Our Collective Voice

Orchestrating the Future of Regulatory Excellence

Nashville
August 5-8, 2008

2008 Annual Meeting Session Book
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**SESSION BOOK | NCSBN 2008 ANNUAL MEETING**

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Directions for Obtaining CEUs for the 2008 Delegate Assembly

In an attempt to streamline the CE process, as well as to be environmentally responsible, we are piloting a process whereby we will award your CEUs electronically.

We are able to award CEUs for the following meetings (4.8 CEUs):

1. Inspirational Keynote: Ann Bancroft — August 5th
2. The First 25 Years of NCSBN — August 6th
3. The Regulatory Challenge of the Future — August 6th
4. Self-Direction, Self-Regulation & Other Myths — August 6th

Please follow these directions carefully if you’d like to receive your CEUs:

1. Sign the CEU Roster at the registration desk.
2. Attendance at all the above sessions is required to obtain the 4.8 CEUs, along with completion of the evaluation form pertaining to those presentations.
3. During the week of August 11th NCSBN will e-mail all of those listed on the CEU Roster and send an electronic evaluation. Please refer to the evaluation form, that you may have completed in the session book, when submitting the electronic evaluation.
4. Once we receive your electronic evaluation, NCSBN will send you an electronic CEU certificate.
2008 Annual Meeting Continuing Education Evaluation

1. Rate the effectiveness of the teaching methods for each presenter by checking the appropriate box: *(5 = Very Effective, 1 = Ineffective)*

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<th>Presenter</th>
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2. Was the speaker knowledgeable, organized, and effective in his/her presentation? *(5 = Very Effective, 1 = Ineffective)*

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3. Please rate the content of the program. Below are the program objectives for your review. *(5 = Very Effective, 1 = Ineffective)*

- ♦ Discuss the power of dreams and steps in order to reach them; overcoming obstacles and thinking outside boundaries to achieve organizational, professional, and personal goals
- ♦ Describe the early history of nursing regulation
- ♦ Discuss the organization of the NCSBN
- ♦ List Major Actions of the NCSBN Delegate Assembly
- ♦ Understand purposes and processes of policy
- ♦ Evaluate potential impact of key trends on future regulations
- ♦ Review and explore the concepts of self-assessment and self-direction
- ♦ Address some of the personal and environmental limitations on these processes
- ♦ Discuss how we might address these limitations in order to evolve safe and effective practitioners

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<tr>
<th>Program Content</th>
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<tr>
<td>Were the objectives of this program met?</td>
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<td>Were the methods of presentation appropriate?</td>
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4. Please rate the following general questions (5 = very effective – 1 = Ineffective)

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<tr>
<th>General Questions</th>
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<td>Was the program engaging?</td>
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<td>Was the program useful to your work?</td>
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<td>Should the program continue?</td>
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<td>Was enough time allotted for this activity?</td>
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<td>Were the physical arrangements conducive to learning?</td>
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5. **Comments**: Please explain very low or very high ratings:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

6. **Recommendations**: Provide suggestions for education sessions that would benefit your work:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Name:__________________________________________

Board of Nursing: _____________________________________________

Phone Number: ____________________________________________

*Participants who leave early will not receive any contact hours.*

*Attendees interested in obtaining CE units must complete and return this form and sign the attendance roster.*
APRN Committee Forum

Presented by:

Ann O’Sullivan, PhD, MSN, CRNP, CPNP, FAAN
Area IV, Chair, APRN Committee
APRN Update

APRN Committee
Ann L. O’Sullivan, Chair

APRN Regulatory Model

- Developed by the NCSBN APRN Committee and the Consensus Work Group through the APRN Joint Dialogue Group
- Progress has been shared with boards of nursing
- One paper was developed
Session I: APRN Committee Forum

Regulatory Model etc.

- APRNs will be regulated at role (CNP, CNS, CNM, CRNA) and population focus (adult/gerontology, across-the-life span) level.
- The role and population focus level will be used for APRN licensure purposes.
- Specialty competencies (oncology, palliative care, etc.,) can be obtained beyond the role and population focus and will not be subject to the requirements for licensure. Certification and other mechanisms can be used to measure specialty competencies.

Regulatory Model etc.

- For regulatory purposes, an individual must graduate from an accredited program that includes:
  - The 3 P’s (advanced health assessment, advanced physiology and pathology, advanced pharmacology)
  - Role Core (CNP, CNM, CNS, CRNA)
  - Population Focus Core
- And have all 3 levels assessed by a psychometrically sound and defensible method. This can be done by national certification.

Activities

- Delegate Assembly voting on parallel APRN Language
- Implementation Strategies for the APRN Regulatory Model
- Development of LACE (Licensure, Accreditation, Certification, and Education)
APRN Legislative Language

Changes to Model Practice Act:
- Prescriptive Authority
- Independent Practice
- Use of Dr. title
- Recognition at role and population focus level
- No temporary permit
- Definition of APRN
Faculty Qualifications Committee Forum

Presented by:

Susan Odom, PhD, RN, CCRM
Area I, Chair, Faculty Qualifications Committee
Faculty Qualifications Committee Recommendations

Susan Odom, PhD, RN, CCRN, Faculty Qualifications Committee Member

2007-2008 Charges

- Advise staff on content of Faculty Shortage Conference
  - Held March 26, 2008, in Chicago
- Review and present recommendations for future nursing faculty qualifications and roles

Background of Charge

- 2005-2006 PR&E studied evidence-based nursing education:
  - NCSBN conducted National Study of Elements in Nursing Education
  - NCSBN conducted systematic review of nursing education outcomes
  - Hosted Invitational meeting for stakeholders, across disciplines
Background of Charge

- The following question pervaded all of this work:

  “There is the need for qualified faculty to supervise and guide students, but ‘how qualified’ is ‘qualified’?”

Background of Charge

- Due to the faculty shortage, programs are struggling to attract “qualified” faculty

- Lawmakers in some states are calling for lower faculty standards

Background of Charge

But is lowering qualifications the answer?

- At the same time, the 1999 IOM and other reports have called attention to practice errors.

- The 2003 IOM report called for an “overhaul of health care education,” stating that health professionals are not prepared for the complexity of health care now.

- The 2008 national Carnegie Study of Nursing Education found that nursing education suffers from inadequate teaching as it is.
2007-2008 Committee Activities

- Met in person for 3 meetings; held 1 conference call meeting
- Held collaborative conference call meeting with:
  - AACN
  - CCNE
  - NAPNES
  - NLN
  - NLNAC

2007-2008 Committee Activities

- Reviewed work from 2006-2007 PR&E Committee
  - "Faculty Shortage Survey" to NCSBN members
  - "National Comparison of Faculty Qualifications" report
- Reviewed 35 evidence-based articles and/or consensus statements by experts in nursing education

2007-2008 Committee Activities

- Reviewed minutes from relevant Education Consultant Network calls
- Reviewed relevant surveys to Education Consultant Network
- Gained input from discussion at March 26th Faculty Shortage: Implications for Regulation conference
2007-2008 Committee Activities

- Developed 8 premises as a foundation for recommendations
- Determined three roles of faculty based on the literature: collaborator, director of learning, role model
- Developed recommendations for the Board of Directors
- Recommended changes to the Education Model Administrative Rules

Review of the Literature

- Orsolini-Hain & Malone (2007) describe the impending gap in nursing expertise
- At the same time, patient acuity is increasing, health care systems are more complex and technologic advances are growing
- Medical errors and patient safety are a major concern

Review of the Literature

- Riner & Billings (1999) studied perceived needs of faculty in Indiana
  - 352 nurse educators in sample
  - Included those teaching from LPN through PhD
  - Found significantly more needs when faculty had BSNs or master’s degrees in other areas
Review of the Literature

NCSBN’s EBNER report

- Based on National Study of Elements of Nursing Education and NCSBN’s systematic review of nursing education
- Found positive outcomes with high-level interactions with students
- Faculty would need graduate coursework to implement research-based teaching strategies identified

Review of the Literature

Graduate preparation in education

- Halstead (2007) reviews the evidence
- Tanner (2007) must develop pedagogies in the science of learning
- NLN and AACN positions
- Carnegie study of nursing education

Review of the Literature

Some national recommendations for faculty to have doctorates

- Carnegie Study of Nursing Education
- AACN’s position statement for baccalaureate programs recommend nursing faculty have doctorates
Faculty Qualifications Committee Model Rule Recommendations

Qualifications for nursing faculty who teach in a program leading to licensure as a registered nurse:

- Change “A. Have a minimum of a master’s degree in nursing or a nursing doctorate degree”… TO “…A. Have a minimum of a master’s degree in nursing or a doctorate in nursing degree.”

Rationale for changing from nursing doctorate to doctorate in nursing degree:

- Editorial for clarity. In some programs the “nursing doctorate” is an actual degree, while “doctorate in nursing” is a general phrase.

Faculty Qualifications Committee Model Rule Recommendations

Qualifications for nursing faculty who teach in a program leading to licensure as a registered nurse:

- Change “C. Have preparation in teaching and learning principles for adult education, including curriculum development and implementation.”… TO “…Have graduate preparation in the science of nursing, including clinical practice, and graduate preparation in teaching and learning, including curriculum development and implementation.”
Faculty Qualifications Committee Model Rule Recommendations

- Rationale for graduate coursework in clinical practice and teaching/learning for RN educators:
  - Rationale: Because of the complexity in today’s health care and nursing education, it is imperative to have graduate coursework in clinical practice and teaching/learning; supported in literature.

Faculty Qualifications Committee Model Rule Recommendations

- Qualifications for nursing faculty who teach in a program leading to licensure as a practical/vocational nurse:
  - Change “E. Have a minimum of a baccalaureate degree with a major in nursing...TO...E. Have a minimum of a master’s degree with a major in nursing”
  - Previous Model Rules said, “It is preferable that the nursing faculty members have a Master’s degree with a major in nursing or a nursing doctorate degree”

Rationale for PN recommendation – guided by looking toward the future

- Complexity in nursing practice and nursing education
- PN faculty take on similar role to RN faculty
- Changing roles in PN practice → graduate prepared faculty essential
- Master’s prepared faculty able to teach intricacies of delegation and supervision
- PNs care for vulnerable populations
Faculty Qualifications Committee Model Rule Recommendations

Qualifications for nursing faculty who teach in a program leading to licensure as a practical/vocational nurse:

- Change “G. Have preparation in teaching and learning principles for adult education, including curriculum development and implementation” TO “Have preparation in the science of nursing, including clinical practice, and graduate preparation in teaching and learning, including curriculum development and implementation.”

Rationale for graduate coursework in clinical practice and teaching/learning for PN educators:

- Rationale: Because of the complexity in today’s health care, it is imperative to have graduate coursework in clinical practice and teaching/learning; supported in literature.

Faculty Qualifications Committee Model Rule Recommendations

Change qualifications of preceptors from "licensed at or above the level for which the student is preparing" TO "educated at or above the level for which the student is preparing."

Rationale: Baccalaureate educated students are taught to practice public health nursing, which is commonly not taught in ADN or diploma programs. Since preceptors are role models for the students, this is appropriate.
Implications for Model Rule Recommendations

- Requirement of advance clinical preparation means that master's degrees with a sole focus on education wouldn't be acceptable.
- Require graduate courses on teaching/learning, rather than continuing education, undergraduate coursework, etc.
- Committee members did not think it appropriate to lower faculty qualifications because of the faculty/nursing shortage.

Other Supportive Recommendations (with no model rule changes)

- Other supportive faculty with graduate degrees in related fields may participate on a RN nursing faculty team to enrich and augment nursing education.
- Other faculty, BSN prepared, may participate on a PN nursing faculty team to enrich and augment nursing education.
- Boards of Nursing are encouraged to collaborate with educators to foster innovation in nursing education.

Supportive Recommendations (with no model rule changes)

- When Boards of Nursing evaluate the preparation of faculty members, it is essential to consider the three roles of faculty that the Committee members developed from a synthesis of literature: collaborator, director of learning, role modeling.
Supportive Recommendations
(with no model rule changes)
- When Boards of Nursing evaluate the preparation of faculty members, it is essential to assess the processes of orientation to be sure that all faculty (including part-time, adjunct, novice, preceptors) are effectively oriented.

Next Steps
- Related to fostering innovation in nursing education, the Board of Directors appointed members to a new Innovations in Education Regulation Committee with the following charges:
  - Identify real and perceived regulatory barriers.
  - Develop a regulatory model for innovative education proposals

QUESTIONS???
Plenary: The First 25 Years of NCSBN

Presented by:
Corinne F. Dorsey, MS, RN, and
Joyce M. Schowalter, MEd, RN
Early Nursing Organizations

1894 - American Society of Superintendents of Training Schools (later the National League of Nursing Education, then the National League for Nursing).

1896 – Nurses’ Associated Alumnae of the United States and Canada (Canada deleted from title later, then name changed to American Nurses Association).

Sophia F. Palmer, Editor, AJN, First president of the New York Board of Nurse Examiners

Speaking to the NY Federation of Women’s Clubs in 1899:

“The greatest need of the nursing profession today is a law that shall place training schools under the supervision of the University of the State of New York. Such a law would require every training school to bring its standards up to a given point; would require every woman who wished to practice nursing to obtain a diploma from a training school recognized by the University to pass a Regent’s examination, and to register her license to practice. It is of vital importance that examination boards be selected from among nurses in practically the same manner that medical boards are chosen from physicians, dentists and teachers and are examined, each by members of their own profession.”

From Lesnik and Anderson, Nursing Practice and the Law, 1977

The First 25 Years of NCSBN

Corinne F. Dorsey

and

Joyce M. Schowalter

The First 25 Years of
NCSBN

Corinne F. Dorsey

and

Joyce M. Schowalter
Session III:
Plenary: The First 25 Years of NCSBN

State Associations Organized

1901 Illinois, New York and Virginia

1902 North Carolina and New Jersey

What Can We Expect from the Law?
Lavinia Dock

Excerpts from an article in the first issue of the AJN, October 1900

“So it comes down to this: not, What can we expect from the law? But, what can we expect from ourselves and from the people all about us? They will not willingly allow us an advantage which they think will disadvantage themselves and we may not disregard their interests in considering our own, but should rather seek to safeguard both, and so go amicably on together.”

and

“Restrictive legislation affecting the professions, then, is not to be gained once and forever; this is another point for us to remember. It does not mean just one effort, but continuous efforts for the rest of time.”

Historic Year in Nursing Regulation

1903
The “Finest Hour for Nursing Regulation”

March 3—first law to regulate nursing signed into law by North Carolina governor.

April 17—law to regulate nursing passed in New Jersey.

April 20—law to regulate nursing passed in New York.

May 13—law to regulate nursing signed into law by Virginia governor.
**Similarities and Differences of the Laws Enacted in 1903**

- **Similarities**—title protection, examinations, grandfathering.
- **Differences**—board and membership, approval of schools.
- **Common to all**: the purpose of regulation of nursing is to protect the health, safety and welfare of the public.

**A Call to Meet Together**

Sophia Palmer, speaking at the ANA Convention in 1905 as reported in the AJN:

It seems to me that it would be a very great help if when all of the members of the State Associations come together at these annual meetings there could be a sort of an informal meeting or conference and discussion by the members of the board [of examiners] and the state officers who might be present. I am sure there are a great many questions we should like to settle at once and talk over in an informal way, and it would send us all home very much better informed and make it possible for us to work on more uniform lines. There are a great many points that...can be discussed privately, but not publicly. They are what you might call family affairs, and we ought to get together and talk them over and find out what course has been taken. We might have a secretary or a chairman to call the members together and have an hour’s talk during the Conventions, when we might have just this kind of an informal conversation.

**State Reciprocity**

Adelaide Nutting spoke about “State Reciprocity” at the 1904 ANA Convention as reported in the AJN:

Nurses are the wandering spirits of the Earth; their training teaches them to be ready to march, like a soldier, at a moment’s notice; they seldom become deeply rooted in one place, seldom accumulate cumbersome belongings; they divest themselves of everything which may impede flight and a change of residence becomes...easy for them.... With this in mind, it seems not unnatural to conclude that reciprocity may have even a deeper meaning for us; its establishment may be more essential to our general welfare than to those whose tendency it is to remain settled and known in one place.
Group for Representatives of Boards of Nursing Named

Beginning in 1912 and continuing until June 1978 the group of representatives of boards of nursing had a variety of names:
- 1912 Legislative Committee
- 1917 Legislative Section
- 1934 Committee on State Board Problems
- 1943 ANA Clearing Bureau on Problems of State Boards of Nurse Examiners
- 1944 ANA Bureau of State Boards of Nurse Examiners
- 1951 ANA Special Committee of State Boards of Nursing Regulation
- 1966 ANA Council of State Boards of Nursing

Interesting Summary

Adda Eldredge of Wisconsin, in an article in AJN in 1931:

“The state boards of examiners, in the 27 years since the appointment of the first board, have done an almost miraculous piece of work. There have been flaws, mistakes, errors in judgment on the part of the members of these boards, due many times to a lack of education and experience for the particular piece of work they had been called upon to do. At times they have been handicapped by suspicion and opposition, both of hospitals and medical boards, and even the general public. In spite of all these conditions, in spite of the very inadequacy of many of the laws, the condition of nursing schools today is far above what we would have a right to expect, and the foundation was laid by these boards of examiners.”

State Board Test Pool Examination

Another “Finest Hour” for Nursing Regulation

Dr. R. Louise McManus, Teachers College, Columbia University, chaired a committee that responded to a call for a national examination beginning in 1938.
From “News About Nursing” in AJN in January 1944:

“The State Board Test Pool, established by the NLNE, begins to function this month with seven full members and two partially-participating members. Cooperatively prepared, objective, machine scored licensing examinations in each subject matter and clinical area are made available to state boards.... Answer sheets are scored, raw and percentile scores of each candidate in each test are reported to the board. Decision as to the candidate’s passing or failing, as well as the grade to be assigned to each test, will rest always with the board of nurse examiners in the state.

The initiation of the State Board Test Pool marks a real milestone in cooperative professional activity and will lay the foundation for improvement in nursing education by providing a means of self-evaluation for individual nurses, for schools of nursing, and for states.”

McManus, in “The State Board Test Pool,” AJN April 1944:

“No attempt was made comprehensively to measure the subject-matter content, but rather to secure evidence of the abilities of the nurse which were the expected outcomes of the total program of instruction – namely, her ability to nurse.

Membership of Bureau of State Boards of Nursing and ANA Position on Membership on State Boards of Nursing

Members of the Bureau of State Boards of Examiners of Nurses were appointed by the ANA Board of Directors from names submitted by the individual state boards. ANA took the position that members of boards of nursing must be RNs and only RNs were appointed to the Bureau. Mary Roberts, Editor of the AJN, commented in 1956, after the ANA Board reaffirmed its position regarding membership on boards of nursing:

‘...that only professional registered nurses ‘who are best qualified by general and professional educational preparation and educational experience should be appointed to the state licensing board for nurses.’

This does not exclude the possibility that a well qualified professional nurse who teaches in an educational program for practical nurses or directs it, might make a valuable contribution as a board member. Nor does it mean that the ANA frowns on the appointment of an advisory committee which includes practical nurses. It does believe, however, that practical nurses are not qualified by experience or education to undertake the complex task of administering licensing laws.”
Moving Forward

The stage is set for another “finest hour” as the representatives of the state boards of nursing meet and counsel together to determine whether or not the time has come to form an independent organization whose members are the state boards of nursing. The purpose of such an independent organization will be to continue to support its members in the protection of the health, safety and welfare of the public.

Special Task Force – State Boards of Nursing

MEMBERS

Area I Beverly Andre, OR
  Replaced by S. Gertrude “Trudy” Malone, MT
Area II Elaine Ellibee, WI – Chairperson
Area III Helen “Pat” Keefe, FL
Area IV Mildred Schmidt, NY

SUPPORT

Staff from Wisconsin Board of Nursing
  Sharon Weisenbeck, Associate Director
  Albert Kelm, Associate Director
  Shari Lawler, Administrative Assistant
Support

Attorneys from Boardman, Suhr, Curry and Field, Madison, WI
- David Grams
- Rebecca Erhardt
- Wade Boardman
Parliamentarian
- Henrietta Marjan, Palos Heights, IL

Selected Comparisons of Organizations - 1978

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<tr>
<th>ANA Council of State Boards of Nursing</th>
<th>National Council of State Boards Nursing</th>
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<tr>
<td>Members-One RN appointed by ANA</td>
<td>Members-Boards of nursing that used the licensing examination</td>
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<tr>
<td>Voting Body-ANA Council</td>
<td>Voting Body-Delegate Assembly representatives designated by each Member Board</td>
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<tr>
<td>Fees-None</td>
<td>Fees-Annual contract fee</td>
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<td>Budget - Developed by ANA</td>
<td>Budget-Adopted by Delegate Assembly</td>
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<tr>
<td>Funding-ANA</td>
<td>Funding-Contract fees from Member Boards and royalties from NLN for exams</td>
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<td>Staff – ANA Coordinator and assistant hired by ANA</td>
<td>Staff-Executive Director hired by Board of Directors, staff hired by Executive Director</td>
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<td>Headquarters-Kansas City, MO</td>
<td>Headquarters-Madison, WI (temporary)Chicago, IL (permanent)</td>
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Major Actions of the Delegate Assembly

- Became an independent organization
- Assumed total control of the examinations
- Made radical changes related to entry-to-practice examinations
- Selected test services
  - Changed to criterion-referenced scoring
  - Implemented computer adaptive testing (CAT)
  - Initiated the process for the international administration of NCLEX®
Major Actions of the Delegate Assembly

- Discontinued the development of computerized clinical simulation testing (CST) after several years of study
- Implemented a disciplinary data bank
- Implemented a nurse information system
- Approved the Nurse Licensure Compact for the mutual recognition model of nursing regulation
- Authorized and later phased out a Special Services Division

Major Actions of the Delegate Assembly

Adopted Guidance Documents for Member Boards:

- Model laws and regulations for registered and practical/vocational nurse licensure
- Regulation of nurse aides & unlicensed assistive personnel
- Regulation of advanced practice registered nurses
- Outcome focused test plans
- Examination accommodations for candidates with disabilities
- Neutrality on entry-level educational requirements

Major Actions of the Delegate Assembly

Adopted Guidance Documents for Member Boards:

- Enforcement
- Regulatory management of chemically dependent nurses
- Continued competence
- Interstate endorsement
- Delegation
- Telemursing
Finance Committee Forum

Presented by:

Ruth Ann Terry, RN, MPH
Area I, Chair, Finance Committee
Finance Committee Report

Presented by: Ruth Ann Terry, Treasurer

Finance Committee Charge

- Financial Policies
- Budget
- Financial Statements
- Audit
- Investments
- Liability Insurance

Finance Strategy

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<th>Outcomes</th>
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<td>Financial Planning</td>
<td>- Internal source of funds</td>
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<td>- Financial stability</td>
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<td>- Financial resource allocation aligned with mission</td>
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<td>Investment Management</td>
<td>- Optimum return on investments</td>
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<td>Internal Control</td>
<td>- Asset protection</td>
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Session IV: Finance Committee Forum

Financial Planning Targets – Reserve

- **Internal Source of Funds**
  - $14 million operating reserve
  - Significant longer-term reserve position. $15 million minimum amount.

**Reserve Compared to Operating Expense in $,000's**

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<th>FY-07</th>
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<td><strong>Total Reserve</strong></td>
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<td><strong>Operating Expense</strong></td>
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*Where it Comes From*

- **NCLEX**: 88%
- **Investments**: 8%
- **Learning Extension**: 3%
- **NURSYS**: 3%
- **Other Revenue**: 1%
- **NCLEX Investments**: 6%
- **Learning Extension**: 3%
- **NURSYS**: 3%
- **Other Revenue**: 1%
Session IV: Finance Committee Forum

Where It Goes

Financial Planning Targets – Resource Allocation

Resource Allocation

- Budget aligned with mission and strategic plan
### Financial Planning

**Performance Summary**

- **Internal Source of Funds**
  - $14 million short-term operating reserve.
  - $85 million long-term reserve.

- **Financial Stability**
  - Budgeted revenues exceed operating expenses. Focus on operating expense budget that can be supported by primary revenue source over the longer term.

- **Resource Allocation**
  - Operating budget linked to mission with consideration for impact on financial reserves.

### Investment Management

**Performance Measurements**

- **Optimum Return on Investments**
  - Returns equal long-term goal: 5.1% last 5 years
  - Policy guides effective investment strategy
  - Investment returns equal benchmarks

### Return Compared to Price Index and Budget**

- **CPI**
- **Actual**
- **Budget**

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<th>% return</th>
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<td>Budget</td>
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Internal Control and Risk Management

Protect Assets

- Unqualified opinion on financial statement audit
- Independent audit committee
- Internal Control Policy
- Favorable report from investment prudence review
- Adequate property and professional liability insurance coverage

Financial Performance Summary

- A strong reserve position that provides an internal source of funds.
- Providing for financial stability by planning operating budgets that can be supported over the long term.
- Preparing budgets that link financial resource allocation to the strategic initiatives and mission of the organization.
- Investment income that has provided a real return on investments above inflation over the last five-year period.
- A policy statement that provides guidance for an effective investment strategy and an optimum return on financial assets.
- An unqualified audit opinion from the independent accountants.
- Policies that guide good internal control practices.
- Liability insurance that supports risk management and protects against loss.
Keynote: The Regulatory Challenge of the Future

Presented by:
Jeffrey Bauer, PhD
Healthcare Futurist
Biographical Sketch (2008)

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Jeffrey C. (Jeff) Bauer, Ph.D., a nationally recognized health futurist and medical economist, is a Chicago-based management consulting partner at Affiliated Computer Services, Inc. (ACS). As leader of the futures practice for ACS Healthcare Solutions, he forecasts the future of health care and describes practical, creative approaches to improving the delivery system.

Dr. Bauer has published more than 150 articles, books, Web pages, and videos on health care delivery. He speaks frequently to national audiences about key trends in health care, medical science, technology, information systems, reimbursement, public policy, health reform, and creative problem-solving. Dr. Bauer is quoted often in the national press and writes regularly for professional journals that cover the business of health care.


As a consultant, he assists health care provider organizations with leadership education, strategic planning and visioning, technology assessment, and service line transformation. He has recently facilitated an expert task force on the future of selected specialties for one of the nation’s largest medical associations, managed technology assessment for a 28-hospital health system, analyzed performance of selected clinical service lines, and developed strategic plans for hospitals and professional associations.

Dr. Bauer was a full-time teacher and administrator at the University of Colorado Health Sciences Center in Denver (1973-1984). He held full-time academic appointments as Associate Professor in the Schools of Medicine and Dentistry and administrative appointment as Assistant Chancellor for Planning and Program Development. He served concurrently as Health Policy Adviser to Colorado Governor Richard D. Lamm (1980-1984). He also worked as a visiting clinical professor in the Administrative Medicine Program at the Medical School of the University of Wisconsin-Madison (1992-1997), where he taught physician executives how to evaluate research reports and other published studies. Additionally, Dr. Bauer was a Senior Fellow at the Center for the New West in Denver (1992-2001). His previous consulting firm, The Bauer Group, Inc., specialized in consumer-focused strategic planning for developing clinical affiliation agreements and multi-hospital networks (1984-1992).

He received his Ph.D. in economics from the University of Colorado-Boulder. He graduated from Colorado College in Colorado Springs with a B.A. in economics and completed a certificate in political studies at the University of Paris (France). During his academic career, he was a Boettcher Scholar, a Ford Foundation Independent Scholar, a Fulbright Scholar (Switzerland), and a Kellogg Foundation National Fellow.

For presentation slides and more information, please visit www.jeffbauerphd.com/ncsbn.htm
The Fourth Factor of Production
Helping Caregivers Work Smarter Instead of Harder

Thanks to a book written in the early 19th century, economics has an unflattering reputation as the dismal science. Thomas Robert Malthus’ characterization of my profession reflected his belief that economic analysis tends to lead to dismal conclusions, such as the inevitability of famine, poverty and war because populations tend to grow faster than their food supply.

Mr. Malthus did not say that being an economist was devoid of comfort. Studying economic activity can be fun when it produces a theoretical model that explains how a system works and provides guidance for avoiding dismal outcomes. The current popularity of Freakonomics, for example, has made economics appealing to a large audience of people who would not have expected to enjoy reading a book about a so-called dismal science.

Consequently, healthcare IT professionals should not be afraid of production theory, which has been a core economic concept for 200 years. It is an appropriate way to introduce the articles in this issue, which apply more recent economic concepts, such as ROI and the operational impact of incentives.

Applying production theory to healthcare in 2007 does not necessarily lead to an unpleasant conclusion. Indeed, the analysis that follows suggests that information technology is essential for avoiding dismal outcomes for healthcare over the next few years.

Factors of Production
Beginning with the Industrial Revolution in the late 1700s, the Scottish philosopher Adam Smith and his contemporaries set the stage for evaluating economic wealth by considering three factors of production: land, labor and capital. Land and labor are self-explanatory. Capital was defined as factories and machines that were operated by labor. Modern references to capital, as in the phrase “access to capital,” share the same meaning. Cash and credit do not have intrinsic economic value; they only become productive when invested in factories and machines.

In the mid-20th century, economists began to consider a fourth factor of production—information. They observed that nations or enterprises with equal endowments of land, labor and capital did not necessarily produce equal wealth. All other things being equal (a favorite saying of economists), economic theory indicated that the entity with better production facility would achieve superior results. The meteoric rise of companies like IBM and Hewlett-Packard in the 1950s and 1960s validated information as a fundamental factor of production.

The production factors model sheds light on healthcare’s problems and prospects in the first decade of the 21st century. Land can be quickly removed as a factor. Some hospitals may not be ideally located, because their customers have moved to another part of the market area, but nobody is worried about a shortage of land on which to build hospitals.

On the other hand, labor is a problem for today’s producers of healthcare services. Professional caregivers of all types are in short supply, creating serious and well-known bottlenecks, such as bed closures and emergency room diversions. The normal economic response would be to increase the supply of labor, but creating new health professionals takes considerable time and money.

Even if money were not an obstacle, the lag time between expanding the capacity of educational programs and graduating competent caregivers ranges from five years for nurses to 10 years for physicians. Providers do not have the luxury of waiting this long to solve the immediate problems caused by the shortage of qualified labor. A quicker fix is needed.

Improving capital is an option, in theory, because new medical buildings and technologies can be acquired much faster than new caregivers. However, information technology is essential for avoiding dismal outcomes for healthcare over the next few years.
to meet the financial obligations suddenly thrust upon them. The net result, rising receivables from insured patients, just adds to providers’ difficulty in borrowing money to solve the problem.

INFORMATION AND THE BOTTOM LINE

In light of current constraints on labor and capital in healthcare, the only viable solution is to increase production of the existing workforce.

Production theory offers two possible paths to increasing output-per-worker. The old approach involves giving workers more money to work more hours. It is not applicable in healthcare today, because caregivers are already working at, if not dangerously beyond, capacity. At this level, more hours could mean more errors and more risks to patients.

The new approach is giving workers more information to work smarter instead of harder, applying the insights of Peter Drucker, W. Edwards Deming, Crosby, Arro and other visionaries who pioneered the use of information to identify more efficient ways for combining land, labor and capital. Unfortunately, healthcare managed to avoid the information revolution that transformed leading industries in the United States and Japan after World War II. American hospitals and doctors were operating in 2000 pretty much the same way they operated in 1950.

The good news is that information has proven its transformational value in healthcare during the past few years. Even better news is that information is relatively available and affordable in provider organizations. It is not free, but management information can be produced faster than labor and more cheaply than capital. Economics 101 clearly shows why information must be factored into the production equation.

The critical challenge for today’s healthcare IT leaders is to develop vision and skills for financing investments in information technology with the money IT will save by eliminating waste in healthcare. This task will not be easy, but it will be worth the effort. On the other hand, the alternatives without healthcare IT are dismal.

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provide useful knowledge and analysis on the various application, planning and economic aspects of EHR initiatives.

In addition, special interest columns and articles provide valuable information and insight on the economics of healthcare IT, predictive informatics, nursing informatics, legal issues and IT education for management executives.

Finally, I would like to thank the professional staff at HIMSS, the peer reviewers and the editorial review board for all the behind-the-scenes work that goes into producing each issue. JHIM continues to look for new ways to provide relevant, important and useful information for healthcare professionals, academicians and HIMSS members. If you have any comments or suggestions that could help us improve in any way, please feel free to e-mail me at rdlang@know-power.com.

The HIT Futurist continues to analyze health IT from the perspective of Economics 101. It presents two economic concepts that are swiftly becoming essential for the survival of health systems: efficiency and effectiveness. Providers have not been forced to be efficient and effective in the past.

Government and business, however, are no longer willing—or able—to pay more money to providers. Third-party payments for healthcare will not continue to rise as they have every year for the past several decades. Some commentators assume that consumers will make up the difference, but they are already spending more than they earn. A strong case can be made that healthcare spending has peaked at 17 percent of the GDP.

**WASTE NOT, WANT NOT**

Consequently, providers must look elsewhere for new resources to survive and grow in a very different economic environment. The most promising source of available resources is already under providers’ control: the abundant waste produced by medical services. Studies consistently show that between one-fifth and one-third of all healthcare dollars are spent unproductively.

Eliminating internal waste and reallocating recovered resources are the biggest challenges providers will face in the coming years; it is probably the key to survival as more buyers cease subsidizing waste. The economic concepts of efficiency and effectiveness provide useful models for finding waste in production processes. Management engineers use these tools to devise the process changes that eliminate waste from daily operations.

**EFFICIENCY: LEAST-COST PRODUCTION**

Efficiency is the lowest point on the U-shaped cost curve, a core principle of Economics 101. It is the point where output is maximized for a fixed budget, or costs are minimized for a fixed output. The cost-minimization perspective is appropriate for most healthcare organizations. A variety of proven management tools can be used to move providers to the bottom of the cost curve, including Lean, Six Sigma, Toyota Production System and Plan-Do-Check-Act/Balanced Scorecard.

To become efficient, providers need to identify defects in production processes and eliminate unnecessary steps in the way medical services are produced. All the methods for moving to desired future states are heavily data-driven. Performance must be measured from the beginning, and in-progress corrections must be made to ensure that changes lead to the least-cost combination of inputs. Infor-
Information technology is the key to improvement at every step along the way.

**EFFECTIVENESS: DELIVERING AS PROMISED**

Effectiveness is a measure of the relative compliance with objective specifications of expected performance. A 100-percent effective process delivers the product of expected quality—ideally, the best one possible given the quality of labor, materials and technologies used to turn these inputs into the final product. The key to effective production is defining characteristics of the desired good or service before it is produced.

Healthcare is obviously not a textbook industry for effectiveness. It falls particularly short in applying the proven key to effectiveness in other industries—process standardization. Hospitals routinely allow different caregivers to do the same things different ways. This often leads to wide variation in outcomes, which is seen as one of the failures of health systems. Fortunately, performance-improvement tools that promote efficiency also improve effectiveness through the standardization made possible by IT.

**EFFICIENCY IS NOT EFFECTIVENESS**

Effectiveness and efficiency are often treated as synonyms. Nothing could be further from the truth. For example, a lot of waste could be generated in the delivery of a top-quality medical service, and the least-expensive combination of inputs will not necessarily produce top-quality care. Efficiency and effectiveness need to be achieved through performance improvement activities that address both concepts simultaneously.

Economics 101 includes another concept that must be reflected in formal programs for becoming efficient and effective. Only one variable can be maximized or minimized in a closed system with limited resources. Healthcare today is clearly a closed system with limited resources, so the commonly stated goal of producing as much healthcare as possible as cheaply as possible is nonsense.

**NEED TO CHOOSE**

One variable can be maximized in the process of becoming efficient and effective. The other must become a constraint, a specific and measurable limit placed on the production process. Healthcare will not make economic sense until its providers decide what to maximize and what to impose as a constraint.

My new book proposes a specific resolution to this problem: providers should standardize quality first, then find the least-expensive way to produce health services that consistently meet pre-determined standards. The book offers a simple slogan for providers who accept the imperatives of efficiency and effectiveness: doing it right all the time, as inexpensively as possible.

**HIT PROFESSIONALS’ NEXT BIG ROLE**

The production of efficient and effective healthcare depends heavily on good IT systems. Workforce shortages and the ever-increasing complexity of clinical databases make IT even more essential to the healthcare industry. When the leaders of healthcare organizations realize that the future of their organization depends on efficiency and effectiveness, information experts will have new and more important roles to play.

To get ready for this exciting challenge, healthcare IT professionals must prepare to support their enterprise’s needs for performance improvement and clinical transformation. In other words, the future of IT will soon involve a whole lot more than the traditional concerns of maintaining a secure network and facilitating the flow of information between the patient floors and the finance office. Managing the interface between efficiency (minimum cost) and effectiveness (standardized quality) will be a big part of the future. This conclusion is as inescapable as Economics 101.

**REFERENCE**

An Early Warning

The -omics Data and Personalized Medicine Are Coming

During the Cold War, when the United States feared an attack by the Soviet Union, our radar constantly scanned the horizons for airborne objects headed our way. Any unexpected or unknown blip on the screen was cause for serious concern. Satellite surveillance ultimately provided us with an early warning system to prepare against a potential threat. In other words, we could see beyond the horizon and anticipate threats rather than waiting for them to materialize on our radar screens.

This column issues an early warning of a major change that is rocketing toward healthcare IT. The timing of its arrival cannot be predicted with certainty, but it is already visible in research reports published leading clinical journals. A few prominent medical centers are starting to incorporate this revolutionary change in selected clinical services, and private investors are already developing businesses that will be ready to commercialize it upon arrival.

The "missile" accelerating toward our horizon is a cluster of brand new medical services made possible by the Human Genome Project (HGP). It is analogous to an intercontinental missile with multiple warheads that will head in different directions before impact. No matter where these clinical bombshells land, in hospitals or outpatient sites, they will generate unprecedented volumes of new data. IT professionals need to start anticipating these changes that are just over the horizon and headed our way.

Genomics and Proteomics as Explosions in Medical Knowledge

We already know that many diseases are rooted in genes. Cancer, heart disease, metabolic disorders, dementia, depression and many other serious health problems tend to run in families. Thanks to new technologies that quickly map the 6 billion base pairs (one massive data set) of the four basic molecules that provide the blueprint for biological activity in each of our bodies, medical scientists can now compare the genomes of healthy and unhealthy people. This testing is still too expensive for commercialization, but prices for genetic sequencing are falling fast.

Various combinations of genetic differences associated with disease—called single nucleotide polymorphisms, or SNPs (“snips”)—are now being used with stunning precision to differentiate life-threatening conditions from less-serious forms of several diseases. Medical science and bioinformatics are starting to identify therapeutically relevant variations in diseases at levels undetectable by visual examination.

For example, breast tumors that appear to be identical on a mammogram or a microscope slide can be very different at a molecular level. (Molecular expressions of genetic structure create the proteins that control cell function. This functional extension of genomics is called proteomics.) Armed with this knowledge, specialists can select the prescription drug or biological agent that targets the molecules of the patient’s specific tumor. This new ability to see disease at the level of the gene and protein will replace “one size fits all” medical care with personalized medicine.

Although personalized medicine in the future will provide direct evidence of diseases that have been suggested indirectly by family histories, the study of disease development in a patient’s family will continue to be important.

Although personalized medicine in the future will provide direct evidence of diseases that have been suggested indirectly by family histories, the study of disease development in a patient’s family will continue to be important. An individ-
The Advent of RHIO 2.0

The Country’s Strategy of Creating Clinical Data Exchanges Is About to Undergo a Difficult Shift from RHIO 1.0 to RHIO 2.0

RHIO 1.0

The creation of regional clinical data exchanges is a centerpiece of the U.S. national healthcare information technology strategy. These exchanges are generally seen as having a regional master patient index, a service that identifies the various organizations that have clinical data about a patient and a mechanism to securely retrieve that data and present an aggregate clinical picture to a patient’s provider. In addition to regional clinical data retrieval, these exchanges are also seen as supporting capabilities such as e-prescribing, biosurveillance, quality data reporting and clinical messaging.

The Regional Health Information Organization (RHIO) is viewed as the organization that will oversee the creation and management of a clinical data exchange. RHIOs are a collaboration of regional healthcare stakeholders who come together to address issues of governance, funding, privacy policies, data sharing agreements and the management of the exchange technology infrastructure.

A National Health Information Network (NHIN) is envisioned as a technology, standards and management approach to integrating regional clinical data exchanges across the country.

One might call this vision RHIO 1.0.

Many communities have risen to the challenge of implementing this vision. While the exact number of RHIOs is uncertain, there are at least 200 such efforts across the country. The federal government has launched initiatives to establish interoperability standards, examine variations in state privacy laws, conduct demonstrations of the NHIN and fund studies of areas such as strategies for state governments. Organizations such as the eHealth Initiative and the Markle Foundation have been exceptionally effective at bringing together the diversity of healthcare stakeholders and communities to share experiences, create tools and identify policies and steps that will facilitate the achievement of this vision of RHIO 1.0.

PROBLEMS WITH THE VISION

The country has been pursuing this vision for almost three years. The experiences of many over this time suggest several significant problems with this vision.

Many communities are unable to come together in an effective, collaborative way. There are several reasons for this—in tense regional competition, disinterest by key stakeholders and overly fragmented communities. These communities lack sufficient social capital or ability—the essential building blocks for the creation of a RHIO. These communities may have never worked together and as a result they have not forged the necessary effective working relationships or trust.

Even when that social capital exists, those who form a RHIO must overcome a series of challenging technical and non-technical challenges. Issues such as patient identification, security, governance and privacy are formidable barriers and many communities are struggling to overcome them.

The creation of a clinical data exchange requires capital, at times significant capital, and means to support the financial requirements of ongoing operations.
Welcome (to the Medical) Home

“Welcome home” usually implies that we are returning to a familiar place at the end of a journey. The concept of a “medical home” is beginning to enter conversations about health care, but it is not yet a familiar destination. Many people have no idea what or where a medical home is, even as its advocates propose sending us on a journey there as part of health reform—indeed, as the cornerstone of reform efforts to shift health care from the hospital-centered universe of the 20th century to a new delivery system that revolves around the patient.

To be clear, a medical home is not home health, in which visiting nurses and therapists, home health aides, infusion therapy, respirators, and a growing array of high-tech durable medical equipment enable home-based medical care that does not require the backup of a full-service hospital. Otherwise, home care is pretty much like health care delivered in a hospital—same interventions, different place.

No care is delivered in a medical home, and the patient’s house is not its main physical location. Instead, the medical home is more likely to be the office of a primary care practitioner (PCP), and/or the virtual links between these practitioners and their patients. If the medical home is successful, many people won’t ever become patients in their homes or hospitals, although people who still need clinical interventions will be steered toward the appropriate setting (which will often be a hospital).

Using his or her depth and breadth of knowledge to monitor, inform, explain, and educate, the PCP will help people navigate the maze of information and options that is health care today, steering them toward the best possible outcomes in the context of their own resources and health goals. In short, people will be empowered by the PCP, who works in the best interests of patients, whether or not these are the interests of a hospital, specialty practitioners, or a health plan.

The medical home is an undeniably attractive concept—so much so that its acceptance seems to be inevitable. It actualizes the widely shared belief that system reform should shift resources from sick care to health care. So when will we all have medical homes?

From a financial perspective, the answer may depend on how fast PCPs can learn an important lesson from another group of specialists in taking a journey—travel agents. Less than 10 years ago, people bought their airline tickets and planned their trips through a travel agent. Then, came the web. Customers suddenly had direct access to all that previously privileged information.

Travelers quickly learned how to buy their own tickets and make their own hotel reservations. Airlines discovered they did not have to pay a commission to an intermediary. Travel agents had to start charging customers a service fee just to stay in business, and a lot of people did not want to pay $45 for something they could easily do on their own for free. To survive, travel agents had to add value that customers could not produce on their own. Their principal role shifted from selling tickets to selling knowledge about desirable destinations and reliable ways to get there.

Likewise, to grow in their new environment—a web filled with information and payment responsibility shifting to patients’ pocketbooks—medical homes will need to create a value package of reasonably priced decision support services—services that promise a better journey than patients can arrange on their own.

Hospitals, health systems, and large medical groups need to begin thinking seriously about whether, when, and where to house medical homes in their organizations. PCPs are working hard to position their new professional domain—learned intermediary and patient advocate—as the starting place for every consumer’s forays into the medical marketplace.

However, the medical home movement has not yet put itself on the healthcare map. Alliances with primary care practitioners, particularly links to larger enterprises’ decision support tools and online resources such as web sites and portals, would help the cause for all concerned. Large provider organizations might think of themselves as anchor tenants in an upscale mall that needs a concierge. That, of course, would be the PCP, welcoming customers home at the front entrance.

Jeffrey C. Bauer, PhD, medical economist and health futurist, is a Chicago-based partner in management consulting for ACS Healthcare Solutions (jeff.bauer@acs-hcs.com).
What Pharmacists Can Teach Us About Curing Medical Errors

Medical errors can be viewed as a disease of our healthcare delivery system. Like pathogens that the system is structured to treat, they create dysfunction, often making the cure even worse than the original disorder. Avoidable mistakes made in the process of giving care are inexcusable failures in a system where the first principle is “do no harm.”

Medical errors have been under intense scrutiny for more than a decade. Their cause is well-known, and the cures are now equally clear: Delivery systems must purposefully restructure the way their work is done. They must change caregivers’ behaviors and fill information gaps that created the errors in the first place. (Despite the temptation to say that this is not rocket science, the fundamental processes for eliminating errors are rocket science. They were developed by and for NASA, but they have been made readily accessible to healthcare.)

Why, then, do we still have so many medical errors? Given the skyrocketing sums that health systems are spending to educate managers and caregivers and to install computerized data systems, shouldn’t we see more progress? What more do we need to do?

Ironically, one good place to look for answers is an area that generates a major share of the mistakes: medication management. Lessons learned from studies of pharmaceutical care can be profitably applied to other aspects of healthcare delivery, and financial managers should make sure this knowledge transfer is happening in their organizations. These studies show that money spent on drug treatment, even life-saving drug treatment, can be wasted in the absence of enforced procedures and behaviors that are as important to the desired outcomes as the drugs themselves.

Safe pharmaceutical therapy presupposes an appropriate match between a correct diagnosis and the prescribed drug. Not surprisingly, giving a wrong drug the right way and giving the right drug a wrong way arc among the most common medical errors. But the right drug for the wrong diagnosis is also a medical error. To avoid all these pitfalls, healthcare organizations need performance improvement and clinical transformation supported by interactive, intelligent, and networked information systems. And there are plenty of tools available to help them achieve those goals, from Lean, Six Sigma, and Toyota Management Principles to a variety of electronic medical record systems.

Get all those things right, however, and you are still not home free. Drug effectiveness studies clearly identify two additional factors that are essential for error-free pharmaceutical care: compliance and persistence. That is, the right drug therapy will not work if the patient fails to fill the prescription (compliance) and/or fails to take the medication as prescribed (persistence).

Likewise, many health systems know they need to select performance improvement tools and install integrated information systems. A wealth of good information about implementing error reduction and patient safety is available, but few organizations have enforced the levels of compliance and persistence that are needed to eliminate medical errors. For that to happen, financial executives need to help ensure that managers and caregivers are creating the necessary production systems and taking the required actions.

Just as pharmacists have developed specific action plans to get patients to fill their prescriptions and take their medicines, healthcare organizations need a checklist of imperatives to create and sustain compliance and persistence in these efforts. Indeed, a relatively small but growing number of health systems have made great strides in reducing medical errors by embedding these principles in the corporate culture:

- Standardization—Developing clinician-driven processes to eliminate unexplained variations in care across the entire enterprise
- Flexibility—Expecting care processes to evolve with rapid advances in medical science and technology
- Creativity—Empowering change with a constant desire to do things better
- Integration—Coordinating internal operations and arrangements with business partners
- Alignment—Ensuring that all are pursuing the same operational objectives and strategic goals
- Sustained commitment—Providing leadership, especially in tough times during the transition from business-as-usual
- Accountability—Managing with transparent, data-driven processes

Successful organizations have used these principles to go from demonstration projects in a few clinical services to error elimination in everything they do. Financial leaders need to use the power of the purse to do their part in ensuring that the enterprise is doing the right things all the time, as inexpensively as possible. The budget is the “spoonful of sugar” that ultimately makes the medicine go down.

Jeffrey C. Bauer, PhD, is a medical economist and health futurist, and a Chicago-based partner in management consulting for ACS Healthcare Solutions (jeff.bauer@acs-khs.com).

*For an extensive review of these critical success factors, see Bauer, J.C., Paradox and Imperatives in Health Care, Productivity Press, 2008 (chap. 7).*
BUSINESS TRENDS

Jeffrey C. Bauer

health reform and payment trends
don’t wait for politicians

Candidates’ plans are unlikely to have any impact on healthcare reform in the foreseeable future, but payment is changing right now.

Americans are keenly interested in how politicians propose to solve the growing problems of cost, quality, and access in the delivery of medical services. Consequently, candidates for national office make lots of promises about the reforms they will implement if elected. Their well-publicized proposals can generate fear or hope among finance professionals who flock to meetings where pundits evaluate the next big thing in health reform. Many executives start to formulate organizational responses as if the promised changes were a sure thing.

History suggests that politicians’ election-year health plans should not be taken so seriously. None of the major changes in payment over the past 60 years was the direct result of a campaign promise. Anyone who cares about the future of payment for health services needs to look beyond election-year politics to understand the trends that are really changing how dollars flow through provider enterprises. Health reform proposals will not have any immediate impact on day-to-day operations of the delivery system. At most, they might help frame subsequent debate.

Proposals in the Political Arena
The final 2008 candidates for national office and the “official” campaign platforms are not known at the time this article is written, but the basic health reform positions of both political parties are relatively clear, coherent, and—to no one’s surprise—diametrically opposed. (If a serious third-party presidential candidate emerges, health care is unlikely to be a significant reason for the challenge.) Consequently, political discourse on reform will almost certainly be defined along two-party lines in the current election cycle.

Republican candidates vary in the extent of their belief that the healthcare delivery system needs to be fixed, but all agree that any changes must be promoted through “free market” competition. Successful reform from this perspective is measured in terms of an increasing number of health plan options offered by
None of the major changes in payment over the past 60 years was the direct result of a campaign promise.

private companies. It reflects a shared philosophical belief that the marketplace works best when informed consumers can choose their health plan in a marketplace that offers many different options. Any innovation in health insurance products is left to the states. Republican candidates also tend to favor shifting the tax deduction for health insurance payments from corporations to individuals and capping the amount of the deduction.

Democratic candidates define the number of people without health insurance as a serious problem which requires federal intervention. They uniformly favor actions that would provide health insurance coverage to all Americans, but they have somewhat different views on the timing and mechanisms to reach the goal of universal coverage (e.g., mandating universal coverage right away versus sequentially adding coverage for specific groups, beginning with children). The mainstream Democratic position is not opposed to private health insurance, but it posits that a government health plan should be one of the choices for all Americans. Democrats tend to favor paying for expanded coverage by not renewing the Bush tax cuts that will expire in 2010.

What’s Wrong with This Picture?
In an ideal world, comparative analysis of Republican and Democratic positions would identify which approach is most favorable for the financial future of healthcare providers and would suggest which candidates would be best for providers. Unfortunately, the world in 2008 is far from ideal. Today’s economic realities suggest that neither side’s core approach addresses very real threats to a typical provider’s bottom line. Health systems and medical groups that do not have a substantial source of reliable nonoperating revenue, such as endowments or royalties, cannot afford to conduct “business as usual” simply because a politician is promising that more real (i.e., inflation-adjusted) money will flow to healthcare if he or she is elected. It won’t happen.

The sources of providers’ revenues—governments, employers, and patients—do not have any more money to allocate to health care:

- Government spending will increase in the foreseeable future, but health care will likely lose the preferential treatment it has enjoyed historically. If the United States is to remain strong as a nation, governments will be forced to place higher priority on modernizing infrastructure, mitigating environmental damage, improving education, and rebuilding defense.
- Employers will continue to transfer responsibility for health care to employees because cost-cutting has become essential to economic survival in a global economy. Employers that provided health benefits paid 73 percent of their employees’ total health care costs in 2002; the employer share is down to 65 percent in 2008. Further, the number of employers providing any coverage at all fell approximately 10 percent over the past decade.
- Patients will continue to experience (unwillingly, of course) increases in their financial responsibility in direct proportion to the decreases in government and business payments. Unfortunately, very few American consumers have spare cash to pay to healthcare providers, and real incomes are declining for the majority of wage earners.

Because the three sources of most providers’ revenues are facing their own serious budget constraints, the net effect is that healthcare spending will likely stabilize at current levels—approximately 17 percent of the gross domestic product. Any politician who promises a quick fix for this deep structural problem is out of touch with economic reality. Healthcare’s financial executives would be wise to assume that the demand side of the marketplace has hit a plateau for the foreseeable future.

"Government is too big and too important to be left to the politicians."
—Claire Hauchey Bishop
And even if a politician could deliver on his or her promise to help people afford more health care, the medical economy does not have the capacity to meet increased demand. Universal insurance would not provide universal access to health services because hospitals, physicians, and other practitioners are working at full capacity. Given serious structural problems on the supply side of the medical marketplace, the immediate impact of more patients with health insurance would be more patients on gurneys in the emergency department, longer wait to see specialists, rising “patient pay” receivables, accelerating medical inflation, and so forth.

Rather than courting candidates who have no chance of honoring campaign promises for health reform, finance leaders should take a payers and a purchaser to lunch.

The Good News
The situation is not hopeless; the dark cloud has a silver lining. Real healthcare spending cannot increase as it always has in the past, but neither is it likely to decline. For the good of their enterprises, health care’s financial leaders should be paying close attention to payment reforms that are not originating with the candidates for national office. Slowly but surely, insurers and employers are changing the fundamentals of healthcare payment.

First-dollar coverage has all but disappeared over the past decade. Deductibles are increasing for most insurance products, not just consumer-directed health plans. On the other hand, health plans are beginning to recognize the value of fully reimbursing selected services in preventive care and disease management (e.g., providing full payment for drugs that demonstrably reduce total costs of care, covering home health services that keep patients out of the hospital). More commercial carriers recognize the cost-effectiveness and consumer benefits of paying clinicians for e-mail communications with their patients. Commercial banks are entering the financial interface among providers, payers, and patients with a variety of new services.

The list of new and different approaches to paying for health care is growing, and the impetus for these changes is coming from creative thinkers in the private sector. Purchasers are starting to sit at the table with payers where changes in coverage are discussed. For payers, these changes can be expected because progressive payers and purchasers recognize that they cannot wait for politicians to solve the problems they face.

This election year would be an ideal time for providers to join efforts for creating private-sector solutions to the problems of healthcare finance. Rather than courting candidates who have no chance of honoring campaign promises for health reform, finance leaders should take a payer and a purchaser to lunch. All three parties should initiate a constructive, consumer-sensitive discussion of problems they can solve together.

The resulting three-way partnerships should focus solely on designing and building a better system, not on assigning blame for systemic problems that politicians cannot possibly solve. The country does not have enough time or money for a political solution. Providers, purchasers, and payers need to move forward on their own without waiting for the election—committed to meeting consumers’ reasonable expectation for top-quality care at the lowest possible price.

Jeffrey C. Bauer, PhD, a medical economist and health futurist, is a Chicago-based partner in management consulting, ACS Healthcare Solutions, and a member of HFMA’s First Illinois Chapter (jeff.bauer@acs-hcs.com).
Plenary: Self-Assessment, Self-Direction, Self-Regulation & Other Myths

Presented by:
Glenn Regehr, PhD
- Richard and Elizabeth Currie, Chair in Health Professions Education Research
- Professor, Faculty of Medicine, University of Toronto
- Scientist, Toronto General Research Institute, University Health Network
- Associate Director, The Wilson Centre
Self-assessment, self-direction, self-regulation and other myths
Deconstructing our beliefs about the adult learner

Glenn Regehr, PhD
Richard and Elizabeth Currie Chair in Health Professions Education Research
Professor, Faculty of Medicine, University of Toronto
Scientist, Toronto General Research Institute, University Health Network
Associate Director, The Wilson Centre

The responsibility for self-regulation

• A cornerstone of professional autonomy
  • Both a privilege and a responsibility
• Manifests in two forms
  • “Authorities” set standards and address breeches of standards by members
  • Individual members ensure personal maintenance of competence

Archetype of the self-regulating professional

• Reflect regularly on daily practice
• Self-assess gaps in knowledge or skill
• Seek opportunities to redress gaps
• Invest energy to learn (or relearn)
• Incorporate new knowledge into practice
• Repeat

(Handfield-Jones, et al, 2002)
Today's talk

• Identify assumptions in this model of the self-regulating professional
• Briefly examine the evidence for each of these assumptions
• Discuss implications for conception of self-regulation
• Construct a more sophisticated understanding of the phenomenon

Problematic assumptions

• We use reflection to look for gaps
• We find gaps when we look
• We try to address gaps through learning
• We incorporate new information into practice

We use reflection to actively search for gaps
The self-protective role of reflection

- Presumption that reflection on practice is used to expose gaps
- But reflection often used to protect self-concept
  - Eg. gamblers’ interpretation of losses (Gilovich, 1983)
  - Eg. surgeons’ reflections on bad outcomes
  - “It’s a one time thing, it just happens a lot”
    - Suzanne Vega

Value of self-protective reflection

- Such re-interpretive reflection important
  - Depressed people have more “accurate” interpretation of own role in events
    - Depressive realism (“sadder but wiser”)
    - Lab-induced “learned helplessness” model of depression
  - Self-efficacy leads to success
    - Confidence to persist in face of initially negative feedback
    - Willingness to keep trying in difficult situations

Implications for practice change

- “Rose colored glasses” approach to reflection understandable and necessary
  - Not just a “selfish” activity
  - Important for ability to function and succeed
- But
  - May get in the way of self-improvement
  - How much rationalization is too much?
Problematic assumptions

- We use reflection to look for gaps
- We find gaps when we look
- We try to address gaps through learning
- We incorporate new information into practice

Problematic assumptions

- We use reflection to look for gaps
- Self-reflection is often "self-protective"
- We find gaps when we look
- We try to address gaps through learning
- We incorporate new information into practice

We find gaps when we look for them
The rhetoric of self-assessment

• Almost every article on self-assessment begins with the same basic sentence:

  “The ability to self-assess is vital to the concept of professional self-regulation”

• Cornerstone of many professional “Maintenance of Competence” programs

The literature on self-assessment

• Hundreds of articles
• Many literature reviews
• One conclusion:

  Self-assessment ability is generally poor

Three key patterns of data

• Little or no relationship between externally generated scores and self-assessed scores
• All but the very highest performers tend to overestimate ability
• Worst offenders are those in lowest quartile of performance
Why is self-assessment so bad?

- Kruger & Dunning (1999): “Unskilled and unaware”
- The skills required to know whether you are performing well are also the skills required to actually perform well

University students’ performance on a grammar test

![Graph showing actual scores and perceived scores.](image)

Kruger and Dunning 1999
Undergraduate Students’ Performance on a Humor Test

Kruger and Dunning 1999
Undergraduate Students’ Performance on a Logic Test

Undergraduate Students’ Performance on a Logic Test

Knuger and Dunning 1999

**“Domain Specificity”** of Self-Assessment

- Good or poor self-assessment is **NOT** a “generalizable” trait of an individual
  - Better for domains where one excels
  - Worse for domains where one is poor
  - Often arises from “local perceptual deficits”
- Therefore:
  - Can’t test for it or improve it: there is no “it”
  - Domains where you are most likely to need self-awareness are the domains where you are least likely to have it

**The “Lake Woebegone Effect”**

- Everyone thinks they are above average
  - Eg, driving
  - Eg, self-assessment
- This is a WE problem:
  - Everyone is prone to these issues
Implications for self-regulation

- Those most in need of improvement are those least likely to know.
- For any given skill, 25% of us are in the bottom quartile of performance.
- Those of us who are in the bottom 25% think we are above average.
- So whose job is it to tell us?

Problematic assumptions

- We use reflection to look for gaps
  - Self-reflection is often “self-protective”
  - We find gaps when we look
- We try to address gaps through learning
- We incorporate new information into practice

Problematic assumptions

- We use reflection to look for gaps
  - Self-reflection is often “self-protective”
  - We find gaps when we look
  - Self-assessment largely ineffective
- We try to address gaps through learning
- We incorporate new information into practice
We try to address gaps through learning

The motivation to learn

- Assumption that the "adult learner" is motivated to fill gaps in knowledge / skill
  - Motivation comes from recognition of the value of learning the information / skill
- But where does assumption come from?

The theoretical support

- Malcolm Knowles
  - "The Adult Learner"
- Anders Ericsson
  - Expert Performance
- Bereiter and Scardamalia
  - "Surpassing Ourselves"
But…

- Think about last conference attended
- How did you select sessions to attend?
  - “Wow, thank goodness they have a session on that, I am really poor at that and should find out how to come back up to speed.”
- Evidence that health care professionals attend CE events that confirm what they already know
  (cf Miller, 2005)

The flaw in the theories

- All theories of adult learning / expertise focus on the reasons why people learn
  - Areas where we excel
  - Areas where we have an interest
- Our own reflections focus on times we chose to learn
  - “I am here aren’t I?”

The flaw in the theories

- Little or no research or theory on why people DON’T learn
  - Areas where we struggle
  - Areas that do not interest us much
- Few examples in our own heads of times we chose not to learn or gave up
  - “Wouldn’t it be fun to learn how to play the guitar?”
Regehr’s axiom of learning

• LEARNING IS NOT FUN
  • Learning fun things is fun
  • Learning hard things is hard
  • Learning boring things is boring

The adult learner redefined

• Differences between adult and child learners:
  • Children have lots of energy
  • You can make children do things

• Regehr’s axiom of adult learners:
  • The older we get, the less willing we are to expend our limited energy on learning, and the fewer people there are who can tell us we have to

The decision to learn

• Decision to learn/change is “cost/benefit” analysis

• Sometimes “cost” of outweighs benefits
  • Decision to avoid rather than engage in learning

• “Because it is the right thing to do” is seldom a sufficient motivator
  • (back to self-justifying reflection)
Implications for self-regulation

• For any given skill, 25% of us are in the bottom quartile of performance

• Placing the responsibility for improving areas of weakness on the individual professional may produce an unbearable burden

• So whose job is it to make us do something about it?

Problematic assumptions

We use reflection to look for gaps
  • Self-reflection is often “self-protective”
  • We find gaps when we look
    • Self-assessment largely ineffective
  • We try to address gaps through learning

• We incorporate new information into practice

Problematic assumptions

We use reflection to look for gaps
  • Self-reflection is often “self-protective”
  • We find gaps when we look
    • Self-assessment largely ineffective
  • We try to address gaps through learning
    • We resist learning in areas of weakness
  • We incorporate new information into practice
We incorporate new knowledge and skills into practice

Translating knowledge to practice

• Surprisingly little research in the CE literature regarding implementation of learning in practice

• When we do look, the data are worrisome (eg Davis et al, 1999)

• Efforts to address this tend to focus on:
  • “What works best?”
  • NOT: “Why doesn’t this work?”

• Easy to underestimate difficulty of incorporating learned activity into practice
  • Sounds logical and sensible in the “class”

• But …
  • Must recognize spontaneously when it is valuable (cf Elman, 2004)
  • Must have confidence to implement (cf Kennedy, 2004)
Problematic assumptions

- We use reflection to look for gaps
  - Self-reflection is often “self-protective”
- We find gaps when we look
  - Self-assessment largely ineffective
- We try to address gaps through learning
  - We resist learning in areas of weakness
  - We incorporate new information into practice

Summary so far...

- Many factors involved in “formal” practice change
  - Must see your way as inadequate
  - Must see new way as better
  - Must see that the difference is worth the energy required to learn the new way
  - Must see how to incorporate the newly learned way into your practice

- Many of the assumptions built into the “self-regulation” version of this process are questionable at best
Better models of maintenance of competence?

- Self-administered objective tests of knowledge and skill with profile identifying areas of relative high and low performance
- “Guidance counselors” to help incorporate data regarding poor performance into self-concept without loss of self-confidence
  - The difficulties involved in corrective feedback

Better models of self-regulation?

- Knowing when you are over your head
  - Knowing when to slow down / look it up / refer
  - Shifting from knowing-in-action to reflection-in-action
- Innovating in practice
  - Problem solving as a form of self-directed learning
- Teamwork and shared responsibility
  - For safe and effective practice
  - For “self-regulation” and feedback

Glenn Regehr is supported as The Richard and Elizabeth Currie Chair in Health Professions Education Research

Advancing health care education and practice through research
Breakout Session: NCSBN Research

Presented by:
Kevin Kenward, PhD, MA
NCSBN Director, Research
ANNUAL PROJECTS

Overview of the regulatory environment
- Data are reported in ten different sections:
  1. Board structure
  2. Educational programs
  3. Educational requirement for entry into practice
  4. Licensure requirements/maintenance
  5. Licensure fees
  6. Continued competence activities
  7. Assistive personnel
  8. Discipline
  9. Scope of practice
 10. Regulation of advanced nursing practice
Breakout Session:
NCSBN Research

CORE

- Performance measurement system
- Identify promising practices
- Survey Boards of Nursing and stakeholders (employers, programs, nurses)

WORKFORCE DATA

- Minimum data set
- Supply data
- Aggregate data to be available for public use
- Collected at license renewal

LICENSURE STATISTICS

Members provide data on the total number of individuals licensed to practice within the jurisdiction during the fiscal year.
Students in the combo and clinical groups were consistently rated higher by faculty reviewing the videotapes than students in the simulation group although the differences were not statistically significant.

Approximately one-third of the time the students in each group were rated by faculty as not performing at satisfactory levels across all scenarios.

Students performed best on level of consciousness relationship items and worst on recognizing chest pain symptoms.
The students' confidence in taking care of critically ill patients was significantly increased after the clinical/simulation experiences (p<.000).

Students in the combo group had the highest increase in confidence level compared to the other two groups, although the differences were not statistically significant.

The students who had more increase in their confidence level were more likely to perform better on clinical scenarios using SPs (p<.000).
**Type of License**

<table>
<thead>
<tr>
<th>License</th>
<th>Percent</th>
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<tbody>
<tr>
<td>RN</td>
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<tr>
<td>PN</td>
<td>36</td>
</tr>
<tr>
<td>AP</td>
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</tbody>
</table>

**Gender**

- Percent of Males in Nurse Population: 6%
- Percent of Disciplined Nurses Who Are Male: 17%

**Years of Experience at Time of Disciplinary Action**

- Avg. = 12 years.
- 1 yr or less: 7%
- 2-5: 20%
- 6-10: 26%
- 11-24: 37%
- 25 or more: 8%
Criminal Violations

- 13% of nurses who were disciplined had a criminal violation
- 11% of all violations were for a criminal conviction

Rate of Recidivism

- Average percentage of recidivism of nurses in a given state was 22%

Drug-related Violations

- 34% of disciplined nurses had a drug-related violation
Medication Errors

- 7% of disciplined nurses had medication error violations

Drug-related Violators

- 18% of drug-related violators were male

Drug-related Cases

- License taken away (revocation, suspension, surrender) in 52% of all drug-related cases
Negotiation Skills Training

"I'm getting the fire-breathing dragon with wings. He wanted $300, but I talked him down to fifty bucka."

POST-ENTRY COMPETENCY

5 year study to explore the development of nursing competence after the entry-level period

CHEMICAL DEPENDENCY COMMITTEE

- Survey to collect descriptive data about alternative programs
- Update Chemical Dependency Handbook
- Propose models and “best practices” for alternative programs
OTHER ACTIVITIES

- Reviewers for
  - Institute for Regulatory Excellence
  - The Center for Regulatory Excellence
- Liaisons to
  - Interagency Collaborative on Nursing Statistics (ICONS)
  - National Institutes of Nursing Research (NINR)

PUBLICATIONS


PRESENTATIONS

- Li, S. The Role of Simulation in Nursing Education: A Regulatory Perspective. Faculty Shortage Conference. March 26, 2008. Chicago, IL.
McCain and Obama ‘take second round’

...At least that’s what London’s Telegraph said.

New Hampshire’s Polling Fiasco

<table>
<thead>
<tr>
<th>Poll</th>
<th>Obama</th>
<th>Clinton</th>
<th>Spread</th>
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<tr>
<td>Marist</td>
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<tr>
<td>CNN/WMUR/UNH</td>
<td>39</td>
<td>30</td>
<td>Obama +9.0</td>
</tr>
</tbody>
</table>

Average                   | 38.3  | 30      | Obama +8.3 |

Final Results             | 36.4  | 39      | Clinton +2.4
WEB SITE

You can learn more about the Department of Research's projects and accomplishments by visiting our Web site at


CONTACT INFORMATION

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Breakout Session:
TERCAP™

Presented by:
Lisa Emrich, MSN, RN
Area II, Chair, TERCAP™ Committee

Mary Doherty, JD, BSN, RN
NCSBN Associate, Practice, Regulation & Education
TERCAP: Taxonomy of Error, Root Cause Analysis and Practice-responsibility

TERCAP
- Taxonomy of
- Error
- Root
- Cause
- Analysis
- Practice-responsibility

TERCAP: what it is
- An NCSBN data collection instrument
- Used prospectively in conjunction in board investigations
- Provides consistent national data about “practice breakdown” that NCSBN will analyze and report in the aggregate.
- Provides analyses of causal relationships and similarities of cases
TERCAP

Eight Practice Breakdown Categories

Practice Breakdown is defined as:

The disruption or absence of any of the aspects of good practice

TERCAP: Practice Breakdown Categories

- Medication Administration

TERCAP: Practice Breakdown Categories

- Documentation
TERCAP: Practice Breakdown Categories

- Attentiveness and Surveillance
- Clinical Reasoning
- Prevention
TERCAP: Practice Breakdown Categories

- Intervention

TERCAP: Practice Breakdown Categories

- Interpretation of authorized provider orders

TERCAP: Practice Breakdown Categories

- Professional responsibility & Advocacy
TERCAP: Categories of questions

- Patient
- Systems
  - Facility, staffing, interdepartmental communication, records, etc.
- Nurse
  - Education,
  - Experience
  - Primary language
  - Number of consecutive hours worked, etc.

IOM Recommendation 7.2

NCSBN, in consultation with patient safety experts and health care leaders, should undertake an *initiative to design uniform processes across states for better distinguishing human errors from willful negligence and intentional misconduct, along with guidelines for their applicability by state boards of nursing and other state regulatory bodies*. (IOM, 2004, p. 15)

TERCAP: Brief History

  - Reviewed discipline cases submitted by seven jurisdictions. NCSBN consulted Patricia Benner, Ph.D., RN, FAAN for the project.
- 2001, total 24 disciplinary cases were qualitatively reviewed
  - Analysis of these cases is the foundation for the Practice Breakdown categories of TERCAP
TERCAP: brief history continued

- 2002-2006 Practice Breakdown Advisory Group worked to refine the instrument.
  - Ease of use
  - Conciseness of information
  - Clarified coding protocol
  - Eliminated redundancy
  - Improved flow of information.

TERCAP Implementation

- 2006 Instrument finalized and web based instrument was further refined.

- 2007 TERCAP Task Force convened
  - Establish policy for use
  - Promote use of the TERCAP by member boards

- February 2007 Web-based TERCAP launched

2008 TERCAP: Recent work

In 2008 the Committee clarified the NCSBN case selection criteria for cases included in national aggregate:

- Nurse involved in practice breakdown
- Patient involvement with one or more identifiable patients
- Cases of practice breakdown in which the board took disciplinary action, or enrollment in an alternative program, or a letter of concern was issued (i.e., any action other than case dismissal).
Importance of Criteria

- No identifiable patient
- No patient data
- Multiple patients
- Questionnaire
- Single Patient
- Patient data

Selection Criteria

- A nurse must be involved in the practice breakdown
- One patient must be identifiable
- The case resulted in practice breakdown with any action other than dismissal

Case Dismissed

- It discloses no recognizable wrong or violation of law, policy, procedures, or regulation
- It is without merit, frivolous, deemed “unfounded” or “insufficient evidence”
- There may still be breakdown issues related to systems issues, team problems etc.
TERCAP Research Questions

What factors are associated with practice breakdown?

- Patient characteristics
- Nurse characteristics (demographics)
- Nurse practice history factors
- Licensure types
- Educational characteristics
- Setting factors
- Healthcare system factors
- Healthcare team factors
- Clusters of practice breakdown associated with the primary types of error
- Types of practice breakdown associated with patient outcome
- Types of patient medical record documentation associated with different types of practice breakdown

What nurse characteristics (demographic data) are associated with different types of practice breakdown?

- Nurse’s gender
- Type of nursing education
- Year of graduation
- Year of initial licensure
- Licensure status
- Language
- Continued Competency
- APRN category if applicable

What nurse practice history factors (scheduling, staffing levels and/or timing of incidents) are associated with different types of practice breakdown?

- Starting, ending and incident time of work
- Length of practice in the patient care location
- Type of shift
- Days worked in a row
- Assignments
- Number of direct care patients
- Number of staff members supervised
- Total number of patients responsible for
Value to Individual Boards

- Each state board may retrieve/access its own data for its various uses.
- Completed cases submitted by member boards are available on an excel spread sheet.
- May compare individual state data to national aggregate.

TERCAP: Value

- Consistency of data collection to validate and support outcomes of investigative findings across jurisdictions.
- Anticipated it will validate correlations that investigators have inherently known.
- Provides individual boards with its own data for comparison to national reports.
- Will provide for evidence based regulation.

Member Boards currently submitting TERCAP cases

- 12 MBs currently submitting cases (AZ, ID, KY, MN, NC, ND, NH, NJ, OH, OK, TX, and WV-PN).
- MBs interested in becoming TERCAP users in the future...
TERCAP: all cases submitted

- TERCAP launched on line February 1, 2007
  - First case received March 20, 2007
  - 50 cases as of August 15, 2007
  - 101 cases as of November 30, 2007
  - 191 cases as of February 25, 2008
  - 200 cases as of March 18, 2008
  - ___ cases as of July 31, 2008

TERCAP Forum
April 7, 2008

- Heard about legal opinion concerning HIPPA and TERCAP and how it was remedied
- Heard from investigators about utilization of TERCAP during investigations
- Heard from boards and barriers and potential barriers to TERCAP use/implementation and how those are being worked through.

TERCAP Forum
April 7, 2008

- 24 Member boards were represented
- 48 Individuals attended in Chicago
- 10 Individuals attended via webcast
Next Steps:

- Continue to inform boards' staff about TERCAP and its value
- Continue to share individual board problem solutions with other boards' staff
- Assist “umbrella” boards in the implementation of TERCAP
- Provide data analyses as soon as it is available

FY 2008 TERCAP Committee

- Julia George, NCSBN Board of Directors, Committee Liaison (NC)
- Lisa Emrich, Chair (OH)
- Karla Bitz (ND)
- Karen Bowen (NE)
- Charlotte Beason (KY)
- Thania Elliott (LA-RN)
- Sue Petula (PA)
- Mary Beth Thomas (TX)
- Carol Walker, (NC)
- Marie Farrell, RN, Ph.D., FAAN Consultant
- Kathy Scott, RN, Ph.D, Consultant

FY 2009 TERCAP Committee BOD Charges

- Provide Member Board resources for the use of TERCAP.
- Advise staff on the content of the 2009 TERCAP Roundtable.
- Determine the implications of the aggregated data analysis.
TERCAP™: in the near future

- Nursing Pathways for Safe Health Care
  - Elsevier Publisher
  - Presently in edit
  - Available for print on demand

NCSBN Staff involved in TERCAP:

- Kevin Kenward, Director NCSBN Research Department
- Elizabeth Zhong, Associate, Research
- Mary Doherty, Associate, Practice, Regulation & Education
- Qiana Hampton, Administrative Assistant, Practice & Regulation
- NCSBN IT Staff (especially Angela Johnston)

TERCAP™
It can do more than you imagine!

Thank you