY02
Revenue			
Out-of-Pocket Expense	*$60,760		
Existing Staff Time Expense			
Net Revenue/(Expense)			

*(projected staff acquisition included in Out-of-Pocket expense)

II. PROJECTED DATES:

Beginning: 10/1/1999

Completion: 8/1/2000

SUBMITTED BY:

Oregon State Board of Nursing
Maryland Board of Nursing

Instructions for Submitting Motions/New Business to the Resolutions Committee During the Annual Meeting

Attached are materials designed to facilitate the submission of resolutions and the review process by the Resolutions Committee. The materials enclosed are:

- Resolutions Committee Operating Policies and Procedures (Attachment A),
- form for introducing new business for consideration by the Resolutions Committee (Attachment B),
- fiscal impact statement (Attachment C), and
- sample motion sheet for use during sessions of the Delegate Assembly (Attachment D).

How To Submit Motions and Resolutions

The form for introducing new business (Attachment B) should be completed and returned to the on-site National Council office, to the attention of the Resolutions Committee, *prior to 2:00 p.m.* on July 30, 1999.

The Resolutions Committee will meet on Friday, July 30, 1999, beginning at 4:00 p.m., to review motions and resolutions. The person(s) submitting a motion or resolution should attend the committee meeting and be prepared to speak to the motion or resolution.

If you have any questions or need assistance with any resolution, please contact Julia vonHaam, National Council's parliamentarian, who will be in attendance throughout the week.

Resolutions/New Business Submitted Directly to the Delegate Assembly

Delegates also may present any new business directly to the Delegate Assembly when delegates begin to discuss new business, scheduled at the end of the business agenda. The parliamentarian should be consulted when presenting new business.

Attachments

Attachment A

Resolutions Committee Operating Policies and Procedures

Description

The Resolutions Committee is a committee appointed by the President to serve the Delegate Assembly.

Purpose

To expedite the work of the Delegate Assembly.

Functions

1. Receive and analyze all motions submitted to it, without changing intent. The analysis shall consist of:
   a) determination of consistency with National Council articles of incorporation, bylaws, mission, goals, objectives, and policies;
   b) determination of relationship to ongoing programs;
   c) assessment for duplication with other proposed motions;
   d) legal implications;
   e) financial impact.
2. Initiate motions.
3. Present oral and written reports of motions and resolutions. The report for each motion and resolution shall include the following *analyses* performed by the Resolutions Committee:
   a) determination of consistency with National Council articles of incorporation, bylaws, mission, goals, objectives, and policies;
      Consistent
      Not Consistent (with rationale)
   b) determination of relationship to ongoing programs;
      Not in current Organization Plan
      In current Organization Plan (site identified)
   c) assessment for duplication with other proposed motion/s;
      No duplication
      Duplication (motion/s identified)
   d) legal implications;
      None
      Implications identified
   e) financial impact.
      None
      Impact identified

Procedures

Motions and resolutions may be submitted by a delegate(s), structural unit or jurisdiction. A fiscal impact statement must accompany the motion or resolution.

Motions and resolutions may be submitted to the Resolutions Committee until the committee convenes its meeting at the Annual Meeting. Thereafter, the submitter shall present the motion or resolution directly to the Delegate Assembly as new business.

Submitters are encouraged to submit motions and resolutions prior to the deadline as identified below, to allow time for the committee and the submitter to work together on format, wording, clarity, etc., should that be needed, and to have the motion or resolution included in the mailing to Member Boards 45 days before the Annual Meeting.

Courtesy resolutions are proposed by the Resolutions Committee.

Motions and Resolutions for Publication

1. Motions and resolutions must be submitted by the deadline published in the National Council *Newsletter* in order to be reviewed by the Resolutions Committee and mailed to Member Boards 45 days before the Annual Meeting.
2. The Resolutions Committee will meet after the submission date and prior to the deadline for receipt of materials. The committee will review all motions and resolutions and work with submitters should editing, rewriting, or combining of motions and resolutions be necessary. All submitters will be advised of the committee analyses of their motions and resolutions. No motions and resolutions will be amended or revised after committee action and until the report is presented at the Delegate Assembly.
3. Motions and resolutions included in the mailing to Member Boards will be presented at the Resolutions Forum.

Motions and Resolutions Received After the Publication Deadline

1. The deadline for receipt of motions and resolutions at the Delegate Assembly shall appear in the Rules of Conduct for the Delegate Assembly.
2. A meeting of the Resolutions Committee shall be scheduled at the Annual Meeting to review motions and resolutions received prior to the deadline appearing in the Rules of Conduct for the Delegate Assembly and not previously reviewed by the committee. This meeting shall occur as close to the session at which new business will be considered as is consistent with the orderly transaction of the committee's business. [This later meeting schedule will allow greater time for resolutions emerging from network groups, Area meetings, and forums to be prepared for the committee's review.]
3. The person(s) submitting a motion or resolution should attend the committee meeting and be prepared to speak to the motion or resolution.
4. The committee will go into executive session to prepare the motion or resolution for submission to the Delegate Assembly.

Other New Business

1. A motion or resolution not received before the Resolutions Committee meeting at the Delegate Assembly shall be presented directly to the Delegate Assembly as new business.
2. The submitter is responsible for duplication of the resolution for distribution to members of the Delegate Assembly. Each resolution or motion should be accompanied by a written analysis of consistency with National Council mission and strategic plan; assessment of fiscal impact and potential legal implications. If it is not, the President shall refer the motion or resolution to appropriate committees and/or staff for preparation and dissemination of such analyses prior to a vote on the motion or resolution.

Definitions

- **Motion**

A proposal for consideration by the Delegate Assembly stated in the format, "I move that..." A motion does not contain the rationale in its wording but the rationale may be submitted with the motion and the proposer should be prepared to speak to the motion after seconding to present the rationale.

- **Resolution**

A proposal for consideration by the Delegate Assembly stated in the format, "Whereas ..." [any number of whereas statements present the rationale for the proposal]; "therefore be it resolved ..." [any number of resolved statements defining the action(s) to be taken].

Approved by Board of Directors, May 1990
Revised, January 1996

Attachment B

Form for Introducing New Business for Consideration by the Resolutions Committee at the Annual Meeting

I move that:

Rationale for Motion:

If the motion is made by an individual:

Person making motion:_____

Member Board:_____

❒Board Member
❒Board Staff

Person seconding motion:_____

Member Board:_____

❒Board Member
❒Board Staff

If the motion is made by a committee:

Committee responsible for motion:_____

Name of Committee Chair:_____

Instructions: Complete and return to the on-site National Council office, to the attention of the Resolutions Committee.

Attachment C

National Council of State Boards of Nursing
Fiscal Impact Statement

FISCAL YEAR 2000

TITLE OF MOTION/RESOLUTION: _____

I. SUMMARY*

	FY00	FY01	FY02
Revenue	_____	_____	_____
Out-of-Pocket Expense	_____	_____	_____
Existing Staff Time Expense	_____	_____	_____
Net Revenue/(Expense)	_____	_____	_____

II. PROJECTED DATES:

Beginning: _____

Completion: _____

SUBMITTED BY: _____

_____

* To be calculated by submittor in conjunction with National Council staff.

Attachment D

Sample Motion Sheet

Below is a sample of the motion sheet used by delegates to make motions during the Delegate Assembly. Official motion sheets can be found on delegate tables on-site. They are to be submitted in triplicate.

NATIONAL COUNCIL

National Council
of State Boards of Nursing, Inc.

MOTION NUMBER: _____
MEETING: _____
DATE: _____

I MOVE, _____

ACTION:
- ☐ Amended
- ☐ Adopted
- ☐ Failed
- ☐ Postponed
- ☐ Tabled
- ☐ Withdrawn
- ☐ Referred

MAKER: _____

SECOND: _____

Notes

Report of the Bylaws Committee

Committee Members

Carol Osman, North Carolina, Area III, *Chair*
Myra Broadway, Maine, Area IV
Marcia Flesner, Missouri, Area II
Valisa Saunders, Hawaii, Area I
Doris Nuttelman, New Hampshire, Area IV, *Finance Committee Liaison*

Staff

Doris Nay, MA, RN, *Director of Member Board Relations*

Relationship to Strategic Plan

Strategic Initiative 6.....*The National Council will have the organizational structure and capacity to lead in regulation.*
Outcome 1.....*A sound organizational governance and management infrastructure to advance the National Council's mission and vision.*

Recommendations to the Delegate Assembly

1. **None.**

Highlights of Activities

- **Review of Bylaws Amendments**

There were no bylaws amendments submitted prior to the April 30, 1999, deadline date as published in National Council's *Newsletter* to Member Boards.

Future Activities

None.

Meeting Dates

- May 10, 1999 *(telephone conference call)*

Attachments

A ..... National Council Bylaws, *page 3*

Attachment A

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*
Amended	*August 20, 1997*
Amended	*August 8, 1998*

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® examination, 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® examination.

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.

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® examination, except that a Member Board that uses both NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

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.

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.

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.

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. At the first committee meeting, the members of the committee shall elect, from its membership, a 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.
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. 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 candidates receiving the highest numbers 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 candidates receiving the highest number of votes (two candidates if one position is to be filled; four candidates 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 candidates with the most votes, then 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, strategic initiatives and outcomes, 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® examination contracts between the National Council and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; select the NCLEX® examination test service; and establish the fee for the NCLEX® examination.

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. 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 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. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.

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.

Orientation Manual

Purpose

The purpose of the Orientation Manual is to provide information about the mission, governance 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.

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.

Organizational Mission, Strategic Initiatives and Outcomes

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.

The role of the National Council is to serve as a consultant, liaison, advocate, and researcher to Member Boards, and as an education and information resource to the public and policy makers.

An organizational chart depicting the relationship between the National Council and Member Boards can be found on page 7.

The National Council has six strategic initiatives (see Strategic Plan, Tab 6), one of which is to assist Member Boards in their role in the evaluation of initial and ongoing nurse competence. Another is to coordinate the identification of effective regulatory outcomes and assist Member Boards to implement and evaluate strategies for sound regulation. The National Council also seeks to analyze the changing practice environment to assist in identifying state and national regulatory implications and to develop strategies to impact public policy. To achieve its strategic initiatives, the National Council identifies expected outcomes, under which tactics for achieving these outcomes 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 strategic initiatives and outcomes 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 late July/early 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 adopt 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, strategic initiatives and outcomes 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. Write-in votes are prohibited. In the event a majority is not established, the Bylaws dictate the reballoting process.

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

All Board meetings are held in Chicago, with the exception of the pre- and post-Annual Meeting Board meetings which are held at the location of the Annual Meeting.

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*.

The agenda is organized around the strategic plan (strategic initiatives and outcomes). Items for Board discussion and action are accompanied by a memo or report that 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 included in the *Newsletter* for Member Boards' 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, strategic 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 the Board.

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 members in advance of the call. These materials include committee or 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 members 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. At the first committee meeting, the members of the committee select a chair.

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

Many 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. Standing committees may be assisted by subcommittees, such as the Subcommittee on Nursing Education (NP&E) or the NCLEX® Item Review Subcommittee (Exam).

Committees and special committees are appointed by the Board of Directors to address special issues and concerns. Examples of special committees include the Information Systems User Group, Mutual Recognition Master Plan Coordinating Group and Policy Futures Panel.

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.

- **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.

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 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, discipline resources, 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 and Board of Directors' policy directives and provide assistance to committees.

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 prior to the Annual Meeting, Member Boards are sent the recommendations to be considered by the Delegate Assembly. A *Business*

Book is provided to all Annual Meeting registrants which contains the agenda, reports requiring Delegate Assembly action, reports of the Board of Directors and standing committees, annual plan and budget.

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. 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 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 parliamentarian. These minutes are then reviewed, corrected as necessary and approved by the Committee to Approve Minutes, which includes the executive director who serves as corporate secretary.

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, strategic initiatives and outcomes 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

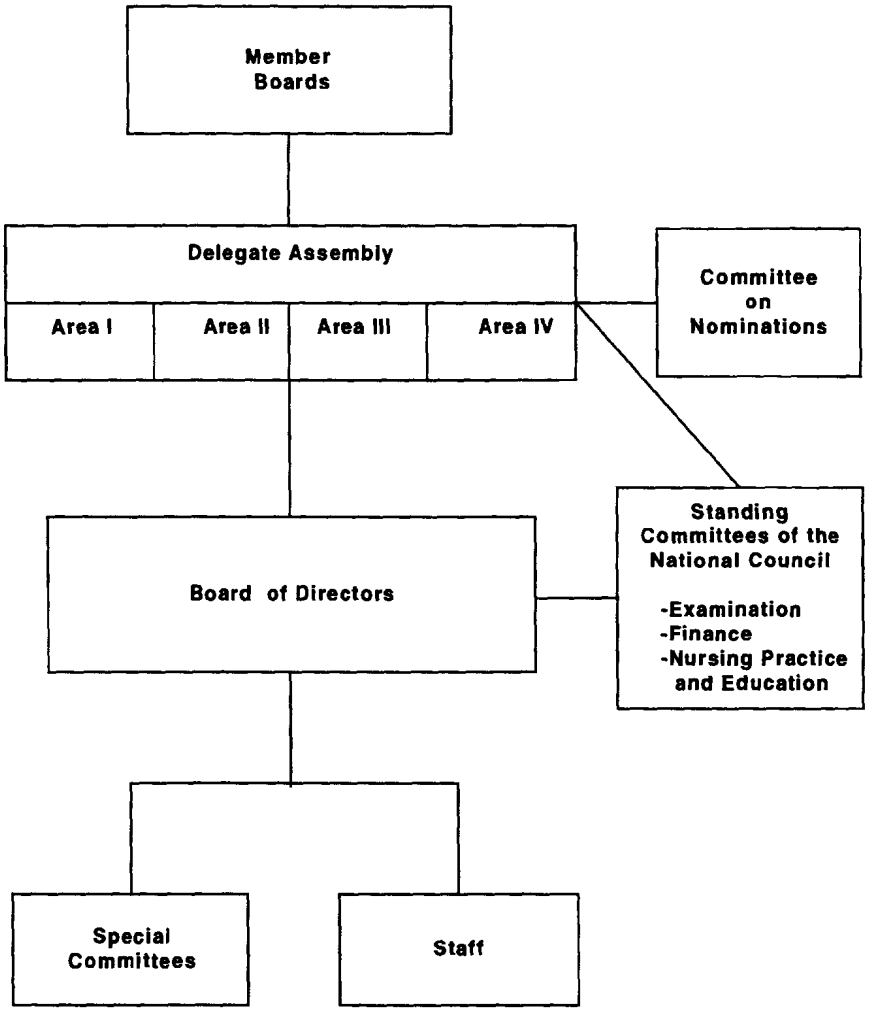
The appointment of representatives of Member Boards to committees of the National Council is a responsibility delegated to the Board of Directors by the bylaws. In order to facilitate this process and ensure a wide representation of Member Boards, board staff and board members, the following procedure 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. The information provided is maintained in the National Council's Volunteer Resource Pool. All information contained in the Pool, 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.

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.

National Council of State Boards of Nursing, Inc.

Organization



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Glossary

AACN
American Association of Colleges of Nursing, or American Association of Critical Care Nurses.

AANA
American Association of Nurse Anesthetists.

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.

Agent Role
A topic under discussion regarding the National Council serving as an agent so that Member Boards could continue to report disciplinary action to National Council's Disciplinary Tracking Service (formerly known as the DDB) without interfacing directly with federal agencies. The National Council would serve as a conduit so that the appropriate information is sent on to the federal data bank and would also be authorized (through individual contractual agreements with each Member Board) to use the information in the National Council's Nur*sys*.

ANA
American Nurses Association.

ANCC
American Nurses Credentialing Center.

AONE
American Organization of Nurse Executives.

APRN
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 geographic regions of National Council's Member Boards. (See the chart on page 2 that lists each state by Area.)

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
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 the NNAAP (National Nurse Aide Assessment Program, formerly known as the NACEP) and the Certification Examination for Practical and Vocational 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.

CCAP
Continued Competence 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.

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 (CGI)
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.

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.

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.

DDB
Disciplinary data bank. A National Council data management system, established in 1981, that serves as a database of disciplinary actions reported by Member Boards (see also Disciplinary Tracking System).

Delegate Assembly (DA)
The registration body of the National Council that comprises 61 Member Boards. Each Member Board is entitled to two votes. Provides direction through adoption of the mission, strategic initiatives and outcomes; 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. An 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 (also see Disciplinary Tracking System).

Disciplinary Tracking System
A new name for the DDB (approved by the Board of Directors in May 1999), as the database is incorporated into National Council's comprehensive nurse licensee information system called Nur*sys*.

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 Tracking System via NCNET for information regarding disciplinary history of action(s) taken against a nurse's license.

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. The Chauncey Group is located in Princeton, New Jersey, and is 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. FARB provides a forum for individuals and organizations to share information related to professional regulation, particularly in the areas of administration, assessment and law.

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.

HIPDB
Healthcare Integrity and Protection Data Bank. A national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements for which no finding of liability have been made) against health care providers, suppliers or practitioners as required by the Health Insurance Portability and Accountability Act of 1996.

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 NNAAP.

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.

Interstate Compact
Legislative language adopted by the Delegate Assembly in special session, December 1997. An interstate compact is the legislation that must be adopted at the state level in order to implement mutual recognition for nursing regulation.

Issues
A quarterly newsletter published and distributed nationally by the National Council to a readership of approximately 10,000 (including all schools of nursing).

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 NNAAP examination.

Job Analysis
A research study that examines the practice of newly licensed job incumbents (RNs, LPN/VNs) or new nursing assistants. The results are used to evaluate the validity of the test plans/blueprints that guide content distribution of the licensure examinations or the nurse aide competency evaluation.

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.

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.

MNAR
Model Nursing Administrative Rules. (A publication of the National Council.)

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.)

MR
Mutual recognition. Mutual recognition for nursing regulation was adopted by the August 1997 Delegate Assembly, and language for an interstate compact that would facilitate mutual recognition was adopted by a special session of the Delegate Assembly in December 1997. As of June 1999, four states have signed interstate compact language into law: Arkansas, Maryland, Texas and Utah.

MSR
Multistate regulation.

NACEP™
Nurse Aide Competency Evaluation Program. (Former name of the 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.

National Council Strategic Plan
Mission, strategic initiatives, and outcomes 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.

NCLEX Item Coding and Tracking (NICT) Database
A database that is designed to store all data, including statistical information, test plan codes, and content codes such as those for nursing process and cognitive levels for each NCLEX-RN and NCLEX-PN item. This database also tracks the history of each item.

NCLEX-RN® Examination
National Council Licensure Examination-Registered Nurse.

NCLEX-PN® Examination
National Council Licensure Examination-Practical Nurse.

NCLEX® Program Reports
Published twice per year for subscribing schools of nursing, 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.).

NCSBN or NC
Abbreviated forms of National Council of State Boards of Nursing, Inc.

Newsletter
A biweekly publication produced by the National Council, distributed to each Member Board and accessible by Member Boards via NCNET. Includes information related to National Council activities, as well as a calendar of events.

NFLPN
National Federation of Licensed Practical Nurses.

NICT
NCLEX Item Coding and Tracking.

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.

NLN
National League for Nursing.

NNAAP
National Nurse Aide Assessment Program. The nurse aide certification examination developed by the National Council and Assessment Systems Inc. (ASI) during FY98 that combines the NACEP and ASI's nurse aide certification programs.

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 still pending as of June 1999.

NPI
National Provider Identifier. On May 7, 1998, rules were posted in the *Federal Register* proposing a standard for a national health care provider identifier and requirements for its use by health plans, health care clearinghouses and health care providers. This is planned to be a new, unique eight-character alpha-numeric identifier.

Nursys
A comprehensive 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 tracking system, licensure verification, interstate compact functions and research on nurses.

OBRA 1987
Omnibus Budget Reconciliation Act of 1987 (contains requirements for nurse aide training and competency evaluation).

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 Assessment Systems, Inc. (ASI), the NNAAP test service who is charged to develop and maintain an evaluation for nurse aide competency as mandated by federal legislation (OBRA 1987). ASI 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 NNAAP. For adaptively administered examinations, such as the NCLEX examination using CAT, the decision consistency statistic is the more appropriate statistic for assessing precision

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 supports 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 *NNAAP Blueprint* changes.

STC
Sylvan Technology Center.

Submission of Reports
A Member Board, upon taking disciplinary action, submits to the National Council Disciplinary Tracking Service (formerly known as the DDB) biographical data about the nurse and information regarding the grounds for and the disciplinary action taken by the board of nursing.

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.

TCA
Test Center Administrator.

Test Plan
The organizing framework for the 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 NNAAP and CEPN-LTC.

The Chauncey Group International, Ltd., or The Chauncey Group
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.

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 (NNAAP). Each test plan or blueprint is developed from a current job analysis of entry-level practitioners.

VIP
Volunteer Information Program. A password-protected site on National Council's World Wide Web page (http://www.ncsnb.org) that can be accessed by board members and staff of boards of nursing.