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Annual Meeting Schedule

Incidental meeting rooms are available throughout the week and may be reserved via sign-up sheets located at the registration desk on-site. Incidental meeting rooms will be allocated on a first-come, first-served basis.

Information About Parliamentary Sessions

National Council's parliamentarian, Nancy Sylvester, MA, PRP, CPP-T, will conduct two sessions on the topic of parliamentary procedure. The sessions are open to all attendees.

Parliamentary Procedure Problem Solving
Tuesday, August 4, 4:30 p.m. - 5:30 p.m.
Fiesta 4
Discover how parliamentary procedure can help solve the problems of running a meeting consistently and fairly. Bring your parliamentary problems to this workshop and Nancy Sylvester will help you discover solutions to them.

Basics of Parliamentary Procedure
Wednesday, August 5, 7:00 a.m. - 8:00 a.m.
Fiesta 4
This workshop is designed to help simplify and make understandable the concepts of parliamentary procedure that will be used in the Delegate Assembly and other business meetings. Nancy Sylvester will guide you through the complexities of motions and procedures.

Monday, August 3

7:00 a.m. - 8:30 a.m.
Registration for Dialogue on Discipline
Pavillion Court

8:00 a.m. - 9:00 a.m.
Registration for Dialogue on Education
Sendero Court

8:00 a.m. - 5:00 p.m.
Dialogue on Discipline
Pavillion I-II

8:30 a.m. - 5:00 p.m.
Dialogue on Education
Sendero I-II

12:30 p.m. - 1:30 p.m.
Luncheon - Dialogue on Discipline and Dialogue on Education
Enchantment A-D

Tuesday, August 4

8:00 a.m. - 9:00 a.m.
Registration for Dialogue on Impaired Practice
Sendero Court

8:30 a.m. - 5:00 p.m.
Dialogue on Impaired Practice
Sendero I-II

11:30 a.m. - 1:00 p.m.
Luncheon - Dialogue on Impaired Practice
Sendero III

8:00 a.m. - 9:00 a.m.
11:30 a.m. - 5:00 p.m.
Annual Meeting Registration
Pavillion Landing

8:30 a.m. - 11:30 a.m.
Executive Officers' Networking Session
Pavillion I-II

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

1:00 p.m. - 2:30 p.m.
Concurrent Educational/Research Sessions

- Supporting Careers of Competence
- A Profile of Colorado Disciplined Nurses
- Decision Making and Delegation: An Education Module
- Genesis of a Health Care Integrated Educational System for Nursing and Allied Health Students

Enchantment A-D, EF, Pavillion III, V

2:30 p.m. - 3:00 p.m.
Poster Session and Refreshment Break
Pavillion Court

3:00 p.m. - 4:30 p.m.
Concurrent Educational/Research Sessions

- Strengthening Nursing Education to Improve End of Life Care
- Curriculum Revision: Program/Regulatory Perspectives
- Computerized Clinical Simulation Testing (CST®) for RN Continuing Education and Assessment of Continued Competence
- Determining Who is Qualified to Study Nursing

Enchantment A-D, EF, Pavillion III, V

4:30 p.m. - 5:00 p.m.
Poster Session
Pavillion Court

4:30 p.m. - 5:30 p.m.
Parliamentary Procedure Problem Solving
Fiesta 4

5:00 p.m. - 6:30 p.m.
Early Bird Social *(cash bar)*
Pavillion VI

Wednesday, August 5

7:00 a.m. - 8:00 a.m.
Basics of Parliamentary Procedure
Fiesta 4

7:30 a.m. - 2:00 p.m.
Registration
Pavillion Landing

8:00 a.m. - 9:15 a.m.
Orientation
Enchantment EF

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

Enchantment A, B, CD, EF

11:15 a.m. - 11:30 a.m.
Coffee Break
Pavillion Court

11:30 a.m. - 12:30 p.m.
Special Interest Groups (SIGs)
- Chemically Impaired Nurse Issues
- LPN/VN Issues
- Member Board Presidents
- Public Policy Issues
- Board Attorney Issues

Enchantment A, B, CD, EF, Fiesta 1-2

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

2:00 p.m. - 3:30 p.m.
"The Future of Health Care: A Look at Nursing"
Jeffrey C. Bauer, PhD
President, The Bauer Group
Pavillion IV-VI

3:30 p.m. - 4:00 p.m.
Refreshment Break
Pavillion Court

4:00 p.m. - 5:00 p.m.
Delegate Assembly
Pavillion IV-VI

5:00 p.m. - 6:30 p.m.
NCLEX® Examination Dialogue
Enchantment EF

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

5:00 p.m. - 6:30 p.m.
NCNET For Member Boards
Enchantment C

Thursday, August

8:00 a.m. - 2:00 p.m.
Registration
Pavillion Landing

8:00 a.m. - 9:00 a.m.
Breakfast with The Chauncey Group/ Sylvan Prometric
Sendero Ballroom

9:00 a.m. - 10:30 a.m.
Candidates' Forum
Pavillion IV-VI

10:30 a.m. - 11:00 a.m.
Coffee Break
Pavillion Court

11:00 a.m. - 12:00 p.m.
Forum Presentation
- CST®

Pavillion IV-VI

12:00 p.m. - 1:45 p.m.
Awards Luncheon
Pavillion I-III

1:45 p.m. - 3:15 p.m.
Forum Presentations
- Assistive Personnel
- Information System
- Mutual Recognition - Overview

Pavillion IV-VI

3:15 p.m. - 3:45 p.m.
Refreshment Break
Pavillion Court

3:45 p.m. - 5:00 p.m.
Forum Presentations
- Mutual Recognition - Discipline
- APRN - Requirements

Pavillion IV-VI

6:00 p.m. - 8:30 p.m.
20th Anniversary Celebration – *"The Road Traveled for 20 Years"*
Sendero Ballroom
Jean Caron, Mistress of Ceremonies
Casual dress is appropriate, including attire from the days of Route 66!

The 1997-98 Board of Directors is your host for the evening.
Front (l. to r.): Anna Yoder, Tom Neumann, Margaret Howard, Lorinda Inman
Back (l. to r.): Julia Gould, Charlene Kelly, Laura Poe, Joey Ridenour, Gregory Howard

The National Council wishes to thank the following for their generous contributions to support this event:

- **Assessment Systems, Inc.**
- **Mr. & Mrs. Tom Abram, in memory of Thomas O'Brien, former counsel for the National Council**
- **Questar Data Systems, Inc.**
- **The Chauncey Group International/Sylvan Prometric**
- **Vedder, Price, Kaufman & Kammholz**

Friday, August 7

8:00 a.m. - 10:00 a.m.
Registration
Pavillion Landing

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

9:00 a.m. - 10:30 a.m.
Forum Presentations
- Mutual Recognition - Operations/Fiscal Issues
- Mutual Recognition - Compact Administration

Pavillion IV-VI

10:30 a.m. - 11:00 a.m.
Coffee Break
Pavillion Court

11:00 a.m. - 12:30 p.m.
Forum Presentations
- Nursing Practice and Education - Overview
- Position on Criminal Convictions
- Board of Directors - Bylaws and Audit

Pavillion IV-VI

12:30 p.m. - 2:00 p.m.
Area Luncheons
- Area I
- Area II
- Area III
- Area IV

Enchantment AB, CD, EF, Pavillion I-II

2:00 p.m. - 3:15 p.m.
Forum Presentations
- NCLEX-PN® Test Plan
- Position on Nursing Education Program Approval

Pavillion IV-VI

3:15 p.m. - 4:00 p.m.
Delegate Assembly
Pavillion IV-VI

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

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

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

Saturday, August [illegible]

7:30 a.m. - 9:00 a.m.
Registration
Pavillion Landing

7:30 a.m. - 8:30 a.m.
Elections
Boardroom East

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

9:00 a.m. - 9:15 a.m.
Delegate Assembly Election Results
Pavillion IV-VI

9:15 a.m. - 9:45 a.m.
Resolutions/New Business Forum
Pavillion IV-VI

9:45 a.m. - 10:45 a.m.
Open Forum
Pavillion IV-VI

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

10:45 a.m. - 11:15 a.m.
Coffee Break
Pavillion Court

11:15 a.m. - 12:30 p.m.
Delegate Assembly
Pavillion IV-VI

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

2:00 p.m. - 5:00 p.m.
Delegate Assembly
Pavillion IV-VI

Information About Forums

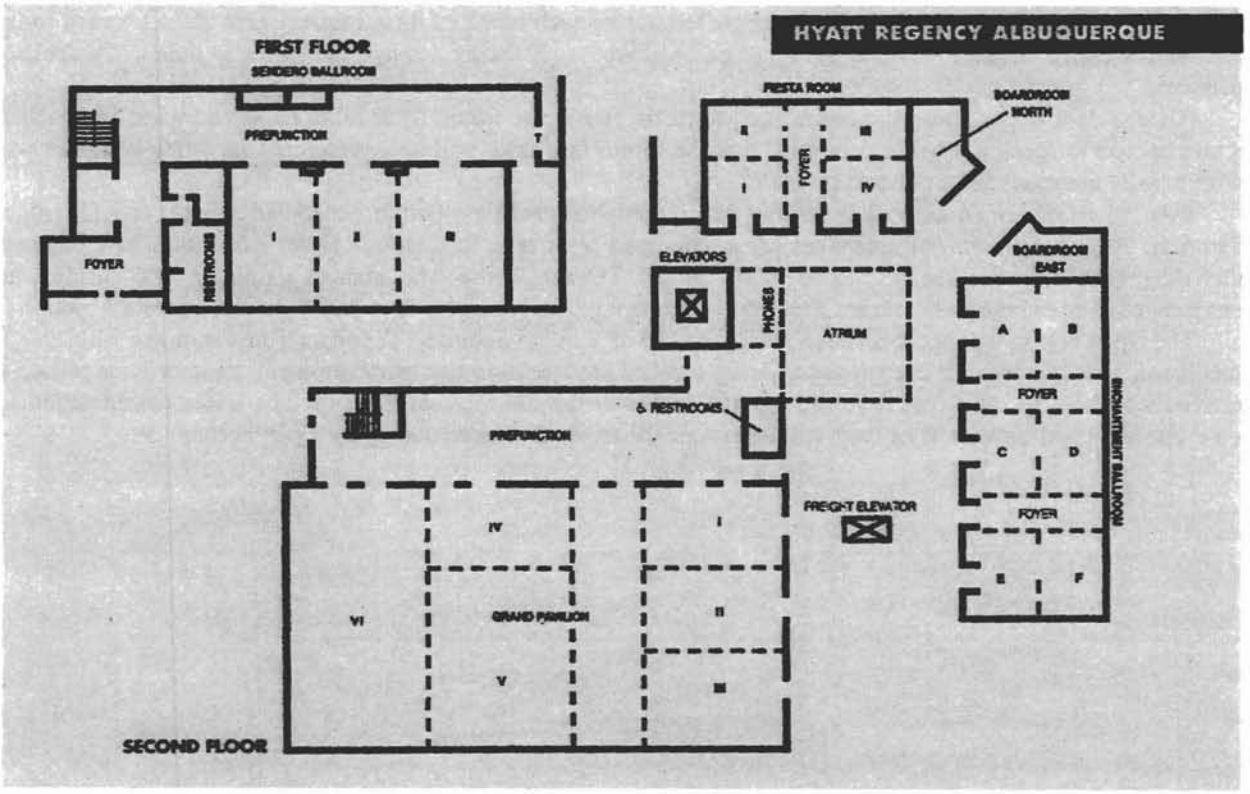
The purpose of scheduled forums is to provide information valuable to decisions to be made by the Delegate Assembly. Forums begin on Thursday, August 6, 1998. The schedule published in the *Business Book* (see page 1 behind this tab) designates the topics to be discussed during each block of forum time. Exact times for each forum are not designated because the discussion will be continuous, advancing through the topics as time and discussion permits.

All attendees are welcome and encouraged to participate in the forum discussion. However, when approaching a microphone to speak, please keep in mind that the forum facilitator will give preference to voting delegates who wish to raise questions and/or discuss an issue.

Resolutions will be considered during the Resolutions/New Business Forum, scheduled to begin at 9:15 a.m. on Saturday, August 8, 1998. All attendees are encouraged to attend. Instructions about submitting new business, including sample motion sheets, can be found behind Tab 10. Those who plan to introduce new business are encouraged to attend the Resolutions Committee meeting on Friday, August 7, at 4:00 p.m. in the Fiesta 4 room.

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

Floor Plan of the Hyatt Regency Albuquerque



Business Agenda of the 1998 Delegate Assembly

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

Wednesday, August 5
4:00 p.m. - 5:00 p.m.

Opening Ceremonies
- Introductions
- Announcements

Opening Reports
- Credentials Committee
- Rules Committee

Adoption of Agenda

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

President's Address

Friday, August 7
3:15 p.m. - 4:00 p.m.

Examination Committee Report

Nursing Practice & Education Committee Report and Subcommittees
- Nursing Program Accreditation/Approval Subcommittee

Saturday, August 8
9:00 a.m. - 5:00 p.m.

Election of Officers and Committee on Nominations

Nursing Practice & Education Committee Report and Subcommittees
- Discipline Resources Subcommittee

Finance Committee Report

Board of Directors' Report
- Auditors' Report
- Bylaws Amendment

New Business
- Resolutions Committee and New Business

Adjournment

Standing Rules of the Delegate Assembly

1. Procedures

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

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

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

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

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

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

2. Motions

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

B. Motions and resolutions submitted prior to Friday, August 7, 1998, at 2:00 p.m., shall be reviewed by the Resolutions Committee according to its Operating Policies and Procedures. Motions and resolutions submitted after the deadline shall be submitted directly to the Delegate Assembly during New Business. All motions and resolutions so submitted will be presented with written analysis of consistency with National Council mission, goals and objectives; assessment of fiscal impact; and potential legal implications. The Resolutions Committee will meet on Friday, August 7, 1998, at 4:00 p.m., with the motion maker(s).

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

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

3. Debate

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

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

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

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

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

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

4. Nominations and Elections

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

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

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

D. Election for officers and members of the Committee on Nominations shall be held Saturday, August 8, 1998, 7:30 a.m.- 8:30 a.m.

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

Recommendations to the 1998 Delegate Assembly with Rationale

To help Member Boards and delegates in their deliberations on recommendations made to the Delegate Assembly prior to attendance at the 1998 Annual Meeting, following are the recommendations, with rationale, received as of June 19, 1998. Additional recommendations may be brought forward during the 1998 Annual Meeting.

Committee on Nominations

1. **Adopt the 1998 Slate of Candidates.**

Rationale

The Committee on Nominations has prepared the 1998 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of the National Council.

Fiscal Impact

None.

Examination Committee

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

Rationale

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

Fiscal Impact

None.

Nursing Practice and Education Committee

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

Rationale

Analysis of the data collected and research findings supports the position paper on approval of nursing education programs by state boards of nursing. The paper identifies the unique roles of Member Boards in the approval process, in addition to describing an accreditation recognition mechanism as an approach to be considered by state boards of nursing in carrying out their responsibilities with respect to nursing education programs.

Fiscal Impact

None.

2. **[Adopt one version of the alternative policy recommendations presented below, developed by the Discipline Resources Subcommittee of the Nursing Practice and Education Committee, regarding licensure requirements and felony convictions.] (To be determined based on feedback at the forum.)**

Version One:

Adopt a policy recommendation to Member Boards that criminal background checks be conducted on applicants for nursing licensure and that individuals are ineligible for nursing licensure on the basis of felony conviction. The licenses of nurses convicted of a felony after licensure would be revoked. This policy would be incorporated in the uniform licensure requirements and the *Model Nursing Practice Act* and *Model Nursing Administrative Rules.*

Version Two:

Adopt a policy recommendation to Member Boards that criminal background checks be conducted on applicants for nursing licensure and that individuals are ineligible for nursing licensure on the basis of felony conviction for violent crimes against persons, including sexual misconduct. For other felony convictions, individuals would be barred from licensure for five years after the absolute discharge of their sentence, and then be considered on a case-by-case basis. The licenses of nurses convicted of a felony after licensure would be revoked. Nurses convicted of felonies which did not involve violent crimes against persons, including sexual misconduct, could be considered for reinstatement on a case-by-case basis five years after the absolute discharge of their sentence. This policy would be incorporated in the uniform licensure requirements and the *Model Nursing Practice Act* and *Model Nursing Administrative Rules.*

Rationale

Based on the extremely high recidivism rate for felons and the advice of a consultant criminologist that felony conviction represented very high risk behavior, the subcommittee members became convinced that felony conviction is an appropriate first-level screen for licensure applicants. In the current criminal justice system, a felony conviction is a highly significant event. Many individuals convicted of felonies are extremely manipulative and adept at working a system. This recommendation makes a strong statement regarding the behavioral expectations for nurses. Given the high stakes nature of the requirement being proposed, the subcommittee members also believe it is essential that criminal background checks be conducted on all applicants for nursing licensure.

The view of the subcommittee is that the limited resources of boards of nursing should not be spent on administrative processes with felons. Rather, such scrutiny should be focused on other applicants. Another important consideration are the implications for mutual recognition if states continue to enact different licensure requirements related to criminal convictions.

The subcommittee recognizes that these recommendations may be perceived by some as extreme. However, the policy suggested above is consistent with policies promoted for other individuals working with at-risk populations. The United States Department of Justice has recently developed *Guidelines for the Screening of Persons Working With Children, the Elderly, and Individuals With Disabilities in Need of Support* (April, 1998). In those guidelines, it is suggested that the "Automatic disqualification of a potential worker or volunteer is appropriate when screening indicates that the individuals, as an adult, perpetrated any crime involving a child and/or a dependent adult, regardless of how long ago the incident occurred, and/or any violent crime within the past 10 years." Consumers needing health care are vulnerable. It is appropriate to establish high behavioral standards for applicants for nursing licensure and licensed nurses. Should boards be right, wrong, or safe?

Fiscal Impact

The costs to the National Council, if this policy were implemented, would be minimal and could be absorbed by existing committees and work groups (e.g., adding language to *Model Nursing Practice Act* and *Model Nursing Administrative Rules*).

The policy could result in both costs and savings to Member Boards. For example Member Boards may incur costs to initiate legislation and/or rule changes and costs to educate legislators, nurses and the public about the policy. Such costs would vary by jurisdiction. Savings would result from this policy if boards did not incur the costs of case-by-case review for applicants ineligible because of felony conviction.

Board of Directors

1. **That Article VII, Section 3, of the National Council Bylaws be amended by deleting the words "goals and objectives" and the words "adoption of" preceding "position statements" so that the sentence would read,**

"The Delegate Assembly, the legislative body of the National Council, shall provide direction for the National Council through adoption of the mission and position statements, and actions at any Annual Meeting or special session."

Rationale

The Board of Directors has been engaged in an intensive process over the past two years, leading to the development of six strategic initiatives and 23 outcomes which are directly related to the mission of the organization, as adopted by the Delegate Assembly in 1997. These strategic initiatives and outcomes were presented by the president at each Area Meeting, and seemed to meet with approval in view of the absence of suggestions for improvement or objections. On the last occasion that a new set of goals and objectives (analogous to "strategic initiatives" and "outcomes") was proposed to the Delegate Assembly, the proposal presented by the Board with member and committee input was also adopted without change by the Delegate Assembly. Under the proposed Bylaw amendment, the Board of Directors would develop strategic initiatives and outcomes and report them to the Delegate Assembly annually.

Member Boards continually provide feedback to the Board of Directors via letters, calls, and requests, and are frequently asked for input formally and informally. The resolutions process at the Delegate Assembly provides a formal opportunity for input and direction as well.

Fiscal Impact

None.

2. **That the Auditors' Report be accepted.**

Rationale

The Board of Directors engages an audit firm on an annual basis to audit the financial records of the National Council. As a part of its fiduciary responsibility to the Member Boards, the Board reviews this report carefully, raises appropriate questions, and gives direction to staff with respect to the recommendations made by the auditors in the management letter. The Board recommends the acceptance of the audit in acknowledgment of its accountability to the delegates and in the interest of openness regarding the financial status of the National Council.

Fiscal Impact

None.

SPECIAL NOTE:
Following the Board of Directors' Forum on Friday, August 7, 1998, the Board of Directors is planning to develop a recommendation for the Delegate Assembly concerning the computerized clinical simulation testing (CST®) project. Input from Member Boards at the forum is very important to the development of this recommendation. Information regarding the CST project can be found as an attachment to the Board's report behind Tab 9. Member Boards are strongly encouraged to come prepared for discussion.

Board of Directors' Comments on Recommendations from Standing Committees

1. The Board supports the recommendation of the Examination Committee for the adoption of the proposed *NCLEX-PN® Test Plan.*
2. The Board made suggestions to the Subcommittee on Educational Program Approval/Accreditation related to the position on educational program approval and accreditation.
3. The Board suggested to the Subcommittee on Discipline Resources (and the Nursing Practice and Education Committee) that both potential positions on the use of criminal background information be brought before the Delegate Assembly for discussion.

Notes

Report of the Committee on Nominations

Committee Members

Helen Zsohar, Utah, Area I, *Chair*
Patricia Block, Alabama, Area III
Monica Collins, Maine, Area IV
Deb Haagenson, North Dakota, Area II

Staff

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

Relationship to Organization Plan

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

Recommendations to the Delegate Assembly

1. **Adopt the 1998 Slate of Candidates.**

Rationale

The Committee on Nominations has prepared the 1998 Slate of Candidates with due regard for the qualifications required by the positions open for election, fairness to all nominees, and attention to the goals and purpose of the National Council.

Highlights of Activities

■ **Preparation of 1998 Slate of Candidates**

By the April 24, 1998, nomination deadline, 15 individuals had submitted completed nomination forms for consideration for the 1998 Slate of Candidates. During its May 4-5, 1998, meeting, the committee issued a call for nominations to Area I Member Boards to obtain candidates for the position of Area I Director, which became open for election in 1998 because the current Area I Director was slated on the 1998 Slate of Candidates for the position of president. The committee finalized the slate on May 11, 1998. The list of slated candidates was published in the May 15, 1998, edition of the *Newsletter* sent to Member Boards. Full biographical information for each candidate is included in this *Business Book* as Attachment A, starting on page 5.

■ **Identification of Competencies for Committee on Nominations Members**

At the request of the Board of Directors, the committee created a list of suggested competencies for and expectations of members of the Committee on Nominations. They are:

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

These competencies supplement the document drawn up by the Board of Directors in February 1997, identifying important competencies of an ideal Board of Directors member.

■ **Committee Observation of Board of Directors Meeting**

On November 4, 1997, the committee observed the Board of Directors meeting. As part of this activity, the committee dialogued with the Board on topics related to the nomination process at the National Council, including: difficulty in obtaining an adequate number of nominees; the possibilities of using Area meetings for nominee

recruitment; time commitment required for Board positions; and the "hot" issues that would probably face the Board in the upcoming few years, particularly regulatory reform. The Board offered suggestions about qualities that are valuable in Board members, including: task force experience; flexibility; some knowledge of the work of the National Council; ability to see the "big picture"; ability to be visionary; knowledge of regulation/regulatory background; and a sense of humor. The committee discussed the Board's input during its own, subsequent meeting.

- **Use of Area Meetings for Recruitment**

During its November 1997 meeting, the committee decided to utilize Area Meetings for recruitment of nominees for National Council office, in addition to pursuing the traditional recruitment vehicles (mailings, telephone calls, etc.). In the aftermath of the Area Meetings, the committee determined that their recruitment efforts at those meetings had been successful and should be continued in future years. Although the number of nominations received by the deadline date was not dramatically greater than the number received in recent years, the committee determined that close to half of the nominations received this year were submitted as a direct result of personal contact with the nominees at the Area Meetings. The committee members found further benefit from their attendance at the Area Meetings in that they subsequently were able to recommend various attendees as having been potentially interested in submitting a nomination for National Council office, even if they had not yet done so. At the committee's request, the Board approved necessary budget allocations for FY99 to fund attendance of the Committee on Nominations' members at their respective Area Meeting in 1999.

- **Addition of Recruitment to Committee Duties**

The committee noted that active recruitment of nominations had been required in order to fill the 1998 Slate of Candidates. As the previous year's Committee on Nominations had noted in the *Getting Involved in the National Council* brochure, it is a myth that "hundreds of nominations are received by the Committee on Nominations each year." This year was no exception despite the committee's efforts, which included: inclusion of a call for nominations and nomination form in five editions of the *Newsletter*; a call for nominations sent directly to board members; a call for nominations/nomination form sent directly to members of the National Council's volunteer pool; a letter to executive officers requesting assistance with obtaining nominations; telephone calls to Member Board executive officers early in 1998; face-to-face contact with attendees at the Area Meetings; and, ultimately, direct telephone contact with more than 20 potential nominees in the course of the committee's May 4-5 meeting. Fewer than two dozen nominations were obtained through these combined efforts.

Although the *Duties of the Committee on Nominations* document does not specifically address recruitment of nominees, suggesting instead that the committee simply "invite nominations" and review the nominations received, the current committee felt obligated to pursue direct recruitment activities in order to accomplish its purpose of preparing a slate of qualified candidates. A slate of candidates containing single names for most positions, and possibly offering no names for others, did not seem in keeping with this purpose. Noting that contact with Member Board executive officers early this year, while cordially received, failed to produce a sufficient number of nominees, the committee unsuccessfully tried to identify other persons or bodies who could disinterestedly recruit nominees in its place. The committee therefore decided that recruitment should be established as a recognized part of the committee's work. The Board subsequently approved the addition of the following duty for the Committee on Nominations: "To actively encourage nominations through direct contact with Member Board members and staff after initial contact has been made with the respective executive officer."

Future Activities

- Offer the nomination form in additional formats to increase ease of access, including an interactive form on the VIP Web site and NCNET, a downloadable form in a standard word processing format, and a fax-on-demand version of the form.
- Maintain an ongoing list of persons expressing interest in submitting nominations in the near future, to serve as an aid to recruitment efforts of subsequent years' committees.
- Begin recruiting nominees immediately following the committee's first meeting, well in advance of the holiday season and the Area Meetings.

Meeting Dates

- November 4-5, 1997
- May 4-5, 1998
- May 11, 1998 *(telephone conference call)*

Recommendations to the Board of Directors

1. **Adopt the 1998 Slate of Candidates.**

Fiscal Impact

None.

Attachments

Attachment A

1998 Slate of Candidates

The following is an overview of the slate developed and adopted by the Committee on Nominations. More-detailed information about each candidate is provided in the subsequent pages of this attachment. This detailed information is taken directly from candidates' nomination forms. Each candidate will have an opportunity to expand on this information during the Candidates' Forum, scheduled to be held Thursday, August 6, 1998, from 9:00 a.m. to 10:30 a.m.

President

Joey Ridenour ..... Arizona ..... Area I

Vice-President

Margaret Howard ..... New Jersey ..... Area IV
Valisa Saunders ..... Hawaii ..... Area I

Treasurer

Nathan Goldman ..... Kentucky ..... Area III
Barbara Morvant ..... Louisiana-RN ..... Area III

Area I Director (one-year term)

Dorothy Fulton ..... Alaska
Laura Poe ..... Utah

Director-at-Large (two positions)

Kathy Apple ..... Nevada ..... Area I
Anna Ferguson ..... Oklahoma ..... Area III
Pat Schlecht ..... Ohio ..... Area II
Cindy VanWingerden ..... Virgin Islands ..... Area IV

Committee on Nominations

<u>Area I</u>
June Sturm-Roller ..... Colorado
Dianne Wickham ..... Montana

<u>Area II</u>
Cordelia Esry ..... Missouri
Mona Hohman ..... South Dakota
Barbara Jean Stamp ..... Ohio

<u>Area III</u>
Thania Elliott ..... Louisiana-RN
Linda Roberts-Betsch ..... Georgia-RN

<u>Area IV</u>
Monica Collins ..... Maine
Maureen McGarry ..... Rhode Island

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

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

President

1. **Joey Ridenour, Arizona, Area I**

2. Executive Director, Arizona State Board of Nursing

3. Arizona State Board of Nursing

4. University of Phoenix, Nursing, MN, 1993
   Arizona State University, Nursing, BN, 1969

5. National Council
   Area I Director, 1995-1998
   Long Range Planning Committee, 1996-1997
   Finance Committee, 1994-1995
   Arizona State Board of Nursing
   President/Board Member, 1992-1995, 1984-1989
   Scope of Practice, Chair, 1993-1995
   Arizona State University
   Adjunct Faculty, 1996-1999
   Maricopa Community Regulation Workforce
   Advisory Panel, 1996-1998
   RWJ/Colleagues in Caring
   Consortium Member, 1996-1998

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

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

8. Having been a National Council Area I Director, an Arizona State Board of Nursing board member and executive director over the past 12 years, I bring a diversity of perspectives and experience to Area I leadership. Commitment to National Council's mission and goals has been demonstrated through the Finance Committee, Long Range Planning, and currently, through the Board of Directors. Three critical challenges are: 1) identifying new strategies to lead the way in regulatory effectiveness as the health care environment and consumer needs change; 2) continuing to leverage the Board's time differently by spending 80% on what is desired to happen in the future, and only 20% on monitoring the past; and 3) improving the match of volunteers to Board and committee positions to increase effectiveness of decisions on critical activities. I offer a deep and genuine interest to be your "servant leader" as president of the National Council. The last four years have been a gift; thank you.

Vice-President

1. **Margaret C. Howard, New Jersey, Area IV**

2. Field Representative, New Jersey Board of Nursing

3. New Jersey Board of Nursing

4. Seton Hall University, Nursing, MSN, 1979
   Seton Hall University, Nursing, BSN, 1968
   All Souls Hospital School of Nursing, Nursing, Diploma, 1960

5. National Council
   Vice-President, 1996-1998
   Educational Programs Task Force, Chair, 1994-1996
   Communications Committee, Chair, 1993-1994
   Communications Committee, Member, 1990-1993
   St. Francis Counseling Service
   Board of Directors, 1992-1998
   Seton Hall University
   Nursing School Alumni Board of Directors, 1986-1998
   University Alumni Board of Directors, 1990-1992

6. Seton Hall University College of Nursing Alumni
   Sigma Theta Tau

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

8. For the past two years I have had the pleasure of serving as vice-president of the National Council and, therefore, bring experience to the position. Also, my role as a field representative for the New Jersey Board of Nursing for the past 17 years has provided me with a variety of regulatory experiences and prepared me for this position.

   These past two years have been filled with a variety of issues that have required collaboration with other nursing organizations, which has given the National Council great visibility as well as increased credibility. The mutual recognition model for nursing licensure, advanced practice, continued competence and discipline will continue to be major issues that the National Council must address. As nursing and health care continue to change, the mission of the National Council to lead in nursing regulation by assisting Member Boards to promote safe and effective nursing practice will become increasingly important.

Vice-President

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

2. Vice-Chair, Hawaii Board of Nursing

3. Kaiser Permanente, Honolulu, Hawaii

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

5. American Nurses Association
   Council of APRNs, 1986-1997
   Nurse Practice Cabinet Restructure Committee, 1992-1993
   Practice Institute, 1992-1995
   Hawaii Board of Medical Examiners
   Formulary Advisory Committee, Secretary, 1994-present
   Hawaii Board of Nursing
   Practice Committee Chair, 1998-2000
   Vice-Chair, 1995-1998
   Hawaii Executive Office on Aging
   End of Life/Surrogate Task Force, 1998-present
   Hawaii Nurses Association
   Congress on Nursing Practice, 1984-1992
   President, 1989-1991
   National Conference of GNPs
   Practice Committee, Chair, 1997-present
   Sigma Theta Tau
   Finance Committee, 1984-1986

6. American Academy of Nurse Practitioners
   American Nurses Association
   Hawaii Nurses Association
   Sigma Theta Tau International

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

8. My clinical background has been combined with administrative experience, leadership and regulatory acumen. My volunteer work has largely related to regulation of nursing and health care at the state and national levels for over 20 years. Thus, my organizational experience, passion for my work and energy are what I can bring to the National Council. Additionally, I have perspectives on regulation from the industry and experience in budget and finance management.

   Over the next couple of years, the many issues of multistate regulation, including the use of technology across state boundaries and the tracking of disciplinary actions, will be priorities for the National Council. Setting standards and helping state boards to achieve them in the areas of RN/VN education, APRN education and regulation, and unlicensed assistive personnel will also continue to need work. Continuing to evaluate the impact of regulations on outcomes important to consumers will also be important challenges to the National Council.

Treasurer

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

2. General Counsel, Kentucky Board of Nursing

3. Kentucky Board of Nursing

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

5. National Council
   Area III Regulatory Day of Dialogue Planning Committee, 1997-1998
   Multistate Regulation Board Attorney Comment Group, 1997
   Subcommittee to Revise Model Act and Rules, 1996-1997
   Disciplinary Case Analysis Focus Group, 1994
   Council of Licensure, Enforcement and Regulation
   Regulatory Issues Committee, 1992-1997

6. Kentucky Bar Association

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

8. It is my belief that the National Council has a major role to play in this country's health care delivery system. Nurses are the largest regulated segment of the health care workforce, and the National Council, as the voice for nursing regulation, has an important role in shaping nursing's future. We have already seen major changes with the advent of multistate licensure. I believe that the most difficult issue facing the National Council in the future will be how to implement the adage, "Think globally, act locally." The National Council will be called on more and more to assist its Member Boards as nursing regulation moves into the 21st century. I believe my 18 years of experience in administrative law and my work with the National Council for the last four years gives me a unique perspective and one that will assist the National Council to further its goals.

Treasurer

1. **Barbara L. Morvant, Louisiana, Area III**

2. Executive Director, Louisiana State Board of Nursing

3. Louisiana State Board of Nursing

4. Louisiana State University Medical Center, Adult Health/ADM, MSN, 1976
   Louisiana State University Medical Center, Nursing, BSN, 1973
   Touro Infirmary School of Nursing, Nursing, Diploma, 1970

5. National Council
   Finance Committee, 1992-present
   Executive Officer Orientation Group, 1998
   Committee on Nominations, 1991-1992; Chair, 1992

6. American Nurses Association
   Louisiana State Nurses Association
   New Orleans District Nurses Association

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

8. As treasurer of the National Council, I would bring a commitment to the sound fiscal management of all organizational resources. As the National Council undertakes major initiatives based on the directives of the Delegate Assembly, project planning must assure that adequate funds are available and all funding sources explored or that careful priority-setting guides decision-making. As a member of the Finance Committee for the past six years, I will bring to the Board knowledge of the budgeting process and investment strategy. I am committed to assuring adequate funding to meet the goals of the National Council, while recognizing the needs of Member Boards.

Area I Director

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

2. Executive Administrator, Alaska Board of Nursing

3. Alaska Board of Nursing

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

5. National Council
   Nurse Practice and Education Continued Competence Subcommittee, 1997-current
   MSR Fiscal Work Group, 1998
   Disciplinary Data Bank Task Force, Chair, 1996-1997
   Nurse Aide Competency Evaluation Program Task Force, 1992-1996
   RWJ Foundation
   Colleagues in Caring Consortium, Member, 1997-current

6. Alaska Association of Nurse Executives
   Alaska Nurses Association
   Sigma Theta Tau, International

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

8. I have served on several boards and committees and would bring leadership qualities to this position. I have worked in clinical nursing, education and administration in both state government and the private sector.

   The diversity of my work experience in health care has afforded me the opportunity to completely understand all aspects of the nursing profession. This background has provided me with an informed and objective perception of nursing practice and the challenges faced by nurses in providing quality nursing care.

   One of my greatest assets is my ability to communicate on all levels, and to diverse audiences. As Area I Director, I feel that I would be in a better position to relate to, work with, and communicate the needs of colleagues in my Area.

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

Area I Director

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

2. Executive Administrator, Utah State Board of Nursing

3. Utah State Board of Nursing

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

5. National Council
   Director-at-Large, 1996-1998
   Information Services Evaluation Task Force, 1995-1996
   Executive Officer Orientation Task Force, 1994-1995
   SL County/State Democratic Party
   Platform Committee, Delegate, District Chair, Legislative Co-Chair, 1986-Present
   Utah Nurses Association
   Board of Nursing Nurse Practice Act Task Force, 1996-1997, 1991-1992
   Congress on Nursing Practice, 1993-1995
   Government Relations Committee, 1984-1995
   Utah State Board of Nursing
   Entry into Practice Task Force, 1985-1986

6. Nursing Leadership Forum
   Phi Kappa Phi
   Sigma Theta Tau
   Utah Nurses Association

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

8. This is a critical period of time for those in regulation, and the National Council will be there taking the lead regarding public policy as it relates to licensure and public protection. I want to be there actively participating in and debating the issues which will usher in the new millennium. Priority issues include the interstate compact, advanced practice, delegation, and scope of practice. I bring to the National Council's Board of Directors a keen mind and sense of humor. I have the critical thinking skills necessary to provide meaningful dialogue. I don't hesitate to ask why or to look to the next curve. I also recognize the rich experience available from those who have been involved in regulation for a number of years and respect their input.

Director-at-Large

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

2. Executive Director, Nevada State Board of Nursing

3. Nevada State Board of Nursing

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

5. National Council
   Multistate Regulation Task Force, 1997-1998
   APRN Coordinating Task Force, 1995-1996
   Task Force to Study Feasibility of a Core Competency Exam for Nurse Practitioners, 1994-1995

6. American Nurses Association
   American Psychiatric Nurses Association

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

8. My committee experience with National Council has taught me that the foundational work provided by committees is invaluable and an important step in accomplishing the organizational mission. Member Boards rely on the work of committees for detailed, thorough reviews of issues followed by workable recommendations. My experience has clarified the importance of the role of Member Boards, the role of National Council and how the two interact for the benefit of effective regulation and public policy.

   My colleagues will tell you that the qualities I bring are my ability to think systemically and to process large volumes of information and distill the essential issues.

   National Council assists Member Boards by working at many levels of nursing regulation. I believe the top priority from the mission statement is to "assist Member Boards."

Director-at-Large

1. **Anna Ferguson, Oklahoma, Area III**

2. Associate Director for Nursing Education, Oklahoma Board of Nursing

3. Oklahoma Board of Nursing

4. Texas Women's University, Nursing, PhD, 1986
   University of Texas, Nursing, MS, 1973
   Washington University-St. Louis, Nursing, BS, 1959

5. National Council
   Nurse Practice and Education Continued Competence Subcommittee, 1997-1998
   Nurse Information Systems Task Force, 1992-1996
   Department of Human Services
   Assisted Living Committee, 1994-1997
   Oklahoma Board of Nursing
   Continued Competence Task Force, 1996-1998
   Nurse Utilization Task Force, 1997-1998
   Unlicensed Assisted Personnel Task Force, 1994-1998
   Oklahoma Nurses Association
   Membership Committee, 1994-1996

6. American Nurses Association
   Oklahoma Nurses Association

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

8. The qualities I will bring to the position are a strong commitment to nursing, a broad base of knowledge and experience in multiple settings and ability to interact effectively with diverse populations. I have a strong work ethic and enjoy challenges.

   Some of the challenges facing the National Council now and in the future are implementation of multistate regulation, the expanding use of technology, scope of practice issues, the proliferation of unlicensed caregivers and incongruence between nursing education outcomes and clinical practice expectations.

   National Council has the resources and expertise to support boards of nursing in regulatory effectiveness. I am excited about actively participating in this process.

Director-at-Large

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

2. Board Member, Ohio Board of Nursing

3. University of Cincinnati, Cincinnati, Ohio

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

5. National Council
   Area II Regulatory Day of Dialogue Planning Committee, 1997-1998
   Ohio Board of Nursing
   Licensure Liaison, 1997, 1998
   Task Force on Advisory Groups, 1997, 1998
   Ohio Nurses Association
   Delegate to Convention, 1993, 1995
   Southwestern Ohio Nurses Association
   Board of Directors, 1992-1993
   Bylaws Committee Chair, 1993-1996
   Human Rights Committee, 1989-present
   Vice-president, 1993-1996

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

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

8. I commit to the National Council as I have to the Ohio Board of Nursing by preparing for, attending and actively participating in meetings. As an educator who is an evaluator for the National League for Nursing's Accrediting Commission, a consultant-evaluator for the North Central Association, and a former member of the Ohio Board of Nursing's Advisory Group on Education, I bring a broad perspective of all levels of educational systems. On the Ohio Board of Nursing, I am an active participant in meetings and am independent when believing in issues. I participated in the board-implemented use of the Carver Model. Time management includes priority setting and scheduling for maximum effectiveness. I believe in delegation, as one individual cannot do the work of National Council, and multiple individuals bring viewpoints increasing the quality of decisions. I have developed extensive relationships in the Ohio nursing community and look forward to developing more mutually beneficial relationships in the National Council community.

Director-at-Large

1. **Cynthia VanWingerden, Virgin Islands, Area IV**

2. Education and Discipline Consultant, Virgin Islands Board of Nurse Licensure

3. Virgin Islands Board of Nurse Licensure/St. Croix Vocational School

4. University of Miami, Education Administration, MS, 1989
   Boston University, Nursing, BSN, 1973

5. National Council
   Nursing Practice and Education Committee, 1996-present
   Nursing Regulation Task Force, 1995-1996
   Secretary, Board of Directors, 1993-1995
   Foreign-educated Nurse Credentialing Committee, 1991-1993
   National Association for Practical Nurse Education and Service
   Educators' Council, 1987-1991, 1998
   National Association of Legal Assistants, 1997-present
   National League for Nursing
   PN Educators' Council, 1991-1995

6. National Association of Legal Assistants
   National League for Nursing
   National Association for Practical Nurse Education and Service

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

8. I served for seven years as a board member on the Virgin Islands Board of Nurse Licensure, and I now serve as education consultant to the board. I have found nursing regulation to be dynamic and continually challenging. As a practical nurse educator for the past 12 years, and in nursing practice and administration for thirteen years prior to that, I am most interested in issues of nursing education—curriculum, continuing approval, and nursing regulation as it impacts continuing competence in practice and public safety and welfare. I will bring to the Board's deliberations the perspective of a small jurisdiction, as well as the experience I have gained from serving on three National Council committees, and a term as secretary on the Board of Directors.

Committee on Nominations: Area I

1. **June Sturm-Roller, Colorado, Area I**

2. Vice President, Colorado Board of Nursing

3. Medical Center of Aurora, Aurora, Colorado

4. University of Denver/Presbyterian Hospital School of Nursing, Nursing, Diploma, 1979

5. Colorado State Board of Nursing
   Liaison Committee, Colorado Board of Medical Examiners, 1993-present
   Advanced Practice Committee, 1992-present
   American Lung Association
   Steering Committee
   Champ Camp for Asthmatic Children
   Aurora Community Mental Health
   Board of Directors, 1995-present

6. Colorado Nurses Association

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

8. I bring to National Council my leadership skills, my ability to communicate clearly, a keen interest in the regulatory process and nursing education. As an experienced staff nurse, I witness entry-level practice. I am committed to the National Council's goal of continued analysis of the changing health care environment as it impacts the regulation of nursing education. Having participated in the implementation of the Advanced Practice Act and defining the rules of prescriptive authority in Colorado, I believe the National Council should focus on a national agreement of these two issues.

Committee on Nominations: Area I

1. **Dianne Wickham, Montana, Area I**

2. Executive Director, Montana State Board of Nursing

3. Montana State Board of Nursing

4. Montana State University, Nursing, MN, 1980
   Montana State University, Nursing, BSN, 1977
   Northern Montana College, Nursing, ADN, 1974

5. National Council
   Examination Committee Item Review Subcommittee, 1997-present
   Licensure Verification Task Force, 1996-1997
   Disciplinary Investigators' Program Task Force, 1995-1996
   Task Force to Implement Education Programs for Disciplinary Investigators, 1994-1995
   Task Force to Develop Educational Programs for Disciplinary Investigators, 1993-1994
   Delegate, 1990-1997
   State of Montana
   Montana University System Nursing Education Committee, 1997-1998

6. Montana Nurses Association

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

8. I have the ability to network with others and share ideas. Organizational skills are strong. In my position with a small staff, I have experience in all aspects of regulation. I have a strong commitment to the goals of the National Council and have the ability to be fair and work with others. A ballot of qualified leaders is essential to the leadership of the National Council. Candidates need to be selected for their ability to be future-minded and committed to the goals of the National Council.

Committee on Nominations: Area II

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

2. Board Member, Missouri State Board of Nursing

3. University of Missouri-Kansas City, Kansas City, Missouri

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

5. Missouri Association Colleges Nursing
   President, 1990-1994
   Missouri Division of Health
   Chair of Loan and Scholarship, 1992-present
   Missouri Guidance Association
   Member, 1965-1975
   Missouri League for Nursing
   Board of Directors, 1992-1996
   Missouri Nurses Association
   Board of Directors, 1990-1992
   Served on finance, education, nominating and Blue Ribbon committees during the last 10 years.
   Missouri Rural Opportunities Council
   Area Representative, 1992-1998
   Sigma Theta Tau
   Counselor, 1993-1995
   University of Missouri National Alumni Association
   Treasurer, 1996-1998
   Vice-President, 1998-1999
   (Automatic progression to President-Elect and President, 1999-2001)

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

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

8. Participation in the deliberations of the National Council would be both stimulating to me personally as well as beneficial for the members of the board on which I serve. I would bring to the National Council the abilities to work effectively with the persons on the committees as well as the other members of the boards of nursing and see the National Council as a very influential and challenging group. My past involvement with the professional organizations on numerous boards, committees and offices brings the expertise and knowledge of how organizations function and thrive, and I am willing to serve if elected. I see the implementation of the multistate licensure as the most challenging task for service and the infusion of multiple players in national accreditation for schools of nursing as the most divisive issue that will face boards of nursing within the next two years.

Committee on Nominations: Area II

1. **Mona Hohman, South Dakota, Area II**

2. Nursing Practice Specialist, South Dakota Board of Nursing

3. South Dakota Board of Nursing

4. Clarkson College, Nursing Administration, MS, 1996
   Augustana College, Nursing, BA, 1989
   Clarkson Hospital, School of Nursing, Nursing Diploma, 1978

5. Canton-Inwood Memorial Hospital
   Advisory Board, Board Member, 1993-present
   South Dakota Association of Health Care Organizations
   Council on Professional Practice, 1995-1997
   South Dakota Colleagues in Caring Consortium
   Regulatory Task Force, 1996-present

6. Sigma Theta Tau, Zeta Zeta Chapter

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

8. Computerized testing for nursing licensure is just one example of recent actions taken by National Council which has positioned the organization as the leader in health professions regulation. Implementation of multistate licensure and the regulatory outcomes study are two of the National Council's current priority issues. It is imperative for the Committee on Nominations to recruit a slate of qualified candidates who have the essential leadership qualities necessary to advance the goals of the National Council into the next millennium.

   I have experiences in nursing theory-based practice, education, and regulation which have afforded me skills in bringing together diverse groups of people to achieve collaborative goals. Through attendance at Area Meetings and Delegate Assembly, I have developed networks with potential candidates. I would be honored to serve as a member of the Committee on Nominations to assist in creating a slate of candidates for the 1999 ballot.

Committee on Nominations: Area II

1. **Barbara Jean Stamp, Ohio, Area II**

2. Board Member, Ohio Board of Nursing

3. Ohio Department of Health, Akron, Ohio

4. Malone College, Management, BA, 1993
   East Liverpool City Hospital School of Nursing, Nursing, RN, 1964

5. American Red Cross
   Board Member, 1989-1995
   Chapter Chair, 1995
   Ohio Board of Nursing
   Vice President, 1998
   Ohio Nurses Association
   District 3, Membership Committee, 1997
   Youngstown State University
   Advisory Committee to the Dean, 1995-1997

6. AIDS Task Force
   American Nurses Association
   American Red Cross-Columbiana County
   Home Care Advantage Advisory Board
   Ohio Family and Children First Council
   Ohio Nurses Association
   Ohio Public Health Association
   Salem Visiting Nurses Association, Advisory Board

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

8. It is my conviction that the nursing profession will continue, in an increasingly significant role, in the determination of health care in the United States. During the next two years National Council should continue development of multistate licensure along with database support, and embrace the formation of a continued competency model to ensure safe and effective nursing practice.

   As a member of the Committee on Nominations I shall bring thirty years of public health experience in both clinical and administrative roles. My experiences have allowed me to develop familiarity in the interpretation and application of multiple criteria and standards as well as the recognition of the benefits of regulation. My actions demonstrate excellent organizational skills, accountability, collaboration, and a willingness to say what needs to be said to promote the safe practice of nursing for the protection of the public and the advancement of the profession.

Committee on Nominations: Area III

1. **Thania S. Elliott, Louisiana, Area III**

2. Nursing Consultant for Compliance, Louisiana State Board of Nursing

3. Louisiana State Board of Nursing

4. Loyola University School of Law, Law, JD, 1991
   Tulane University School of Public Health and Tropical Medicine, Public Health Nursing, MSH, 1969
   Louisiana State University, Nursing, BSN, 1963

5. National Council
   Nursing Practice and Education Discipline Resources Subcommittee, 1997-1998
   Discipline Modules Task Force, 1996-1997
   Complex Discipline Cases Subcommittee, 1995-1996
   Gulf States Nurse Attorney Association
   Treasurer, 1995-present
   New Orleans District Nurse Association
   Membership Committee, 1997-1998

6. American Nurses Association
   Gulf States Nurse Attorney Association
   Louisiana Bar Association
   Louisiana State Nurses Association
   NODNA

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

8. During the past six years, I have had the opportunity to work with the Louisiana-RN Board in managing the busy and complex discipline/compliance department. In this role, I have gained valuable experience in understanding the board's purpose, and the mission of the National Council, in protecting the public from unsafe nursing practice. By attending Area, Annual, and committee meetings, I have met and worked with a variety of individuals who share this concern for protecting the public. I believe that the Committee on Nominations is crucial in achieving the mission of the National Council. Only by selecting the most qualified slate of candidates can the members elect officers who will lead the organization towards making appropriate policy decisions for the future. Priorities of the National Council should include the changing expectations of

the public for regulation of nursing education and practice, and for ensuring public safety in the most efficient, effective, and rational manner.

Committee on Nominations: Area III

1. **Linda Roberts-Betsch, Georgia, Area III**

2. Board Member, Georgia Board of Nursing

3. North Georgia College and State University, Department of Nursing, Dahlonega, Georgia

4. University of Alabama-Birmingham, Nursing, Education Administration, DSN, 1988
   University of Alabama-Birmingham, Nursing, Maternal-Child Health, MSN, 1986
   East Carolina University, Child Development/Family Relations, MSHE, 1975
   East Carolina University, Nursing, BSN, 1970

5. National Council
   Nursing Practice and Education Nursing Program Accreditation/Approval Subcommittee, 1997-1998
   Delegate, Special Delegate Assembly, 1997
   Board of Regents, University System of Georgia
   Health Professions Advisory Committee, Member-at-Large, 1998-1999
   Subcommittee for Nursing, Chair, 1993-1997
   Georgia Nurses Association
   Council on Nursing, 1993-1997
   Georgia Nurses Foundation
   Board of Directors, 1994-1996
   North Georgia College and State University
   Faculty Senate, CEO, 1995-1998

6. American Nurses Association
   Georgia Nurses Association
   Phi Kappa Phi

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

8. I have over 25 years' experience in working toward common goals in academic settings (nursing education programs), as well as on a wide array of committees for various organizations. I have been in nursing for 28 years and have dealt with numerous issues and concerns affecting the profession from an educational as well as practice prospective. One of my major strengths is consensus-building.

   For the next two years, the National Council will be focusing on the implementation and evaluation of multistate regulation (interstate compacts), computerized clinical simulation testing and promoting collaboration between nursing education programs and accrediting agencies.

Committee on Nominations: Area IV

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

2. Board Member, Maine State Board of Nursing

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

4. University of Maine, Educational Leadership, EdD, 1996
   Boston University, Maternal - Child Health Nursing, MS, 1975
   Boston College, Nursing, BSN, 1967

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

6. National League for Nursing
   Sigma Theta Tau, Kappa Zeta Chapter

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

8. This year as a member of the Committee on Nominations, I was actively involved in sharing the value of participation on the National Council with particular emphasis on the Area IV membership. I believe that I effectively communicated to the membership with the goal of establishing a slate of candidates. If given the opportunity, I will continue the marketing process initiated this year. I would appreciate this opportunity.

   Multistate licensure and computerized clinical simulation testing (CST®) as a component of the NCLEX-RN® examination will be the priorities for the National Council.

Committee on Nominations: Area IV

1. **Maureen McGarry, Rhode Island, Area IV**

2. Vice-President, Rhode Island Board of Nurse Registration and Nursing Education

3. Community College of Rhode Island, Lincoln, Rhode Island

4. University of Connecticut, Professional Higher Education, PhD, 1992
   Rhode Island College, Counselor ED, CAGS, 1983
   University of Rhode Island, Nursing Administration, MSN, 1981
   Rhode Island College, Counselor ED, BS, 1971
   St. Joseph Hospital School of Nursing, Nursing, Diploma, 1965

5. Massachusetts/Rhode Island League for Nursing
   Rhode Island Representative on the Board Nominating Committee, 1983-1985
   National League for Nursing
   Visions II Project, Task Force Member, 1995-1998
   Rhode Island Board of Nurse Registration and Nursing Education
   Secretary, 1997-present
   Member, 1995-present, 1977-1982
   President, 1996-1997
   Vice-President, 1997-1998, 1979-1982

Rhode Island State Nurses Association
Cabinet on Nursing Education
Co-Chair, 1997-1998
Member, 1985-1990, 1992-1995, 1998-present

6. American Nurses Association
National League for Nursing
National Board of Certified Counselors
National Association of Associate Degree Nursing
Phi Lambda Delta
Sigma Theta Tau, Delta Upsilon Chapter

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

8. I believe I would bring the perspective of a seasoned nurse (34 years), nurse educator previously in diploma nursing and currently with associate degree and practical nursing education. Having served as a board of nursing member at two separate times, I have knowledge of the regulatory aspects, issues facing regulators, nursing educators and nurses in practice. Further, I strongly feel that Area IV, including New England, needs representation on a national basis and am ready and prepared to serve in this important function.

Instructions for Using the Computerized Voting System

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

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

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

STEP ONE: Check In

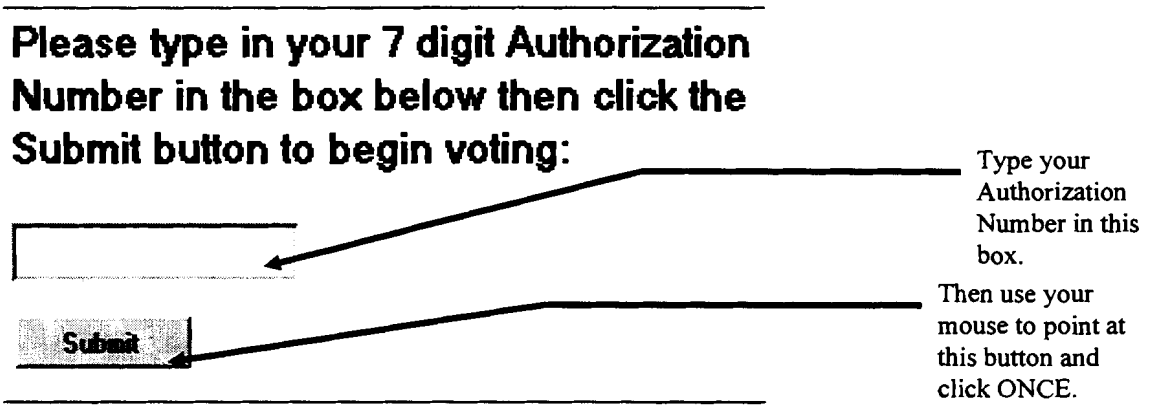
When you arrive at the voting area Saturday morning, proceed to your Area representative for check in. Upon inspection of your credentials, you will be given a color-coded slip of paper containing a voting Authorization Number. The computer program uses this secret number to prevent vote tampering and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

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

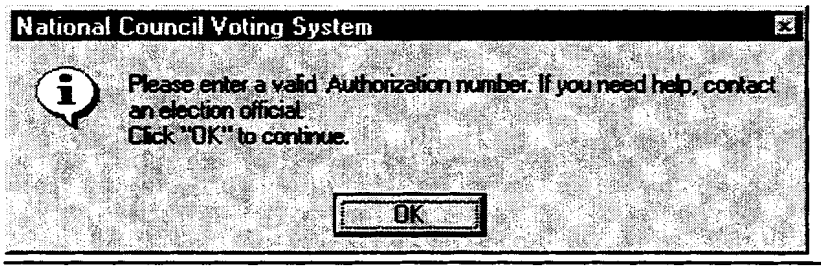
Once you have your Authorization Number(s), you will be escorted to a voting terminal to cast your ballot(s).

STEP TWO: The Voting Terminal

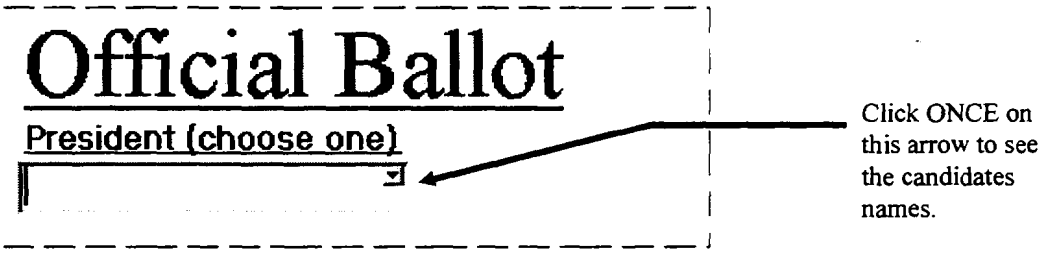
At the voting terminal, you will see the opening screen:



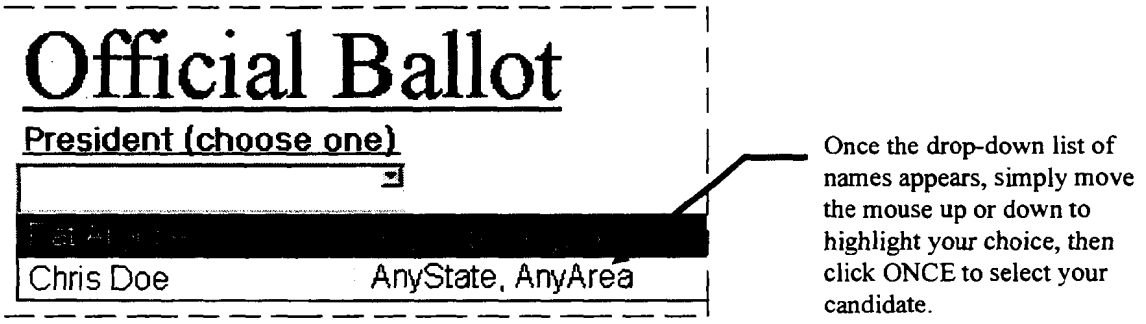
If you enter an invalid number, the system will not let you continue. You will see the following screen:



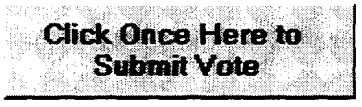
If you entered a valid Authorization Number, then the Official Ballot screen will appear automatically. Here is a portion of that screen:



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



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



STEP THREE: Check Out

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

YOU'RE DONE!

Sample Ballot

Election Voting System: Sample Ballot

Area Director (choose one) ***Note that in the actual election voting system, only the candidates for Area Director for YOUR Area will appear on the ballot.***

[Single-click Here for Drop-down List]

Director-at-Large (two positions): (choose one per box, only one vote per candidate)

[Single-click Here for Drop-down List]

[Single-click Here for Drop-down List]

Committee on Nominations: (choose one from EACH of the 4 boxes)

Area I: [Single-click Here for Drop-down List]

Area II: [Single-click Here for Drop-down List]

Area III: [Single-click Here for Drop-down List]

Area IV: [Single-click Here for Drop-down List]

Before submitting, make sure you've considered all of the available boxes. You are not required to vote for each office, but the actual election voting system will warn you if any boxes are left empty.

Report of the President

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

I warmly welcome you to the twentieth annual meeting of the National Council of State Boards of Nursing. This year's agenda includes time set aside to celebrate and reflect on the history of the establishment of the National Council in 1978, and to recognize the dedicated Member Boards, volunteers and staff who have been so instrumental in contributing to the integrity and growth of the organization since that time.

In the National Council publication *From An Idea to an Organization*, which represents the history of the founding of the National Council, Elaine Ellibee, first president, writes: "Each of you associated with a board of nursing holds a responsibility for the public health, safety and welfare. I commend you for holding that trust high, above all other consideration of forces or potential gain, and carrying forward the vision which came to creation when the National Council of State Boards of Nursing was born, June 5, 1978." It has been clearly evident since the founding date that this unique charge of regulatory boards related to public protection has been held high by the standard bearing Member Boards, and has permeated all our goals as an organization

Our efforts to be alive, survive and thrive as an organization have continued during this past year through the organizational leadership program spearheaded by the Board of Directors. At the Board retreat in November 1997, Jamie Orlikoff facilitated a meeting and provided consultation regarding strategic planning and decision-making for the National Council. He guided Board members and leadership staff through an analysis of environmental opportunities and threats for the organization which led to determination of strategies to address identified significant issues before Member Boards. At the February 1998 Board meeting, the Board of Directors approved strategic initiatives and outcomes for decision-making related to six key issues of concern to Member Boards. Through identifying and responding to targeted environmental issues, the Board is leading the National Council in achieving its mission, with the anticipated result that National Council will continue to be a dynamic, learning organization.

The National Council of State Boards of Nursing, made up of the Member Boards, acts and counsels together, jurisdiction to jurisdiction, Area to Area, or collectively as a whole, to synergistically lead in the development and implementation of sound regulatory initiatives. In doing so, the National Council therefore carries out its mission, and stands solidly behind its belief in the promotion of safe, effective nursing practice in the interest of protecting public health and welfare.

We are positioned to optimistically view the new curves ahead of us, ready to leap beyond the danger zones, and evade the death which awaits those who ignore strategic planning and decision-making. Just like the visionaries of 1978, we must be willing to take the risks in changing the face of regulation to reflect the current needs of Member Boards and the public we purport to protect.

I want to again sincerely thank the many volunteers who have participated on committees, task forces, focus groups, panels and in other capacities during the past year. Similarly, I owe a debt of gratitude to the staff of the National Council who also spent countless hours addressing regulatory issues and providing expert guidance to Member Boards. And, of course, I am deeply grateful to the Board of Directors who have been supportive of me and indispensable to me in my role as President. They were always well-prepared for Board meetings, having done their reading, and were ready to discuss and take action on the many agenda items.

Collectively, we have again addressed multiple issues since the last annual meeting in Chicago, including multistate regulation and the mutual recognition model, regulatory outcomes, implementation of the revised *NCLEX-RN® Test Plan* and passing standard, proposed revision of the *NCLEX-PN® Test Plan*, computerized clinical simulation testing (CST®) pilot study, nursing education program approval/accreditation, advanced nursing practice, and a host of other trends and priorities for nursing regulation.

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

I also represented the National Council at other meetings such as the Council on Licensure, Enforcement and Regulation (CLEAR) Annual Meeting and the American Association of Colleges of Nursing Fall Semi-Annual Meeting.

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

Twenty years of synergistic efforts and accomplishments on the part of the National Council is evidence that the whole is definitely greater than the sum of its parts. I am proud to have been one of those parts leading the organization in the role of president, now looking back on the past two years, but also looking ahead enthusiastically to the world of regulation that will be.

Thank you for the opportunity to serve you as president of the National Council. It has been most gratifying to lead the National Council during such controversial and challenging times for regulation, and to collegially address the seemingly endless issues facing us as an organization made up of Member Boards. May the next twenty years be as rewarding and productive as those which have gone before us.

Report of the Examination Committee

Committee Members

Lynn Norman, AL, Area III, *Chair*
Christine Alichnie, PA, Area IV
Karen Brumley, CO, Area I
Julie Campbell-Warnock, CA-RN, Area I *(until April 1998)*
Cora Clay, TX-VN, Area III
Madelon Cook, OR, Area I
Sheila Exstrom, NE, Area II
Deborah Feldman, MD, Area IV
Sandra MacKenzie, MN, Area II
Carol McGuire, KY, Area III
Anita Ristau, VT, Area IV
Lori Scheidt, MO, Area II

Item Review Subcommittee Members

JoAnn Allison, NH, Area IV
Leona Beezley, KS, Area II
Teresa Bello-Jones, CA-VN, Area I
Charlene Carafelli, OH, Area II
Jill Degregorio, RI, Area IV
Nancy Durrett, VA, Area III
Carol Parsons Miller, WV-PN, Area II
Cynthia (Pat) Purvis, SC, Area III
Marcia Rachel, MS, Area III
Dorothy Ramsey, NY, Area IV
Teresa Rock, UT, Area I
Dianne Wickham, MT, Area I

Staff

Brian Bontempo, MA, *Acting Psychometrician*
Barbara Halsey, MBA, *NCLEX® Administration Manager*
Anne Wendt, PhD, RN, *NCLEX® Content Manager*
Anthony Zara, PhD, *Director of Testing*

Relationship to Organization Plan

Goal I.....Provide Member Boards with examinations and standards for licensure and credentialing.
Objective B.....Provide examinations that are based on current accepted psychometric principles and legal considerations.

Recommendation to the Delegate Assembly

1. **Adopt the proposed revisions of the *NCLEX-PN® Test Plan* (Attachment A).**

Rationale

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

Background

A subcommittee of members of the Examination Committee researched the work of nursing theorists such as Benner and Watson, and reviewed other licensure examination blueprints to investigate alternative conceptual frameworks as part of the overall evaluation of the *NCLEX-PN® Test Plan.*

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

Integration of "Nursing Process" is recommended in order to emphasize its importance in all areas of the *NCLEX-PN® Test Plan,* reduce the potential for redundant content, allow for flexible terminology in a rapidly changing health care environment, and clarify the content dimensions of the *NCLEX-PN® Test Plan.* "Nursing Process" remains as a key organizing concept, only in an integrated fashion rather than as a specific content dimension. Re-organization and re-sequencing of the "Client Needs" categories and subcategories are recommended to provide conceptual clarity and improve item coding.

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

The draft revised *NCLEX-PN® Test Plan* was sent to all Member Boards in October 1997 for first comment on the proposed changes. This input was considered by the Examination Committee at its January 1998 meeting, and a subsequent draft revised *NCLEX-PN® Test Plan* was again sent to all Member Boards for comment and discussion at Area Meetings. The final draft of the proposed revised *NCLEX-PN® Test Plan* was developed by the committee at its April 1998 meeting.

After consulting with Chauncey and legal counsel, the committee determined that the new *NCLEX-PN® Test Plan* could be implemented no sooner than April 1999, in conjunction with the regularly scheduled item pool rotation. This proposed timeline enables the National Council, Member Boards and Chauncey to effectively plan for and communicate the *NCLEX-PN® Test Plan* changes to all appropriate individuals and agencies, and allows a Panel of Judges to use the newly approved *NCLEX-PN® Test Plan* in its criterion-referenced standard setting process scheduled for October 1998. Any changes in the PN passing standard would be implemented coincident with the *NCLEX-PN® Test Plan* change. The proposed timeline allows information about a new PN passing standard to be communicated to all the relevant individuals and agencies. Finally, this timeline is consistent with the National Council's goal to decrease the length of time from Delegate Assembly approval to new *NCLEX-PN® Test Plan* implementation, thus enhancing the fidelity between the examination and current nursing practice as depicted in the most recent incumbent PN job analysis.

Highlights of Activities

■ Developed and Monitored NCLEX® Examination Policies and Procedures

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

■ Conducted Committee Item Review Sessions

In the interest of maintaining consistency in the manner in which NCLEX examination items are reviewed before becoming operational, the committee continued to review new items only after they have been tried out and have accompanying statistics. To enhance consistency, two Examination Committee members led the Item Review Subcommittee meetings. Issues of revisions to Operational Definitions, Detailed Test Plans, and Guidelines for Currency Review are referred back to the Examination Committee for final action to maintain the consistency of the process. This year, each new tryout item and at least 25 percent of the base pool were reviewed over the course of

four meetings. The use of the Examination Committee Item Review Subcommittee to assist in the item review process has significantly diminished the heavy item review workload of the Examination Committee itself.

■ **Monitored Item Production**

The Chauncey Group's item development plan to meet the contractual goal of three optimal item pools has continued to be a chief concern of the committee. In analyzing the rate of new item production and survival as well as the attrition rate of items from the base pool (items are removed primarily due to currency issues) the net gain in total NCLEX examination items has been carefully scrutinized by the committee. Chauncey increased the number of traditional item writing sessions held each year and made changes in the structure of the item writing workshops to increase the time available for writing. In addition, the implementation of supplemental strategies (which included initiating item development at home by experienced item writers, development of a "fast track" item writer variation, rewriting of committee-flagged items by test service staff, "cloning" of items and development of graphic items) has been monitored, and outcomes evaluated on an ongoing basis by the committee. The committee also continued to monitor implementation of a new item database, the NCLEX Item Coding and Tracking (NICT) database, which allows for fine-grained analyses of the item content, coding, difficulty, history, statistical performance, validations, and other variables for each item within the entire master pool.

■ **Evaluated Item Development Process and Progress**

The committee evaluated Chauncey Item Writing and Item Review sessions for process and productivity. Committee representatives attended and monitored the item development sessions whenever possible in order to provide feedback to the committee and to Chauncey.

RN ITEM DEVELOPMENT PRODUCTIVITY COMPARISON

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed	Items Approved	Survival Rate
April 95 - March 96	6	74	1,791	6	1,523	1,355	89%
April 96 - March 97	10	134	3,815	11	3,225	2,952	92%
April 97 - March 98	8	90	2,929	11	3,326*	3,252	97.7%

PN/VN ITEM DEVELOPMENT PRODUCTIVITY COMPARISON

Year	Writing Sessions	Item Writers	Items Produced	Review Sessions	Items Reviewed	Items Approved	Survival Rate
April 95 - March 96	6	52	1,564	5	1,112	1,026	92%
April 96 - March 97	8	92	2,503	8	2,417	2,001	83%
April 97 - March 98	7	83	2,362	7	2,439*	2,419	99%

**Note: Items reviewed from April 1997 to March 1998 included 397 RN items and 77 PN items that were written during the previous year.*

To facilitate the item development process as well as assist candidates preparing for the NCLEX examination, the committee revised and approved the *Guidelines for NCLEX-PN® Item Writers* and the *Detailed Test Plan for the NCLEX-RN® Examination* (previously known as *Guidelines for NCLEX-RN® Item Writers*).

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

The Examination Committee met with the research department at each of its regularly scheduled meetings to provide input into the *NCLEX-PN® Test Plan* development process. The committee received periodic updates on pending job analyses and offered ideas for enhancements to the quarterly job analysis questionnaire.

■ **Monitored Examination Analyses**

The committee periodically evaluated the NCLEX examination by reviewing reports on item and candidate performance, including item exposure rates, overlap among the items administered to different candidates, non-test-

plan content coverage, questioned or challenged items, precision of competence estimates and pass/fail decisions, and passing rates and examination-completion rates for many subgroups of candidates. These reports support that the NCLEX examinations meet National Council and industry-wide quality standards. See Attachment B for The Chauncey Group's test service report.

- **Monitored *NCLEX-RN® Test Plan* Implementation**

Shortly after the new *NCLEX-RN® Test Plan* entered the field, an error in the computer algorithm was discovered. Testing was shut down immediately until further investigation was conducted and the problem was fixed. Testing was suspended for two days, during which time the problem was resolved and the affected candidates' results were found to be valid. Procedures are being revised to detect and prevent these kinds of errors from occurring in the future.

- **Revised the NCLEX-RN® Candidate Diagnostic Profile**

The committee reviewed the format of the diagnostic profile and determined that the explanation of candidate performance by test plan area could be improved. The format was changed from a graphic representation to textual explanations and moved to the back page of the diagnostic profile. The initial candidate and Member Board response to the new format has been very positive.

- **Monitored the Development of Two Parallel Operational Item Pools**

The committee continued to monitor the ongoing process for annually configuring and implementing two parallel RN and PN item pools. The committee reviewed and approved Chauncey's plan for configuring the item pools, incorporating the use of the NICT database item codes for splitting the pools. Since the number of items coded for each pool configuration variable regularly changes, the committee provided direction as to how to use the NICT codes for identifying the variables to be used to split the pools. The committee will review these variables prior to each pool configuration. After the pools are configured, the committee will be able to review the pool configuration reports and face validity reports enabling the committee to monitor the pool configuration process.

The committee determined that both the RN and PN pools should continue to be rotated semi-annually for the period of April 1998 through March 1999, as they were during the first two years of computerized adaptive testing administration of the NCLEX examination.

- **Directed Member Board Office System (MBOS) Fixes and Enhancements**

The committee continued to monitor implementation of the MBOS enhancements approved in fiscal year 1996 which were anticipated to be delivered to Member Board offices in April 1997. Several software development issues caused delays in the release of the updated MBOS to Member Boards. The enhancements have been programmed and four boards of nursing are currently Beta testing the new MBOS software and a new version of expEDIte/PC (called Expedite Manager). The new MBOS and Expedite Manager is expected to be released to all Member Boards over a period of four to six weeks starting in June 1998.

- **Monitored Procedures for Candidate Tracking; Candidate Matching Algorithm**

The Examination Committee continues to monitor the status and effectiveness of the candidate matching algorithm. Each week, Chauncey conducts a scan of the database, using additional matching criteria, to detect records received during the past week that appear to match a previously received record, yet did not combine during initial processing. Any suspect cases are resolved by staff. In addition, a full database audit is conducted on an annual basis to detect any additional suspect cases and monitor the efficacy of the weekly process.

- **Monitored Electronic Irregularity Reports and Site Compliance**

Examination Committee members reviewed summary reports on electronic irregularity reports (EIR) and carefully monitored reported incidences of hardware, software, scheduling or other customer service problems in an attempt to discern any evidence of trending. The committee continued to review site compliance reports filed by Member Boards and National Council staff to determine compliance with existing policies, procedures and security requirements at all Sylvan Technology Centers and Educational Testing Service institutional testing centers. Reported violations of policies, procedures, or security measures require follow-up and resolution of Sylvan or Chauncey, and resolutions are monitored by the Examination Committee.

Committee members also monitor investigations into potential security breaches, review final reports from the ETS Office of Test Security and make determinations as to the security of the NCLEX examination administrations and item pools. No incident during the past year was found to compromise the NCLEX examination item pools.

- **Monitored Compliance with the Americans with Disabilities Act (ADA)**

All approved requests for ADA modifications are routed to a Special Conditions Coordinator at the Sylvan Candidates Services Call Center (CSCC) in order to ensure candidates are scheduled in a timely manner and that all approved accommodations are provided. At the 1997 Delegate Assembly, the delegates approved a change in the state contracts regarding Member Board involvement in selecting readers for candidates approved with special accommodations. Since that time, only one Member Board which previously had not furnished such a list has done so. Sylvan continues to request assistance from Member Boards in providing lists of approved readers.

- **30/45 Day Scheduling Compliance**

The Examination Committee, Board of Directors and National Council staff monitor compliance with the 30/45 day scheduling rule. Sylvan experienced some capacity issues at specific sites during the 1997 NCLEX® examination peak testing season, forcing some candidates to schedule their appointments outside of the 30/45 day compliance period. Following review of causes for this unusual situation, Sylvan has implemented additional tracking procedures at the Customer Service Call Center (CSCC).

Future Activities

In order to move toward the creation of three targeted NCLEX-RN and NCLEX-PN examination item pools, large-scale item development will continue throughout FY99. In addition, the Examination Committee will continue to work with the test service towards maximizing the pretest pools so that newly written items can pass through pretesting at a quicker rate. In order to improve the examination process for candidates who run out of time, the Examination Committee will continue to work with the test services to investigate the feasibility of extending the time limit. The Examination Committee will continue to encourage the test service to develop software modifications for psychometric, content, and administration issues. Any problems associated with examination administration will continue to be a high priority for the Examination Committee, and regularly scheduled assessments of the efficacy of administration and the quality of customer service will be conducted. The Examination Committee will continue to request the test services to provide the creative solutions/resolutions to meet the daily challenges and opportunities related to the administration of the NCLEX examinations.

Meeting Dates

- September 29 - October 2, 1997
- October 2-5, 1997 *(Item Review Subcommittee)*
- December 1, 1997 *(Examination Committee telephone conference call)*
- December 2-6, 1997 *(Item Review Subcommittee)*
- January 20-22, 1998
- January 22-25, 1998 *(Item Review Subcommittee)*
- April 21-23, 1998
- May 18, 1998 *(Examination Committee telephone conference call)*
- May 20, 1998 *(Examination Committee telephone conference call)*
- June 15-18, 1998 *(Item Review Subcommittee)*
- July 31, 1998 *(Examination Committee telephone conference call)*

Recommendations to the Delegate Assembly

1. **Adopt the proposed revisions of the *NCLEX-PN® Test Plan* (Attachment A).**

Fiscal Impact

There is no extraordinary fiscal impact for implementing a new test plan beyond the normal budgeting necessary for sufficient NCLEX examination staffing and monitoring.

Attachments

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

B ..... Annual Report of The Chauncey Group International and Sylvan Prometric, *page 15*

Attachment A

Test Plan for the National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-PN®)

DRAFT 4/98

INTRODUCTION

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

The initial step in developing the NCLEX-PN examination is the preparation of a test plan to guide the selection of content and behaviors to be tested. In this plan, provision is made for an examination reflecting entry-level nursing practice as identified in the *1997 Job Analysis Study of Newly Licensed Entry-Level Practical/Vocational Nurses* (Yocom, 1997). The activities identified in this study were analyzed in relation to the frequency of their performance, their impact on maintaining client safety and the settings where performed. This analysis guided the development of a framework that delineates specific client needs, and integrated concepts and processes for entry-level practice. The variations in each jurisdiction's laws and regulations guide the development of the test plan.

The test plan derived from this framework provides a concise summary of the content and scope of the examination. The plan also serves as a guide for both examination development and candidate preparation. Based on the test plan, the NCLEX-PN examination reflects the knowledge, skills and abilities essential for the practical/vocational nurse to meet the needs of clients requiring the promotion, maintenance and restoration of health. The following sections describe beliefs about nursing and clients that are integral to the examination, the cognitive abilities that will be tested in the examination, and the specific components of the *NCLEX-PN® Test Plan.*

BELIEFS

Beliefs about people and nursing underlie the test plan. People are viewed as finite beings with varying capacities to function in society. They are unique individuals defining their own systems of daily living which reflect values, cultures, motives and lifestyles. Additionally, they are viewed as having the right to make decisions regarding their health care needs and participate in meeting those needs. The profession of nursing makes a unique contribution in helping clients (individuals or families/significant others) to achieve an optimal level of health in a variety of settings.

Nursing is an art and a science that integrates concepts from the liberal arts and biological, psychological and social sciences. The nature of nursing is dynamic and evolving. The goal of nursing in any setting is to promote health and assist individuals throughout the life span to attain an optimal level of functioning by responding to the needs, conditions or events that result from actual or potential health problems (American Nurses Association, 1995). The domain of nursing and the relevant knowledge, skills and abilities exist along a continuum and are organized and defined by professional and legal parameters.

The practical/vocational nurse "utilizes specialized knowledge and skills which meet the health needs of people in a variety of settings under the direction of qualified health professionals" (NFLPN, 1997). The practical/vocational nurse uses the nursing process to collect and organize relevant health care data and assist in the identification of the health needs/problems of clients throughout the clients' life span and in a variety of settings. The entry-level practical/vocational nurse, under appropriate supervision, provides competent care for clients with commonly occurring health problems having predictable outcomes. "Competency implies knowledge, understanding, and skills that transcend specific tasks and is guided by a commitment to ethical/legal principles" (NAPNES, 1997).

LEVELS OF COGNITIVE ABILITY

The NCLEX-PN examination consists of multiple-choice questions at the cognitive levels of knowledge, comprehension, application and analysis (Bloom et al., 1956).

TEST PLAN STRUCTURE

The framework of *Client Needs* was selected for the NCLEX-PN examination because it provides a universal structure for defining nursing actions and competencies for a variety of clients across a variety of settings and is congruent with state laws and statutes.

CLIENT NEEDS

Four major categories of *Client Needs* organize the content of the test plan. These client needs are further divided into subcategories that define the content contained within each of the four major *Client Needs* categories. These categories and subcategories are:

A. Safe, Effective Care Environment
1. Coordinated Care
2. Safety and Infection Control

B. Health Promotion and Maintenance
3. Growth and Development Through the Life Span
4. Prevention and Early Detection of Disease

C. Psychosocial Integrity
5. Coping and Adaptation
6. Psychosocial Adaptation

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

INTEGRATED CONCEPTS AND PROCESSES

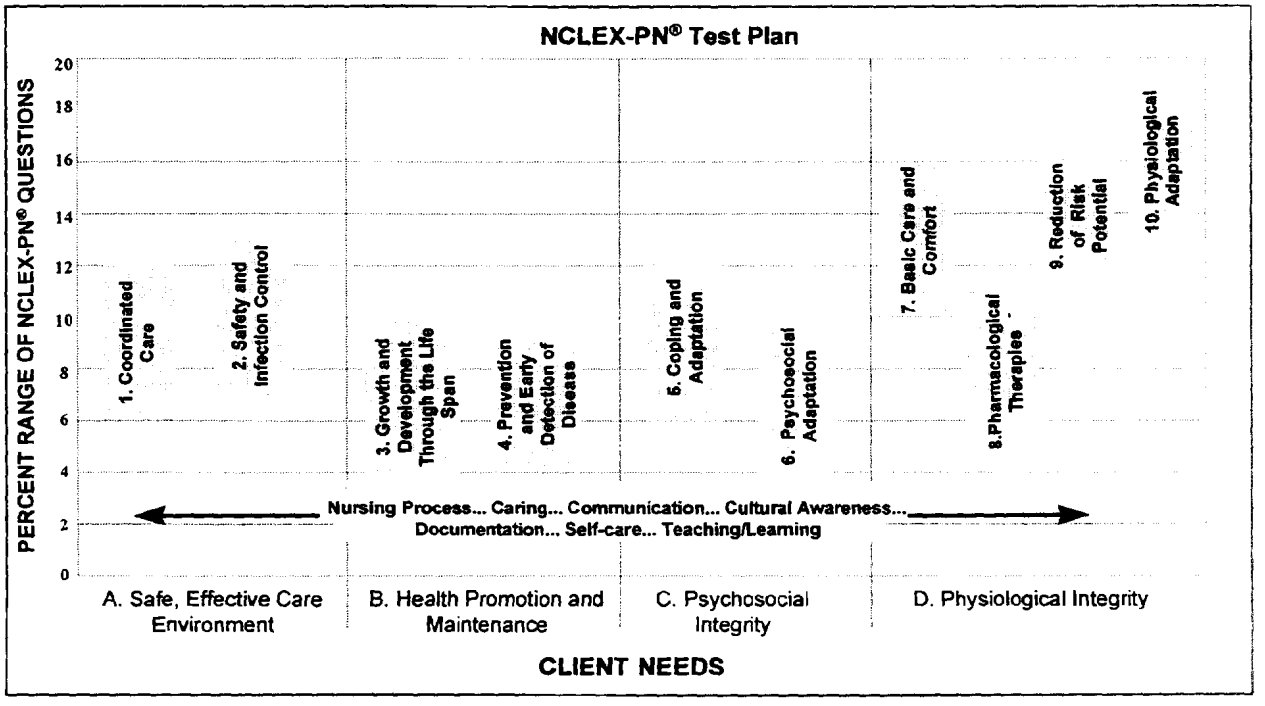
Concepts, principles and processes are integrated throughout the four major categories of *Client Needs* because they are fundamental to the practice of nursing. The integrated concepts, principles and processes include:

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

DISTRIBUTION OF CONTENT

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

CATEGORIES	PERCENTAGE OF TEST QUESTIONS
A. Safe, Effective Care Environment	
1. Coordinated Care	**6-12%**
2. Safety and Infection Control	**7-13%**
B. Health Promotion and Maintenance	
3. Growth and Development Through the Life Span	**4-10%**
4. Prevention and Early Detection of Disease	**4-10%**
C. Psychosocial Integrity	
5. Coping and Adaptation	**6-12%**
6. Psychosocial Adaptation	**4-10%**
D. Physiological Integrity	
7. Basic Care and Comfort	**10-16%**
8. Pharmacological Therapies	**5-11%**
9. Reduction of Risk Potential	**11-17%**
10. Physiological Adaptation	**13-19%**



OVERVIEW OF CONTENT

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

A. Safe, Effective Care Environment

1. *Coordinated Care* - The practical/vocational nurse collaborates with other health care team members to facilitate effective client care.

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

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

2. *Safety and Infection Control* - The practical/vocational nurse protects clients and health care personnel from environmental hazards.

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

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

B. Health Promotion and Maintenance

3. *Growth and Development Through the Life Span* - The practical/vocational nurse assists the client and significant others in the normal expected stages of growth and development from conception through advanced old age.

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

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

4. *Prevention and Early Detection of Disease* - The practical/vocational nurse provides client care related to prevention and early detection of health problems.

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

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

C. Psychosocial Integrity

5. *Coping and Adaptation* - The practical/vocational nurse promotes the client's ability to cope, adapt and/or problem solve situations related to illnesses or stressful events.

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

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

6. *Psychosocial Adaptation* - The practical/vocational nurse participates in providing care for clients with acute or chronic mental illness.

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

   - Abuse and Neglect
   - Behavioral Interventions
   - Chemical Dependency
   - Crisis Intervention
   - Mental Illness Concepts
   - Therapeutic Environment

D. Physiological Integrity

7. *Basic Care and Comfort* - The practical/vocational nurse provides comfort and assistance in the performance of activities of daily living.

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

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

8. *Pharmacological Therapies*- The practical/vocational nurse provides care related to the administration of medications and monitors clients receiving parenteral therapies.

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

   - Adverse Effects
   - Expected Effects
   - Medication Administration
   - Pharmacological Actions
   - Pharmacological Agents
   - Side Effects

9. *Reduction of Risk Potential* - The practical/vocational nurse reduces the client's potential for developing complications or health problems related to treatments, procedures or existing conditions.

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

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

10. *Physiological Adaptation* - The practical/vocational nurse participates in providing care to clients with acute, chronic or life-threatening physical health conditions.

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

    - Alterations in Body Systems
    - Basic Pathophysiology
    - Fluid and Electrolyte Imbalance
    - Medical Emergencies
    - Radiation Therapy
    - Respiratory Care
    - Unexpected Response to Therapies

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Attachment B

Annual Report of The Chauncey Group International and Sylvan Prometric

Test Development Activities

- **Item writing workshops**

For the NCLEX-RN examination, there were eight item writing workshops held between April 1997 and March 1998. A total of 90 item writers, representing all four major practice areas, developed 2,929 items. For the NCLEX-PN examination, seven sessions were held with a total of 83 item writers producing 2,362 items.

Members of the Princeton-based and Atlanta-based Chauncey/ETS test development staff conducted the sessions. Item writers represented all four National Council geographic regions at each workshop. Members of the National Council Examination Committee and National Council staff also audited several of the workshops.

- **Item review meetings**

The 11 NCLEX-RN Item Review Panels that met between May 1997 and March 1998 approved 3,252 (97.7%) of the 3,326 items reviewed, while seven NCLEX-PN Item Review Panels that met between April 1997 and March 1998 approved 2,419 (99%) of the 2,439 items reviewed. All of the meetings were held either at the Princeton site or the Atlanta site. Each Item Review Panel consisted of participants who represented each of the four National Council geographic areas. Examination Committee members and National Council staff also audited these meetings.

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

Between May 1997 and December 1997, the Examination Committee approved 1,310 NCLEX-RN and 564 NCLEX-PN tryout items for inclusion in a future operational pool. At the May 1997, October 1997, December 1997 and January 1998 meetings, the Examination Committee reviewed base pool items for currency. The committee approved a total of 1,020 (89.9%) of the 1,134 NCLEX-RN and 566 (92.3%) of the 613 NCLEX-PN items for continued use in the operational pools.

- **Targeting item difficulty**

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

- **Monitoring**

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

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

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

- **Construction of 1998 CAT Pools**

Prior to configuring the April 1998 CAT pools, a master pool of available items was evaluated. For the NCLEX-RN examination, the master pool consists of approximately 6,600 total items, an increase of over 1,100 items from the previous year. For the NCLEX-PN examination, the master pool consists of approximately 4,550 total items, an increase of 400 items from the previous year.

- **Progress of pools**

At each meeting of the Examination Committee, Chauncey staff presents an item pool status report on both the NCLEX-RN and the NCLEX-PN master pools and on the progress towards meeting the demands of the optimal item pools. National Council and Chauncey staffs have been working together to evaluate the entire item development process and to propose modifications to the current procedures.

- **Face validity reviews**

The Chauncey test development staff routinely review actual and simulated examinations based on criteria established by the Examination Committee. The criteria include non-test plan content areas, such as maternal/child, infection control, medications, pediatrics, and geriatrics, which are not controlled by the computerized adaptive testing selection algorithm. The review also includes the identification of items based on similar content within an actual examination.

The actual candidate and simulated CAT examinations reviewed for face validity are generated at five ability levels: low ability; moderately low ability; borderline (pass/fail) ability; moderately high ability; and high ability.

The face validity review of the simulated and actual examinations for the April and October 1997 operational pools indicated that some content areas overlap which is most apparent in the longer exams.

- **Sensitivity reviews**

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

To address test-level concerns such as gender balance and juxtaposition of items, sensitivity reviews are done on the simulated CAT examinations generated for the respective CAT pools. The review of the October 1997 and the April 1998 operational pools indicated that the pools are generally in accordance with ETS sensitivity guidelines, which Chauncey uses. As the Examination Committee proceeds with its planned systematic review of the existing pool, these sensitivity issues can be easily resolved as editorial changes are made to address these concerns.

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

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

DIF statistics are computed comparing the performance of males with females and of Whites with other ethnic/focal groups: Blacks, Hispanics, Asian Indians, Asian Others, Native Americans, and Pacific Islanders. Items containing moderate to large DIF are reviewed at a DIF Review Panel Meeting.

The sources of the items for review at the July 1997 meeting were the October 1996 operational pools and the October 1996 and January 1997 pretest pools. The panel reviewed a total of 82 RN and 94 PN items from the operational pools and 25 RN and 48 PN items from the pretest pools. The panel recommended the referral of six RN and four PN items from the operational pools to the Examination Committee for review and disposition.

The sources of the items for review at the January 1998 meeting were the April 1997 operational pools and the April 1997 and July 1997 pretest pools. The panel reviewed a total of 117 RN and 98 PN items from the April 1997

operational pools and six RN and three PN items from the tryout pools. The panel recommended the referral of five RN and two PN items from the operational pools and one RN item from the pretest pools to the Examination Committee for review and disposition.

The reasons for referral included idiomatic use of language, assumptions regarding the nuclear family and dominant culture, and judgments related to "role-playing" by the nurse in hypothetical situations. The Examination Committee reviewed the items from the July 1997 DIF Review Panel meeting at the October 1997 meeting and the items from the January 1998 DIF Review Panel meeting at its January 1998 meeting. Items were approved for reuse in the operational pools, put on hold for revising, or removed from the pool.

- **Readability levels of CAT pools**

The Fry method of determining readability levels was used to calculate the reading levels of the NCLEX-RN and NCLEX-PN operational pools for October 1997 and April 1998. This method calculates readability based on non-medical terminology. According the Fry index, the estimated reading levels of the October 1997 and April 1998 RN operational pools are 6.5 and 5.9 respectively, and the estimated reading levels of the October 1997 and April 1998 PN operational pools are 6.4 and 6.4 respectively. These levels are below the National Council policy for a maximum reading level of tenth grade for the NCLEX-RN examination and of eighth grade for the NCLEX-PN examination.

- **Member Board reviews**

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

In the fall 1997, 13 Member Boards scheduled review sessions, while in the spring 1998, 14 Member Boards have scheduled reviews.

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

Operations Activities

- **Status of Sylvan Technology Centers**

As projected in the 1997 report, Sylvan continues to expand the size of the testing network. As of April 21, 1998, the NCLEX examination is administered in 249 labs housing 2,399 workstations located in the United States and its territories. The current size of the network represents an increase of 579 workstations and 39 testing labs since the 1997 report. Expansion of the network will continue through 1998 and NCLEX examination candidates will continue to be able to choose from an increasing variety of test sites and testing hours.

- **30/45-day compliance**

Sylvan experienced some capacity issues at specific sites during the 1997 NCLEX examination peak testing season, forcing some candidates to schedule their appointments outside of the 30/45 day compliance period. In most cases, capacity problems were quickly remedied by Sylvan Technology Center staff opening more hours. In a few cases, true design capacity was the cause of the problem and Sylvan opened temporary "non-NCLEX" examination sites. This action alleviated some of the non-NCLEX examination demand until additional permanent sites could be installed or overall volumes in the market decreased.

The peak 1997 statistics were analyzed to determine the cause of the anomaly and processes were enhanced to better track 30/45 day compliance on an ongoing daily basis. Since the enhanced processes were implemented, the number of non-compliant appointments has decreased from a few hundred in 1997 to less than a dozen per year. Sylvan is confident that we have appropriately planned for the 1998 peak NCLEX examination testing season.

- **Relocation of Sylvan's Candidate Services Call Center**

Sylvan's Candidate Services Call Center (CSCC), previously known as the NRC, was successfully relocated to a new, state-of-the-art 18,000 square foot facility over the 1997 Memorial Day weekend. Scheduling services to candidates through the 800 number were seamlessly resumed after the holiday weekend. Once the relocation was

completed, the CSCC staff tripled in size and the number of automated telephone scheduling lines was increased, allowing more than twice as many candidates to schedule, reschedule, confirm and cancel appointments simultaneously. Candidate hold times when calling the 800 number have averaged under 2 minutes since the relocation and complaints regarding long hold times as heard in previous years have been virtually eliminated.

- **Quality assurance update**

Sylvan Prometric's Quality of Service Delivery Department is responsible for ensuring candidates are delivered a level of service consistent with Sylvan's quality standards. All testing centers are monitored on an ongoing basis, using a variety of statistical data including the Examinee Exit Evaluation summaries (EEEs) and Electronic Irregularity Reports (EIRs). A quarterly report is provided to the Examination Committee at each business meeting detailing the status of any center appearing not to be performing up to standards.

- **Automated scheduling system**

From the summer of 1995 to the spring of 1998, NCLEX examination candidates were able to schedule, reschedule, cancel and confirm their testing appointments using an automated linear scheduling system. In early March 1998, an enhanced system with expanded phone lines was installed. Currently, 62 candidates may utilize the automated scheduling system simultaneously (double the number of lines previously available). The enhanced system allows candidates to loop back to the beginning of the script so they can perform more than one function during the same call, confirms each entry as soon as the candidate makes it, and provides detailed confirmation of the scheduled appointment including the confirmation number, appointment date, time and day of the week as well as the location of the center and the center number.

- **Sylvan Cares Program**

The "Sylvan Cares" Ombudsman Group was formed in late spring of 1997 and provides an 800 number for candidates who wish to ask questions or file a complaint about their testing session. All issues which cannot be resolved immediately continue to be investigated and responded to by the Program Management team.

- **MBOS Update**

An update for MBOS is being released as this report is being written. This update includes the ability to list candidates with appointments at a particular center, provides a summary by A, B, C, and D codes at the end of rosters of tested candidates, and prints the Transaction Activity Roster in alphabetical sequence of last name.

In addition, a new version of Expedite is being distributed. Expedite is the software that actually sends and receives transactions to and from the Chauncey Group via the Advantis network. This version of Expedite is a windows-based version, is supported by IBM and will be easier for Member Boards to use.

Both the enhanced MBOS and the new version of Expedite have been installed in four Member Boards. With the experience of those installations and the assistance of those Member Boards in suggesting improvements to the installation and set-up instructions, we will move the software out to the rest of the Member Boards.

In the meantime, MBOS is being further adapted to produce the revised NCLEX-RN® Diagnostic Profile and revised request for special conditions (ADA). As soon as those changes are finished and tested, they will be provided to the Member Boards.

- **RN Diagnostic Profile**

A new RN test plan and passing standard were introduced with the April 1, 1998, pool rotation. Simultaneously, a new Diagnostic Profile was implemented. This version of the Diagnostic Profile, designed by the National Council staff with the advice of a sub-committee of the Examination Committee, is a major change in the way candidates are provided with information about their performance on the examination. The graphics have been replaced with text, part of which is interspersed throughout the description of the test plan. This Diagnostic Profile has been introduced without any problems and the early indications are that it is being well received in the field.

As noted above, MBOS is being enhanced to produce the revised version of the Diagnostic Profile.

- **Miscoded Repeaters for Massachusetts Candidates**

In the fall of 1997, Chauncey became aware of an error in the coding of the repeater codes for many candidates from Massachusetts. LGR (the processor for the Massachusetts Board) sent Chauncey a file of corrections, which

has been applied. However, in working with the resulting files to rerun various reports, Chauncey became aware that some cases of errors in the repeater codes remained. The file was scanned for all cases of apparent repeater code errors and all cases that could be determined to be in error were corrected. As this report is being written, Chauncey is rerunning the last of the reports (Quarterly Reports aka Green Sheets, Technical Reports and Program Reports for Massachusetts) based on the corrected files.

■ **Telephone activity**

For the quarter ending March 1998, NCLEX examination customer service staff at The Chauncey Group International answered 30,883 calls, which is a 5 percent increase from the same quarter last year. Telephone registrations for the same quarter increased by 11 percent when compared to the same quarter last year, to a total of 5,640 records. Overall, phone activity on the candidate toll-free line has remained steady and predictable, with a slight increase in volumes of calls each year. Since February 1994, NCLEX examination customer service staff has answered 536,000 calls.

Registration and Testing Activities by Calendar Year					
Registration Type	**1994**	**1995**	**1996**	**1997**	**Total**
Scanned Registration	122,493	122,814	116,575	113,871	475,753
Telephone Registration	22,745	26,136	26,281	25,233	100,395
Electronic Registration	38,435	42,531	41,549	39,894	162,409
Other Registrations	3,017	3,322	3,541	2,475	12,355
Total Registrations	186,690	194,803	187,946	181,473	750,912
Test Sessions	155,111	189,057	181,726	174,793	700,687

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

We are now in our fifth year of production and are gearing up for the busiest period of the year. Once again, agency personnel are being trained to handle the increased telephone workload and clerical tasks that accompany increased registration and testing volumes beginning in May. Chauncey expects to have a team of 12 full-time agency workers as well as five regular operations staff positions to ensure a continuing smooth operational process. Operations staffers work closely with Sylvan and the National Council to research and resolve NCLEX candidate and nursing board issues. In addition operations personnel process requests to deliver tests to candidates with special needs, prepare and mail quarterly reports and education program reports, authorizations to test, results reports, publications, and respond to candidate phone calls and correspondence.

Since production start-up in April 1994 through March 1998, 736,700 test sessions have been delivered. The operations group has processed 500,100 scannable registration forms, 106,000 telephone registrations and over 169,000 electronic registration records.

■ **Customer satisfaction survey**

Each quarter, the effectiveness of our customer service staff is measured by randomly sampling NCLEX examination candidates who have called the toll-free customer service line. The intention of the survey is to measure the perceptions of our service, identify areas of weakness based on respondents' written comments and address any concerns with individual customer service representatives. For the quarter ending March 1998, all survey questions received 96 to 100 percent positive responses from the 91 candidates who returned the survey. Free form comments stressed the ease of the telephone registration service and the professionalism of the staff.

■ ***NCLEX® Program Reports***

Three annual cycles of the *NCLEX® Program Reports* have been produced and distributed to educational program subscribers. (The *NCLEX® Program Reports* replaced the CTB Summary Profiles in providing information to nursing programs about performance of their candidates on the NCLEX examination.) Each annual cycle covers two cumulative testing periods: April through September and October through March. Subscribers generally receive two reports each year unless all graduates test within one reporting cycle. Included in each report is information

about a program's passing rate for the testing cycle, as well as historical passing rate information, candidate performance on the *NCLEX® Test Plan* dimensions, a program's national and state rank, candidate performance on Categories of Human Functioning: Categories of Health Alterations; A Wellness/Illness Continuum; Stages of Maturity; and a Stress, Adaptation and Coping model.

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

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

■ **Summary of NCLEX examination results for the January through December 1997 testing period**

Tables 1 and 3 provide a technical summary of the NCLEX examination results from January through December 1997. In addition, summaries for the January through December 1996 testing interval are provided. Tables 1 and 2 present results for the NCLEX-RN examination, and Tables 3 and 4 present results for the NCLEX-PN examination. Summary statistics for the total group of candidates and the reference group of candidates (that is, first-time, U.S.-educated candidates) for 1997 are presented in Table 1 for the NCLEX-RN examination and in Table 3 for the NCLEX-PN examination. It should be noted that the data provided here are intended only to serve as a general summary. For more comprehensive information about the statistical characteristics of the NCLEX-RN examination and NCLEX-PN examination, the reader is referred to the NCLEX examination technical reports.

The following bullet points are **candidate** highlights of the 1997 testing year for the **NCLEX-RN examination**.

- Overall, 122,101 RN candidates tested during 1997, compared to 127,481 during the 1996 testing year. This represents a decrease of 4.2 percent.
- 89,693 first-time, U.S.-educated candidates tested, compared to 94,278 for the 1996 testing year, representing a decrease of 4.9 percent.
- The 1997 average passing rate for the total group was slightly lower than in 1996. The overall passing rate was 76.1 percent in 1997 compared to 76.5 percent in 1996, and the reference group passing rate was slightly lower in 1997 than in 1996 (87.7 percent in 1997 compared to 88.0 percent in 1996). The reference group includes all first-time and U.S.-educated candidates.
- 51.8 percent of the total group and 56.4 percent of the reference group ended their tests after a minimum of 75 items were administered. This is slightly lower than the 1996 testing year in which 52.6 percent of the total group and 57.1 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 13.4 percent for the total group and 11.4 percent for the reference group. This is slightly higher than last year's percentages (13.0 percent for the total group and 10.8 percent for the reference group).
- The average time needed to take the NCLEX-RN examination during the 1997 testing period was 2.19 hours (or two hours, 11 minutes) for the overall group, and 2.01 hours (or two hours, one minute) for the reference group.
- 34.4 percent of the candidates took the mandatory break that occurs after two hours of testing, and approximately 3.3 percent of the candidates chose to take the optional break.
- Overall, 3.3 percent of the total group, and 2.1 percent of the reference group, ran out of time before completing the test. These percentages of candidates timing out were slightly higher but comparable to the overall cumulative percentages for candidates during the 1996 testing year.

- In general, the NCLEX-RN examination summary statistics for the 1997 testing period indicated patterns that were similar to those observed for the 1996 testing period. These results provide continued evidence that the administration of the NCLEX-RN examination is psychometrically sound.

The following bullet points are **item-level** highlights of the 1997 testing year for the **NCLEX-RN examination**.

- The operational item statistics were consistent across the year and with the 1996 testing year. Point biserial correlations were generally in the range of 0.21-0.22 and model-data fit statistics were -0.01 to 0.26. Point biserial correlations are commonly used to assess item functioning. A positive point-biserial correlation value indicates that candidates with high abilities tend to correctly answer the item, and candidates with low abilities tend to incorrectly answer the item. A model-data fit statistic summarizes the difference between the observed proportion of the reference group answering an item correctly and what would be expected based on the estimated difficulty of the item. If the absolute value of the model-data fit statistic associated with the item is close to 0.0, this indicates good performance. Average item times were 59.8 to 65.0 seconds, indicating that candidates took slightly more than one minute, on average, to answer each question.
- Tryout item statistics indicated that 2,959 items were pretested during 1997, an increase of 1,105 items compared to 1996. The number of tryout items flagged (42.5 percent) was slightly higher than last year (36.6 percent), but was well within the expected range of percentage of tryout items flagged. The number of approved pretest items increased from 1,175 in 1996 to 1,701 in 1997.
- The mean B-Value of the RN tryout items for the 1997 year was -0.65, compared to -0.58 for the 1996 testing year. Each item has a B-value indicating the difficulty level of the item. The more difficult items generally have larger B-values.

The following bullet points are **candidate** highlights of the 1997 testing year for the **NCLEX-PN examination**.

- Overall, 52,692 PN candidates tested during 1997, compared to 54,245 during the 1996 testing year. This represents a decrease of 2.9 percent.
- 40,659 first-time, U.S.-educated candidates tested, compared to 43,689 for the 1996 testing year, representing a decrease of 6.9 percent.
- The 1997 average passing rate for the total group was slightly lower than in 1996. The overall passing rate was 80.2 percent in 1997 compared to 82.6 percent in 1996, while the reference group passing rate was slightly lower in 1997 than in 1996 (88.4 percent in 1997 compared to 90.5 percent in 1996). The reference group includes all first-time and U.S.-educated candidates.
- 56.1 percent of the total group and 59.2 percent of the reference group ended their tests after a minimum of 85 items were administered. This is slightly lower than the 1996 testing year in which 58.7 percent of the total group and 62.6 percent of the reference group took minimum length exams.
- The percentage of maximum length test takers was 16.8 percent for the total group and 14.6 percent for the reference group. This is slightly higher than last year's percentages (15.6 percent for the total group and 13.0 percent for the reference group).
- The average time needed to take the NCLEX-PN examination during the 1997 testing period was 2.07 hours (or two hours, 4 minutes) for the overall group, and 1.94 hours (or one hour, 56 minutes) for the reference group.
- 34.1 percent of the candidates took the mandatory break that occurs after two hours of testing, and approximately 1.8 percent of the candidates chose to take the optional break.
- Overall, 0.8 percent of the total group, and 0.5 percent of the reference group, ran out of time before completing the test. These percentages of candidates timing out are comparable to the 1996 testing year timing out percentages (0.7 percent for overall, 0.4 percent for reference group).
- In general, the NCLEX-PN examination summary statistics for the 1997 testing period indicated patterns that were similar to those observed for the 1996 testing period. These results provide continued evidence that the administration of the NCLEX-PN examination is psychometrically sound.

The following bullet points are **item-level** highlights of the 1997 testing year for the **NCLEX-PN examination.**

- The operational item statistics were consistent across the year and with the 1996 testing year. Point biserials correlations were 0.22 to 0.23 and model-data fit statistics were 0.06 to 0.20. Point biserial correlations are commonly used to assess item functioning. A positive point-biserial correlation value indicates that candidates with high abilities tend to correctly answer the item, and candidates with low abilities tend to incorrectly answer the item. A model-data fit statistic summarizes the difference between the observed proportion of the reference group answering an item correctly and what would be expected based on the estimated difficulty of the item. If the absolute value of the model-data fit statistic associated with the item is close to 0.0, this indicates good performance. Average item times were 57.2 to 60.4 seconds, indicating that candidates took slightly less than one minute, on average, to answer each question.
- Tryout item statistics indicated that 2,326 items were pretested during 1997, an increase of 764 items compared to 1996. The number of tryout items flagged (39.6 percent) was slightly higher than last year (33.0 percent), but was well within the expected range of percentage of tryout items flagged. The number of approved pretest items increased from 1,046 in 1996 to 1,406 in 1997.
- The mean B-Value of the PN tryout items for the 1997 year was -0.46 which was the same as last year. Each item has a B-value indicating the difficulty level of the item. The more difficult items generally have larger B-values.

References

Fry, E.B. (1972). Reading instruction for classroom and clinic. New York: McGraw-Hill.

Table 1
Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for the 1997 Testing Year

	Jan 97 - Mar 97		Apr 97 - Jun 97		Jul 97 - Sep 97		Oct 97 - Dec 97		Cumulative 1997	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	24,948	17,544	31,913	23,809	49,948	42,488	15,292	5,852	122,101	89,693
Percent Passing	73.3	87.4	79.1	90.5	80.9	87.5	59.1	78.3	76.1	87.7
Ave. # Items Taken	122.3	115.1	116.4	109.2	118.2	114.6	135.0	124.2	120.7	113.9
% Taking Min # Items	50.6	55.5	55.0	60.3	53.1	55.6	42.9	49.5	51.8	56.4
% Taking Max # Items	13.8	11.7	11.8	9.8	12.7	11.8	18.1	14.3	13.4	11.4
Ave. Test Time (Hrs)	2.23	2.04	2.11	1.91	2.11	2.01	2.55	2.28	2.19	2.01
% Taking Mand. Break	35.7	29.2	31.7	24.8	31.9	28.4	45.9	36.6	34.4	28.1
% Taking Opt. Break	3.4	1.9	2.9	1.7	2.8	2.2	5.4	3.3	3.3	2.1
% Timing Out	3.5	2.1	3.0	1.7	2.7	2.0	5.3	4.0	3.3	2.1

Table 2
Longitudinal Technical Summary for the NCLEX-RN® Examination
Group Statistics for the 1996 Testing Year

	Jan 96 - Mar 96		Apr 96 - Jun 96		Jul 96 - Sep 96		Oct 96- Dec 96		Cumulative 1996	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	25,794	18,110	36,968	29,048	49,049	41,223	15,670	5,897	127,481	94,278
Percent Passing	74.9	88.5	81.0	91.0	80.3	87.2	56.8	77.0	76.5	88.0
Ave. # Items Taken	119.4	111.7	114.4	107.9	118.6	115.1	138.1	127.7	119.9	113.0
% Taking Min # Items	53.0	58.3	56.5	60.7	53.3	55.6	40.5	46.8	52.6	57.1
% Taking Max # Items	12.7	10.4	11.1	9.1	12.7	11.6	18.9	15.3	13.0	10.8
Ave. Test Time (Hrs)	2.19	2.00	2.09	1.92	2.15	2.06	2.57	2.33	2.19	2.02
% Taking Mand. Break	34.9	28.2	31.6	26.2	34.0	30.8	48.0	39.9	35.2	29.5
% Taking Opt. Break	3.4	2.2	3.0	1.9	3.1	2.3	5.8	3.8	3.5	2.3
% Timing Out	3.0	1.9	2.6	1.5	2.8	2.1	5.7	4.2	3.1	2.0

Table 3
Longitudinal Technical Summary for the NCLEX-PN® Examination
Group Statistics for the 1997 Testing Year

	Jan 97 - Mar 97		Apr 97 - Jun 97		Jul 97 - Sep 97		Oct 97- Dec 97		Cumulative 1997	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	11,120	8,192	10,717	7,491	18,695	15,606	12,160	9,370	52,692	40,659
Percent Passing	80.3	89.9	77.1	87.3	84.0	89.9	77.1	85.3	80.2	88.4
Ave. # Items Taken	115.0	110.4	116.9	113.2	112.8	110.3	118.0	115.0	115.3	111.9
% Taking Min # Items	56.9	61.4	54.5	57.7	58.9	61.0	52.3	55.3	56.1	59.2
% Taking Max # Items	16.9	13.9	18.0	15.7	15.2	13.6	18.2	16.2	16.8	14.6
Ave. Test Time (Hrs)	2.05	1.88	2.13	1.97	1.97	1.87	2.20	2.07	2.07	1.94
% Taking Mand. Break	33.1	26.2	36.9	30.3	30.2	25.8	38.7	33.3	34.1	28.4
% Taking Opt. Break	1.8	0.9	1.9	1.0	1.5	0.1	2.3	1.5	1.8	0.7
% Timing Out	1.1	0.4	1.1	0.6	0.1	0.1	1.4	1.0	0.8	0.5

Table 4
Longitudinal Technical Summary for the NCLEX-PN® Examination
Group Statistics for the 1996 Testing Year

	Jan 96 - Mar 96		Apr 96 - Jun 96		Jul 96 - Sep 96		Oct 96- Dec 96		Cumulative 1996	
	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED	Overall	1st Time U.S. ED
Number Testing	10,866	8,157	11,319	8,613	19,555	16,877	12,505	10,042	54,245	43,689
Percent Passing	81.5	91.4	79.6	89.3	86.5	92.2	80.0	88.0	82.6	90.5
Ave. # Items Taken	114.7	108.5	114.0	109.3	109.6	106.8	116.2	113.0	113.1	109.0
% Taking Min # Items	57.2	63.5	57.9	62.9	62.3	65.1	54.9	57.6	58.7	62.6
% Taking Max # Items	16.5	12.5	16.5	13.5	13.1	11.3	17.8	15.7	15.6	13.0
Ave. Test Time (Hrs)	2.01	1.84	2.04	1.88	1.89	1.80	2.04	1.93	1.98	1.85
% Taking Mand. Break	32.7	25.4	33.7	26.8	27.6	23.5	33.8	28.8	31.3	25.7
% Taking Opt. Break	1.8	0.8	1.9	0.9	1.2	0.8	1.7	0.8	1.6	0.8
% Timing Out	0.8	0.3	0.9	0.4	0.5	0.3	0.9	0.5	0.7	0.4

Notes

Report of the Nursing Practice and Education Committee

Committee Members

Jan Zubieni, CO, Area I, *Chair*
Nancy Bafundo, CT, Area IV
Marjorie Bronk, TX-VN, Area III
Kenneth Lowrance, TX-RN, Area III
Toma Nisbet, WY, Area I
Linda Seppanen, MN, Area II
Cindy Van Wingerden, VI, Area IV

Staff

Vickie Sheets, JD, RN, *Director for Practice and Accountability*

Relationship to Organization Plan

Goal I.....Provide Member Boards with examinations and standards for licensure and credentialing.
Objective G.....Promote consistency in the licensing and credentialing process.

Recommendations to the Delegate Assembly

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

   Rationale

   Analysis of the data collected and research findings supports the position paper on approval of nursing education programs by state boards of nursing. The paper identifies the unique roles of Member Boards in the approval process, in addition to describing an accreditation recognition mechanism as an approach to be considered by state boards of nursing in carrying out their responsibilities with respect to nursing education programs. The Nursing Practice and Education Committee supports the adoption of this position paper by the Delegate Assembly.

2. **[Adopt one version of the alternative policy recommendations presented below, developed by the Discipline Resources Subcommittee of the Nursing Practice and Education Committee, regarding licensure requirements and felony convictions.] (To be determined based on feedback at the forum.)**

   Version One:

   Adopt a policy recommendation to Member Boards that criminal background checks be conducted on applicants for nursing licensure and that individuals are ineligible for nursing licensure on the basis of felony conviction. The licenses of nurses convicted of a felony after licensure would be revoked. This policy would be incorporated in the uniform licensure requirements and the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*.

   Version Two:

   Adopt a policy recommendation to Member Boards that criminal background checks be conducted on applicants for nursing licensure and that individuals are ineligible for nursing licensure on the basis of felony conviction for violent crimes against persons, including sexual misconduct. For other felony convictions, individuals would be barred from licensure for five years after the absolute discharge of their sentence, and then be considered on a case-by-case basis. The licenses of nurses convicted of a felony after licensure would be revoked. Nurses convicted of felonies which did not involve violent crimes against persons, including sexual misconduct, could be considered for reinstatement on a case-by-case basis five years after the absolute

discharge of their sentence. This policy would be incorporated in the uniform licensure requirements and the *Model Nursing Practice Act* and *Model Nursing Administrative Rules.*

Rationale

Based on the extremely high recidivism rate for felons and the advice of a consultant criminologist that felony conviction represented very high risk behavior, the subcommittee members became convinced that felony conviction is an appropriate first-level screen for licensure applicants. In the current criminal justice system, a felony conviction is a highly significant event. Many individuals convicted of felonies are extremely manipulative and adept at working a system. This recommendation makes a strong statement regarding the behavioral expectations for nurses. Given the high stakes nature of the requirement being proposed, the subcommittee members also believe it is essential that criminal background checks be conducted on all applicants for nursing licensure.

The view of the subcommittee is that the limited resources of boards of nursing should not be spent on administrative processes with felons. Rather, such scrutiny should be focused on other applicants. Another important consideration are the implications for mutual recognition if states continue to enact different licensure requirements related to criminal convictions.

The subcommittee recognizes that these recommendations may be perceived by some as extreme. However, the policy suggested above is consistent with policies promoted for other individuals working with at-risk populations. The United States Department of Justice has recently developed *Guidelines for the Screening of Persons Working With Children, the Elderly, and Individuals With Disabilities in Need of Support* (April, 1998). In those guidelines, it is suggested that the "Automatic disqualification of a potential worker or volunteer is appropriate when screening indicates that the individuals, as an adult, perpetrated any crime involving a child and/or a dependent adult, regardless of how long ago the incident occurred, and/or any violent crime within the past 10 years." Consumers needing health care are vulnerable. It is appropriate to establish high behavioral standards for applicants for nursing licensure and licensed nurses. Should boards be right, wrong, or safe?

The Nursing Practice and Education Committee supports the adoption of a regulatory policy regarding criminal convictions. Both versions of this recommendation were brought forward to provide opportunity for careful consideration by Member Boards prior to the Annual Meeting, and will promote active debate of this critical issue during the subcommittee forum and on the delegate floor.

Background

The 1996 Delegate Assembly adopted a resolution that the National Council of State Boards of Nursing develop resource modules that will assist Member Boards in licensure decisions involving chemical dependency and criminal/fraudulent behavior. The Nursing Practice and Education Discipline Resources Subcommittee was appointed in 1997 to work on discipline modules. The subcommittee focused on completing the chemical dependency module in 1997, and has focused on developing resources to support Member Boards decision-making regarding criminal/fraudulent behavior in 1998. The policy recommendation under consideration by the Delegate Assembly was one of the work products of the subcommittee in 1998.

Recommendation to the Board of Directors

1. That the National Council explore collaboration regarding continued competence with RN and LPN/VN specialty certifying organizations.

Rationale

Both the Nursing Practice and Education Committee and the Continued Competence Subcommittee have identified that several players have important roles in assuring ongoing competence of nurses. In the initial discussions with the American Nurses Association regarding the possible development of a joint model, continued competence was identified as a possible starting point for collaboration. This challenge is bigger than any single group, and seems to be a natural for working together. This recommendation comes from both the Continued Competence Subcommittee and the Nursing Practice and Education Committee, and was developed at a conference call between the two groups.

Background

National Council's efforts to develop a regulatory approach to continued competence date back to the 1980s when the Nursing Practice and Standards Committee struggled with this topic. In 1991, the Nursing Practice and Education Committee developed a significant paper entitled *Conceptual Framework for Continued Competence*, which identified the need for competency assessment as well as strategies to attain or maintain competence. In 1993, the Nursing Practice and Education Committee discussed a paradigm shift, recognizing the need to define competence before continued competence could be articulated. Subsequently, a subcommittee of the Nursing Practice and Education Committee developed a definition of competence that incorporated application of knowledge and skills, standards for competence to compare and evaluate the practice of individual practitioners, and identification of behaviors that demonstrate competence. Critical regulatory points for review of competence were identified as at entry, at renewal, at reinstatement and after discipline. In 1997, the Nursing Practice and Education Committee built on the subcommittee's work to develop a practical approach for implementation of the regulatory role in continued competence. The chosen approach was a competency profile, developed using the framework of the nursing process applied to a nurse's practice and professional development. The committee emphasized that collaboration between the individual nurse, educator, employer and board of nursing is needed to assure continued competence.

This year, the Nursing Practice and Education Continued Competence Subcommittee was appointed to continue work on the *Continued Competence Accountability Profile (CCAP).*

Highlights of Activities

■ Nursing Practice and Education Committee Coordination Role

The National Council Bylaws create the Nursing Practice and Education Committee as a standing committee of the organization, comprised of at least one member from each Area. The bylaws charge the Nursing Practice and Education Committee to provide general oversight of nursing practice and education regulatory issues by coordinating related subcommittees. This year, the Nursing Practice and Education Committee has coordinated three subcommittees: Continued Competence, Discipline Resources, and Nursing Education Approval/ Accreditation.

Since the revision of the bylaws in 1994, the Nursing Practice and Education Committee has tried different approaches to meeting this responsibility. In 1995, the Nursing Practice and Education Committee met before the subcommittees began their work and again at the end of the year to review the year's outcomes. In 1996, the Nursing Practice and Education Committee worked on its own project, professional accountability and developed a paper and conducted a pilot study of discipline cases related to accountability. In 1997, the Nursing Practice and Education Committee grappled with the concept of continued competence and developed the *Personal Accountability Profile* as a framework for boards of nursing to use as an approach to ongoing competence. In both 1996 and 1997, the coordination role, while included on every agenda, often seemed like a "rubber-stamp" – the committee members gave great deference to the subcommittees and were not sure how much they really were contributing to the overall work products.

This year, encouraged by the flexibility provided by the Chicago governance model, the Nursing Practice and Education Committee decided not to meet as a group in Chicago for a mid-year meeting. Instead, it used its travel resources to support Nursing Practice and Education Committee members to attend and participate in the subcommittees to which they were assigned as liaison.

The Nursing Practice and Education Committee members were readily accepted and felt part of the subcommittees, and feel that this was facilitated by the joint meeting between the Nursing Practice and Education Committee and all subcommittees in the fall. The Nursing Practice and Education Committee believes that its coordination role this year provided opportunity for in-depth discussion regarding the work and outcomes of each subcommittee, and the objectives of the organization were advanced as a result. The committee remained within its budgetary allotment for FY98. The committee plans to organize the committee's work in the same way in FY99.

■ Continued Competence

The Nursing Practice and Education Committee was most involved with the work of the Continued Competence Subcommittee this year. This was partly to provide continuity as the topic was transferred from the Nursing Practice and Education Committee's direct responsibility to a subcommittee. The committee held a joint conference call with the Continued Competence Subcommittee to discuss concerns that had arisen regarding the two

continued competence projects underway. Subcommittee members expressed concern because response to the *Continued Competence Accountability Profile* presentations at Area Meetings was lukewarm, at best, in most Areas, with particular concerns related to the administrative feasibility of CCAP and the legal defensibility. Much of the negative feedback came when the suggested audit process was discussed. In addition, the Nursing Practice and Education Committee and Continued Competence Subcommittee members, all who have agreed to volunteer for phase I of the NCLEX® examination project, were informed about procedural concerns raised by staff.

The subcommittee and the Nursing Practice and Education Committee together agreed that development of CCAP should continue, but that promotion of use by Member Boards should focus on discipline and re-entry uses (not renewal at this time). In addition, because of the interest expressed by a variety of individuals and entities, CCAP packets (consisting of instructions, guidelines, suggestions for use, and other supporting resources) would be made available for boards and upon request by individuals or agencies. The Continued Competence Subcommittee will coordinate and monitor requests for CCAP packets and request that users report back on their experiences. The Continued Competence Subcommittee and the Nursing Practice and Education Committee jointly determined to move forward with the NCLEX® examination pilot, phase I, as planned.

The final outcome of the joint discussion was the recommendation to the Board of Directors that the National Council explore collaboration with ANCC and other certifying organizations, including LPN/VN groups, regarding continued competence. The subcommittee and the Nursing Practice and Education Committee had noted the importance of collaboration in the previous National Council papers, being that continued competence is a complex challenge that would benefit greatly from the expertise and insight of multiple groups.

- **Uniform Licensure Requirements**

The Nursing Practice and Education Committee worked on proposed uniform licensure requirements, anticipating that the requirements would be taken to the 1998 Delegate Assembly for a policy decision. With this in mind, the uniform requirements grid was presented at each Area Meeting. In particular, the Nursing Practice and Education Committee hoped that it would receive feedback as to whether the uniform requirements were too broad, thereby resulting in elements that might need greater specificity. However, after the Area Meetings, it was the consensus of the Nursing Practice and Education Committee members who presented and others in attendance that the potential impact on individual boards should be considered before going forward with a policy recommendation regarding uniform requirements. Rather than take these requirements to the delegates prematurely, the Nursing Practice and Education Committee members decided to use the 1998 Annual Meeting to get additional feedback regarding the proposal, focusing on requirements at "entry" rather than renewal or reinstatement. The presentation this year would be a paper one, with an opportunity for each Annual Meeting participant to provide feedback at the planned Nursing Practice and Education Booth. The Nursing Practice and Education Committee proposes to use the feedback obtained at Annual Meeting as the basis for review and revision of the requirements. Rationale for the uniform requirements and impact statements regarding existing requirements of individual boards will be developed in FY99.

- **Functional Abilities Guidelines**

The committee completed the Functional Abilities Guidelines begun last year.

- ***Model Nursing Practice Act* and *Model Nursing Administrative Rules***

The Nursing Practice and Education Committee considered how the revision of models should be approached in the future. In the past, models were revised as a whole, approximately every five years. The work by the 1997 Nursing Practice and Education Subcommittee on Revision of Models brought forward the electronic model notebook, which is not dependent upon publication of written models. The electronic model can be updated as the need occurs, changing only the affected parts of the models. This flexibility to revise selected sections necessitates the need for careful analysis of the whole model, to assure congruence between the changed section and the rest of the documents.

The Nursing Practice and Education Committee suggests that it could assume a coordination role for the models, and be responsible for assessing the "big picture" impact of model changes. The need for changes and the actual content for the models would be developed by the group working on topic. The Nursing Practice and Education Committee would also review to identify areas needing revision and would share those reviews with the Board of Directors. This seems to be a natural fit with the bylaws charge to the Nursing Practice and Education

Committee for general oversight of nursing practice and education regulatory issues by coordinating related subcommittees. Part of that coordination would include analysis of impact of proposed changes on other model provisions. The drafting of model language would take place under supervision of the Nursing Practice and Education Committee, with opportunity for review by the content group as well as other National Council committees, task forces and Member Boards.

If the Board of Directors supports this activity for the Nursing Practice and Education Committee, then the committee proposes that this process be piloted with the development of education approval language in FY99. Sections of the models dealing with discipline and licensure would be the next sections in line for revision, but the direction will depend on the outcomes of the work with the mutual recognition model for nursing regulation.

- **Professional Interface/Blending Scopes**

The Nursing Practice and Education Committee members discussed at length the implications of blended scopes of practice and the interfaces between nurses and assistive personnel, LPN/VNs and RNs, RNs and APRNs, nurses and other health professions. This huge, complex topic ranges from cross-training issues to "from whom do nurses take orders" to "to whom do nurses give orders." The Nursing Practice and Education Committee recommends that any discussions or work in this area would benefit from the analysis of the similarities and differences among a variety of health professions. The Nursing Practice and Education Committee suggests that this study be initiated through the Interprofessional Work Group, and would consist of 1) comparison of different professions' model scopes, licensure requirements, continued competency and grounds for discipline; 2), analysis of compared and contrasted test plans, job analysis studies and role delineation studies for all health professions with national examinations. The analysis would look for core competencies, similar requirements across professions, and where the professions differ.

- **Additional Nursing Practice and Education Committee Activities**

The Nursing Practice and Education Committee reviewed *Profiles of Member Boards*, offering suggestions for content and organization, including suggesting a separate section for discipline. The committee suggested topics and identified possible authors for the nursing practice and education edition of *Issues*. The committee discussed and offered suggestions regarding organization fluidity, flexibility and responsiveness. The committee discussed LPN/VN issues and importance of including the LPN/VN in the blended scopes work. The 1998 Annual Meeting forum was planned, and the concept of a "Nursing Practice and Education Booth" was created to present opportunities for participants to view the various National Council resources related to nursing practice and education and to provide feedback to inform future committee and subcommittee activities.

Future Activities

- Continue Nursing Practice and Education Committee Coordination Role
- Other topics as assigned by the Board of Directors

Meeting Dates

- November 10-14, 1997
- April 23-25, 1998
- January 27, 1998 *(telephone conference call)*
- June 5, 1998 *(telephone conference call)*
- *In addition, NP&E Committee members participated in subcommittee meetings as assigned*

Recommendations to the Delegate Assembly

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

Fiscal Impact

None.

2. **[Adopt one version of the alternative policy recommendations presented below, developed by the Discipline Resources Subcommittee of the Nursing Practice and Education Committee, regarding licensure requirements and felony convictions.] (To be determined based on feedback at the forum.)**

***Version One*:**

Adopt a policy recommendation to Member Boards that criminal background checks be conducted on applicants for nursing licensure and that individuals are ineligible for nursing licensure on the basis of felony conviction. The licenses of nurses convicted of a felony after licensure would be revoked. This policy would be incorporated in the uniform licensure requirements and the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*.

Version Two:

Adopt a policy recommendation to Member Boards that criminal background checks be conducted on applicants for nursing licensure and that individuals are ineligible for nursing licensure on the basis of felony conviction for violent crimes against persons, including sexual misconduct. For other felony convictions, individuals would be barred from licensure for five years after the absolute discharge of their sentence, and then be considered on a case-by-case basis. The licenses of nurses convicted of a felony after licensure would be revoked. Nurses convicted of felonies which did not involve violent crimes against persons, including sexual misconduct, could be considered for reinstatement on a case-by-case basis five years after the absolute discharge of their sentence. This policy would be incorporated in the uniform licensure requirements and the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*.

Fiscal Impact

The costs to the National Council, if this policy were implemented, would be minimal and could be absorbed by existing committees and work groups (e.g., adding language to *Model Nursing Practice Act* and *Model Nursing Administrative Rules*).

The policy could result in both costs and savings to Member Boards. For example Member Boards may incur costs to initiate legislation and/or rule changes and costs to educate legislators, nurses and the public about the policy. Such costs would vary by jurisdiction. Savings would result from this policy if boards did not incur the costs of case-by-case review for applicants ineligible because of felony conviction.

Attachments

None.

Report of the Nursing Program Accreditation/Approval Subcommittee

Subcommittee Members

Eileen Deges Curl, KS, Area II, *Chair*
Linda Roberts-Betsch, GA-RN, Area III
Judith Mayer, MD, Area IV
Helen Zsohar, UT, Area I
Linda Seppanen, MN, Area II, *Liaison member to Nursing Practice and Education Committee*
Cindy VanWingerden, VI, Area IV, *Liaison member to Nursing Practice and Education Committee*

Staff

Ruth Elliott, EdD, RN, *Director of Education and Practice*

Relationship to Organization Plan

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

Recommendations to the Nursing Practice and Education Committee

1. **That the Nursing Practice and Education Committee approves the position paper related to approval of nursing education programs by boards of nursing.**

   Rationale

   Analysis of the data collected and research findings support the position paper on approval of nursing education programs by boards of nursing. The paper identifies the unique roles of Member Boards in the approval process in addition to describing an accreditation recognition mechanism as an approach to be considered by boards of nursing in carrying out their responsibilities with respect to nursing education programs.

2. **That continued work related to mechanisms for approval of nursing education programs be completed (as described under future activities).**

   Rationale

   Continued development of resources to assist Member Boards in implementation of the position paper is needed. Model rules and regulations for nursing education need to be developed. Additional opportunities for collaboration between Member Boards, external organizations, the National Council and the accreditation community will be provided during the year.

Background

To carry out its charge, the subcommittee completed several significant tasks. These activities included: completion of a quantitative research study related to nursing program approval, completion of a qualitative research study related to stakeholder perceptions regarding nursing program approval, survey regarding state boards of nursing recognizing national accreditation as a criterion for renewal of approval, hosting an accreditation roundtable, secondary analysis of results of the Member Board needs assessment completed in 1997, and development of a position paper on approval of nursing education programs.

Highlights of Activities

- **Completion of a Member Board needs assessment related to approval/accreditation**

In 1997, the subcommittee completed a Member Board needs assessment related to approval/accreditation of nursing education programs. The survey explored the effectiveness of various approaches to approval/accreditation, participation in standards for nursing education, desirability of uniform requirements for approval/accreditation,

National Council services and future directions. The survey instrument was divided into the following major areas: terminology and fees, basic nursing education programs, advanced practice nursing programs, issues, future direction and demographics. The results of the Member Board needs assessment were shared with the Delegate Assembly in 1997. These results were compared with findings obtained in 1998 from the research studies described below.

- **Completion of a quantitative research study related to approval of nursing education programs**

A survey instrument exploring the perceptions of nursing education programs regarding the approval process was mailed to a stratified random sample of all types of nursing education programs in January 1998. A response rate of 73 percent was obtained from the survey instrument. The survey instrument examined basic nursing education (RN and LPN/VN education programs), advanced practice nursing education and future issues. Results of the research study are found in Attachment A.

- **Completion of a qualitative research study related to the relationship between the approval and accreditation processes for basic nursing education programs (RN and LPN nursing education programs)**

This study focused on the current knowledge and practices of key stakeholders relative to the approval of nursing education programs. Questions pertained to the strengths and weaknesses of the current processes for approval of programs. The study also assessed what types of changes are desired by key stakeholders in the approval process. Results are found in Attachment A.

- **Completion of a survey related to boards of nursing recognizing national nursing accreditation in the approval of nursing education programs**

Ten jurisdictions presently recognize national nursing accreditation in the continuing approval of nursing education programs. Nine of these jurisdictions were surveyed to determine the strengths and areas for improvement in the approval process. Eight of the nine jurisdictions would recommend this model to other boards of nursing. One state board indicated that it was too early in the process to make a recommendation.

- **Hosting of an approval/accreditation roundtable**

On April 21, 1998, the subcommittee hosted the first approval/accreditation roundtable. The purpose of the roundtable was to analyze current issues in the approval/accreditation process. Representatives from the American Nurses' Credentialing Center, National League for Nursing Accrediting Commission, and the Commission on Collegiate Nursing Education were in attendance. Update reports were received from each of the organizations. The subcommittee chair presented a report including: historical foundations, completion of the Member Board needs assessment in 1997, and current status of research related to approval of nursing education programs.

- **Development of a position paper related to approval of nursing education programs**

Based upon an analysis of data sources and research findings, a position paper related to the approval of nursing education programs was developed.

Analysis of the data collected and research findings support the position paper on approval of nursing education programs by boards of nursing. The paper identifies the unique roles of Member Boards in the approval process. In addition, this paper describes an accreditation recognition mechanism as an approach to be considered by state boards of nursing in carrying out their responsibilities with respect to continuing approval of nursing education programs (see Attachment B).

Future Activities

Future activities are planned to implement the recommendations within the position paper.

- Sponsor a roundtable with Member Boards and representatives of accrediting agencies to discuss issues related to approval/accreditation
- Develop standards for nursing education in the *Model Nursing Administrative Rules* and *Model Nursing Practice Act*
- Facilitate implementation of feedback mechanisms between boards of nursing and national nursing accrediting agencies
- Develop services for Member Boards interested in using the accreditation recognition mechanism

Meeting Dates

- November 10-12, 1997
- February 19, 1998 *(telephone conference call)*
- March 9-10, 1998
- April 1, 1998 *(telephone conference call)*
- April 14, 1998 *(telephone conference call)*
- April 20-22, 1998
- April 28, 1998 *(telephone conference call)*
- May 18, 1998 *(telephone conference call)*
- June 2, 1998 *(telephone conference call)*
- June 10, 1998 *(telephone conference call)*

Recommendations to the Nursing Practice & Education Committee

1. That the Nursing Practice and Education Committee approves the position paper related to approval of nursing education programs by boards of nursing.

2. That continued work related to mechanisms for approval of nursing education programs be completed (as described under future activities).

Fiscal Impact

$20,160 (Four committee members for four meetings at three days each)

Attachments

Attachment A

Report of Research Findings and Data Sources: Approval of Nursing Education Programs by Boards of Nursing

I. Introduction

In 1997, the Subcommittee on Nursing Program Approval/Accreditation completed a Member Board needs assessment related to approval/accreditation of nursing education programs. The survey explored the effectiveness of various approaches to approval/accreditation, participation in setting standards for nursing education, desirability of uniform requirements for approval/accreditation, potential National Council services and future directions. The survey instrument was divided into the following major areas: terminology and fees, basic nursing education programs (RN and LPN/VN nursing education programs), advanced practice programs, issues, future directions and demographics.

To obtain comprehensive data on approval/accreditation issues, in 1998, the subcommittee completed two additional major research studies. One study was a nationwide survey of nursing education program administrators to assess their perceptions regarding the approval process. The second study used a qualitative design to assess the perceptions of various stakeholders (i.e., nursing accrediting agencies, consumers, government agencies and employers) regarding the approval process. An approval/accreditation roundtable with national nursing accreditation organizations was also held on April 21, 1998, to discuss issues surrounding approval/accreditation. After the preliminary research findings were obtained, a phone survey was completed with respect to those boards of nursing recognizing national nursing accreditation as a criterion for continuing approval of nursing education programs.

This report presents the research findings obtained by the subcommittee in 1997 and 1998. Following the operational definitions, topics presented include: 1) Sample and Demographics, 2) Methodology, 3) Approval of Nursing Programs, 4) Redundancy, 5) Standards, 6) Unique Roles and Issues, and 7) Accreditation Roundtable. Each of these topics will be discussed in terms of the various data sources and study findings.

II. Operational Definitions

Accreditation — official authorization or status granted by an agency other than a state board of nursing; a voluntary process conducted by peers (NCSBN, 1997a)

Approval — official recognition of nursing education programs which meet standards established by the board of nursing (NCSBN, 1994)

Model A — Board grants initial approval to a nursing education program and continuing approval to that program based on board of nursing survey (subsequently referred to as Separate and Distinct Mechanism)

Model B — Board grants initial approval to a nursing education program based on board survey of an education program and recognizes voluntary accreditation as a criterion for continuing approval (subsequently referred to as Accreditation Recognition Mechanism)

Model C Board is not involved in approval of nursing education programs (subsequently referred to as Non-involvement Mechanism)

Model D Other approach used for approval of nursing education programs

III. Samples and Demographics

A. Member Board Needs Assessment

The total number of surveys received from Member Boards was 99 (53 staff; 46 board members). Upon deletion of duplicate copies of surveys, the final response rate was 78.6 percent (n=48) for board staff and 57.3 percent (n=35) for board members. A total of 50 jurisdictions responded for a response rate of 81.9 percent of the membership.

Most staff members completing the survey were education consultants. Most board members responding were educators representing all types of nursing education programs. The length of time of service between board members and staff were similar, with a mean of 2.68 years for board members and 2.70 years for staff. Most boards of nursing identified at least one staff member as having primary responsibility for nursing education issues. Five boards stated that a staff member for nursing education was not employed at the board office. The range of staff members in board offices was between zero to five staff (NCSBN, 1997b).

B. Nursing Education Programs Study

The sample included a stratified random sample of 560 nursing education programs. Strata included (1) state/territory (n=56); and (2) type of nursing program offered (n=5): practical, diploma, baccalaureate degree, graduate degree (no overlap of schools across the five strata; number of schools per cell = 2).

The types of nursing education programs included the following: LPN/VN 113 or 28 percent, AD 125 or 30 percent, Diploma 84 or 20 percent, BS 164 or 40 percent, RN-BSN completion 162 or 40 percent, RN-MS program 54 or 13 percent, Master's degree 122 or 30 percent, Post baccalaureate 2 or 0 percent, Post-master's certificate 49 or 12 percent, Doctoral degree 39 or 10 percent, and Other 10 or 2 percent. Overall the two largest groups of respondents were the BS and RN-BSN programs at 40 percent each, followed by the AD and Master's degree each at 30 percent and the LPN/VN at 28 percent. Of note is that Diploma programs represented 20 percent of the total even though there were none (0) in Area I.

Of 407 valid respondents, 344 or 85 percent reported that their programs are nationally accredited. Only 63 or 15 percent were not nationally accredited at the time of the survey. Sixty percent reported that they went through one (29 percent) or two (41 percent) accreditation processes on a regular basis. Only 2 percent reported five or more processes.

About one-third of the respondents reported that they had faculty who had served on their respective state board of nursing (27 percent) in the past five years. However, a much higher number reported that they had faculty who had served as an accreditation visitor within the past five years (45 percent).

C. Organizations Study

In-depth qualitative telephone interviews with respondents from 20 key organizations identified by the subcommittee were planned. Sixteen in-depth interviews (and two additional interviews with National Council consultants) were conducted. Participating respondents represented consumer interest organizations, professional organizations (representing both RNs and LPN/VNs), accrediting bodies/organizations, and employers.

D. Study of Boards Recognizing Accreditation for Continuing Approval

After the preliminary research findings were obtained, nine of the ten boards of nursing (Arizona, Delaware, Hawaii, Kentucky, Massachusetts, New Mexico, Pennsylvania, Texas-RN, Utah, and Wisconsin) currently

recognizing national nursing accreditation as a criterion for continuing approval were surveyed. Telephone interviews were completed with all but one jurisdiction at the time of this report.

IV. Methodology

A. Member Board Needs Assessment

The needs assessment survey instrument was mailed to Member Boards on February 7, 1997. Each Member Board was invited to participate by having one copy of the survey completed by staff and one copy completed by a board member. Survey results were collected until April 25, 1997. Some boards of nursing copied and returned additional copies of the survey to the National Council. All responses were reviewed by the subcommittee. Duplicate copies were randomly eliminated so that a maximum of two responses per jurisdiction was included in the final analysis.

B. Nursing Education Programs Study

In January 1998, a survey was mailed to 560 nursing education programs using a three-phase mailing procedure. The survey, a ten-page paper/pencil instrument, included questions similar to those asked of Member Boards in the needs assessment survey. Analysis of the nursing education programs survey data included both descriptive and inferential statistics. Descriptive statistical techniques included frequency distributions and percentages for all quantitative data, cross tabs of frequencies/percent by program type and geographic area (n=4) and the calculation of means. The survey response rate was 73 percent (n=410). This high response rate, combined with the stratified random sampling frame, make the results generalizable.

C. Organizations Study

In spring 1998, a qualitative study using telephone interviews with 16 professional nursing organizations, accrediting bodies, consumer groups and employers was conducted. These interviews were approximately 45 minutes in length.

The flow of the interviews followed a discussion guide jointly developed by TVG (research company) and National Council. However, these interviews were qualitative in nature, that is, the discussion did not follow a structured instrument. Questions were phrased as appropriate to the flow of the interview based on respondents' answers. Answers to some questions required the need to ask others. The taped interviews were transcribed and content analysis was completed by TVG.

V. Approval of Nursing Education Programs

A. Member Boards Needs Assessment

The predominant model (Model A) for approval of nursing education programs involved the board of nursing granting initial approval and continuing approval of nursing programs based on board surveys (n=66, 79.5 percent). In 1997, a total of 7.2 percent (n=6) of respondents reported using the model that the board of nursing grants initial approval and then accepts voluntary accreditation status from a recognized accrediting agency for continuing approval (Model B). One individual (1.2 percent) reported that the board of nursing was not involved in the approval/accreditation process. Six respondents (7.2 percent) indicated that another approach was used in approval of nursing education programs (e.g., state education agency approves nursing programs).

Jurisdictions were asked to evaluate the effectiveness of their approval model (on a scale of zero to three with 0=ineffective; 1=somewhat effective; 2=effective; and 3=very effective) based on several outcome indicators. Approval models were evaluated on the following outcome indicators: public protection, promotion of quality in education, responsiveness to health care changes, responsiveness to innovation in education, cost to schools/jurisdictions, time efficiency for board, board staff time required for education program review, and user friendliness for nursing education programs. The responses ranged from zero to three.

Most boards of nursing reported being satisfied with the model they used in approval of nursing education programs. Eighty-nine percent (n=74) indicated that the model used at the present time would continue to safeguard the public in the changing health care environment. Four respondents (4 percent) indicated that the present model their jurisdiction used would not continue to meet the needs of the changing environment. Most respondents rated each of the outcome indicators as effective to very effective. Boards believed that the model used in their jurisdiction was very effective in terms of cost to schools and jurisdictions.

Responses were analyzed with respect to a jurisdiction's recognition by the U.S. Department of Education (DOE) as a recognized accrediting agency. Most jurisdictions (n=73; 87.9 percent) reported that they were not recognized by the DOE. Ten respondents (12.1 percent) identified that the board of nursing was DOE recognized. Of the respondents affirming DOE recognition, the survey explored whether or not DOE recognition made a difference in the aforementioned outcome indicators. A range of zero to three, from ineffective to very effective, was reported for each of the outcome indicators. The range of means for each of the outcome indicators was from 1.06 to 1.87. A limitation of these findings was that few Member Boards hold DOE recognition and, thus, it is difficult to discern conclusions relative to the impact of this recognition on the outcome indicators.

Additional information was gathered with regard to approval needs of the future. Most jurisdictions reported that future needs would be met by boards of nursing granting initial approval and continuing approval of nursing education programs (n=60; 72.2 percent). An increase from 7.2 percent (n=6) to 18 percent (n=15) was noted in the number of respondents who indicated that recognizing nursing accreditation status from a accrediting agency for continuing approval would meet future needs. Four (8 percent) boards of nursing perceived not being involved in approval of nursing education programs in the future.

B. Nursing Education Programs Study

Based on data from nursing education program respondents, currently 80 percent of the boards of nursing grant initial approval and continuing approval of basic nursing education programs (RN and LPN/VN education programs). Another 15 percent grant initial approval and then accept voluntary accreditation status from a recognized accrediting agency to renew approval of basic nursing education programs. Together this represents 95 percent of the ways in which current approval is conducted. Fourteen (3.5 percent) reported that their board is not involved in the approval of basic nursing programs. Five (1.3 percent) cited "Other" and two (0.5 percent) reported "Unknown" as method of involvement of their boards of nursing in this process.

Survey data clearly indicated that both Model A and B are effective in demonstrating accountability and protection of the public, effective in promoting quality in nursing education programs, somewhat effective in exhibiting responsiveness to changes in health care, and somewhat effective in exhibiting responsiveness to innovations in educational programs (See Table 1).

Overall, Model B was viewed as more cost-effective, more of a time saver, and more user-friendly than Model A. This may be due to the strong indication that respondents felt there is redundancy between the approval processes of boards of nursing and the accreditation processes of other agencies. This redundancy, primarily between boards of nursing and national nursing accreditation agencies, was not viewed as a desirable characteristic.

Fifty percent (50.3 percent) of the nursing program respondents agreed that the preferred role for boards of nursing should be Model B, where the board grants initial approval and then accepts voluntary accreditation status from a recognized accrediting agency for continuing approval of basic nursing programs (See Table 2). However, 42.9 percent reported that the board should use Model A, 4.5 percent reported that boards of nursing should not be involved in approval, and 2.3 percent marked the "Other" option.

Overwhelmingly, the responses referred to the highly desirable cost savings and improved efficiency of recognizing national accreditation for continuing approval (Model B).

Table 1. Rates of Effectiveness of Models A, B, C on Outcomes as Identified by Nursing Education Respondents

Outcome Indicator	Model A	Model B	Model C
Demonstrates accountability and protection of the public			
Very effective	205 (52.3%)	106 (36.3%)	10 (3.6%)
Effective	141 (36.0%)	122 (41.8%)	12 (4.3%)
Somewhat effective	36 (9.2%)	49 (16.8%)	20 (7.1%)
Ineffective	10 (2.6%)	15 (5.1%)	239 (85.1%)
Promotes quality in education programs			
Very effective	144 (36.7%)	115 (39.5%)	15 (5.4%)
Effective	139 (35.5%)	123 (42.3%)	13 (4.7%)
Somewhat effective	87 (22.2%)	43 (14.8%)	29 (10.5%)
Ineffective	22 (5.6%)	10 (3.4%)	220 (79.4%)
Exhibits responsiveness to changes in the health care system			
Very effective	83 (21.2%)	78 (26.8%)	18 (6.5%)
Effective	139 (35.5%)	115 (39.5%)	25 (9.0%)
Somewhat effective	126 (32.1%)	79 (27.1%)	31 (11.2%)
Ineffective	44 (11.2%)	19 (6.5%)	204 (73.4%)

Outcome Indicator	Model A	Model B	Model C
Exhibits responsiveness to innovations in educational programs			
Very effective	91 (23.3%)	83 (28.8%)	23 (8.3%)
Effective	120 (30.8%)	124 (43.1%)	24 (8.7%)
Somewhat effective	118 (30.3%)	61 (21.2%)	23 (8.3%)
Ineffective	61 (15.6%)	20 (6.9%)	206 (74.6%)
Cost-effective for schools			
Very effective	121 (31.3%)	136 (46.9%)	114 (41.8%)
Effective	108 (27.9%)	76 (26.2%)	48 (17.6%)
Somewhat effective	80 (20.7%)	40 (13.8%)	25 (9.2%)
Ineffective	78 (20.2%)	38 (13.1%)	86 (31.5%)
Cost-effective for state boards of nursing			
Very effective	58 (15.9%)	190 (66.0%)	138 (50.9%)
Effective	113 (31.0%)	71 (24.7%)	47 (17.3%)
Somewhat effective	102 (27.9%)	18 (6.3%)	22 (8.1%)
Ineffective	92 (25.2%)	9 (3.1%)	64 (23.6%)

Outcome Indicator	Model A	Model B	Model C
Demonstrates efficient use of time by state boards of nursing			
Very effective	63 (16.5%)	165 (57.3%)	65 (23.9%)
Effective	129 (33.9%)	86 (29.9%)	30 (11.0%)
Somewhat effective	96 (25.2%)	24 (8.3%)	64 (23.5%)
Ineffective	93 (24.4%)	13 (4.5%)	113 (41.5%)
User-friendly for nursing education program			
Very effective	112 (28.6%)	129 (44.5%)	81 (30.0%)
Effective	128 (32.7%)	99 (34.1%)	37 (13.7%)
Somewhat effective	96 (24.5%)	38 (13.1%)	31 (11.5%)
Ineffective	56 (14.3%)	24 (8.3%)	121 (44.8%)

Table 2. Nursing Education Program Respondents Perceived Advantages and Disadvantages of Model B: Granting Initial Approval and Recognizing National Nursing Accreditation for Continuing Approval

Advantages	Disadvantages
1. Economical	1. Length of time between accreditation, currently eight years
2. Prevents duplication and redundancy	2. Voluntary nature of accreditation
3. Improvement in quality of programs	3. Loss of "connection" with state board
4. Demonstrates accountability	4. Current conflicts between NLN/AACN
5. Demonstrates continued safety of the public	5. Loss of some "responsiveness" by the board
6. Promotes efficiency at both the schools and at the boards	
7. Improved use of resources	
8. More rapid response to changes and problems by the board	
9. Maintains consistent high standards	

C. Organizations Study

A strong majority of participants identified that voluntary accreditation of a school of nursing by the National League for Nursing Accrediting Commission (NLNAC) or Commission on Collegiate Nursing Education (CCNE) should be accepted as proof of meeting continuing approval criteria.

A strong majority of respondents from organizations that represented colleges and universities, RNs, and specialty accrediting bodies were supportive of an approval model that recognizes voluntary accreditation as being indicative of meeting continuing approval criteria. Importantly, these respondents were supportive of recognizing accreditation by the NLNAC, CCNE or another body of this type. Generally, these participants claimed that the accreditation standards encompass (for the most part) and far exceed the approval standards for any given state. Conversely, they perceived that program accreditation calls for nursing schools to meet true national standards that "far" exceed the minimum state requirements.

Respondents from organizations representing licensed practical nurses (LPNs), associate degree programs, consumer organizations, and employers were less enthusiastic about accepting accreditation as proof of meeting approval criteria.

Respondents representing consumer and employer interests were concerned about protecting public input and influence in the approval process. Generally, they did not favor accepting accreditation as a substitute for approval.

Employer group representatives commented that accrediting bodies tend to be too academically oriented, out-of-touch with market realities, and slow to respond to changes in the marketplace. However, a majority of these respondents noted that acceptance of accreditation (either regional or specialty) as proof of meeting approval standards would be acceptable, if the process ensured that the accreditation criteria encompasses the approval standards. Further, the accrediting bodies should include representatives from the boards (both professionals and public members) as part of the accrediting team.

According to the majority of respondents, the approval process for basic nursing education programs (RN and LPN/VN nursing education programs) has minimal impact on the quality of the program. The respondents noted that approval establishes the minimum level of quality needed to prepare students for the licensing exam, and that approval only impacts on the minimum requirements. Relatedly, these respondents agreed that accreditation has a more significant impact on the academic quality of a program than does approval.

Conversely, industry and consumer representatives viewed quality as a set of core competencies necessary to provide care and meet employer needs. These participants tended to think that approval has a significant impact on ensuring that the programs meet a set standard of quality, but also agreed that these standards only address the minimum.

D. Survey of Boards Recognizing Accreditation for Continuing Approval

Eight of the nine boards of nursing surveyed who use Model B would recommend Model B to other boards of nursing. One board recently adopted this model and stated it was too early to make a recommendation.

VI. Redundancy

A. Member Boards Needs Assessment

Redundancy between the approval and accreditation processes was explored. Most Member Board respondents (n=56; 67.4 percent) identified that redundancy existed in the approval and accreditation processes related to basic nursing education programs. Approximately 26 percent (n=22) indicated that redundancy did not exist within the state, region or nation in approval/accreditation. For those who observed redundancy, specific areas of redundancy related to overlap between board approval and voluntary accreditation (n=54; 65 percent), overlap between board and other state agencies (n=1; 1.2 percent) and overlap between board approval and regional accreditation (n=3; 3

percent). Overlap between board approval and voluntary accreditation processes reflected the highest reported area of redundancy (n=54; 65 percent). Most Member Boards (n=55; 66.2 percent) reported that redundancy between the board of nursing and other accrediting agencies was a desirable characteristic in providing a check-and-balance system for the approval/accreditation process.

B. Nursing Education Programs Study

A very high number of nursing education program respondents (81 percent) reported that they believe there is redundancy between board of nursing approval processes and the accreditation processes by other state, regional or national accrediting agencies. Seventy-one percent (71 percent) viewed this redundancy as being between board of nursing approval and national accreditation agencies. Additionally, 64 percent reported that this redundancy is not desirable. Many commented about the "checks and balances" of having both, but also many commented on the high cost of redundancy.

C. Organizations Study

Respondents from organizations representing colleges, universities, nurses and specialty accreditation bodies reported seeing little or no value in redundancy as a system of checks and balances. Rather, they claimed that such redundancy is typically burdensome and of little value. Additionally, many of these respondents noted that, in an era of limited resources, boards should not duplicate efforts but should recognize accreditation and devote the savings to other areas of interest. About half of the respondents suggested using the savings to increase efforts for ensuring continuing competency for licensed nurses.

VII. Standards

A. Member Boards Needs Assessment

Standards related to basic nursing education programs were explored. Six percent (n=5) of the respondents felt that only national standards should be used in approval of nursing education programs. State and national standards should be used according to 56 percent (n=47) of respondents. Only state standards should be used in approval/accreditation of nursing education programs, according to 31 percent (n=26) of respondents. Therefore, most boards reported that national and state standards were desirable in approval of basic nursing education programs (RN and LPN/VN nursing education programs).

The role of various groups related to core state standards was assessed. Most respondents identified that boards of nursing have a significant role in input, review and approval of core state standards for basic nursing education. Significant input roles were identified for National Council, national nursing organizations, state nursing organizations, nurse educators, employers and consumers. In comparing, the input role and the review role of various groups in core state standards, all groups reflected a decreased role in the review of core state standards when compared to input. The role of groups other than boards of nursing in approval of core state standards was perceived as limited.

The roles of groups related to core national standards were analyzed with regard to input, review and approval. Most groups were identified as having a significant input role in establishment of core national standards. Nurse educators, National Council, national nursing organizations, employers, consumers and boards of nursing were perceived as having the most significant role in establishment of core national standards. Review of core national standards was a significant role for state boards of nursing, National Council and nurse educators. Boards of nursing and National Council were perceived as having significant roles related to core national standards for basic nursing education programs.

Uniform processes and procedures related to approval/accreditation of basic nursing education programs were explored. Of the boards responding, most respondents (n=41; 49.3 percent) supported uniform processes and procedures.

The relative importance of board of nursing involvement in approval/accreditation of nursing education programs was investigated. Each respondent was asked to evaluate whether or not board involvement in basic nursing education programs, registered nursing (RN) completion programs, master's degree programs and doctoral programs was essential. Most boards of nursing reported that board involvement in basic nursing education programs was very essential. Boards perceived it was somewhat essential to be involved in RN completion programs. Respondents reported that it was not essential for boards to be involved in approval/accreditation of master's degree programs and doctoral programs.

Another section of the needs assessment related to advanced practice nursing programs. The role of various agencies and organizations in the development of core state standards for advanced practice programs was reviewed. Significant roles were identified for boards of nursing, National Council, national and state nursing organizations, specialty nursing organizations, nurse educators, employers and consumers.

The role of organizations in development of core national standards for advanced practice programs was analyzed. With regard to input, significant organizations were identified as boards of nursing, National Council, national nursing organizations, nurse educators, employers and consumers. For review of core national standards, major agencies were identified as boards of nursing, National Council, national nursing organizations, specialty nursing organizations and nurse educators. Approval of core national standards was perceived as a significant role for boards of nursing and the National Council.

Future approval/accreditation needs related to advanced practice programs was evaluated. The relative importance of board of nursing involvement in programs preparing nurse anesthetists, nurse midwives, nurse practitioners and clinical nurse specialists was evaluated. Most respondents reported that involvement of Member Boards in all advanced practice nursing programs was essential to very essential to meet the needs of the future. It is noted that Member Board interest in approval/accreditation of advanced practice programs was less than that reported for basic nursing education programs. The rating scale reflected values of zero=nonessential to three=very essential.

Uniform processes and procedures related to advanced practice nursing programs were reviewed. Most respondents reported that the use of uniform processes and procedures for approval/accreditation of advanced practice programs was desirable (n=53; 63.9 percent). Approximately 15 percent (n=13) reported that uniform processes and procedures were not desirable. A number of individuals (n=17; 20.4 percent) did not respond to the survey question.

B. Nursing Education Programs Study

Over half of the respondents (52 percent) believed that national and state standards should be used to provide core criteria for approval of basic nursing education programs (RN and LPN/VN nursing education programs).

Trends for Core State Standards:

- 96 percent reported that boards of nursing should play a role in standard setting for basic programs.
- 76 percent reported that boards should have the role of approval of standards, with 30 percent reporting the role of input and 25 percent reporting review as the role.

Trends for Core National Standards:

- 89 percent reported that boards of nursing should play a role in national standard setting for basic programs.
- 38 percent reported that boards should have the role of approval of standards, with 53 percent reporting the role of input and 31 percent reporting review as the role.
- 90 percent reported that National Council of State Boards of Nursing and national level nursing organizations should play a role in standard setting through input and review, but not in the role of approval.

The great majority of respondents (78 percent) believed that boards of nursing in every state/jurisdiction should follow uniform processes and procedures for approval of basic nursing education programs. Consistency was cited by 50 respondents as an advantage of such uniformity.

Over 87 percent reported that it is very essential or essential that the board of nursing be involved in the approval of basic nursing education programs (PN/VN Diploma, AD, BSN). This was the reverse for higher education: 55 percent reported not essential for doctoral, 41 percent reported not essential for master's, and 33 percent reported not essential for RN-BSN or RN-MSN educational programs.

Over 50 percent of the respondents did not believe it is essential for boards of nursing to approve the following:

Clinical Nurse Specialist Master's Degree (59 percent)
Nurse Anesthetist Master's Degree (53 percent)
Nurse Midwife Master's Degree (53 percent)
Nurse Practitioner Master's Degree (53 percent)
Post-baccalaureate Certificate (72 percent)
Post-master's Certificate (66 percent)

The perceptions of the respondents regarding the role of various stakeholders in standard setting for advanced practice nursing education programs revealed nearly identical trends for both state and national standard setting for advanced practice nursing programs.

Trends for Setting State Standards for Advanced Practice:

- 73 percent reported that the boards of nursing should set standards with the role of input (41 percent), review (35 percent), and approval (42 percent) fairly evenly supported.

- 63 percent reported that the National Council of State Boards of Nursing should have a role in setting state standards, but again were nearly split between input, review, and approval.

- 82 percent reported that national level nursing organizations should have a role in setting state standards, but were nearly split between input, review and approval.

- Respondents were in agreement that state-level nursing organizations, specialty nursing organizations, nurse educators, employers of nurses, and consumers of nursing should play a role in standard setting, but should not have the role of approval of those standards.

Trends for Setting National Standards for Advanced Practice:

- 73 percent reported that boards of nursing should set standards with the roles of input (62 percent) , review (29 percent), and approval (22 percent).

- 72 percent reported that the National Council of State Boards of Nursing should have a role, but were nearly split between input, review, and approval.

- 89 percent reported that national level nursing organizations should have a role, but were split between input, review and approval.

Respondents were in agreement that the state level of nursing organizations, specialty nursing organizations, nurse educators, employers of nurses, and consumers of nursing should play a role in standard setting, but should not have approval of these standards.

C. Organizations Study

Nearly all respondents agreed that a single set of national guidelines/standards should be created that detail the approval criteria for basic nursing education programs.

The respondents consistently noted that such standards are needed in order to provide a rational basis for licensure, particularly the transfer of a license from one state to another when a nurse moves, and to provide a solid foundation for the interstate practice of nursing. Consequently, the participants identified that a set of national guidelines/standards would ensure that nurses from every state graduate from an institution that meets the same minimum standards.

The majority of respondents agreed that national standards should encompass a common set of minimum criteria, that states should be allowed to add additional criteria based on perceived state needs/interests, but that states should not establish criteria that are less stringent than those established at the national level (11 fully agreed that national standards/guidelines are needed).

VIII. Unique Roles of Member Boards and Issues in Nursing Education

A. Member Board Needs Assessment

Significant regulatory issues surrounding nursing education were identified by respondents. These issues included: faculty qualifications, community-based care, distance learning, proliferation of practical nursing programs and emerging technologies in education. Additional questions were raised related to national standards for faculty qualifications, home health experiences, core competencies for community-based practice, review of the *Model Nursing Practice Act* and rules and regulations in a changing health care environment, and the adequacy of one nursing license to meet the changing needs of health care delivery. These issues were referred to the Nursing Practice and Education Committee and Nursing Education Planning Group for further review and analysis.

Member Boards assessed the unique role of the board of nursing in approval as compared to other groups. A unique role of the board of nursing was identified as public protection because of enforcement of standards without vested interest. This unique responsibility was perceived as being carried out through establishment of curriculum criteria, evaluation of clinical agencies, accountability of nursing education programs for NCLEX® examination results, monitoring compliance with standards, and renewal of approval.

B. Nursing Education Programs Study

There was very high agreement that the following are unique roles of the boards of nursing. Participants (89 percent) agreed that initial approval of nursing education programs was a unique role of the boards of nursing. Respondents agreed that the ability to sanction or close programs (84 percent), the ability to monitor programs at risk (78 percent), and the greater awareness of statewide nursing education program needs than is possible for other agencies to have (79 percent) are unique roles.

The majority of comments regarding the role of boards to sanction or close programs related to the fact that boards "are the only ones by law who can do this."

Comments on the ability to monitor programs at risk were mostly about proximity to the programs, improved communication, and directions given to programs for the improvement of education.

Participants also submitted many comments on the ideal relationship between the nursing education program and the board of nursing. Over sixty comments included the descriptor "collaborative." Related terms were frequently used in the comments such as: advisor, partners, cooperation, collegial, consultant, complementary, mutually supportive, and open communication. One writer summarized, "A collaborative working relationship — one that involves consultative as well as evaluative roles." Two others stated, "Collegial relationship with discussion of relevant issues affecting education and practice. The state board should be a resource to schools[,] providing

consultation and ... accept[ing] accreditation as the measure of quality and compliance after initial approval ..." "Working together to advance nursing education and practice in the state."

There were many more comments that spoke to the need to eliminate redundancy between boards of nursing and national nursing accreditation agencies. One writer's comment was very representative, "State Boards of Nursing — review and recognize national accrediting agencies. After initial state Board of Nursing program approval, accept national approval with [the] right to request state specific supplementary data or ... follow-up to recommendations for improvement [required] by national accrediting agency as appropriate."

C. Organizations Study

Frequently cited unique roles of the boards of nursing included granting nursing licenses, taking disciplinary actions against licensed nurses, and representing the public interest in ensuring quality professionals. In addition to the identified roles, many respondents noted that boards of nursing have the unique role of representing the public interest in basic nursing education.

Respondents generally agreed with the identified unique functions/roles of boards of nursing, but noted that their agreement was strongly dependent on how these functions are defined.

Overall, many respondents recognized the historically necessary role of boards of nursing in establishing approval criteria and in regulating schools of nursing. Given the advances in professional standards, conduct and roles, these respondents perceived less regulatory need for boards of nursing to be involved in the educational process in the future. In general, these respondents argued that while boards of nursing have a unique role in terms of approval of basic nursing education programs, the conditions leading to this role have changed, and that the boards should not be involved in this way in the future.

IX. Accreditation Roundtable

The National Council of State Boards of Nursing hosted the first Nursing Approval/Accreditation Roundtable meeting on April 21, 1998, in Chicago, Illinois. Participating organizations included the American Nurses' Credentialing Center, represented by Carolyn Lewis and Mary Smolenski; the Commission on Collegiate Nursing Education, represented by Jay Levrio; and the National League for Nursing Accrediting Commission, represented by Geraldene Felton. Members of the Subcommittee on Nursing Program Approval/Accreditation who were in attendance included: Eileen Deges Curl, chair; Helen Zsohar; Judy Mayer; and Linda Roberts-Betsch. Julia Gould participated as the liaison member to the Board of Directors. Linda Seppanen and Cindy VanWingerden represented the Nursing Practice and Education Committee of the National Council. Significant issues in approval of nursing education programs were discussed, including outcomes, effectiveness of approval and accreditation, federal funding issues, consistency of standards, redundancy and economy of resources. Specific questions and comments related to the following areas:

- resources required for approval/accreditation processes
- lack of standardization of approval processes
- need for mechanism to communicate issues regarding nursing education programs
- comparison of approval process and accreditation process
- potential models for approval/accreditation in the future
- legal standards and professional standards for review of programs
- need for consistent language in approval/accreditation processes
- services needed to provide quality education in 2005
- relationship between regional accreditation and specialized accreditation
- research-based standards
- pressure to lengthen accreditation cycle
- need for triggers or identified factors as causes for follow-up in nursing education programs

Representatives expressed support for continuing the roundtable in 1999.

X. Summary

Since 1997, the Subcommittee on Nursing Program Approval/Accreditation has explored the role of the board of nursing in approval of nursing education programs. A Member Board needs assessment was conducted in January 1997 to analyze various approaches used by boards of nursing in approval of nursing education programs. This study revealed that boards of nursing have a need to continue in initial approval of nursing education programs. Furthermore, the data showed that some boards of nursing indicated interest in exploring alternative models for continuing approval of nursing education programs to decrease associated costs to the state and to reduce redundancy. The study also indicated that data were needed from all types of nursing education programs and external organizations with respect to approval/accreditation issues.

In light of these findings, the subcommittee completed two research studies during 1998 to assess the perceptions of nursing education programs and external organizations related to approval of nursing education programs by boards of nursing. The nursing education program study involved 560 nursing education programs of all types and from all geographic areas. The response rate was 73 percent and provided highly generalizable results. Survey data clearly indicated that both Models A and B are effective in demonstrating accountability and protection of the public, effective in promoting quality in nursing education programs, somewhat effective in exhibiting responsiveness to changes in health care and somewhat effective in exhibiting responsiveness to innovations in education programs. Overall, Model B (accreditation recognition mechanism) was viewed as more cost-effective, more of a time saver and more user-friendly than Model A. Fifty percent of the nursing program respondents agreed that the preferred role for boards of nursing should be Model B, where the board grants initial approval and then recognizes voluntary accreditation status from a national nursing accreditation agency for continuing approval of basic nursing programs. Overwhelmingly, responses identified the highly desirable cost savings and improved efficiency of recognizing national accreditation for continuing approval.

The organizations study also supported the accreditation recognition approach as a possible mechanism to be considered by boards of nursing in continuing approval of nursing education programs. A strong majority of respondents from organizations that represent colleges and universities, RNs, and specialty accrediting bodies were supportive of an approval model that recognizes voluntary accreditation as being indicative of meeting continuing approval criteria.

Boards of nursing currently recognizing national nursing accreditation as a criterion for continuing approval were surveyed after completing the nursing education program study and organizations study. This survey of boards of nursing revealed that eight of the nine boards of nursing using the accreditation recognition approach would recommend this mechanism to other boards of nursing. The other board recently adopted this model and stated that it was to early to make a recommendation.

In summary, analysis of the data collected and research findings support the position paper on approval of nursing education programs by boards of nursing. The position paper identifies the unique roles of Member Boards in the approval process, in addition to describing an accreditation recognition mechanism as an approach to be considered by boards of nursing in carrying out their responsibilities with respect to nursing education programs.

References

National Council of State Boards of Nursing. (1997a). *A position paper on the terminology of approval and accreditation.* Chicago: NCSBN.

National Council of State Boards of Nursing. (1997b). *Report of the subcommittee on nursing program approval/accreditation.* Chicago: NCSBN.

National Council of State Boards of Nursing. (1994). *Model nursing administrative rules.* Chicago: NCSBN.

Attachment B

Position Paper Related to Approval of Nursing Education Programs by Boards of Nursing

Introduction and Purpose

Recognizing that boards of nursing carry out an important role in the approval of nursing education programs, the National Council of State Boards of Nursing appointed a subcommittee of the Nursing Practice and Education Committee to look at the issues surrounding approval and accreditation of nursing education programs. The purpose of this paper is to make recommendations that boards of nursing may utilize in the approval process of nursing education programs, based on an analyses of several studies conducted by the National Council of State Boards of Nursing.

Historical Perspective

To understand the issues involved in the approval and accreditation process, one must look at the historical context in which approval and accreditation of nursing education programs began. Early in the 20th century, nursing leaders helped to establish boards of nursing and set standards for licensure and for approval of nursing programs. Such standards did not exist within or between states prior to that time. Initially, boards of nursing were created with the legal authority to license nurses, discipline nurses for unsafe practice, and develop rules and approve nursing education programs for the purpose of protecting the health, safety and welfare of the public. When national nursing organizations evolved to accredit nursing education programs, boards of nursing continued their approval processes utilizing the legal standards of nursing education that were found in the various nursing practice acts and rules and regulations. As a result, a dual process for evaluation of nursing programs emerged. In concert with boards of nursing purpose to protect the public, boards reviewed nursing education programs according to essential standards. National nursing organizations reviewed programs for the purpose of promoting excellence in education according to professional standards. The efficiency and cost effectiveness of the dual system is currently being questioned in light of increasing pressure on nursing education programs, approval bodies, and accreditation bodies to develop processes which are timely and cost-effective in protecting the public.

Current Approval Process

Graduation from an approved school of nursing is a criterion for licensure in every jurisdiction. Currently, fifty-eight boards of nursing approve basic nursing education programs. Although most boards of nursing grant initial and continuing approval for nursing education programs, at least ten boards of nursing recognize national nursing accreditation as a criterion for continuing approval. National nursing accrediting organizations are recognized by the United States Department of Education. Only three jurisdictions utilize an agency other than a board of nursing for the approval process.

A position paper on the terminology of "approval" and "accreditation" was adopted by National Council's Delegate Assembly in 1997. *Approval* is defined as "official recognition of nursing education programs which meet standards established by the board of nursing" (NCSBN, 1994, p. 2). The term *accreditation* is defined as "the official authorization or status granted by an agency other than a state board of nursing" (NCSBN, 1994, p. 2).

Different mechanisms are utilized by boards of nursing for approval of nursing education programs. These fall into three categories:

- **Separate and Distinct Mechanism** - The board of nursing grants initial and continuing approval of nursing programs based on the board's separate and distinct review of the nursing education program.

- **Accreditation Recognition Mechanism** - The board of nursing grants initial approval based on the board's separate and distinct review, and grants continuing approval based on the board's recognition of national nursing accreditation as a criterion for continuing approval for those programs that choose to be nationally accredited. Boards of nursing retain their authority for program approval. For those programs not accredited, the separate and distinct mechanism would apply.

- **Non-involvement Mechanism** - The board of nursing is not involved in the approval process; another agency approves nursing education programs.

Data Sources

Over the past two years, data were collected from several sources regarding the approval process. Data were obtained from boards of nursing; nursing education programs; accrediting and credentialing agencies; and external groups comprised of consumers, employers, and nursing organizations. The methodologies included surveys of Member Boards and nursing education programs; semi-structured interviews with consumer groups, accrediting agencies, employers of nurses, and professional nursing organizations; roundtable discussion with national nursing accreditation/credentialing agencies; and phone interviews with boards of nursing using recognition of accreditation status as part of the continuing approval process for nursing education programs. (See complete listing of data sources at the end.) The data showed similarities in responses regarding the unique role of boards of nursing in the approval process of nursing education programs.

Unique Roles of Boards of Nursing

There was consistent agreement from the constituencies surveyed that boards of nursing do have unique and rightful roles in the regulation of nursing education programs. These roles are identified as:

- **Granting initial approval of basic nursing education programs**
  In most jurisdictions there is no alternative mechanism for granting initial approval. Across the studies there was strong agreement that this was a unique role.

- **Monitoring and sanctioning programs at risk by means of statutory authority**
  Across the studies, there was strong agreement and acceptance of the role of the board of nursing to monitor and sanction programs at risk. This includes denial of initial approval, imposing conditional approval, or withdrawal of approval. The nursing approval/accreditation roundtable discussion identified a critical need to develop reciprocal feedback mechanisms between boards of nursing and national nursing accrediting agencies for monitoring nursing education programs.

- **Demonstrating greater awareness of statewide nursing education program needs**
  There was general agreement that needs vary by state and community. Boards of nursing have a current understanding of statewide trends based on proximity and knowledge of individual programs and on the needs of practice settings within their jurisdictions.

- **Participating in standard setting for basic nursing education programs**
  There was consensus that boards of nursing should be involved in setting standards for nursing education programs through input, review, and/or approval. Respondents acknowledged the unique regulatory perspective that would be brought to standard setting by boards of nursing.

While it is clear from the results that all constituencies believed that boards of nursing have a significant role in the initial approval processes for nursing education programs, there were issues raised around mechanisms for continuing approval.

Comparison of Continuing Approval Mechanisms

Currently, the majority of approval mechanisms used by boards of nursing center on a separate and distinct board review of nursing education programs. Another mechanism that is increasingly gaining support is the recognition of a program's accreditation status from a national nursing accreditation agency as a criterion for continuing approval. Although the mechanism where a board does a separate and distinct review was viewed as redundant by all constituencies surveyed, boards of nursing often saw this as a system for positive checks and balances. Nursing education programs viewed redundancy as an undesirable characteristic related to ineffective utilization of time and resources. Both mechanisms, that is use of separate and distinct reviews by the board of nursing as well as recognition of national nursing accreditation, were perceived in the surveys as being effective in demonstrating accountability, protecting the public, and promoting quality in nursing education programs. These mechanisms were reported to be somewhat effective in exhibiting responsiveness to changes in health care, and in exhibiting responsiveness to innovations in educational programs.

According to boards of nursing and nursing education programs, the mechanism of recognizing accreditation was identified as being more cost-effective for state boards of nursing and for schools of nursing, more efficient in use of time by state boards of nursing, and more user friendly for nursing education programs than conducting a separate and distinct review by the board of nursing. Since both approval mechanisms are perceived as protecting the public, cost-effectiveness and efficiency become important issues for consideration. While acceptance of accreditation for continuing approval may be viewed as more cost-effective for boards and nursing education programs, accreditation is still a voluntary process and it is not the intent of this position paper to mandate accreditation as a criterion for continuing approval of nursing education programs. It is also recognized that approval of nursing education programs continues to be the responsibility of boards of nursing, whether through separate reviews by boards of nursing or some other mechanism.

Recommendations Based on Research Findings

Based on an analysis of the research findings, the following recommendations are made:

1. Boards of nursing continue to grant initial approval of nursing education programs based on the board's separate and distinct review.

2. Boards of nursing maintain a review process for continuing approval for nursing education programs which may include recognition of national nursing accreditation.

3. Boards of nursing continue to monitor and impose sanctions for programs that place public health, safety, and welfare at risk.

4. Boards of nursing, through National Council, collaborate with national nursing accrediting agencies to develop timely reciprocal feedback mechanisms between boards of nursing and national nursing accrediting agencies for monitoring nursing education programs.

Reference

National Council of State Boards of Nursing. (1994). *Model Administrative Rules*. Chicago: NCSBN.

Data Sources

Nursing Program Approval Study, by Questar Data Systems, April 14, 1998.
Approval and Accreditation Processes for Basic Nursing Education Programs by TVG, April 1998.
1997 Member Boards Needs Assessment by NCSBN, 1997.
Accreditation Roundtable, April 21, 1998.
Survey of States Accepting Voluntary Accreditation for Reviewing Approval by NCSBN, April 1998.

Report of the Nursing Practice and Education Discipline Resources Subcommittee

Subcommittee Members

Jane Werth, AZ, Area I, *Chair*
Giovanni DiPaloa, CT, Area IV
Thania Elliott, LA-RN, Area III
Dianne Glynn, KS, Area II
Marjorie Bronk, TX-VN, Area III, *Liaison member to Nursing Practice and Education Committee*
Toma Nisbet, WY, Area I, *Liaison member to Nursing Practice and Education Committee*

Staff

Vickie Sheets, JD, RN, *Director for Practice and Accountability*

Relationship to Organization Plan

Goal II.. .....Provide information, analyses, and standards regarding the regulation of nursing practice.
Objective D.....Provide for Member Board needs related to disciplinary activities.

Recommendations to the Nursing Practice and Education Committee

1. **That the Delegate Assembly adopt one version of the alternative policy recommendations presented below, developed by the Discipline Resources Subcommittee of the Nursing Practice and Education Committee, regarding licensure requirements and felony convictions, with the version to be selected based on feedback at the Annual Meeting forum.**

   ***Version One*:**

   Adopt a policy recommendation to Member Boards that criminal background checks be conducted on applicants for nursing licensure and that individuals are ineligible for nursing licensure on the basis of felony conviction. The licenses of nurses convicted of a felony after licensure would be revoked. This policy would be incorporated in the uniform licensure requirements and the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*.

   Version Two:

   Adopt a policy recommendation to Member Boards that criminal background checks be conducted on applicants for nursing licensure and that individuals are ineligible for nursing licensure on the basis of felony conviction for violent crimes against persons, including sexual misconduct. For other felony convictions, individuals would be barred from licensure for five years after the absolute discharge of their sentence, and then be considered on a case-by-case basis. The licenses of nurses convicted of a felony after licensure would be revoked. Nurses convicted of felonies which did not involve violent crimes against persons, including sexual misconduct, could be considered for reinstatement on a case-by-case basis five years after the absolute discharge of their sentence. This policy would be incorporated in the uniform licensure requirements and the *Model Nursing Practice Act* and *Model Nursing Administrative Rules*.

   Rationale

   Based on the extremely high recidivism rate for felons and the advice of a consultant criminologist that felony conviction represented very high risk behavior, the subcommittee members became convinced that felony conviction is an appropriate first-level screen for licensure applicants. In the current criminal justice system, a felony conviction is a highly significant event. Many individuals convicted of felonies are extremely manipulative and adept at working a system. This recommendation makes a strong statement regarding the behavioral expectations for nurses. Given the high stakes nature of the requirement being proposed, the subcommittee members also believe it is essential that criminal background checks be conducted on all applicants for nursing licensure.

The view of the subcommittee is that the limited resources of boards of nursing should not be spent on administrative processes with felons. Rather, such scrutiny should be focused on other applicants. Another important consideration are the implications for mutual recognition if states continue to enact different licensure requirements related to criminal convictions.

The subcommittee recognizes that these recommendations may be perceived by some as extreme. However, the policy suggested above is consistent with policies promoted for other individuals working with at-risk populations. The United States Department of Justice has recently developed *Guidelines for the Screening of Persons Working With Children, the Elderly, and Individuals With Disabilities in Need of Support* (April, 1998). In those guidelines, it is suggested that the "Automatic disqualification of a potential worker or volunteer is appropriate when screening indicates that the individuals, as an adult, perpetrated any crime involving a child and/or a dependent adult, regardless of how long ago the incident occurred, and/or any violent crime within the past 10 years." Consumers needing health care are vulnerable. It is appropriate to establish high behavioral standards for applicants for nursing licensure and licensed nurses. Should boards be right, wrong, or safe?

Background

Boards of nursing have obtained information regarding prior criminal convictions from applicants for nursing licensure by asking questions on licensure applications. Decisions regarding whether or not to license were determined on a case-by-case basis. In recent years, concerns regarding screening of applicants have led some boards to explore other approaches to validation of background. The 1996 Delegate Assembly adopted a resolution directing the National Council to develop resources to support Member Board decisions regarding chemical dependency and criminal convictions. The 1997 Discipline Resources Subcommittee focused its efforts on developing a chemical dependency resource, but began to explore the topic of criminal convictions. The 1998 Discipline Resources Subcommittee continued this exploration.

To carry out its charge, the subcommittee completed several significant tasks. In addition to a literature search, the subcommittee reviewed the results of previous surveys conducted regarding Member Board approaches to criminal convictions. To supplement that information, the subcommittee conducted additional survey activities. The subcommittee also consulted with a criminologist to assist in locating information and resources to support its activities.

Highlights of Activities

- **Completion of Survey Activities**

The subcommittee conducted an e-mail survey to identify boards currently, or recently, working on this topic. Structured interviews were conducted with the staff of these targeted boards to obtain in-depth information about the respective board's approach to criminal convictions. These results will be reported in an *Emerging Issues* this summer.

- **Planning for the 1998 Dialogue on Discipline**

The subcommittee planned for the third *Dialogue on Discipline*, to be held in conjunction with National Council's Annual Meeting on Monday, August 3, 1998. The program this year will focus on Board of Nursing Evaluation of Criminal Behavior: Public Protection vs. High Risk Behavior vs. Individual Rights vs. Limited Board Resources. The program also includes an afternoon session addressing the discipline challenges presented by multistate practice and mutual recognition.

- **Development of policy recommendation to take to the 1998 Delegate Assembly**

The subcommittee considered the information and resources found in the literature, information provided by the consultant, legal analysis conducted by the National Council attorney, and the approaches being considered and/or implemented by Member Boards in bringing the policy recommendation to the 1998 Delegate Assembly.

- **Development of *Criminal Behavior Handbook for Boards of Nursing***

The subcommittee planned a *Criminal Behavior Handbook for Boards of Nursing* to support Member Boards in their decision-making involving applicants and nurses with criminal backgrounds. The handbook will have a wealth of information easily accessible for Member Board use. The publication of this resource is planned for fall 1998.

Future Activities

- Hold the third *Dialogue on Discipline*, in conjunction with the 1998 Annual Meeting.
- Publish the *Criminal Behavior Handbook for Boards of Nursing*, expected in fall 1998.
- Future discipline modules are planned for managing cases involving nursing practice or quality of care. In addition, if a policy recommendation is adopted by the Delegate Assembly, development of language for incorporation in the *Model Nursing Practice Act* and *Model Nursing Administrative Rules* and other activities to support such policy would be undertaken.

Meeting Dates

- November 11-12, 1997
- February 26-28, 1998
- April 27-29, 1998
- June 5, 1998 *(telephone conference call)*

Recommendations to the Nursing Practice and Education Committee

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   ### *Fiscal Impact*

   The costs to the National Council, if this policy were implemented, would be minimal and could be absorbed by existing committees and work groups (e.g., adding language to *Model Nursing Practice Act* and *Model Nursing Administrative Rules*).

   The policy could result in both costs and savings to Member Boards. For example Member Boards may incur costs to initiate legislation and/or rule changes and costs to educate legislators, nurses and the public about the policy. Such costs would vary by jurisdiction. Savings would result from this policy if boards did not incur the costs of case-by-case review for applicants ineligible because of felony conviction.

Attachments

Attachment A

1998 Dialogue on Discipline: Agenda

Board of Nursing Evaluation of Criminal Behavior: Public Protection vs. High Risk Behavior vs. Individual Rights vs. Limited Board Resources

7:30 - 8:00 Registration

8:00 - 8:15 Introduction and Overview of Work of Discipline Resources Subcommittee - *Jane Werth*

8:15 - 9:45 **Crime & Punishment, and Nursing Regulation** - *Greg Cooper, Provo Police Chief (former FBI Profiler)*

- Criminal justice system overview
- Misdemeanor vs. felony
- Statistics/profiles/predicting behavior
- What other professions are doing
- Do criminals think differently?
- Underlying behavior vs. "labels"
- Recommendations for nursing regulators

9:45 - 10:00 Break

10:00 - 11:30 **High Risk Behavior vs. Public Protection** - *Marilyn Kieffer-Andrews, Nurse-Psychologist*

- Differences between someone who commits a crime and other people
- What motivates, inspires them to do what they do?
- Criminal mind - "Don't get it" vs. "Don't care"
- Methods of evaluation
- Specific cases evaluated (or served as expert witness)
- Making predictions for "safety to practice"

11:30 - 12:30 **Alternative Approaches to Criminal Convictions: Member Boards Relate Experiences**
Panel of Member Board Representatives

- Doing criminal checks before student clinical experiences - *Thania Elliott, LA-RN*
- Absolute bar to licensure - *Marjorie Bronk, TX-VN*
- "Time-limited" bar to licensure - *Nathan Goldman, KY*
- Denial vs. discipline, and category bar - *Dianne Glynn, KS*

12:30 - 2:00 **Networking Luncheon with Education Workshop Participants** - *guest speaker, Barbara Donaho*

2:00 - 4:30 **MSR Discipline Challenge: Member Board Dialogue Regarding Discipline in a Multistate Practice Environment**
Panel representing investigators, attorneys, and board discipline staff discuss how different discipline scenarios might be approached with mutual recognition

- Iva Boardman
- Robert Buck
- Donna Mooney
- James Smith

4:30 - 5:00 **Closing Thoughts, Evaluations**

Attachment B

Nursing Practice and Education Discipline Resource Subcommittee

Criminal Behavior Handbook for Boards of Nursing

Working Outline

I. Introduction and Purpose

II. Background
- An Overview of the Criminal Justice System
- An Overview of Criminal Theory
- A Discussion of Felonies and Misdemeanors

III. Boards of Nursing Evaluation of Criminal Behavior: Can you Predict Future Behavior Based on Past Actions?
- How Boards of Nursing Currently Approach Criminal Convictions
- How Other Professions/Occupations Approach Criminal Convictions
- Why Boards of Nursing Should be Concerned about Criminal Convictions
- The Public Perspective: Results of a Consumer Focus Group
- The Best Use of Resources: A Cost/Benefit Analysis
- To Bar or Not to Bar

IV. Facilitating Access to Criminal Background Information

V. Fraudulent Behavior and Nursing Regulation

VI. Using Criminal Background Information
- Facilitating Review of Criminal Background Information
- Facilitating Board Decision-making: Applicants/Nurses with Criminal Convictions
- Designing Effective Remedies: Elements to Consider

VII. Other Resources
- Board Orientation on Evaluating Criminal Convictions: A Workshop Model
- Case Law Review
- Criminal Convictions and School of Nursing Admission Criteria/Decisions
- Works Referenced
- Glossary
- Other Resources

Appendices
- Survey Results
- Disciplinary Data Bank Statistics
- Model Statute and Model Rule
- Sample Procedures, Letters and Orders

Attachment C

Criminal Convictions and Nursing Regulation
A Supporting Paper

By Gregory M. Cooper, MPA and Vickie R. Sheets, JD, RN

Introduction

The public expects safe and competent nursing care, and the nursing profession demands professional standards of conduct which support the public's confidence. The majority of encounters between clients and nurses are positive, allowing nurses to meet the health needs of the individuals entrusted to their care. Although the chances are relatively small that the nurse providing an individual's care is someone whose behavior may place the client at risk, incidents of serious incompetence or abuse traumatizes the victims and shakes public trust in care providers and organizations serving vulnerable populations.

One possible predictor of future behavior is a history of past criminal conviction. Most states currently ask questions on licensure applications regarding prior criminal convictions, and utilize a case-by-case approach to scrutinize the applications of those individuals who have had such history. This paper explores the reasons why additional criminal background screening is needed. The paper also provides information to support a policy recommendation for a consistent approach to licensure decision-making regarding applicants and nurses with criminal convictions.

Statement of the Problem

It is a different world today, in so many ways. Increasingly, health care is provided away from traditional institutional settings. More care settings are in the home, or community, away from the scrutiny of supervisors or close association with colleagues. Consumers are sent home after brief hospital stays, with significant care needs and increased vulnerability because of those needs. And we can all think of examples of how the world is more dangerous - from road rage to stalking behavior, from school shootings to violent rampages against former employers, and from terrorist threats to fear of nuclear clashes between countries. It is a complicated, dangerous world we live in.

Life is all about choices. Choices made at an earlier time in an individual's life have significant impact and consequences on later life activities. An individual must meet identified requirements before being granted a license and the authority to practice nursing. If a person chooses not to obtain post-secondary education, professional nursing opportunities are not available. If a person makes poor judgments – getting involved in criminal activities – those choices affect the person's subsequent ability to exercise selected privileges in our society. The burden is upon the individual to provide evidence that the person has met the education, examination, behavioral and other requirements of nursing licensure. Past criminal behavior raises concerns regarding the behavioral competence of the individual.[1]

More individuals with felony convictions are applying for licensure. Arizona reports a 1400 percent increase in felony applicants for RN and LPN licensure, and for certified nurse aide (CNA) registration in one year (from 4 the entire year in 1995 to 52 for the year in 1996). The higher rate was maintained in 1996 (60 applicants with felony

[1] Competence includes knowledge, skills and attitudes. Competence conduct refers to health and conduct expectations which may be evaluated through reports from the individual practitioner, employer reports, and discipline checks. (National Council, *Assuring competence,* 1996)

convictions). (Walsh, 1998). Other states also report increases in the number of applicants indicating prior history of criminal convictions on licensure applications.

Responding to the problems of life with anger, violence and exploitation is not limited to any single cultural group. Society reflects its environment, and the pool of licensure applicants and nurses reflects society. The board of nursing role in screening out those individuals who may pose a threat to consumers has never been more important.

The Role of the Board of Nursing

Licensing boards are charged with maintaining the balance between the board's responsibility to protect the public health, safety and welfare and the rights of the professional to practice a chosen profession. Licensing requirements define what is necessary for the majority of individuals to be able to practice the profession safely. Boards validate that an applicant has met those requirements through review of educational credentials, a national licensing examination, and review of other sources of information regarding the applicant. Crimes that have potential impact on the ability to practice a profession safely or predict how the professional might treat vulnerable clients in his or her care should be considered as part of a credentialing decision. They are indicative of that aspect of competence composed of affective or behavioral elements. (National Council, *Response to Pew Foundation Report*, 1996)

Health care consumers are dependent upon boards to conduct appropriate screening of applicants. It is often impossible for the average consumer to collect and evaluate information about health care providers before he/she is the recipient of care. There is need for timeliness and expediency when dealing with illness and injury, and even consumers who would be willing to evaluate a number of potential resources before making critical decisions may be prevented from doing so. People dealing with crisis may be in shock, grieving, or may be unable to make this type of decision. In addition, the consumer usually does not have the option to select the nurses assigned to provide care. The majority of nurses are employees of health care agencies. As such, the agency and the nurse are "bundled" – if you choose hospital A, you get nurse A, the hospital B nurse is not an option. The same is true of a variety of health care services. Regulation of health care providers provides some assurance that providers in all settings have met government set requirements before entering practice. (Sheets, 1997) An additional component of the board role is the enforcement of professional standards of conduct for continuing legal authority to practice. When grounds for discipline are violated, including criminal conviction that occurs after licensure, the nurse is subject to disciplinary action.

Background – The Criminal Justice System

Criminal law is for the purpose of preventing harm to society, declaring what conduct is criminal and prescribing the punishment to be imposed for such conduct. Primary societal interests include protection of people from physical harm and property from loss, destruction, or damage. Other interests include protection of: the public health, the public peace and order, the government (from injury or destruction), the administration of justice (from interference), safeguards against sexual immorality and other continually evolving interests. (Northrop,1987) Substantive criminal laws are commonly codified into criminal or penal codes. The seriousness of a criminal offense is related to the penalty assigned for its violations, and a felony is a crime of serious nature. Under federal law and most state statutes, any offense punishable by death or imprisonment for a term exceeding one year is considered a felony. (Black's Law Dictionary)

Criminal procedure is concerned with the procedural steps through which a criminal case passes. Limitations are placed on the government so that an individual's liberty and exercise of constitutional rights are not unduly impeded.[2] The definition of a crime must provide adequate notice of what conduct is prohibited. The courts strictly construe criminal statutes to assure that the historical notions of fundamental fairness are maintained. Generally, the law requires the elements of an act (*actus reus*), a criminal intent or guilty mind (*mens rea*), and causation to be

[2] "The necessity of greater procedural protections in the criminal and quasicriminal setting than those available in the civil context is due to the nature of what is at stake in each of these. In criminal proceedings, life and liberty are usually at stake. In civil proceedings, generally money is the issue. The criminal trial provides the accused with a process that includes full notice of the charges, the right to compel witnesses on the accused's behalf at the trial, and the right to confront the witnesses against him or her." (Northrop, p. 395)

present for the conviction of a crime. The specific elements of crimes vary and are specified in penal codes. (Northrop, 1987)

The Criminal Justice System Interface with Regulation

In the current criminal justice system, a felony conviction is a highly significant event. Many individuals convicted of felonies are extremely manipulative and adept at working a system. (Cooper, 1998) The regulatory agency reviewing an individual with a criminal history must be cognizant of the burden of proof required in criminal proceedings and the scrutiny of the decision-making by a jury or experienced judge. By the time an individual is convicted of a felony, that individual has interfaced with the police, prosecutors, defense attorneys, judges, correctional officials and parole and/or probation authorities in the investigation, prosecution and sentencing aspects of the conviction. (Northrop, 1987) When cases involve plea agreements, an individual also has multiple interactions with a variety of authorities. It is not the role of the licensing board to retry or second guess these authorities. It is the role of the licensing board to use the conviction (including plea agreements) history in decision-making regarding competence conduct and licensure.

Screening of Licensure Applicants for Criminal Background

According to the Department of Justice, statutes governing state social welfare and licensing agencies have increasingly required that certain screening practices be used for those workers and volunteers working in settings in which individuals come into contact with children, the elderly and individuals with disabilities. (Department of Justice, 1998). Nurses provide nursing care to all age groups, from babies through the elderly. Nurses work in a variety of settings – hospitals, nursing homes, intermediate care, rehabilitation, congregate care, board and care, group homes, psychiatric hospitals, residential treatment facilities as well as the home and community. Licensing provides a logical opportunity to identify concerns regarding the qualifications of those who care for the members of society most susceptible to abuse.

National Council efforts to facilitate access (in some type of agent role on behalf of Member Boards) to national criminal bases to date have been unsuccessful. However, individual states do have access to national criminal fingerprint checks. Public Law 92-544 empowers the Federal Bureau of Investigation (FBI) to conduct a criminal records check for boards authorized by a state statute that has been approved by the Attorney General of the United States. Such authorization must be the result of a legislative enactment, must require fingerprinting of the applicant, and must authorize use of FBI records for the screening of the applicant. The FBI routinely charges $22-24 for processing each fingerprint card submission under Pub. L. 92-544. A caveat explaining the restrictions for use and challenge requirements is placed on each FBI record that is disseminated for employment and licensing purposes. (U.S. Department of Justice, 1998, p. 38-39)

The FBI release of criminal history record information (CHRI) and the safeguards undertaken demonstrate a concern for the proper use, security and confidentiality of such information. Since many governmental information sources were developed for purposes other than the screening of health care workers, conflicting policy goals between the protection of consumers from potential abusive individuals vs. the rehabilitation of offenders, due process issues and privacy interests has resulted in wide variation in the type and scope of screening required. (U.S. Department of Justice, 1998, p. 7)

Many boards of nursing access state or regional criminal statistics through state criminal agencies. There are also private agencies that will conduct criminal background checks using Social Security numbers or other data. These are usually state or regional in scope. Some boards required to conduct criminal background checks for nurse aides utilize these services (e.g., Colorado).

In a 1998 survey conducted by the National Council of State Boards of Nursing, five states were authorized to conduct fingerprint checks of licensure applicants, and three boards of nursing were requiring fingerprint checks to validate criminal background for applicants for nursing licensure (additional boards conducted background checks for nursing assistants). The California Board of Registered Nursing has been requiring fingerprint checks since 1990. The purpose of the checks is to prevent licensure of potentially unsafe nurses who have criminal records. The background check validates the information provided on applications by licensure applicants. After fingerprint checks were implemented, a significant increase in the number of self-disclosures was observed. An additional

benefit of fingerprint checks is that the board is notified by the California Department of Justice if nurses have criminal convictions subsequent to licensure. In addition to conducting state checks on licensure applicants, California is authorized in Business and Professions Code Section 144 for FBI checks on licensure applicants, and has this screening conducted on applicants for licensure by endorsement. (Lawrence, 1998) The California Vocational Board of Nursing has also been conducting fingerprint checks for all applicants since 1996.

The Nevada State Board of Nursing, which has been conducting fingerprint checks of licensed nurses since 1996, identified the following pros and cons related to fingerprinting:*

Positives

- Establishes concrete evidence of past criminal history
- Serves as a motivator for self-reporting by the individual seeking licensure/certification
- Produces revenue for the state treasure (Criminal History Repository)
- Utilized in the final decision-making process to grant or deny licensure/certification
- Continually identifies a greater number of individuals submitting fraudulent applications
- Nurses and nurse assistants benefit by the indirect secondary gain

Negatives

- Inconvenient and time consuming - acts as a barrier for rapid licensure and certification
- Requires use of temporary license and may delay permanent licensure/certification
- Disruptive to the licensure/certification process as the application remains incomplete until results of fingerprinting has been received by the NSBN [Nevada State Board of Nursing]
- Adds to the applicant's cost for licensure or certification
- Can be viewed as demeaning and an invasion of an individual's privacy
- Increases staff time when an aberrance occurs attributable to the applicant (noncompliance with process) or the system (lost report or isolated reports)
- Reports arrests and convictions, but sometimes doesn't report when charges are dropped or dismissed

* *Used with permission.*

The Nevada State Board of Nursing has concluded that as protectors of health care consumers, "...it is better to be too stringent, and err on the side of vigilance for the compromised ill, than to make licensure and certification readily accessible for a potential predator practicing in a health care environment." (O'Rourke-Langston, 1997, p. 5.)

Recidivism Statistics

Aggregate criminal statistics are available from a variety of sources (e.g., Bureau of Justice Statistics, National Corrections Reporting Program, Uniform Crime Reports), and the numbers are staggering. In 1995, for example, the FBI reported 13.9 million Crime Index offenses reported to law enforcement across the nation. This total represented a rate of 5,278 offenses for every 100,000 inhabitants in the United States. (U.S. Department of Justice, FBI National Press Release, 1996) Even more astounding are the results of an earlier (1982) survey conducted by the Rand Corporation of inmates in California, Michigan and Texas prisons. This study found that crimes rarely occur as isolated incidents and that arrests and convictions are a fraction of the total crimes committed. Some of the Rand findings include:

One Criminal	Crimes per Year
Burglar	76-118 burglaries
Robber	41-61 robberies
Auto Thief	76-100 auto thefts
Forger	62-98 frauds
Drug Dealer	880-1299 drug deals

While criminal statistics are tracked annually, the recidivism studies were conducted with statistics from the 1980s. This is in part due to the nature of the problem under study -- some time has to elapse before recidivism can be determined. For the purposes of this paper, recidivism means any act where a felon has violated public trust (e.g., re-arrest for the same felony or one of similar gravity, return to prison on a parole violation, and/or reconviction for a similar or new offense). (Cooper, 1998)

Samenow observes that, despite a multitude of differences in their backgrounds and crime patterns, criminals are alike in one way: how they think, and they think differently than non-criminals. He views crime as a way of life, not an occasional aberration. To effect a lasting change in a criminal, the process of the criminal's thinking has to be changed. Obviously, not every person who commits a crime is a hard-core criminal, but still, crimes result from the way a person thinks. And it is difficult to change the cognitive patterns of a lifetime. Recidivism is a major measure of whether such cognitive change has occurred.[3] (Samenow, 1984)

The research on the recidivism rate for post-release felons is not encouraging. According to Harer (1987), within three years of their release from the Federal Bureau of Prisons in 1987, 40.8 percent of the former inmates had either been rearrested or had their parole revoked. This finding is based on a representative sample of 1,205 Bureau of Prisons inmates released to the community during the first six months of 1987. Another study from the state of Minnesota reports that 66 percent of property offenders and 45 percent of violent offenders released from prison were arrested for a new felony or gross misdemeanor within three years. In a study conducted by the Tennessee Bureau of Investigation, of 3,793 offenders released in a two-year period, from 1989 to 1981, 53.5 percent were either recommitted or rearrested within two years of the date of their release. A Canadian study (1983-1984) found that of 3,267 released male offenders, nearly half (49%) reoffended within three years, and approximately one-third (36%) of the 81 female offenders studied committed a further offense.

According to the U.S. Department of Justice (1983), of the 108,580 persons released from prisons in 11 states in 1983, representing more than half of all released state prisoners that year:

- 62.5 percent were rearrested for a felony or serious misdemeanor within three years, 46.8 percent were reconvicted and 41.4 percent returned to jail or prison.
- An estimated 68,000 of the released prisoners described above were rearrested and charged with more than 326,000 new felonies and misdemeanors (including approximately 50,000 violent offenses, more than 141, 000 property offenses, and 46,000 drug offenses).
- Recidivism rates were highest in the first year (one of four released prisoners were rearrested in the first six months and two of five within the first year of release).
- The older the prisoner, the lower the rate of recidivism.
- Over 74 percent of those with 11 or more arrests were rearrested.
- 38 percent of first-time offenders were rearrested.
- Released prisoners were often re-arrested for the same type of crime for which they had served time (within three years, 31.9 percent of released burglars were rearrested for burglary, 24.8 percent of drug offenders were rearrested for a drug offense, 19.6 percent of robbers were rearrested for robbery).
- Released rapists were 10.5 times more likely than non-rapists to be rearrested for rape.
- Released murderers were five times more likely to be rearrested for murder.
- Nearly one in three released violent offenders and one in five released property offenders were arrested within three years for a violent crime following their release from prison.

When criminals repeat criminal behavior, they demonstrate that their thought patterns have not changed, and there is a high probability that there will be a new victim. Health care populations are immensely vulnerable. What is the

[3] In Samenow's view, the causal factors for criminality have not been identified and no one really knows why the criminal opposes the social order. But he opines that it is about choice and responses to temptation and adversity. This is not a new concept, it is biblical: "As a man thinketh in his heart, so is he." (Proverbs 23:7) Throughout life, the criminal has gotten away with far more than what has been discovered. Recidivism statistics indicate only whether he has been careless enough to be caught. (Samenow, 1984)

regulatory responsibility in linking what is known about serious criminal (felony) behavior juxtapositioned against a highly vulnerable population? Regulators face the following issue in reviewing these grim numbers: should health care consumers be placed at even a 10 percent chance of being victimized, let alone a 40 percent chance of violent crime victimization or nearly a 70 percent chance of property crime victimization?

Criminal Conviction Policy Approaches

Criminal background checks, specifically fingerprint checks, can be an invaluable tool for meeting board of nursing responsibility to protect the public. There are several possible approaches to policies based on criminal background checks (a bar means that a person cannot be licensed):

- Absolute bar to felony convictions – a person with a history of felony conviction is ineligible for licensure
- Permanent bar to certain categories of felonies
- Time-limited bar to felony convictions
- Case-by-case review of applicants/nurses with felony convictions

Absolute bar to felony conviction. Cooper suggests that the first and broadest consideration for possible screening mechanisms for individuals caring for vulnerable populations is the elimination of applicants who have been charged and convicted for committing a felony. This regulatory approach recognizes that a felony conviction is a significant event and that a person has "to work very hard" to be convicted of a felony in the current criminal justice system. (Cooper, 1998) Samenow believes that criminals need to be treated as responsible for their behavior, held accountable, and assisted in altering their thinking patterns. (Samenow, p. 213) To determine whether such cognitive change has truly occurred requires extensive assessment, with review of court records, clinical and forensic interviews as well as evaluation of situational context. (Cohen, 1996) With increasing numbers of applicants who have had such convictions and with limited resources of boards of nursing, the comprehensive assessment necessary to screen effectively those few (by the recidivism statistics) felons who might be rehabilitated from those individuals who continue to pose a danger to vulnerable consumers may be beyond the resources available to boards of nursing. This option allows boards to focus their administrative processes on other applicants needing special scrutiny. Some will think this approach harsh, and cite examples of former criminals who have rehabilitated and gone on to model lives. However, given the recidivism statistics cited above, this is the safest approach. The Texas Board of Vocational Nurse Examiners and the Louisiana State Board of Nursing have implemented absolute bars to licensure for felony convictions.

Permanent bar to certain categories of felonies. Another policy option is the identification and bar of felonies involving serious or violent offenses. A category of serious offenses has been identified by the FBI, which lists five serious crimes: murder, non-negligent manslaughter, forcible rape, robbery and aggravated assault. (Douglas, Burgess & Ressler, 1992) These crimes could be prima facie criteria for immediate elimination from further consideration. Other criminal convictions may be reviewed or classified according to the nature and circumstances associated with the crime. Violent crimes represent the highest risk of dangerousness and have high recidivism rates. This approach is appealing because the number of applicants with violent crime convictions is a small proportion of the applicants with felonies, and this approach is being used by at least two boards (Oregon and Tennessee). This approach does not bar other types of crime. The high recidivism rate for property crimes does raise concerns regarding the vulnerability of clients to property crimes, especially in autonomous settings.

Time-limited bar to felony convictions. Another approach is a time-limited bar to felony convictions. This option looks at the time elapsed since the felony conviction. Since most recidivism occurs in the first three years, this approach provides a safety cushion, and time for the individual to get his/her life back together following the felony conviction. This approach is being used in Kentucky and legislation implementing this approach is pending in Arizona.

Case-by-case review. Based upon applicant self reporting has been the historical approach for boards of nursing in making licensure decisions involving applicants with criminal convictions. This approach allows boards to evaluate not only the nature and context of the crime, but also the rehabilitation efforts since as well as considering the time elapsed and other factors. All boards have the authority to deny licensure or take disciplinary action on the basis of

a criminal conviction. Currently, some boards may have statutory requirements to consider the rehabilitative efforts and other factors (e.g., Minnesota). Using the case-by-case review approach, boards have the discretion to deny or grant licensure. At its best, such an approach gives someone a chance. At its worst, boards may be manipulated into an unsound decision. Additionally, there may be inconsistency of decisions due to changing board composition over time or inconsistency between jurisdictional policies and/or approaches which could have implications for individuals moving between states. The majority of states currently decide cases in this manner.

Implications of Criminal Convictions for Nursing Education Programs

No specific statutory provision was found prohibiting post-secondary education institutions (including nursing education programs) from excluding and/or denying admission to applicants who have had a prior felony conviction. Title VI of the Civil Rights Act of 1964 may, however, be interpreted as prohibiting any practice which gives rise to adverse impact against minorities in post-secondary education. Attorneys advising schools may therefore have concerns that denying admission solely on the past criminal history which is not shown to be related to educational objectives, without additional educational reason, could subject a school to allegations of discrimination. (Abram, 1998) Any prospective nursing student should be fully advised as to the licensure implications of having a history of a criminal conviction. If a board had a policy regarding limiting access to nursing licensure to individuals with felony convictions, giving notice to schools of such a licensure bar might support schools making hard decisions before a student has devoted time, resources and energy in obtaining an education that might not be used as expected.

Rational Relationship

An appellate court will not usually second guess a legislature regarding the wisdom of a particular statute if there is a rational basis for its enactment. Similarly, the courts have historically deferred to the expertise of administrative agencies regarding rules and decisions if there is a rational basis for the decision. (Tribe, 1978, p. 511). In most jurisdictions, an individual is viewed as gaining a property interest in a professional license, and such license cannot be revoked or otherwise disciplined without affording the individual due process. The degree of due process due an individual in a disciplinary action is governed by state law and may vary state to state. The right to a professional license is not typically deemed a fundamental right, thus the standard for review is the rational basis test. The courts have upheld statutes requiring automatic suspension or revocation of a license based on criminal conviction. To date, courts have declined to second guess the state's authorization of sanctions for a broad class of convictions. And the courts have uniformly held that the action of a state regulatory body in suspending or revoking an a individual's license on the basis of a criminal conviction does not constitute double jeopardy. (Abram, 1998)

Unlike the situations discussed above where the board has the burden of proof to demonstrate that a licensee has violated a ground for discipline, namely criminal conviction, an applicant for licensure bears the burden of demonstrating that he/she has met all the requirements for licensure. If the courts have upheld licensure revocation, it is only logical that licensure denial on the basis of criminal conviction would be upheld. One case was found involving the challenge of a nursing applicant for denial to take the licensing examination based on prior felony conviction. In *Davis v. Louisiana State Board of Nursing*, a Louisiana Court of Appeals found that a nursing student had been properly denied the opportunity to take the nurse licensing examination. Although the applicant had been granted a "first offender" pardon after serving a prison sentence for the arsenic poisoning death of her husband, the pardon did not return her to innocence, and the board's conclusion that she was guilty of a felony was lawful. The Court held that, "The underlying crime was serious, bore directly on her moral fitness and trustworthiness, and went to the very heart of the activities of the nursing profession." (*Davis vs. Louisiana*, p. 1)

Discussion

Automatic bar to licensure without consideration of the circumstances of the crime and what has happened to the individual in the time elapsed since the conviction may be uncomfortable for some regulators, and indeed, would require statutory change in some states. The profession of nursing has tended to open its arms to promising individuals, offering a second chance to persons in selected situations.[4] However, crimes against society do not fit

[4] For example, many boards provide alternative programs for nurses who are chemically dependent, and some concerns have been expressed regarding the implications for those nurses participating in alternative programs of some type of felony bar to licensure. However, many programs already indicate in the admission criteria that

the attitudinal aspect of competence conduct and reflect inadequate critical thinking skills. And, as the number of convicted felons desiring nursing licensure increases and the practice setting become more autonomous, the risks have also increased. And, the traditional protections (structure, supervision, working closely with peers) are absent in many work situations. The costs of providing case-by-case review for every individual with a criminal conviction are rising. Having a policy regarding felony criminal convictions allows boards to devote their limited resources to providing scrutiny and case-by-case decision-making to applicants with more serious misdemeanors, and to other issues which raise concerns regarding an individual's ability to practice nursing safely and competently.

Conclusion

The truth is that regulation does pose barriers – necessary barriers that provide assurance that complex professional activities are reserved to those individuals who have demonstrated competence to practice a profession. Whenever mandatory requirements for entering a profession are implemented, some people are denied the privilege to practice the profession. The fact that there needs to be a disciplinary process at all indicates that entry requirements in and of themselves cannot screen every unsafe professional.

The Delegate Assembly of the National Council of State Boards of Nursing has the opportunity to provide screening guidelines to boards of nursing for the purpose of reducing risk levels of licensing "high risk" nursing candidates. A nurse who violates either legal and/or professional standards tarnishes the reputation of the profession as well as diminishes the confidence of the public. "Fingerprinting is a minor inconvenience in obtaining the privilege to practice...Ultimately, fingerprinting all applicants ensures that the few who have patterns of domestic assault and/or violence, substance abuse, fraud and other chronic criminal acts are thwarted, and the public is protected from physical, emotional, and financial exploitation." (O'Rourke-Langston, 1998, p. 5) An applicant with a declared history of a felony conviction presents a confirmed history of serious deviance from societal standards. Consumers needing health care are vulnerable. Nursing is a stressful profession. Stress tends to cause bad habits to reappear. It is appropriate to establish high behavioral standards for applicants for nursing licensure and licensed nurses. Based upon the recidivism rates, the increasing autonomy of nursing practice, the changing society and the prior court decisions in this area, there is a rational basis for a policy approach limiting access to nursing licensure by convicted felons.

Gregory M. Cooper, Chief, Provo, Utah Police Department, is a former Supervisory Special Agent and was head of the FBI's behavioral profiling unit

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participation may be denied if a nurse has pending criminal action or prior conviction. (National Council, 1997) Arguably, notice of severe licensure consequences if one is convicted of drug offenses could encourage earlier identification of nurses with chemical problems, prior to entanglement with the criminal justice system.

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Notes

Report of the Finance Committee

Committee Members

Charlene Kelly, NE, Area II, Treasurer and Chair
Lanette Anderson, WV-PN, Area II
Sandra Evans, ID, Area I
Barbara Morvant, LA-RN, Area III
Ellen Toker, PA, Area IV

Staff

Jennifer Bosma, PhD, CAE, *Executive Director*
Thomas Vicek, MBA, CPA, *Director of Administrative Services*

Relationship to Organization Plan

Goal V.. .....Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective B.....Maintain a sound resource management system for the National Council.

Recommendations to the Board of Directors

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

2. **Recommended the initial FY98 operating and capital expenditure budgets and several mid-year budget adjustments. (Copy of operating budget is Attachment A)**

3. **Recommended a $450,000 increase in the Special Services Division (SSD) designated fund.**

4. **Recommended corporate resolutions required to open additional bank accounts to receive fees deposited by the outside organizations employed to handle Annual and Area Meeting registration functions and proceeds from sales of the SSD Professional Boundaries video.**

5. **Recommended approval of a revised policy for funding meeting travel requests.**

Highlights of Activities

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

- Reviewed the FY98 operating and capital expenditure budget requests and recommended their approval to the Board of Directors.

- Reviewed data from the candidate projection research study, requested a study to determine if projections for end of year candidate volume can be made based on quarterly candidate volume, and made adjustments in the current year budget and financial forecasts based on the study.

- Met with the auditors from Ernst & Young, and reviewed the audited fiscal 1997 financial statements and management letter.

- Directed the small-scale evaluation of Special Services Division operations.

- Monitored insurance coverage, investments, all expenditures over $15,000 and all financial policies.

Meeting Dates

- October 28, 1997

- January 26, 1998
- March 30, 1998 *(telephone conference call)*
- April 13, 1998 *(telephone conference call)*
- April 21, 1998
- April 28, 1998 *(telephone conference call)*
- May 4, 1998, *(telephone conference call)*
- July 9, 1998

Attachments

Attachment A

FY98 Budget by Organization Plan, Goals and Objectives

	FY98 Budget

Goal I. Provide Member Boards with examinations and standards for licensure and credentialing.

A. Conduct job analysis studies to serve as the basis for examinations.

Salaries, Benefits and Taxes	$62,875
Professional/Contractual Fees	30,002
Travel	9,020
Printing and Publications	26,036
Postage and Shipping	35,900
Other Expenses	6,535
Allocation of Administrative Costs	14,754
Total	$185,122

B. Provide examinations that are based on current accepted psychometric principles and legal considerations.

NCLEX® Examination Revenue	$(16,045,000)
Salaries, Benefits and Taxes	659,714
NCLEX Processing Costs	11,360,000
Professional/Contractual Fees	83,889
Travel	223,290
Telephone and Communications	14,950
Printing and Publications	27,060
Postage and Shipping	14,000
Other Expenses	6,200
Allocation of Administrative Costs	154,409
Total	$(3,501,488)

C. Conduct research and development regarding computerized clinical simulation testing for initial and continued licensure.

Salaries, Benefits and Taxes	$430,349
Professional/Contractual Fees	481,780
Travel	141,120
Telephone and Communications	16,850
Other Expenses	12,670
Allocation of Administrative Costs	100,980
Total	$1,183,749

	FY98Budget
D. Provide a competency evaluation program for nurse aides.	
Royalty Income	$(420,000)
Salaries, Benefits and Taxes	76,108
Professional/Contractual Fees	1,250
Travel	6,930
Printing and Publications	500
Other Expenses	800
Allocation of Administrative Costs	17,858
Total	$(316,554)
E. Provide a comprehensive approach for the regulation of advanced nursing practice.	
Salaries, Benefits and Taxes	$44,945
Professional/Contractual Fees	5,000
Travel	38,520
Other Expenses	3,650
Allocation of Administrative Costs	10,546
Total	$102,661
F. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel.	
Salaries, Benefits and Taxes	$71,631
Professional/Contractual Fees	77,500
Travel	24,480
Other Expenses	925
Allocation of Administrative Costs	16,808
Total	$191,344
G. Promote consistency in the licensure and credentialing process.	
Salaries, Benefits and Taxes	$19,948
Travel	14,400
Printing and Publications	950
Professional/Contractual Fees	11,350
Other Expenses	3,925
Allocation of Administrative Costs	4,680
Total	$55,253

	FY98 Budget
H. Identify the role of a board of nursing related to continued competence.	
Salaries, Benefits and Taxes	$28,912
Travel	19,530
Other Expenses	1,200
Professional and Contractual Fees	70,400
Allocation of Administrative Costs	6,784
Total	$126,826
Goal I Total	$(1,973,087)

Goal II. Provide information, analyses and standards regarding the regulation of nursing practice.

A. Analyze the health care environment for trends and issues affecting the regulation of nursing practice.	
Salaries, Benefits and Taxes	$56,455
Professional/Contractual Fees	127,500
Allocation of Administrative Costs	13,248
Total	$197,203
B. Provide resources regarding health care issues which affect the regulation of nursing practice.	
Salaries, Benefits and Taxes	$17,239
Professional/Contractual Fees	2,000
Travel	28,350
Other Expenses	1,075
Allocation of Administrative Costs	4,045
Total	$52,709
C. Conduct research on regulatory issues related to disciplinary activities.	
Salaries, Benefits and Taxes	$8,311
Professional/Contractual Fees	4,850
Travel	15,660
Other Expenses	550
Allocation of Administrative Costs	1,951
Total	$31,322

	FY98 Budget
D. Provide for Member Board needs related to disciplinary activities.	
Meeting Revenue	$(4,280)
Other Revenue	(900)
Salaries, Benefits and Taxes	100,259
Professional/Contractual Fees	33,939
Travel	4,320
Meetings and Conferences	5,280
Other Expenses	2,800
Allocation of Administrative Costs	17,478
Total	$158,896
Goal II Total	$440,130

Goal III. Provide information, analyses and standards regarding the regulation of nursing education.

A. Analyze the health care environment for trends and issues affecting the regulation of nursing education.	
Salaries, Benefits and Taxes	$21,825
Professional/Contractual Fees	69,314
Travel	32,040
Allocation of Administrative Costs	5,121
Telephone and Communications	4,525
Other Expenses	1,800
Total	$134,625

B. Provide resources regarding issues that affect the regulation of nursing education.	
Salaries, Benefits and Taxes	$30,736
Professional/Contractual Fees	5,807
Other Expenses	1,050
Allocation of Administrative Costs	7,211
Total	$44,804
Goal III Total	$179,429

Goal IV. Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

A. Implement a comprehensive repository of information.	
Salaries, Benefits and Taxes	$242,617
Professional/Contractual Fees	77,050
Travel	26,910
Telephone and Communications	49,830
Equipment Rental and Maintenance	64,000
Other Expenses	29,526
Allocation of Administrative Costs	49,068
Total	$539,001

FY98 Budget

B. Establish a nurse information system (NIS) for use by Member Boards and others.

Salaries, Benefits and Taxes	$112,958
Professional/Contractual Fees	81,999
Travel	16,751
Equipment Maintenance and Rental	65,366
Other Expenses	18,298
Allocation of Administrative Costs	26,237
Total	$321,609

C. Facilitate communication between National Council, Member Boards and related entities.

Communication Projects Revenue	$(106,000)
Meeting Revenue	(119,625)
Salaries, Benefits and Taxes	384,654
Professional/Contractual Fees	55,479
Travel	214,410
Printing and Publications	254,200
Other Expenses	33,745
Allocation of Administrative Costs	85,306
Meetings and Conferences	233,620
Total	$1,035,789

D. Conduct and disseminate research pertinent to the mission of the National Council.

Salaries, Benefits and Taxes	$142,755
Professional/Contractual Fees	14,031
Travel	29,520
Other Expenses	8,000
Allocation of Administrative Costs	33,497
Total	$227,803
Goal IV Total	$2,124,202

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

A. Implement a planning system to guide the National Council.

Salaries, Benefits and Taxes	$189,893
Professional/Contractual Fees	4,000
Allocation of Administrative Costs	53,456
Total	$247,349

	FY98 Budget
B. Maintain a sound resource management system for the National Council.	
Investment Income	$(800,000)
Membership Fee Revenue	(183,000)
Salaries, Benefits and Taxes	424,749
Professional/Contractual Fees	77,606
Travel	15,750
Other Expenses	4,540
Allocation of Administrative Costs	99,666
Total	$(360,689
C. Maintain a system of governance for the National Council that facilitates leadership and decision-making.	
Salaries, Benefits and Taxes	$237,606
Professional/Contractual Fees	33,363
Travel	86,220
Printing and Publications	7,100
Other Expenses	9,400
Allocation of Administrative Costs	51,807
Total	$425,496
D. Provide consultation and services to meet unique Member Board needs.	
Salaries, Benefits and Taxes	$3,893
Allocation of Administrative Costs	914
Total	$4,807
E. Develop and implement a systematic approach for shaping health care policy related to regulation.	
Salaries, Benefits and Taxes	$76,113
Professional/Contractual Fees	8,900
Travel	52,560
Other Expenses	3,890
Allocation of Administrative Costs	17,859
Total	$159,322
F. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes.	
Salaries, Benefits and Taxes	$90,190
Professional/Contractual Fees	75,000
Travel	31,000
Other Expenses	1,000
Allocation of Administrative Costs	21,162
Total	$218,352

FY98 Budget

G. Continue developing the concept of a regulatory model which incorporates the characteristics of multistate practice.

Salaries, Benefits and Taxes	$71,870
Professional/Contractual Fees	15,000
Travel	107,460
Meetings and Conferences	63,500
Other Expenses	4,325
Allocation of Administrative Costs	16,865
Total	$279,020

H. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division.

Special Services Division Revenue	$(422,500)
Salaries, Benefits and Taxes	194,663
Royalties	10,800
Marketing	60,000
Operations	270,900
Research and Development	122,500
Allocation of Administrative Costs	45,677
Total	$282,040
Goal V Total	$1,255,697
GOAL I-V TOTAL	$2,026,371

Summary

Total Revenue	$(18,101,305)	
Less: Total Expenditures	20,127,676	
Net (Revenue)/Expenditures		$2,026,371

Notes

Report of the Board of Directors

Board Members
Tom Neumann, WI, President
Margaret Howard, NJ, Vice-President
Charlene Kelly, NE, Treasurer
Joey Ridenour, AZ, Area I Director
Lorinda Inman, IA, Area II Director
Julia Gould, GA-RN, Area III Director
Anna Yoder, MA, Area IV Director
Gregory Howard, AL, Director-at-Large
Laura Poe, UT, Director-at-Large

Staff
Jennifer Bosma, PhD, CAE, *Executive Director*
Leadership Team in Board Partners Program

Relationship to Organization Plan

The Board of Directors is responsible for oversight of all tactics to accomplish the Organization Plan (Mission, Goals and Objectives) under its bylaws duty to supervise the affairs of the National Council between meetings of the Delegate Assembly. Additionally, the Board bears unique responsibility in several specific areas, as follows:

Mission
The mission of the National Council of State Boards of Nursing is to lead in nursing regulation by assisting Member Boards, collectively and individually, to promote safe and effective nursing practice in the interest of protecting public health and welfare.

Goal IV.....Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.
Objective C.....Facilitate communication between National Council, Member Boards, and related entities.

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

Recommendations to the Delegate Assembly

1. **That Article VII, Section 3, of the National Council Bylaws be amended by deleting the words "goals and objectives" and the words "adoption of" preceding "position statements" so that the sentence would read, "The Delegate Assembly, the legislative body of the National Council, shall provide direction for the National Council through adoption of the mission and position statements, and actions at any Annual Meeting or special session."**

Rationale

The Board of Directors has been engaged in an intensive process over the past two years, leading to the development of six strategic initiatives and 23 outcomes which are directly related to the mission of the organization, as adopted by the Delegate Assembly in 1997 (see Organization Plan attached). These strategic initiatives and outcomes were presented by the president at each Area Meeting, and seemed to meet with approval in view of the absence of suggestions for improvement or objections. On the last occasion that a new set of goals and objectives (analogous to "strategic initiatives" and "outcomes") was proposed to the Delegate Assembly, the proposal presented by the Board with member and committee input was also adopted without change by the Delegate Assembly. Under the proposed Bylaw amendment, the Board of Directors would develop strategic initiatives and outcomes and report them to the Delegate Assembly annually. Member

Boards continually provide feedback to the Board of Directors via trend analysis, survey responses, letters, calls and requests, and are frequently asked for input formally and informally. The resolutions and forum discussion processes at the Delegate Assembly provide a formal opportunity for input and direction as well.

2. **That the Auditors' Report be accepted.**

Rationale

The Board of Directors engages an audit firm on an annual basis to audit the financial records of the National Council. As a part of its fiduciary responsibility to the Member Boards, the Board, in concert with the Finance Committee, reviews this report carefully, raises appropriate questions, and gives direction to staff with respect to the recommendations made by the auditors in the management letter. The Board recommends the acceptance of the audit in acknowledgment of its accountability to the delegates and in the interest of openness regarding the financial status of the National Council.

Comments on Recommendations from Standing Committees

1. The Board supports the recommendation of the Examination Committee for the adoption of the proposed *NCLEX-PN® Test Plan.*
2. The Board made suggestions to the Subcommittee on Educational Program Approval/Accreditation related to the position on educational program approval and accreditation.
3. The Board suggested to the Subcommittee on Discipline Resources (and the Nursing Practice and Education Committee) that both potential positions on the use of criminal background information be brought before the Delegate Assembly for discussion.

Highlights of Activities

Note: Bold text is used for all 1997 Delegate Assembly actions and their follow-up activities

Goal I. Licensure and Credentialing

■ **NCLEX® Examinations**

Following approval by the 1997 Delegate Assembly of the revised *NCLEX-RN® Test Plan*, the Board of Directors re-evaluated and slightly raised the passing standard. The revised test plan and passing standard were implemented on April 1, 1998. The Board of Directors provided feedback to the Examination Committee on the proposed *NCLEX-PN® Test Plan* revisions, and supports the Examination Committee's recommendation. A forum will be provided at the Annual Meeting for questions and discussion.

The Examination Committee structure, as amended in the bylaws by the 1997 Delegate Assembly, was successfully implemented this year. The use of item review panels enabled the Examination Committee to concentrate on its overall policy and quality monitoring responsibilities.

The contract with The Chauncey Group, for October 1999 through September 2002, was executed following the 1997 Delegate Assembly adoption, and the $120 fee published. During the past year, the Board has monitored test service performance on a regular basis (see test service report attached to Examination Committee report). Two problem areas came to the Board for action: violations of the 30/45-day scheduling rule and temporary suspension of testing due to misprogramming of the selection algorithm for the revised test plan for the NCLEX-RN examination. Even with such incidents, the Board and the Examination Committee have assured that the NCLEX examinations remain a psychometrically and legally defensible program for nursing licensure testing. A time for dialogue with test service and National Council staff on NCLEX examination-related issues will be provided during the Annual Meeting.

The Board concurred with the Examination Committee's recommendation that on-site reporting of NCLEX examination scores not be considered at this time due to the need to incorporate the safeguards and quality control measures currently in place to verify the validity of candidate results. The Board endorsed the committee's suggestion that a telephone results reporting service be reconsidered.

Member Board contract renewals included the provision adopted by 1997 Delegate Assembly that Member Boards assist the test service in obtaining qualified readers for NCLEX examination candidates granted this accommodation. Processes for obtaining lists are currently underway.

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

The Board adopted "go-no go" criteria to determine whether or not the CST pilot test would proceed. All criteria were met and pilot testing took place from April 14 through the end of July. Over 2,000 students were scheduled to test. When it became apparent that extended timelines would be necessary for analyzing pilot study data and collecting other information and statistics necessary to inform a decision regarding inclusion of CST in the NCLEX-RN® examination, the Board decided that the Delegate Assembly decision could be delayed until no later than the Annual Meeting in 2000.

At the June meeting of the Board of Directors, the Board decided to seek direction from the Delegate Assembly regarding future direction for research and development of CST as a potential component of the NCLEX-RN examination. In order to prepare for giving this direction, there will be Annual Meeting forum time dedicated to a CST Task Force and staff presentation of information, followed by discussion with the Board. In addition, a comprehensive project overview (Attachment F) was distributed to Member Boards with the July 10 edition of the *Newsletter* and made available on the National Council's VIP Web site for advance review by Member Board staff and board members.

■ **Advanced Practice Registered Nurses (APRNs)**

The Board of Directors endorsed the document "Criteria for Evaluation of Nurse Practitioner Programs 1997" as developed by the National Organization of Nurse Practitioner Faculty (NONPF). Also endorsed was the American Association of Colleges of Nursing's document, "Essentials of Master's Education." The Board monitored completion of the National Council's responsibilities related to the nurse practitioner pharmacology project funded by the Division of Nursing. The Board provided a letter of support for the proposed HCFA rules that would allow states to make their own determination as to whether or not to require physician supervision for nurse anesthetists.

In cooperation with the APRN Task Force, the Board monitored the regulatory sufficiency of nurse practitioner certification programs. All four organizations certifying nurse practitioners have now attained National Commission for Certifying Agencies' accreditation. An annual report has been requested of all organizations certifying advanced practice nurses of any type. The APRN Task Force is in the process of reviewing the responses.

With respect to APRNs and mutual recognition, the Board endorsed a mutual recognition model for nursing regulation for all levels of nursing, with appropriate timelines. The Board directed the APRN Task Force to study the issues surrounding implementation of a mutual recognition model of regulation for APRNs, and develop strategies. The APRN Task Force has reported its strategies for attaining similarity of licensure/authorization to practice requirements to the Board. A presentation and opportunity for feedback will occur during a forum at the Annual Meeting.

■ **Unlicensed Assistive Personnel (UAP)**

The transition from the Nurse Aide Competence Evaluation Program (NACEP) to the National Nurse Aide Assessment Program (NNAAP) has progressed with implementation of the written NNAAP scheduled for June 1998 and the Manual Skills NNAAP for June 1999. National Council has participated by monitoring all test development sessions (see ASI report attached). A nurse aide job analysis is currently underway. The National Council continued publication of *Insight* and hosting of the annual conference on nurse aides and assistive personnel.

The Board interacted with the UAP Task Force as the latter further developed resource materials designed to address regulatory issues related to the use of assistive personnel. In particular, the Continuum of Care concept was more extensively articulated; feedback from Member Boards will be sought in a forum at the Annual Meeting.

Goal II. Nursing Practice

The Board of Directors recommended, and the 1997 Delegate Assembly adopted, a resolution to empower the National Council to serve as agent on behalf of Member Boards for reporting and querying disciplinary actions to the National Practitioner Data Bank. The Board appointed a task force to review rules for implementing the federal law and determining the implications for Member Boards and the National Council, but the rules have not yet been published. The Board also determined that, when the government so requires, the National Council will aid boards in compiling lists of all disciplinary actions taken from January 1992 to present, using the records in the National Council's Disciplinary Data Bank.

The Board charged the Nursing Practice and Education Committee with continuing work on the development of uniform core licensure requirements for RNs and LPN/VNs. Member Board feedback will be solicited at the Annual Meeting.

The Board provided feedback to the Subcommittee on Discipline Resources with respect to the use of criminal conviction information. Two potential positions are being submitted to the Delegate Assembly, and a forum will be provided for discussion.

The Board approved an *Emerging Issues* on criminal history data.

Goal III. Nursing Education

The 1997 position clarifying use of the terms "approval" and "accreditation" was disseminated and consistently applied in National Council communications and committee work. The Board monitored the rapidly changing environment of nursing education throughout the year. General direction and feedback were given to the Subcommittee on Nursing Education Program Approval/Accreditation as it conducted the quantitative and qualitative research on roles related to approval and accreditation and developed a recommended position. A forum will be provided for presentation and discussion at the Annual Meeting.

An *Emerging Issues* on the regulatory implications of the use of distance education was approved by the Board.

Goal IV. Information

- **Information System**

The Board recommended, and the 1997 Delegate Assembly adopted, an addition to Member Board contracts to allow for new licensee data to be used to build the database for the licensure verification service. This provision was included in all contract renewals. Subsequently, the Board has prepared an optional contract clause for Member Boards who wish to fully participate in this service and determined that the fee per verification applicant would be $15. The Board of Directors approved the resources necessary to engage vendors to build the licensure verification database. Vendors have been contracted to perform data collection, program a customized licensee database structure, provide database software and appropriate hardware, and test software for acceptance. The Board accepted a recommendation from the Information System User Group to call the information system NURSYS.

- **Meetings**

Plans were made to celebrate the 20th anniversary of the National Council at the 1998 Annual Meeting in Albuquerque. Atlanta, Georgia, was selected as the site for the 1999 Annual Meeting, and Minneapolis, Minnesota, was selected as the site for the 2000 Annual Meeting.

The Institute for the Promotion of Regulatory Excellence surveyed Member Boards with regard to their educational needs, and recommended topics for the Regulatory Day of Dialogue to the Areas. Based on evaluations of the 1998 Area Meetings, the Board decided to switch the sequence of the days, so that the Regulatory Day will follow the Area Meeting day beginning in 1999. The Board concurred with the Institute's recommendations to explore the MedScholars program for electronic delivery of educational offerings and a summer institute for regulatory personnel.

The Board determined that an on-site *Business Book* would replace the traditional *Book of Reports*. To share and preserve information on work of committees and other entities which does not result in a recommendation for action by the Delegate Assembly, the Board established a policy that all such reports, throughout the year, be placed on the VIP Web site which can be accessed by board members and board staff.

Goal V. Organization

Following the endorsement of a mutual recognition model for nursing regulation by the 1997 Delegate Assembly, the Board and Multistate Regulation Task Force proceeded with the development of an interstate compact and other implementation strategies. The position on telenursing adopted by the 1997 Delegate Assembly has been disseminated and made available on the National Council's Web site. At a special session of the Delegate Assembly in December, the delegates approved the standard language of the interstate compact, along with 12 strategies for implementation. To guide the implementation, the Board has developed a Master Plan and allocated appropriate resources. The Board continues to guide and monitor implementation, in the best interests of the entire membership, on a regular basis. (See Attachment E for a detailed report.)

The President and Executive Director continued the program of executive liaison meetings (see President's Report). In addition, the Board represented the National Council at meetings of 15 organizations with related interests, and staff maintained contact with another 45 organizations as part of their ongoing environmental scanning.

With the assistance and input of the Policy Futures Panel, the Board identified emerging policy issues having potential impact on Member Boards or the National Council. Routing these issues quickly to appropriate groups is one of the ways in which the Board implemented its high priority on increasing organizational responsiveness, fluidity, and flexibility. The regulatory issues surrounding the federal law and rules pertaining to immigration were the topic of an *Emerging Issues.*

The Policy Futures Panel was requested by the Board to serve as the advisory group for Phase I of the study of regulatory outcomes: "Commitment to Public Protection through Excellence in Nursing Regulation." The Urban Institute has been contracted to perform Phase I, which is intended to identify the set of regulatory functions and outcomes for which a board of nursing is held accountable by government and society, by identifying consensus among consumers, nurses, state government officials and employers..

The Board adopted and monitored the implementation of tactics to accomplish the Organization Plan (mission, goals, and objectives) for the fiscal year 1998 (see Attachment A). **Based on the mission statement adopted by the 1997 Delegate Assembly, a broader-ranging effort encompassed a trend analysis survey of Member Boards, the identification of top-priority strategic issues, transforming these into strategic initiatives, and defining measurable outcomes within each initiative area (see Attachment B).** This strategic decision-making framework completed a two-year process of long range planning with consultant Jamie Orlikoff.

The Committee on Nominations met with the Board of Directors at its November meeting for a dialogue on the process for compiling a slate of qualified candidates for office. **The committee implemented the bylaws change adopted by the 1997 Delegate Assembly by electing its chairperson in November. Similarly, the amendments pertaining to the process of electing Directors-at-Large were implemented during the 1997 elections.** In another important part of its governance role, the Board of Directors performed the annual evaluations of each test service, service provider (e.g., legal, audit), the executive director, and the Board itself.

A plan for organization development was adopted by the Board. It includes various orientation programs for all categories of individuals beginning a role with the National Council, leadership development opportunities for those assuming leadership roles in the organization, and planning/evaluation and decision-making programs to assure continued learning and growth as an organization. A key component of the latter is the Board Partners Program, whereby each Board member has a member of the staff senior leadership team as a partner, with a focus on a particular substantive area of the organization's mission and goals. The partners maintain regular contact on emerging issues, seek out and exchange information, and look for ways to enhance National Council's awareness and activity in their area of focus.

The Board, with the advice and counsel of the Finance Committee, allocates and monitors use of National Council resources throughout the year. **In keeping with the 1997 Delegate Assembly resolution, the Board of Directors has directed that all recommendations to the 1998 Delegate Assembly include a fiscal impact statement.**

The Special Services Division (SSD) was granted $450,000 to support further development of projects, pending SSD reaching the break-even point. The Board required that a small-scale review of the division, using an external consultant, be performed in FY98, and that the large-scale five-year evaluation be reported to the Delegate Assembly in 2000.

Meeting Dates

- August 23, 1997 (post-Delegate Assembly meeting)
- September 19, 1997 (telephone conference call)
- November 3, 1997 *(Board retreat)*
- November 4-5, 1997 *(fall meeting)*
- November 21, 1997 *(telephone conference call)*
- November 26, 1997 *(telephone conference call)*
- December 14 and 15, 1997 *(pre- and post- special Delegate Assembly meetings)*
- February 11-13, 1998 *(winter meeting)*
- April 1, 1998 *(telephone conference call)*

- April 13, 1998 *(telephone conference call)*
- May 13-15, 1998 *(spring meeting)*
- May 22, 1998 (telephone conference call)
- June 25-26, 1998 *(summer meeting)*
- August 1-2, 1998 *(pre-Delegate Assembly meeting)*

Recommendations to the Delegate Assembly

1. **That Article VII, Section 3, of the National Council Bylaws be amended by deleting the words "goals and objectives" and the words "adoption of" preceding "position statements" so that the sentence would read, "The Delegate Assembly, the legislative body of the National Council shall provide direction for the National Council through adoption of the mission and position statements, and actions at any Annual Meeting or special session."**

   ### *Fiscal Impact*

   None.

2. **That the Auditors' Report be accepted.**

   ### *Fiscal Impact*

   None.

Attachments

Attachment A

National Council of State Boards of Nursing, Inc. Organization Plan

Including Fiscal Year 1998 Tactics

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

Goal I. Licensure and Credentialing

Provide Member Boards with examinations and standards for licensure and credentialing.

Objective A. Conduct job analysis studies to serve as the basis for examinations.

- Tactic 1: Conduct nurse aide job analysis study.
- Tactic 2: Perform periodic assessments of the work environment of newly licensed RNs and LPN/VNs.
- Tactic 3: Evaluate alternative methodologies for performance of RN/PN job analysis studies and revise RN job analysis study methodology.

Objective B. Provide examinations that are based on current accepted psychometric principles and legal considerations.

- Tactic 1: Maintain and enhance licensure examination test plans based on current job analysis studies.
- Tactic 2: Develop and implement mechanisms and policies for NCLEX® examination content development, for increasing volunteer participation, and for decreasing the time from approval to new test plan implementation.
- Tactic 3: Develop and implement mechanisms and policies for NCLEX examination scoring, score reporting, and psychometric performance analysis.
- Tactic 4: Assure NCLEX examination is administered according to approved procedures; review and revise policies.
- Tactic 5: Provide quality customer service, including identifying information needs and facilitating development of appropriate communications activities, e.g., brochures, presentations, *NCLEX® Program Reports*.
- Tactic 6: Conduct research and activities related to the National Council/Chauncey Joint Research Committee.
- Tactic 7: Provide information about other countries' licensure examinations through developing collaborative relationships (e.g., Canada, Mexico).

Objective C. Conduct research and development regarding computerized clinical simulation testing (CST®) for initial and continued licensure.

- Tactic 1: Complete CST case development activities in preparation for spring 1998 pilot test.
- Tactic 2: Complete scoring key development and continue exploration of scoring procedures.
- Tactic 3: Conduct pilot study to determine psychometric soundness of CST for initial licensure.
- Tactic 4: Support Member Board research of CST for use in RN education and continued competence.
- Tactic 5: Develop transition plan for CST use re: licensure requirements.

Objective D. Provide a competency evaluation program for nurse aides.

- Tactic 1: Jointly develop and monitor the National Nurse Aide Assessment Program with Assessment Systems, Inc.

Objective E. Provide a comprehensive approach for the regulation of advanced nursing practice.

- Tactic 1: Identify, monitor and analyze trends related to APRN practice which have regulatory implications including: evolution of clinical nurse specialist and nurse practitioner roles; state and federal legislation; reimbursement issues; workplace issues; and APRN education and certification.
- Tactic 2: Coordinate approaches to APRN regulation including identification and analysis of regulatory options with strategies for implementation.
- Tactic 3: Develop strategies to encourage Member Boards to include National Organization of Nurse Practitioner Faculties and Family Nurse Practitioner Pharmacology Project criteria in Member Board rules and regulations.
- Tactic 4: Continue to monitor nurse practitioner certifying organizations for compliance with standards for regulatory sufficiency, and ensure dissemination of relevant certification examination information to Member Boards.

Objective F. Provide a comprehensive approach for addressing nursing issues resulting from the utilization of unlicensed assistive personnel (UAP).

- Tactic 1: Monitor and disseminate information regarding UAP issues (trends, blending roles, new categories, legal, workplace, delegation/assignment, regulatory changes).
- Tactic 2: Implement strategies for addressing UAP issues.
- Tactic 3: Continue to monitor and disseminate information regarding ongoing and completed research addressing the impact of the substitution of UAPs for licensed personnel (RNs/LPN/VNs) on public safety.
- Tactic 4: Describe and evaluate the congruence between practice, education, and supervision of unlicensed assistive personnel who provide nursing-related tasks.
- Tactic 5: Sponsor annual self-supporting conference addressing issues related to nurse aides/assistants/UAP.

Objective G. Promote consistency in the licensure and credentialing process.

- Tactic 1: Review and revise *Model Nursing Practice Act* and *Model Nursing Administrative Rules*, incorporating multistate practice, other committee wok and project results.
- Tactic 2: Continue development of uniform core licensure requirements.

Objective H. Provide a comprehensive approach to assessing continued competence.

- Tactic 1: Pilot model mechanism for continued competence (Personal Accountability Profile), including assessment options and "triggers."
- Tactic 2: Collect additional information and collaborate with other health-related organizations to develop additional resources regarding continued competence and promote use of competence resources.

Goal II. Nursing Practice

Provide information, analyses, and standards regarding the regulation of nursing practice.

Objective A. Analyze the environment for trends and issues affecting the regulation of nursing practice.

- Tactic 1: Identify and monitor nursing practice issues that impact nursing regulation including changes in delivery of nursing care, evolution of nursing scopes of practice and movement from acute care to community based care.
- Tactic 2: Update Role Delineation Study (NA, LPN/VN, RN, APRN).

Objective B. Conduct research on regulatory issues related to disciplinary activities.

- Tactic 1: Provide periodic statistical summaries of Disciplinary Data Bank information.
- Tactic 2: Support Member Boards' study of subsequent discipline for licensees with reported criminal history as applicants.

Objective C. Provide for Member Board needs related to disciplinary activities.

- Tactic 1: Manage Disciplinary Data Bank services.

- Tactic 2: Facilitate national reporting of licensure disciplinary actions, including access to criminal background checks.
- Tactic 3: Complete development of discipline resource module on criminal/fraudulent behavior and begin development of discipline resource module that will support licensure decisions in cases involving quality of care/nursing practice.
- Tactic 4: Reconsider expansion of Disciplinary Data Bank services to include reports on unlicensed assistive personnel.
- Tactic 5: Support third annual conference of alternative program for chemically dependent nurses.

Goal III. Nursing Education

Provide information, analyses and standards regarding the regulation of nursing education.

Objective A. Analyze the environment for trends and issues affecting the regulation of nursing education.

- Tactic 1: Identify, monitor and analyze trends and issues across the education continuum for regulatory implications within a changing global environment, e.g., approval and accreditation, emerging technologies in education, students and criminal convictions, education competencies required for safe and effective nursing practice, board of nursing authority related to students, international education, federal/state legislation/initiatives, including ADA.
- Tactic 2: Analyze various models and processes for approval/accreditation of nursing education programs.

Objective B. Provide resources regarding issues that affect the regulation of nursing education.

- Tactic 1: Develop scenarios and synthesis papers related to issues that impact the regulation of nursing education, e.g., guidelines related to the transition of new graduates into the nursing practice settings, including the study of temporary work permits.
- Tactic 2: Develop systems to facilitate the exchange and analysis of regulatory issues related to nursing education between Member Boards, National Council and other groups.
- Tactic 3: Develop services and programs to meet Member Board needs related to nursing education.

Goal IV. Information

Promote the exchange of information and serve as a clearinghouse for matters related to nursing regulation.

Objective A. Implement a comprehensive repository of information.

- Tactic 1: Maintain and enhance the technical infrastructure for the information repository through design, development and delivery of electronic services.
- Tactic 2: Provide technical and training support services for Member Boards and staff.
- Tactic 3: Create a data warehouse of indexed and fully searchable research data, e.g., *Profiles of Member Boards*, licensure and examination statistics, and research results as reported by Member Boards.

Objective B. Establish a nurse information system (NIS) for use by Member Boards and others.

- Tactic 1: Implement strategies to collect, capture, unduplicate and assure the quality of comprehensive licensee data in NIS.
- Tactic 2: Develop a structure to support collection of endorsement candidate fees. (National Council portion)
- Tactic 3: Complete the technical programming that fully automates the NIS to support ELVIS, including the incorporation of scan form data.
- Tactic 4: Provide ELVIS training and support services for Member Board users.

Objective C. Facilitate communication between National Council, Member Boards, and related entities.

- Tactic 1: Maintain and enhance publications and other media communications between and among Member Boards, the National Council, the nursing community, and other related entities.
- Tactic 2: Maintain and enhance meeting opportunities between and among Member Boards, the National Council, the nursing community, and other related entities.
- Tactic 3: Provide a program of educational offerings for Member Boards.

- Tactic 4: Provide timely response to external inquiries regarding nursing regulation issues.
- Tactic 5: Provide communications opportunities for groups within Member Boards with common focus/needs.
- Tactic 6: Maximize the exchange and sharing of interorganizational perspectives and information.

Objective D. Conduct and disseminate research pertinent to the mission of the National Council.

- Tactic 1: Update research agenda for the National Council.
- Tactic 2: Collect, analyze, and disseminate data and statistics in such areas as licensure, educational programs, and regulatory functions.
- Tactic 3: Compile and disseminate abstracts of completed, ongoing and projected surveys/studies performed by Member Boards and the National Council.
- Tactic 4: Facilitate research activities of Member Boards, committees, staff groups, and other relevant groups.
- Tactic 5: Continue redesign and incorporation of data collection and reporting methodologies for statistical information databases into Member Board accessible electronic media.

Goal V. Organization

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

Objective A. Implement a planning system to guide the National Council.

- Tactic 1: Facilitate intraorganizational coordination to accomplish the Organization Plan.
- Tactic 2: Use the identified strategic decision making system for the National Council to guide decision-making and organization positioning.
- Tactic 3: Integrate Member Board needs and environmental data into an effective knowledge base and use it to guide strategic decision-making.

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

- Tactic 1: Oversee use of the organization's assets to assure prudence and integrity of fiscal management and responsiveness to Member Boards' needs.
- Tactic 2: Develop financial plans for the National Council and monitor implementation through regular financial reporting.
- Tactic 3: Conduct the organization's financial and business affairs in an efficient and effective manner.
- Tactic 4: Manage human resources to effect the goals of the organization.
- Tactic 5: Continue collection and analysis of projected graduations from basic education programs.
- Tactic 6: Assure continued high-performance information services administration and maintenance, including ongoing systems evaluation.
- Tactic 7: Prepare a plan for the evaluation of the Special Services Division to be reported to the Delegate Assembly in 2000; perform a small-scale evaluation in the current year.

Objective C. Maintain a system of governance for the National Council that facilitates leadership and decision-making.

- Tactic 1: Identify needs, assign responsibilities, and provide guidance to address topics important to the National Council's mission.
- Tactic 2: Maximize the use of volunteer resources through an effective volunteer program.
- Tactic 3: Formalize and implement a development program to support National Council volunteers/leaders.
- Tactic 4: Improve responsiveness, flexibility and fluidity at every organizational level.
- Tactic 5: Implement a program of succession planning for member-elected officials.

Objective D. Provide consultation and services to meet unique Member Board needs.

- Tactic 1: Respond to Member Board requests for unique resources and/or services via the Resource Network.

Objective E. Develop and implement a systematic approach for shaping health care policy related to regulation.

- Tactic 1: Facilitate inclusion of National Council (regulatory) perspective on nursing/public issues with regulatory implications at the federal/national and international levels.
- Tactic 2: Implement systematic approaches for regulatory influence with key policy and decision-makers.
- Tactic 3: Devise strategies to influence specific health care and regulatory policy at the national/federal level.
- Tactic 4: Provide leadership within the nursing and regulatory communities to mutually explore future regulatory approaches, and collaborate on implementation mechanisms when possible.

Objective F. Analyze approaches to the regulation of nursing based on evolving health care and environmental changes.

- Tactic 1: Maintain and enhance a comprehensive system for monitoring and identification of policy implications of issues and trends affecting nursing regulation, including federal and state legislation; international issues; changes in state regulatory or governmental structure; the health care environment and delivery system, telecommunications technology and political, economic, and social trends affecting regulation.
- Tactic 2: Facilitate analysis and exchange of policy and regulatory information including implications about the impact of health care and governmental system changes on Member Boards and National Council.
- Tactic 3: Provide a forum for boards to explore opportunities for regulatory role enhancement as well as collectively respond to external entities regarding the role, value and effectiveness of nursing regulation.
- Tactic 4: Conduct regulatory outcomes indicator study.

Objective G. Develop strategies for implementing a mutual recognition model of nursing regulation.

- Tactic 1: Facilitate licensure process and operational transition for Member Boards.
- Tactic 2: Foster development of effective cross-state discipline processes.
- Tactic 3: Coordinate a strategic approach to implementation of mutual recognition model for nursing regulation.
- Tactic 4: Address policy environment implications to implementing mutual recognition model for nursing regulation.

Objective H. Maintain a sound basis to support the mission and programs of the National Council by providing services or products through the Special Services Division (SSD).

- Tactic 1: Explore income producing opportunities and create business plans to support those opportunities.
- Tactic 2: Observe Special Services Division Administrative Guidelines.
- Tactic 3: Report to the Board of Directors and Member Boards on projects at their appropriate stage of development.

Attachment B

Strategic Decision-making Framework, 1999 - 2001

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

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

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

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

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

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

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

Outcome 3:
Uniform requirements/standards for nursing regulation.

Outcome 4:
Educational offerings and resources for Member Boards.

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

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

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

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

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

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

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

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

Outcome 1:
A comprehensive nurse database.

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

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

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

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

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

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

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

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

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

Outcome 3:
Technology enhancement for regulatory activities.

Attachment C

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

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

We have audited the accompanying statements of financial position of National Council of State Boards of Nursing, Inc., as of September 30, 1997 and 1996, and the related statements of activities and cash flows for the years then ended. These financial statements are the responsibility of management of National Council of State Boards of Nursing, Inc. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of National Council of State Boards of Nursing, Inc., at September 30, 1997 and 1996, the changes in its net assets and its cash flows for the years then ended in conformity with generally accepted accounting principles.

As discussed in Note 2 to the financial statements, National Council of State Boards of Nursing adopted Statement of Financial Accounting Standards No. 116, *Accounting for Contributions Received and Contributions Made;* No. 117, Financial Statements of Not-for-Profit Organizations; and No. 124, *Accounting for Certain Investments Held by Not-for-Profit Organizations* in 1996.

Ernst & Young LLP
December 31, 1997

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

	September 30	
Assets	**1997**	**1996**
Current assets:		
Cash and cash equivalents	**$1,471,674**	$1,015,041
Accounts receivable	**576,731**	680,315
Examination fees due from Member Boards	**236,880**	240,030
Accrued interest, prepaid expenses and other	**418,509**	406,371
Total current assets	**2,703,794**	2,341,757
Investments, at fair value	**12,538,020**	12,154,648
Cash held for others	**349,441**	557,553
Property and equipment:		
Furniture, fixtures and leasehold improvements	**259,998**	206,416
Equipment and computer software	**1,464,172**	1,276,456
	1,724,170	1,482,872
Less: Accumulated depreciation	**(1,257,202)**	(1,049,690)
	466,968	433,182
Total assets	**$16,058,223**	$15,487,140
Liabilities and Net Assets		
Current liabilities:		
Accounts payable	**$1,957,859**	$2,057,376
Accrued salaries and payroll taxes	**376,384**	337,515
Total current liabilities	**2,334,243**	2,394,891
Deferred revenue – Examination fees collected in advance (net of prepaid processing fees of $2,894,408 in 1997 and $2,532,142 in 1996)	**1,213,784**	1,061,866
Liability for cash held for others	**349,441**	557,553
Unrestricted net assets:		
Board-designated	**2,231,629**	2,720,376
Other	**9,929,126**	8,752,454
	12,160,755	11,472,830
Total liabilities and net assets	**$16,058,223**	$15,487,140

See notes to financial statements.

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

	Year Ended September 30	
Revenues	**1997**	**1996**
Examination fees	**$15,539,538**	$15,658,079
Grant revenue	**265,124**	286,288
Net investment income	**1,509,123**	847,922
Membership fees	**183,000**	183,000
Royalty revenue	**450,000**	429,685
Other income	**505,309**	440,599
	18,452,094	17,845,573
Expenses		
Program services:		
Licensure and credentialing	**13,351,611**	13,173,881
Nursing practice	**261,075**	449,738
Nursing education	**85,941**	35,248
Information	**1,586,835**	1,411,689
Special services division	**546,354**	393,360
Organizational	**679,148**	353,278
Total program services	**16,510,964**	15,817,194
Supporting services:		
Management and general	**1,253,205**	1,109,105
Total supporting services	**1,253,205**	1,109,105
Total expenses	**17,764,169**	16,926,299
Increase in unrestricted net assets before cumulative effect	**687,925**	919,274
Cumulative effect of change in accounting principle *(Note 2)*	**–**	(67,204)
Increase in unrestricted net assets	**687,925**	852,070
Net assets, beginning of year	**11,472,830**	10,620,760
Net assets, end of year	**$12,160,755**	$11,472,830

See notes to financial statements.

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

	Year Ended September 30	
Operating Activities	**1997**	**1996**
Increase in net assets	**$687,925**	$852,070
Adjustments to reconcile revenue increase in net assets to net cash provided by operating activities:		
Cumulative effect of accounting change	**–**	67,204
Depreciation	**207,512**	228,263
Realized gains on sale of investments	**(81,186)**	–
Changes in operating assets and liabilities:		
Accounts receivable and examination fees due from Member Boards	**106,734**	(245,100)
Accrued interest, prepaid expenses, inventories and other	**219,258**	(565,604)
Accounts payable	**(307,629)**	1,194,420
Accrued salaries and payroll taxes	**38,869**	65,218
Deferred revenue, net	**151,918**	213,834
Net cash provided by operating activities	**1,023,401**	1,810,305
Investing Activities		
Net additions to property and equipment	**(241,298)**	(167,252)
Increase in investments, net	**(325,470)**	(711,013)
Net cash used in investing activities	**(566,768)**	(878,265)
Increase in cash and cash equivalents	**456,633**	932,040
Cash and cash equivalents at beginning of year	**1,015,041**	83,001
Cash and cash equivalents at end of year	**$1,471,674**	$1,015,041

See notes to financial statements.

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

September 30, 1997 and 1996

1. Organization and Operation

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

The goals of the National Council are as follows:

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

2. Summary of Significant Accounting Policies

Accounting Changes

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

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

Use of Estimates

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

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

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

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

In 1995, the National Council was awarded an additional $499,995 from the Robert Wood Johnson Foundation which was to be fully received by January 31, 1997. Of this amount, the National Council has received $137,145 in fiscal year 1997 and $155,674 in fiscal year 1996.

Cash Equivalents
Cash equivalents consist of money market funds.

Pension Plan
The National Council maintains a defined-contribution pension plan covering all employees who complete six months of employment. Contributions are based on employee compensation. The National Council's policy is to fund pension costs accrued. Pension expense was $223,555 and $198,245 for the years ended September 30, 1997 and 1996, respectively.

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

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

3. Investments

Investments are carried at fair value. Investments consist of the following at September 30, 1997 and 1996:

	1997		1996	
	Cost	Market Value	Cost	Market Value
U.S. government and government-backed obligations	**$5,735,648**	**$5,680,327**	$9,676,915	$9,883,911
Corporate securities	**5,112,028**	**5,572,246**	2,183,209	1,991,552
Other	**1,044,893**	**1,285,447**	269,044	279,185
	$11,892,569	**$12,538,020**	$12,129,168	$12,154,648

Net investment income consists of the following for the years ended September 30, 1997 and 1996:

	1997	1996
	Unrestricted	Unrestricted
Dividends and interest	**$807,966**	$755,238
Net realized and unrealized gains	**701,157**	92,684
Total net investment income	**$1,509,123**	847,922

4. Commitments

The National Council leases office space under an operating lease arrangement.

Future noncancelable rental commitments as of September 30, 1997, are as follows:

1998	**$314,990**
1999	**296,767**
2000	**302,704**
2001	**308,754**
2002 and thereafter	**825,737**

Rent expense for 1997 and 1996 under the lease was $257,664 and $242,862, respectively.

Attachment D

1997 Annual Report of Nurse Aide Testing Services

Submitted by Assessment Systems, Incorporated (ASI)

1997 Program Highlights

The 1997 calendar year was marked by a number of significant accomplishments by ASI's Nurse Aide testing program. These include:

- Completion of the integration of The Psychological Corporation NACEP program into ASI's operations. The level of service and customer satisfaction has remained very high. ASI has been very responsive to the concerns of the NACEP customer base as evidenced by the results of a client survey previously reported to the National Council. A number of states reported better service and responsiveness; e.g., "Exceptional Customer Service Received," "Overall, ASI's responsiveness to the agency is very prompt and effective," "ASI has been very responsive to questions, concerns, and complaints as raised by the board."

- The award of several new state contracts has meant continued growth. ASI was awarded the testing contract in Mississippi, which was successfully implemented on time. ASI also secured a contract with the Chancellor's office of the California Community Colleges to administer nurse aide testing in the state. Three very large and complex programs were also implemented during 1997 in Florida, Virginia, and Washington. It is a credit to the dedication of the client states and the ASI staff that all three programs became fully functional in 1997. Finally, contracts with two of the largest volume states, New York and Texas, were successfully renewed through the RFP/proposal process.

- A strengthening of the working relationship between the National Council of State Boards of Nursing and ASI which will contribute to the assessment quality of the nurse aide examination.

The National Nurse Aide Assessment Program (NNAAP)

- Since the 1995 acquisition of ASI by The Psychological Corporation, both the ASI and NACEP examinations have been maintained and administered by ASI. These two testing programs have existing databases of questions that require significant maintenance efforts. ASI has been working diligently to merge the two databases into a single examination program that could be more effectively maintained and supported. This effort has resulted in the development of the National Nurse Aide Assessment Program (NNAAP). The NNAAP test reflects activities and knowledge for the entry-level nurse aide based on the 1995 job analysis conducted by the National Council.

- Between March and October 1997, ASI conducted five NNAAP test development meetings. A committee of Subject Matter Experts (SMEs) from across the country was tasked with identifying the activities and knowledge required of the minimally competent nurse aide across all settings (long-term care, acute care, and home health care settings). Once that had been accomplished, SMEs from twenty-two (22) of ASI's thirty (30) client states participated in these meetings which accomplished the tasks need to develop the test. Those tasks consisted of: 1) development of the Content Outline which contain expanded sections on the role of the nurse aide and client rights; 2) review of actual test questions from both the ASI and NACEP item banks. Terminology was updated and items that reflected legal and ethical issues were considerably refined; 3) establishing the new national passing standard for the minimally competent entry-level nurse aide; and 4) identifying the manual skills that will comprise the new Manual Skills Test. It was agreed that all skills would be demonstrated (as opposed to some skills being simulated or verbally described).

- The written test was piloted in October 1997 in eight states, including FL, MD, OH, PA, SC, TX, VA, and WA. The pilot allowed the establishment of a uniform standard resulting in a new recommended national cut score. The results indicated that the test would be valid, reliable, and defensible. Another important outcome of this effort is that state agencies can be assured of consistency when candidates apply for certification via reciprocity, or endorsement, from one state to another.

- New passing standards have been established resulting in a more difficult test. Initially, states may experience a drop in the historical passing rates. ASI Program Directors have been proactive in alerting the client states to this situation so that state agencies or boards of nursing will be prepared to answer questions from training programs, facilities, nurse aide instructors, nursing home associations, and any other constituencies.

- The new NNAAP written test contains 70 questions: 60 questions will be scored, and ten questions will be pretest or non-scored questions. The NACEP had sixty-five (65) scorable questions and ten (10) pretest questions, while the ASI test contained fifty (50) scorable questions and ten (10) pretest questions. Candidates taking the NNAAP test will have two hours to complete the written test. Finally, the new test has incorporated new terminology. Instead of "patient," the person who is receiving care is referred to as the "client."

- The NNAAP written test will have six forms, two (2) oral English forms, and three (3) Spanish oral forms. Spanish-speaking SMEs from Florida, New Mexico, and Texas will be reviewing the Spanish forms for accuracy of vocabulary and syntax. Answer sheets will also be available in Spanish.

- Client states were issued regular progress reports of the test development activities. ASI developed a phased implementation plan that was submitted to each state for approval of its implementation date. All dates are now confirmed.

- New prototypes for user-friendly candidate handbooks were developed with both a standard format and state-specific information.

- A prototype for a brand new test booklet format that includes the answer sheet was also developed.

Marketing Activities

- Development of marketing brochures designed to highlight ASI nurse aide testing programs and client satisfaction was completed.

- A survey of NACEP clients to assess the level of client satisfaction with ASI services was completed.

- ASI staff attended the 1997 national Nurse Aide/UAP Conference in Chicago. ASI hosted an open house reception and a luncheon, and will do the same in 1998.

- ASI staff has been very proactive in marketing efforts in Michigan, Arkansas, Oregon and Georgia.

1998 Objectives

- Full implementation of the NNAAP Written Test.

- Conduct a series of item writing meetings based on the National Council's 1998 nurse aide job analysis study for the purpose of increasing the number of pretest questions ultimately available for future test assembly. The item writing meetings will contribute to a refinement of the existing NNAAP item bank so that there is a uniform textual styling across the pool.

- Complete the development process of the Manual Skills Test, including establishment of the passing standard.

- Develop a Plan for Implementation of the Manual Skills Test in 1999. The Skills implementation will be more complex than the implementation of the NNAAP Written Test. First, the Manual Skills Test will have its content and format approved by the SMEs. Next, a schedule for training the nurse aide evaluators in each state will need to be established. Evaluator training materials must be developed and produced to support the evaluator training sessions. Other logistics to be accounted for include securing suitable sites in which to conduct the training sessions, and arranging for a sufficient number of trainers to conduct the various training seminars. Once the implementation plan is finalized, the individual client states will be notified when the new Skills test will begin to be administered in their respective states. Sufficient advance notice will be provided to the individual approved nurse aide training programs in each state to ensure candidates are fully prepared for the format of the new Skills test.

- ASI developed redesigned candidate handbooks that contained the new content outline for the NNAAP Written Test. In 1999, the candidate handbooks will once again be revised to reflect the new Written *and* Skills tests. Facility manuals will also be revised and distributed for each client state.

Appendices

1. List of States and Test Providers
2. Table with State-by-State Volume and Passing Rates

APPENDIX 1
List of States and Test Providers

STATE		TEST PROVIDER	VOLUME
1.	Alabama	Multi-provider (ASI & ETS)	8000
2.	Alaska	ASI	500
3.	Arizona	ASI	3700
4.	Arkansas	ETS	5000
5.	California	Multi Provider (ASI & ARC)	20,000
6.	Colorado	ASI	3500
7.	Connecticut	ASI	3000
8.	Delaware	ASI	700
9.	District of Columbia	ASI	700
10.	Florida	ASI	15,000
11.	Georgia	State Administered	12,000
12.	Hawaii	ETS	700
13.	Idaho	ASI	2200
14.	Illinois	State Administered	8000
15.	Indiana	State Administered	5000
16.	Iowa	ETS	4000
17.	Kansas	State Administered	7500
18.	Kentucky	State Administered	6000
19.	Louisiana	ASI	700
20.	Maine	ASI	200
21.	Maryland	ASI	3900
22.	Massachusetts	American Red Cross	7000
23.	Michigan	ETS	10,000
24.	Minnesota	ASI	7800
25.	Mississippi	ASI	3000
26.	Missouri	State Administered	2500
27.	Montana	D and S Technologies	2500
28.	Nebraska	State Administered	1500
29.	Nevada	ASI	1000
30.	New Jersey	ASI	5000
31.	New Mexico	ASI	2000
32.	New York	ASI	21,000
33.	North Carolina	State Administered	13,000
34.	North Dakota	ASI	1500
35.	Ohio	ASI	12,000
36.	Oklahoma	ETS	4000
37.	Oregon	ETS	4000
38.	Pennsylvania	ASI	12,000
39.	Rhode Island	ASI	2000
40.	South Carolina	ASI	5300
41.	South Dakota	ASI	1100
42.	Tennessee	University of Tennessee	12,000
43.	Texas	ASI	25,000
44.	Utah	State Administered	2000
45.	Vermont	ASI	400
46.	Virginia	ASI	5000
47.	Virgin Islands	ASI	100
48.	Washington	ASI	5000
49.	West Virginia	State Administered	4000
50.	Wisconsin	State Administered	5000
51.	Wyoming	ASI	1000
		Total Estimated Annual Volume	**286,000**

APPENDIX 2

Preliminary 1997 State-by-State Volume and Passing Rates

	State	Exam Program	Written Test		Skills Test	
			Volume	Passing %	Volume	Passing %
1.	Alabama	NACEP	3,007	82%	2,762	95%
2.	Alaska	NACEP	494	91%	473	97%
3.	Arizona	NACEP	3,793	90%	3,709	98%
4.	California	ASI	5,497	92%	5,828	97%
5.	Colorado	NACEP	3,556	90%	3,275	98%
6.	Connecticut	ASI	2,817	94%	3,095	82%
7.	Delaware	NACEP	715	90%	680	97%
8.	District of Columbia	NACEP	657	79%	657	93%
9.	Florida	NACEP	13,168	80%	11,527	93%
10.	Idaho	NACEP	2,198	96%	*	*
11.	Louisiana	NACEP	653	76%	553	94%
12.	Maine	NACEP	217	98%	217	91%
13.	Maryland	NACEP	3,923	84%	3,698	95%
14.	Minnesota	ASI	7,608	96%	7,847	92%
15.	Mississippi	ASI	1,577	84%	1,373	85%
16.	Nevada	NACEP	989	99%	968	95%
17.	New Hampshire	NACEP	580	89%	583	96%
18.	New Jersey	ASI	5,256	88%	4,886	89%
19.	New Mexico	ASI	1,973	89%	*	*
20.	New York	ASI	20,794	88%	19,166	90%
21.	North Dakota	NACEP	1,322	92%	1298	97%
22.	Ohio	ASI	11,891	99%	12,260	95%
23.	Pennsylvania	ASI	11,588	97%	11,889	92%
24.	Rhode Island	NACEP	1,946	89%	*	*
25.	South Carolina	NACEP	5,317	75%	4,760	90%
26.	South Dakota	NACEP	1,105	91%	1,310	94%
27.	Texas	ASI	25,546	89%	*	*
28.	Virginia	NACEP	5,254	87%	4,938	95%
29.	Virgin Islands	NACEP	120	70%	111	96%
30.	Washington	NACEP	5,113	86%	4,888	96%
31.	Wyoming	NACEP	1,024	96%	1,031	95%
	Totals		**149,698****		**113,782**	

* The ASI Skills exam is not administered in this state

** Represents 53% of 1997 national nurse aide testing population

Attachment E

Report on the Mutual Recognition Master Plan

Multistate Regulation (MSR) Task Force Members

Joan Bouchard, OR, *Chair*
Kathy Apple, NV, Area I
Iva Boardman, DE, Area II
Shirley Brekken, MN, Area II
Shirley Camp, GA-RN, Area II
Faith Fields, AR, Area III
Miriam Limo, PA, Area IV
Ida Wrigley, ND, Area II
Sharon Weisenbeck, KY, Area III

Staff

Jennifer Bosma, PhD, CAE, *Executive Director*
Susan H. Williamson, MPH, RN, *Director of Credentialing and Practice*

Relationship to Organization Plan

Goal V.....Foster an organizational environment that enhances leadership and facilitates decision-making in the nursing regulatory community.
Objective G.....Develop strategies for implementing a mutual recognition model for nursing regulation.

Recommendations to the Board of Directors

None.

Highlights of Activities

Following the special session of the Delegate Assembly in December 1997, a comprehensive master plan to implement mutual recognition was developed and approved by the Board of Directors. The plan is organized in three levels: Phases, Activities and Tasks. The phases of the plan are: Member Board Operational Support, Member Board Legislative Support, Member Board Discipline Process Support, Education and Information, Collaboration and Coalition Building, Compact Administration, Information System for Mutual Recognition (Phase II), and Project Administration. The Mutual Recognition (MR) Master Plan is based on the strategies adopted (approved) by the December 1997 Delegate Assembly.

The Board of Directors has responsibility for oversight of the entire Mutual Recognition Master Plan and is the lead for implementing all the phases except those delegated by the Board to the MSR Task Force. The MSR Task Force has responsibility for two phases (Member Board Operational Support and Member Board Discipline Support) and one activity in the Compact Administration Phase (development of model rules for compact implementation).

This report will follow the phase format of the MR Master Plan itself, to facilitate understanding of the status of implementation activities.

- **Phase A. Member Board Operational Support** (Lead responsibility: MSR Task Force)

This phase is on time; activities and tasks have been accomplished by the timeline specified on the plan.

The MSR Task Force has two work groups, Operations and Fiscal, that are accomplishing the activities in this phase. The Operations Work Group met twice and held two conference calls. The Operations Work Group considered the input from the MSR Task Force, the Fiscal Work Group, the Board of Directors and others, including: the Discipline Work Group and the Alternative Programs Work Group. The Operations Work Group developed the *Mutual Recognition: Member Board Operations/Fiscal Analysis Tool* (included in this report as

Attachment 1). The purpose of the tool is to facilitate current, future party-state, and future nonparty state Member Boards to analyze the changes in terms of its own specific impacts. The *Mutual Recognition: Member Board Operations/Fiscal Analysis Tool* was distributed to Member Boards, accompanied by resource materials, in early July. To assist Member Boards as they work with the tool, a feedback mechanism was developed. The National Council's director of Member Board relations will receive the questions, comments, concerns and route them to the appropriate person or group. Support will be provided by members of the Operations and Fiscal Work Groups serving as "peer consultants" (SWAT Team) to Member Boards as they work through the process.

The Fiscal Work Group met twice and developed an initial survey to identify current and proposed Member Board revenue sources (report and surveys are included as Attachment 2). Based on the results of that survey, another survey was developed and sent to collect additional information on eleven specific revenue sources, and to identify the number of non-resident active licensees by state. The Fiscal Work Group identified a series of questions that Member Boards could use in analyzing the fiscal impact of mutual recognition, both as party and nonparty states. These questions were combined with the Operations Work Group's tool, *Mutual Recognition: Member Board Operations/Fiscal Analysis Tool.* At its June meeting, the work group developed a tool for Member Boards to calculate revenue and cost impacts, and considered possible opportunities for Member Boards to exchange strategies related to revenue replacement.

The work groups are working jointly to provide a Mutual Recognition: Operations/Fiscal Issues Forum to be held at the Annual Meeting. The forum is designed to provide an opportunity for Member Boards to exchange strategies related to operations and fiscal issues impacted by mutual recognition.

- **Phase B. Member Board Legislative Support** (Lead responsibility: Board of Directors).

This phase is on time; activities and tasks have been accomplished by the timeline specified on the plan.

A number of consultants and strategists were contacted to identify potential resources for board assistance with state legislative activities. It was determined that finding a single strategist who possessed expertise in the unique political environment of all 50 states was impossible. The decision was made to schedule a state legislative strategy session to provide support and enhance activities which any state chose to initiate. All boards were invited to participate in a one-day legislative strategy session held on July 13, 1998. Every effort was made that the program be cost-effective, and expenses were paid by the individual attendee. The session was facilitated by Dr. Mary Wakefield, director of the Center for Health Policy at George Mason University, and Mr. Josef Reum, executive director and CEO for the American Health Quality Association. The objectives were: to better understand public sector decision-making, to improve communication and coalition building in and among key stakeholders, and to build responsive infrastructure to effect public policy. The goal is for Member Boards to be equipped with tools to influence state legislatures and others.

A database for monitoring and tracking state mutual recognition legislation has been developed and will support maintenance of all information on mutual recognition at the state level. A new section in *Policy Currents*, a biweekly publication for dissemination of updates on state legislative activities, was created for focusing on mutual recognition legislation. To date, Utah and Arkansas legislative activities have been featured.

- **Phase C. Member Board Discipline Process Support** (Lead responsibility: MSR Task Force)

This phase is on time; activities and tasks have been accomplished by the timeline specified on the plan with the exception that the second discipline work group will convene after Annual Meeting in August.

The MSR Discipline Work Group #1 met once in a two-day meeting to further develop a multistate discipline process. This is the same work group that began discussions of multistate discipline in October 1997. Although finding meeting dates that accommodated all schedules was impossible, all previous work group members participated either in person, by telephone or by fax.

The work group began its work by identifying particular discipline cases or scenarios that it believes would pose challenges under a multistate discipline system. Then the work group developed a discipline process. The generic process could be adapted to the particular statutes, rules, procedures and traditions of each jurisdiction. The work group recommends that the same process used for licensure actions be followed for privilege actions (see Multistate Discipline Process, Attachment 3). The work group applied the discipline process to the scenarios (see Discipline Case Scenarios, Attachment 4) and produced a summary of its findings and recommendations (see Attachment 5). The plan calls for a second new discipline work group to be convened for the purpose of a having a

group initially unfamiliar with the mutual recognition discipline process apply it to the same scenarios, with the outcome of refining the process. Finally, the process will be demonstrated utilizing distance technology.

The MSR Alternative Program Work Group met once for three days to develop recommendations regarding how to accommodate alternative programs within mutual recognition. The work group developed a process for an alternative program and developed scenarios. The work group developed content areas suggested for inclusion in rules and produced a summary of its findings and recommendations (see Attachment 6).

The work groups are working jointly to provide a forum to be held at the Annual Meeting. The forum is designed to provide an opportunity for Member Boards to exchange strategies related to discipline issues. In addition, two and one-half hours of the *Dialogue on Discipline* will be devoted to the MSR Discipline Workgroup #1 outcomes, and the *Dialogue on Impaired Practice* will give the same amount of time to the outcomes of the MSR Alternative Program Workgroup.

Additional work has begun with assistance from consultants on several other topics including standards of proof, processes dealing with subpoenas, and cease and desist orders.

- **Phase D. Education and Information** (Lead responsibility: Board of Directors).

  This phase is on time; activities and tasks have been accomplished by the timeline specified on the plan.

  The Mutual Recognition Resource Binder was produced and provided to Member Boards and updated material was sent. Articles giving updates on the activities related to accomplishing the plan have been in the *Newsletter*. *MSR Communiqués* have been produced approximately bimonthly. Communications staff will be present during the Legislative Strategy Workshop on July 13 to assess, from the Member Boards, the needs in relationship to developing resource materials to support legislative initiatives. The National Council Web site is maintained with mutual recognition information. An editorial in response to inaccurate information printed in *The American Nurse* was written by the executive director, submitted and printed by ANA, and an article written by staff was printed in *Nursing 98*. An additional article by staff has been submitted to an advanced practice journal.

- **Phase E. Collaboration and Coalition Building** (Lead responsibility on national level: Board of Directors; on state level: MSR Task Force)

  This phase is on time; activities and tasks have been accomplished by the timeline specified on the plan.

  Ongoing activities include:

  - Response is provided for the large volume of telephone and e-mail inquiries about the project or specific detail about an aspect of the project.
  - All presentations with national and state organizations include a component with information about MR, drawing linkage to implications for the specific group or population.
  - Targeted follow-up for persons expressing interest in MR during conferences, meetings or other networking conversations.
  - Informational material developed for dissemination from National Council exhibit booth at national and state meetings.
  - Information about coalition building expressly included in the state legislative strategy workshop.

  National and federal activities to collaborate and build coalitions include:

  - Specific contact made with targeted national and federal organizations to determine possibility for organizational support of MR.
  - Strong interest in support expressed, to date, by at least two health care provider organizations and two associations.

  Efforts to solicit federal budgetary support for transition for those state pursuing adoption of the interstate compact in 1999 have resulted in a proposal of $450,000 to be appropriated to "early adopter" states. This grant would likely be administered through the Agency for Health Care Policy and Research.

- **Phase F. Compact Administration** (Lead responsibility: Board of Directors; development of compact rules and procedures: MSR Task Force)

  This phase is on time; activities and tasks have been accomplished by the timeline specified on the plan.

The Board of Directors appointed a subcommittee, the Board Committee on Compact Administration. This subcommittee in collaboration with the staff Leadership Team, developed ideas about the potential structure and functions for the Compact Administrators Group (CAG) (see Attachment 7). The process includes an interim CAG before the official CAG will begin functioning no earlier than January 1, 2000, when the first compacts take effect. The Board Committee on Compact Administration believes that the Interim Group is crucial to the goal of establishing the Compact Administrators Group as a semi-autonomous entity operating within the general framework of the National Council. The aim is that the National Council may be the choice for supplying the needs of the official CAG, based on quality and cost advantages. As the transition goes forward, frequent, open communication among future compact administrators and nonparty state Member Boards is essential.

The MSR Task Force continues to draft model rules and procedures for implementation of the compact by party states. A forum is planned at the Annual Meeting for Member Boards to review the progress thus far and provide feedback on the rule development accomplished up to that date. The development will continue after the Annual Meeting as the planned activities of the Discipline and Information System Phases will occur after August 1998.

- **Phase G. Information System Development for Mutual Recognition (Phase II)** (Lead responsibility: Board of Directors)

Work on the specific mutual recognition, Phase II, portion of the information system is not scheduled to begin until January 1999; progress is occurring on Phase I.

A crucial component of the infrastructure for mutual recognition to be developed prior to January 1, 2000, is the information system. This system is intended to be a repository of licensing records, one for each licensed nurse. The record will contain demographic data (for identification purposes), license status data (including final/public disciplinary actions), and other records of pending discipline-related processes as allowed under state law and the interstate compact.

The information system is being developed in phases. Phase I development, currently underway, will include public licensee information from all participating jurisdictions to facilitate electronic licensure verification. Already existing is the Disciplinary Data Bank (DDB), which is expected to be incorporated into the new information system's database in order to take advantage of additional features, functionality and reporting the new system will offer. Phase II, to begin immediately upon completion of Phase I, will add functions related to the sharing of additional data allowed under the interstate compact. Current progress is in line with the expectation of complete readiness before January 1, 2000. A forum is scheduled during the Annual Meeting to facilitate understanding of the development status of the information system.

The overall flow of the information system has been designed. The flow calls for a data collection process and a repository function. Database America Companies, Inc., has been contracted to perform data collection duties, and will serve as a central collection point for licensee data from Member Boards, transform data into a common format, merge "same nurse" records into one, perform a check against current postal addresses, and download a file to the National Council. Initially under Phase I, downloading will occur on a monthly basis. Over the first year, capability will be added to reduce download times to weekly. In Phase II, daily updates have been targeted.

The repository function will be housed at the National Council. The National Council has signed a license agreement with the Oracle Corporation for its widely used and respected relational, table-driven database. This type of database greatly simplifies the process of changing database structure to accommodate future needs. The database for the National Council's information system, which will be called NURSYS, will incorporate the file downloaded from Database America Companies, Inc., and disciplinary data updates. In Phase I, NURSYS data will be accessible only to Member Boards, with access to selected data by appropriate additional users planned in Phase II.

The hardware for the database utilizes client-server architecture and consists of two Hewlett Packard (K300 series) servers. One will be used for development work and one for production (service delivery). This will provide assurance of complete testing and proper functioning of any program in development before the program is transferred from the development to the production server and put into use. A diagram of the system will be provided to those attending the forum at the Annual Meeting.

For the software which provides the interface to users, the National Council has contracted with Client Servers for a customization of its licensing product currently in use by a number of boards. This program will provide a Web-based system to allow Member Boards to retrieve licensure information for viewing, monitoring, and querying; direct entry capability will be provided for disciplinary data only. A feature will allow Member Boards to

extract data to download to their own systems, as desired. A help desk will be staffed by the National Council to assist Member Boards in the use of the system.

The Information System User Group, in addition to contributing to the above design by providing user-perspective input, has addressed the business model for the licensure verification service. The model being worked out currently will allow verification queries by one or more Member Boards to the system for the $15 fee paid by the endorsement applicant, for a specified time period. Models for handling the business aspects of the system under the mutual recognition compact are currently under preliminary discussion.

■ **Phase H. Project Administration** (Lead responsibility: Board of Directors)

This phase is on time; activities and tasks have been accomplished by the timeline specified on the plan.

This phase incorporates those coordination and management activities that National Council must accomplish to keep the implementation plan on track.

The special session of the Delegate Assembly adopted two strategies that directed reporting to the 1998 Delegate Assembly. These strategies are as follows: "1) The Board of Directors develop additional strategies for implementation of the mutual recognition model as it deems necessary and appropriate by the 1998 Delegate Assembly; and 2) The Board of Directors identify the additional incremental cost to Member Boards and to the National Council of implementing CLIS [*editor's note:* coordinated licensure information system, now called NURSYS], and the strategies for the mutual recognition compact by the 1998 Delegate Assembly." The first strategy is addressed by the Mutual Recognition Master Plan in total and this report. The second strategy is addressed in Phase H.

An activity under this phase is to identify the additional incremental cost to Member Boards and to the National Council of implementing the coordinated information system and the Mutual Recognition Master Plan (which is based on and incorporates the Strategies for the Implementation of the Mutual Recognition Model adopted by the Delegate Assembly). The results of this analysis are to be presented to the 1998 Delegate Assembly. The Board approved the resources necessary to carry out this plan:

Phase of Plan	Operating	Capital
A. Member Board Operational Support	$34,720	0
B. Member Board Legislative Support	$40,400	0
C. Member Board Disciplinary Process Support	$79,250	0
D. Education and Information	$54,350	0
E. Collaboration and Coalition Building	$14,600	0
F. Compact Administration	$28,595	0
G. Information System	N/A	**
H. Project Administration	$107,005 *	$17,200
Staffing: .6 project manager, .6 editor	$99,700	$2,600
Totals	$395,020	$19,800

* Includes $63,600 to be devoted to two fundraising efforts: one, an effort to obtain a federal appropriation to assist states to prepare for transition, and the other a series of foundation grants designed to cover some of the costs and augment activities in Phases A, B, C, D, E, and G. Does not include previously budgeted MSR Task Force expenses.

** Does not include the cost of the information system currently being built for licensure verification (Phase I of the information system). Although information system costs incurred in Phase I (licensure verification) are not directly attributable to mutual recognition, the Board's capital investment of $1.75 million will lay the foundation for the information exchange functions of the interstate compact. Information industry experience indicates that a major enhancement to a data system, which is likely to be what the mutual recognition functional specifications constitute, may cost as much as 25 percent of the initial development cost

Determining the costs for each Member Board would be extremely difficult, as well as inappropriate, for National Council. The Operations Work Group identified those areas where incremental costs are anticipated to be incurred by Member Boards so Member Boards could perform their own assessment. The *Member Board*

Operations/Fiscal Analysis Tool facilitates application of these areas to each Member Board's situation. The areas include:

1) Equipment:
   Computers
      purchase and/or upgrades
      modems
      programming/reprogramming

   Telephones
      phone lines for additional modems
2) Administrative
   Promulgation of rules and regulations
   Communicating educational materials to licensees and external parties including supplies, printing, mailing
   Travel to discuss mutual recognition
   Training and development - board members, board staff, investigators, attorneys, other agencies, etc.
3) Personnel
   Consultants

A contract has been established with a grant facilitating consultant, Robert J. Miller, to seek external funding for implementing portions of the Mutual Recognition Master Plan. Numerous funding sources are being contacted.

A forum at the Annual Meeting will give Member Boards an opportunity to provide input and ask questions on any part of the Mutual Recognition Master Plan.

Future Activities

Continue implementation of the Mutual Recognition Master Plan, and update the plan to extend beyond January 1, 2000.

Meeting Dates of the MSR Task Force

- October 2-4, 1998
- November 7-8, 1997
- November 20, 1997 *(telephone conference call)*
- November 21, 1997 *(telephone conference call)*
- December 6-7, 1997
- January 6-7, 1998
- January 12, 1998 *(telephone conference call)*
- January 27-28, 1998
- February 26-28, 1998
- April 30-May 1, 1998
- June 11-13, 1998
- July 27-28, 1998

Attachments

Attachment E1

Summary of MSR Operations Work Group Activities

Relationship to Mutual Recognition Master Plan:

A. Member Board Operational Support

1. *Develop a mechanism to identify Member Board operation issues, considering impact as party-to-nonparty, party-to-party, and nonparty to party state; relate to Member Board functions (licensure, practice, discipline, education, administration) and impact on resources, fiscal, human, material.*
2. *Develop Member Board operations process analysis for each transition issue.*

Background

The MSR Task Force asked the MSR Operations Work Group to assist by: *1) identifying all Member Board transition operation issues, and 2) developing Member Board operations process analysis for each transition issue.* The work group was asked to use the framework of "current, future party-state, and future nonparty state" to analyze the changes and arrive at tools to be provided to each Member Board to facilitate an analysis of its own specific impacts.

Highlights of Activities

Prior to finalizing the design of and operations related questions in the *Mutual Recognition: Member Board Operations/Fiscal Analysis Tool*, the MSR Operations Work Group considered input from the MSR Task Force, the Fiscal Work Group, the Board of Directors and others, including: the MSR Discipline Work Group, the Attorney Work Group and the Alternative Programs Work Group. In addition, the tool was "piloted" by members of the work group. Members responded to the questions in the tool as they related to their own board operations. A copy of the *Mutual Recognition: Member Board Operations/Fiscal Analysis Tool* follows this report (Attachment E1a).

The *Mutual Recognition: Member Board Operations/Fiscal Analysis Tool* was distributed to Member Boards, accompanied by resource materials, in early July. The resource materials included a copy of the Nurse Licensure Compact with the analysis; results of the surveys conducted by the Fiscal Work Group; and responses to questions received from other groups, e.g., discipline, MSR Task Force, etc. In addition, the tool was sent electronically (as a word processing file) to enable Member Boards to adapt it to their individual needs.

To assist Member Boards as they work with the tool, a feedback mechanism was developed. The National Council's director of Member Board relations will receive the questions, comments, concerns and route them to the appropriate person or group. Support will be provided by members of the Operations and Fiscal Work Groups serving as "peer consultants" (SWAT Team) to Member Boards as they work through the process. In addition, a Mutual Recognition: Operations/Fiscal Issues Forum will be held at the Annual Meeting. The forum is designed to provide an opportunity for Member Boards to exchange strategies related to operations and fiscal issues impacted by mutual recognition.

Future Activities

The MSR Operations Work Group has completed its charge.

Attachment

Attachment E1a

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Licensure by Examination - Compact Reference Article III; IV

Party	Non-Party		Questions	BON Staff Responsible
✓		1.	How will you handle the dual process for multi-state and individual state licensing?	
✓	✓	2.	Will you communicate with initial licensees to clarify what state(s) their license is good in and their responsibility for compliance with the NPA in remote states? If so, how?	
✓		3.	What process will you use to verify place of residence for initial licensees? At what stage in the process?	
		4.	Do your application forms contain all of the information needed to issue a multistate license? If not, what will it costs to change the forms?	
✓	✓	5.	How will you incorporate a check of the Information System into your process? at what point(s)?	
✓	✓	6.	Will your process for licensure by examination change for non-US educated applicants?	
✓		7	When will an individual state license be required?	
		8.	Will you use temporary permits for examination applicants?	
✓		9.	Will temporary/interim permits grant multi-state practice privileges?	
		10.	How will you decide whether to make the individual eligible to practice in multiple states or only in your state?	
✓	✓	11.	Will you consider charging an application fee or an examination fee in addition to the license fee?	
✓		12.	How many of your current exam applicants reside in another state?	
		13.	How many of your exam applicants leave the state before the first renewal?	
		14.	What are the costs for the extra steps, such as those identified above, in the review process for initial licensure?	
		15.	What are the costs for providing information regarding MSR to exam applicants, i.e., increased telephone calls, printed information, presentation?	

Comments/Notes

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Licensure by Endorsement - Compact Reference Article IV

Party	Non-Party		Questions	BON Staff Responsible
✓	✓	1.	How will you handle the situation when an endorsement applicant is from a party state and no longer holds a current license in the original state of licensure or a current license in any state?	
✓		2.	How, and when, in the endorsement process will the license in the prior party-state become invalid?	
✓		3.	How will your endorsement application process need to change in terms of questions asked, e.g.: person resides in party-state or in a nonparty state, timeframe specified, documentation?	
✓		4.	Will you use temporary permits for endorsees, and or/allow any period of practice on the previous party state's license?	
✓		5.	How will you incorporate a check of the Information System into your endorsement process? At what point(s)?	
✓		6.	How will you notify nurses residing in your state, and practicing in a party state that they must now be licensed in your state?	
✓	✓	7.	When a nurse seeks licensure in a nonparty state, coming from a party state, how will the party state know whether it was due to change in residence or something else?	
✓	✓	8.	What will you do with notice of residence change? Will the process for submitting that to you change? What will you do with notification from other than licensee?	
✓		9.	How will you decide whether to make the individual eligible to practice in multiple states or only in your state?	
✓		10.	What process will you use to convert an individual's multi-state to an individual-state license when their residence changes to a nonparty state?	
✓		11.	When will an individual state license be required?	
✓	✓	12.	With the Information System in place, how will you perform verification? Will the work flow change?	
		13.	Will your process for licensure by endorsement change for non-US educated applicants?	
✓	✓	14.	Can your state charge a verification fee as part of the endorsement process for querying the information system? (in addition to the fee the applicant will pay NC)?	
		15.	Have you considered charging an application fee in addition to a licensure fee?	
✓	✓	16.	How many of your endorsement applicants continue to reside in another state?	
		17.	Will your application forms need to be revised? What will it cost?	
		18.	What additional communication costs related to endorsement will result from MSR—increased telephone calls, written communications, presentations?	
✓		19.	Do you know the breakdown of the states to which you verify licenses? Knowing this will help anticipate revenue loss as states join the compact.	
✓		20.	If licensee moves from one party state to another, what status is license placed on and is "inactive" an option? Could this be a revenue source?	

Comments/Notes

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Licensure Renewal - Compact Reference Article IV; V

Party	Non-Party		Questions	BON Staff Responsible
✓		1.	How will the applicant indicate type of license (multi-state or individual) they are applying for?	
✓		2.	How will you decide whether to make the individual eligible to practice in multiple states or only in your state?	
✓		3.	When will an individual state license be required?	
✓		4.	How will you adapt your system for sending renewal notices so you don't send them to licensees residing in another party state?	
✓		5.	What will you do if a nurse practices in your state, as a remote state, on a lapsed (non-renewed) license? Authority to fine? Cease and desist with cost recovery?	
✓		6.	If a post office number is disallowed because it does not show residence, how will you obtain the required address information from the licensee?	
✓		7.	Would differing state renewal cycles have any effect on your renewal process?	
		8.	What are the costs associated with "screening out" MSR renewals for nurses whose addresses have changed to another party-state?	
		9.	How do you keep individual state licenses separate from multi state licenses? What are the costs associated with this process?	
✓		10.	What fees will be charged in a party state for a nurse who previously held a multistate license in that state, moved away, and has now returned? --renewal fee? Additional (penalty) fee? No fee until next renewal? Does it matter if she/he is returning from a party state or a nonparty state?	

Comments/Notes

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Advanced Practice - Compact Reference Article III

Party	Non-Party		Questions	BON Staff Responsible
✓		1.	How will you assure there is always a current RN license underlying the APRN credential you issue to APRNs practicing in your state? What action will you take if not?	
✓		2.	What process will you use to verify current RN licensure in another party state for a non-resident APRN practicing in your state, as prerequisite for issuing APRN credential?	
✓		3.	What requirements in your regulations relating to licensure or recognition might have to change?	
		4.	Should fees for issuing APRN credentials go up or an extra fee be added in party states due to more work needed to verify underlying RN license?	

Comments/Notes

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Education - Compact Reference Article II

Party	Non-Party		Questions	BON Staff Responsible
✓	✓	1.	How will schools be provided with accurate information to help students understand where their license will be good and how it works?	
✓		2	What requirements in your nursing education rules and policies relate to licensure, and may require amendment? e.g., check that faculty-preceptor hold (state) license? What will it cost to amend the rules?	
✓		3.	Will the licensure requirements for students in the clinical area need to change? (e.g.: RN to BSN, LP/VN to RN)	
✓	✓	4.	What will it cost to develop presentation/written materials to inform schools of provisions related to MSR?	

Comments/Notes

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Discipline - Compact Reference Article II; III; V; VI; VII; VIII

Party	Non-Party		Questions	BON Staff Responsible
			GENERAL QUESTIONS	
✓		1.	Should you consider adding a ground for taking disciplinary action based on a practice privilege action in another state?	
✓		2.	Should you consider adding a ground for taking practice privilege action based on practice privilege action or licensure action in another state?	
✓	✓	3.	Should you consider adding grounds or promulgating rules defining unprofessional conduct to include failure to comply with scope of practice/standards when practicing under practice privilege in another state?	
✓	✓	4.	What additional information will you enter into the information system about licensure denials? How, when?	
	✓	5.	Will you seek authority to share disciplinary (investigative) information, similar to what can be shared under the compact?	
✓	✓	6.	How will you input "pending action" or "criminal conviction" self reports from applications for renewal/licensure into Information System? What resources will be needed?	
✓		7.	How can you project whether discipline costs would go up if you knew, for example, that you might see __% more informal hearings and __% fewer formal hearings due to likely MR-related discipline scenarios?	
✓	✓	8.	How will the discipline process in your jurisdiction change as a result of MR?	
✓	✓	9.	Would the law in your jurisdiction allow you to discipline for violation of the practice act in another jurisdiction?	
		10.	What percentage of your disciplinary actions involve a nurse who resides in another state?	
		11.	How many disciplinary actions does your state take based on action in another state (Under MSR these costs may decrease.)	
		12.	Do you have a mechanism to itemize your disciplinary costs? (Needed to recoup costs under the compact—both remote or home state)	
		13.	Have you determined the cost of disciplinary hearings vs. Informal resolution?	

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Discipline - Compact Reference Article II; III; V; VI; VII; VIII

Party	Non-Party		Questions	BON Staff Responsible
			COMPLAINT RECEIPT	
✓	✓	1.	Does your discipline process allow staff to accept anonymous complaints? If no, should this be reconsidered?	
✓		2.	What changes in staff orientation related to receiving complaints will be needed to prepare them to differentiate between licensure complaints and practice privilege complaints?	
✓	✓	3.	What additional information is necessary to identify a specific nurse related to a complaint?	
✓	✓	4.	What impact will Information System inquiry have on staff, computer resources, etc.?	
✓		5.	What additional education of potential complainants will be needed? (Consumers, HMOs, insurance companies, demand management, nontraditional sources, etc.) and how will this be accomplished?	
✓		6.	What additional resources will be needed to provide education regarding the complaint/discipline process?	
✓		7.	What additional staff resources will be needed if more complex or additional calls and complaints are generated?	
			COMPLAINT REVIEW, ANALYSIS	
✓		1.	What complaint information will be shared, with whom and when?	
✓	✓	2.	Which board staff will have access to various levels of discipline information?	
✓	✓	3.	What will be the impact on staffing related to complaint review analysis??	
✓	✓	4.	What will be the impact on computer resources, etc. for entry and update of Information System?	
✓		5.	What criteria would be used to determine if a case would benefit from a collaborative approach to investigation?	
		6.	What licensee information will be considered confidential?	
			EMERGENCY	
✓	✓	1.	What processes are currently available to the board to take disciplinary action? (Summary or emergency suspension, cease and desist order, go to court for injunction, other)	
✓		2.	What change in process would be needed to implement emergency cease and desist orders?	
✓	✓	3.	What criteria will be used to identify cases needing emergency action?	
✓		4.	If numbers of cases involving emergency action should increase, what would be the impact on board resources?	

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Discipline - Compact Reference Article II; III; V; VI; VII; VIII

Party	Non-Party		Questions	BON Staff Responsible
			FACT GATHERING	
✓	✓	1.	What are possible mechanisms to facilitate cooperation and collaboration with other states regarding investigations?	
✓		2.	Are there agencies, centers, corporations, in a jurisdiction that would have an impact on the number of potential licensure actions based on incidents in remote states?	
✓		3.	What will be the impact on staff, investigator, attorney work load and board members based upon need for collaboration in cases involving multistate practice? (e.g., increased phone calls, computer contacts, conference calls, video conferencing) What will be the increased cost?	
✓		4.	What will be the impact of multistate investigations on other state agencies? (e.g.: investigations, reporting)	
✓		5.	What will be the educational needs for staff, investigators, attorneys and board members and other state agencies regarding multistate cases? What will be the increased cost?	
✓		6.	What are state law implications for waivers for treatment records - can they be shared out-of-state?	
✓		7.	Are there other ways to access records, e.g., obtain through another state? Will there be a cost?	
✓		8.	How might the challenges presented by variations in organizational structures (e.g., board investigators vs. umbrella agency investigators) be addressed?	
✓		9.	What is the process for conducting depositions in the state? How can they be adapted to allow telephonic or video deposition?	
✓		10.	Is there a backlog of investigations in the jurisdiction? What are the implications for cases arising under mutual recognition? What support or assistance would be useful in dealing with the backlog?	
✓		11.	What are implications of requirement in Compact to give remote state case same priority as similar case in home state?	
✓		12.	What will be the impact on investigative personnel (e.g., need to make a call before investigative site visit or witness interview, to determine any additional areas to cover, if collaborating with another state)? Investigatory cost? Who will pay?	
✓		13.	What are available technological resources that could support collaborative investigations?	
✓		14.	What needs to be added to investigative report format to assure that all elements needed for multistate investigation are addressed?	

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Discipline - Compact Reference Article II; III; V; VI; VII; VIII

Party	Non-Party		Questions	BON Staff Responsible
✓			CHARGING DECISION	
		1.	Who will enter disciplinary data into Information System?	
✓			INFORMAL PROCEEDINGS	
		1.	What will be the impact of doing practice privilege actions on the numbers of cases that proceed through informal proceedings? (Staff time, board member time/per diem/expenses, etc.)	
✓			FORMAL PROCEEDINGS	
		1.	What will be the impact of practice privilege actions on the number of cases that proceed through formal proceedings? (Staff time, board member time/per diem/expenses, hearing examiner/ALJ costs, etc.)	
✓		2.	What adaptation, if any, would be needed for serving process (e.g., nurse residing out-of-state)?	
✓		3.	What other adaptation to formal process, if any, would be needed to accommodate practice privilege actions?	

Comments/Notes

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Discipline - Compact Reference Article II; III; V; VI; VII; VIII

Party	Non-Party		Questions	BON Staff Responsible
			BOARD DECISION-MAKING	
✓	✓	1.	How can consistency in board decisions - both intra- and interstate be promoted?	
✓	✓	2.	Who would be responsible for reporting information about action to Information System?	
✓	✓	3.	At what point is the action reported to Information System? At what point does the board authorize reporting to NPDB/HIPDB?	
✓		4.	How could provision be added to orders requiring a nurse who has had license or practice privilege action to notify a remote state when practicing under condition/probation/ limitations?	
✓	✓	5.	Would requirements for nurses to appear when applying for reinstatement need to be reviewed? Would you allow alternative technology options?	
			APPEAL	
✓		1.	What are implications for appeal procedures, particularly related to collaborative or concurrent proceedings? What are the costs?	
			MONITORING	
✓		1.	What are implications for monitoring for compliance for licensure and practice privilege actions? What are the costs?	

Comments/Notes

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Alternative Programs - Compact Reference Article II; V; VIII

Party	Non-Party		Questions	BON Staff Responsible
✓		1.	How will your agreement with your program participants need to change to comply with the compact?	
✓		2.	How will a request by a party-state licensee for practice privileges in your state be handled? and decision be made?	
✓	✓	3.	What kinds of programs would qualify as "voluntary, non-disciplinary monitoring programs"?	
✓		4.	How will agreements with alternative program participants, (self-referals and Board referals) need to be changed to require participants to agree not to practice in any other party state during the term of the alternative program without prior authorization from such other party state?	
✓		5.	What process would be needed to allow an alternative program participant to apply for practice privileges in a remote state? How will the decision be made, and by whom?	
✓		6.	How would monitoring be conducted if an alternative program participant in a home state practiced in a remote state? By whom? Would there be increased cost?	
✓		7.	Will nurses practicing in a remote state be allowed to enter the remote state alternative program? If so, what would be the criteria for admission? What would be the financial implications (e.g., charge for services)? Would the home state be notified of entry or non-compliance?	
✓	✓	8.	What information, if any, would be reported to the Information System?	
✓	✓	9.	How do you assure confidentiality of records?	
✓	✓	10.	Can a nurse sign a waiver?	
✓	✓	11.	What federal/state laws and regulations are applicable?	
✓		12.	Can a nurse already in an alternative program where practicing (and currently licensed) complete that program after the compact goes into effect and the program is now in a remote state?	
✓	✓	13.	What are other transition issues?	
✓	✓	14.	What are other fiscal implications?	

Comments/Notes

Mutual Recognition
Member Board Operations/Fiscal Analysis Tool

Administration - Compact Reference Article I - XI

Party	Non-Party		Questions	BON Staff Responsibl
✓		1.	Do you have any state facility licensing laws in conflict with the compact? e.g. "possess active (state) license" If so, how will resolution occur? What will be the cost?	
✓		2.	Do you have any state reimbursement provisions in conflict with the compact? e.g.: insurance codes? If so, how will resolution occur? What will be the cost?	
✓		3.	Are there conflicting provisions in your NPA or rules in conflict with the compact? If so, what revisions need to be made, when, how? What will be the cost?	
✓		4.	Are there conflicting provisions in other state laws such as Administrative Procedures Act, Freedom of Information, etc.? (conflicts could be in the areas of references to licensure, disclosure of disc.info, due process, etc.) What will be the cost?	
✓	✓	5.	What means will you use for effective dissemination of accurate information about MR? (meetings, video-conference, mailings, newsletter articles, Website) What will be the cost?	
✓		6.	Is there a mechanism for a nurse practicing in a remote state to access practice information for that remote state? Could this be a revenue source?	
✓		7.	What influential/verbal advocacy and constituency groups must you keep informed and encourage input from? How, when? What will be the cost?	
✓	✓	8.	Which other state licensing boards/agencies must you keep informed and encourage dialogue with? How, when? What will be the cost?	
✓	✓	9.	How will you be prepared to respond to inquiries? (who is authorized, what kind of responses, what materials) Need for additional resources? What will be the cost?	
✓		10.	How will you educate your staff regarding implications, new processes, commonly asked questions? What will be the cost?	
✓		11.	Considering your current budget process (e.g. performance based, how requests are presented to legislature) and timelines, how will you incorporate MR-related factors? What will be the cost?	
✓		12.	Are there opportunities to redesign workflow and/or reallocate responsibilities for greater efficiency and lesser cost?	
✓		13.	What are the strategies including cost required to pass compact legislation?	
✓	✓	14.	Is licensure verification an obligation for employers? If yes, how will they verify licenses, from whom and what will it cost employer?	
		15.	After reviewing the operations, what impact will MSR have on your personnel?	
		16.	What are the costs associated with revision of rules and regulations?	
		17.	What level of rights and privileges will be assigned to staff for accessing the information system?	
		18.	Will you make other agreements (e.g. with neighboring states or National Council) regarding information to be shared?	
		19.	What will authorize you to change name and address of licensees?	
		20.	What license information will be considered confidential, e.g., pending investigation, alternative program	
		21.	What are the administrative costs for implementing MSR? (Additional board meetings needed?)	

Comments/Notes

Attachment E2

Summary of MSR Fiscal Work Group

Relationship to Mutual Recognition Master Plan:

A. Member Board Operational Support

1. Analyses of each fiscal transition issue.

2. Facilitate opportunities for Member Boards to exchange strategies related to revenue replacement.

Activities

The first meeting of the MSR Fiscal Work Group was held on May 18-19, 1998. The work group developed surveys to identify current and proposed Member Board revenue sources (Attachment E2a), collect additional information on eleven specific revenue sources (Attachment E2b), and identify the number of non-resident active licensees by state (Attachment E2c). The work group also commenced identifying a series of questions that Member Boards could use in analyzing the fiscal impact of mutual recognition, both as party and nonparty states.

The Fiscal Work Group met on June 23-24, 1998, to evaluate the results of the various surveys, continue the identification of fiscal implication questions for Member Boards, develop a tool for Member Boards to calculate revenue and cost impacts, and consider possible opportunities for Member Boards to exchange strategies related to revenue replacement.

Attachments

Attachment E2a

National Council of State Boards of Nursing
Member Board Fiscal Resources Survey

The MSR Fiscal Workgroup has been charged with the responsibility of identifying all Member Board revenue sources (current and proposed) including methods of revenue recovery (e.g., disciplinary, licensure and education). In preparation for our meeting in May 1998, we would like to get a head start on accomplishing this task by collecting the following information from the Member Boards. This survey is being distributed to all executive officers via FAX and e-mail. **Please respond by FAX, using only <u>one</u> of these forms, by May 13, 1998.** Please address any questions to Tom Vicek at the National Council. He can be reached at extension 154.

Directions: For each possible Source of Revenue, (1) indicate which are current or proposed revenue sources for your board and (2) the approximate percentage of your board's total annual revenue that currently comes from that source. An opportunity to add additional revenue sources (e.g.., they didn't make our list) is provided. If you use this section, please be as specific as possible in your descriptions.

Sources of Revenue	**Current Source**		**Proposed Source**		**Percentage of Total Current Revenue (approximate)**
	Yes	**No**	**Yes**	**No**	
1. Examination fees (state-retained portion)	1		1		1
2. Initial licensure (collected as a fee separate from examination-related fees)	2		2		2
3. Combined examination and initial licensure fees	3		3		3
4. License renewal	4		4		4
5. Endorsement license	5		5		5
6. License verification	6		6		6
7. Reactivation/reinstatement (only that which is in addition to the renewal fee)	7		7		7
8. Placement on inactive status	8		8		8
9. Name change	9		9		9
10. Reissued/duplicate license	10		10		10
11. Credential review	11		11		11
12. Returned check (bad/insufficient funds)	12		12		12
13. Education program approval - initial	13		13		13
14. Education program approval - continuing	14		14		14

Sources of Revenue	Current Source Yes	Current Source No	Proposed Source Yes	Proposed Source No	Percentage of Total Current Revenue (approximate)
15. Speaker's fees/honoraria	15		15		15
16. CE provider approval	16		16		16
17. CE program approval	17		17		17
18. Board-sponsored program (CE, etc.) registration fees	18		18		18
19. Recovery of costs for discipline	19		19		19
20. Fines (if retained by the Board)	20		20		20
21. Licensee lists/mailing labels	21		21		21
22. Printed materials (e.g., newsletter subscriptions, copies of statutes, regulations, etc.) if retained by the Board	22		22		22
23. Other:					
a.	a		a		a
b.	b		b		b
c.	c		c		c
d.	d		d		d

Jurisdiction: _____

Person completing survey: _____

Telephone number: _____

RETURN COMPETED SURVEY BY: May 13, 1998

RETURN TO: Tom Vicek **FAX:** 312-787-6898
Director of Administrative Services
National Council of State Boards of Nursing
676 n. St. Clair, Suite 550
Chicago, IL 60611

Attachment E2b

Member Board Fiscal Resources Survey Follow-up
Potential Revenue Sources

The MSR Fiscal Workgroup has reviewed the responses to the recent Member Board Fiscal Resources Survey. The workgroup identified eleven potential revenue sources for which they need more information. If any of these revenue sources are applicable to your state, please answer the questions that apply.

You do not need to limit your comments to the questions listed. Any information you can provide will be appreciated. This information will be used to provide fiscal resource information to Member Boards.

This survey is being distributed to all Member Board Executive Officers via FAX and e-mail. **Please respond by FAX or e-mail by Monday, June 15, 1998.** Please address any questions to Tom Vicek at the National Council, 312-787-6555 ext. 154. **FAX: 312-787-6898**

INACTIVE STATUS

1. How much is the fee?

2. How does a person obtain inactive status?

3. Is a document issued? _____Yes _____No
   If "yes," what type of document?

4. Is inactive status granted for an indefinite time period or is it periodically renewable?

5. Does the person with inactive status receive benefits, i.e., newsletter? If so, what are these benefits?

EDUCATION PROGRAM APPROVAL—Initial and Continuing

1. Does your state do: Initial approval?_____ Continuing approval?_____ (Indicate "yes" by placing an "**X**" on the line.)

2. Are initial approval fees different from continuing approval fees? _____Yes _____No
   If "yes," explain how the fees differ.

3. What is/are the fee/s for education approval? Initial $_____ Continuing $_____

4. What do the fees cover? (i.e., flat fee, expense recovery)

5. When is the fee charged? (e.g., prior to approval or after the approval process)

RECOVERY OF COSTS FOR DISCIPLINE

1. Is there a flat fee ? (amount_____) or itemized fee? (amount_____)

2. If itemized, what item(s) are recoverable and what is the fee for each? Please list.

Item	Amount

3. Under what conditions are costs recovered? (List separately for consent, hearings, etc.)

FINES

1. For what actions are fines assessed?

2. Do you have guidelines for amounts of the fines? _____Yes ____No

3. Do you have non-disciplinary proceedings that result in fines? _____Yes ____No

PRINTED MATERIALS

1. Do you charge a fee for printed materials? ____Yes ____No
   If "yes," what types of printed materials?

2. How are the charges determined?

APPLICATION FEE

1. Describe what you identify as an application fee.

2. How much do you charge?

3. Is it refundable?

4. Is the application fee charged in addition to a license or examination fee? ____Yes ____No

INTEREST ON INVESTMENTS

1. Is there a structure in place in your agency that allows you to retain interest on investments? ____Yes ____No

2. If there are any restrictions on the utilization of the interest, describe briefly.

PEER ASSISTANCE

1. Are revenues from peer assistance part of the licensure fee? _____ Or a separate fee? _____
2. How much is the fee? _____ How is it calculated?

3. Are all funds collected restricted for use by the peer assistance program?

4. Describe what your peer assistance program covers.

NURSING EDUCATION LOAN PROGRAM

1. Describe this program and explain how it is a revenue source.

REISSUED RENEWAL FORMS

1. If the renewal forms are mailed and they are returned as undeliverable, does the state charge to reissue the forms to a new address? _____ Yes _____ No

2. If "Yes", how much do you charge?

3. When is payment collected?

RETIRED NURSE CERTIFICATION

1. How much is the fee? _____ Is it renewable? _____ ("**X**" indicates "yes")

2. Are retired nurses permitted to actively practice nursing? _____Yes _____No
   If "yes," describe any **limitations** to their practice.

3. Does your state have a practice requirement for licensure? _____Yes _____No
   If "yes," please describe.

Jurisdiction:_____

Person Completing Survey:_____

Telephone number:_____

RETURN COMPLETED SURVEY BY: JUNE 15, 1998

You may reply to this e-mail, send a fax or mail

RETURN TO: Tom Vicek
FAX: (312) 787-6898
Director of Administrative Services
National Council of State Boards of Nursing
676 N. St. Clair St., Suite 550
Chicago, IL 60611

Thank you for your assistance.

Attachment E2c

Member Board Survey of Non-Resident Active Licensees By State

In order to provide Member Boards with relevant information related to the possible fiscal impact of implementing the mutual recognition model of nursing regulation, the MSR Fiscal Workgroup would like to collect information on the number of non-resident active licensees, by state, from each Member Board. **DIRECTIONS:** For each state listed (column 1), report in columns 2 and 3 the number of RNs and LPN/VNs living in that state who hold an active license in your jurisdiction.

This survey is being distributed to all Member Board Executive Officers via FAX and e-mail. **Please respond by FAX or e-mail by Friday, June 19, 1998.** Please address any questions to Tom Vicek at the National Council, 312-787-6555 ext. 154. **FAX: 312-787-6898**

	Number of Non-Resident Active Licensees	
	RN (Includes APRNs)	LPN/VN
Alabama		
Alaska		
American Samoa		
Arizona		
Arkansas		
California		
Colorado		
Connecticut		
Delaware		
District of Columbia		
Florida		
Georgia		
Guam		
Hawaii		
Idaho		
Illinois		
Indiana		
Iowa		
Kansas		
Kentucky		
Louisiana		
Maine		
Maryland		
Massachusetts		
Michigan		
Minnesota		
Mississippi		
Missouri		
Montana		

Nebraska		
Nevada		
New Hampshire		
New Jersey		
New Mexico		
New York		
North Carolina		
North Dakota		
Northern Marianas		
Ohio		
Oklahoma		
Oregon		
Pennsylvania		
Rhode Island		
Puerto Rico		
South Carolina		
South Dakota		
Tennessee		
Texas		
Utah		
Vermont		
Virgin Islands		
Virginia		
Washington		
West Virginia		
Wisconsin		
Wyoming		

Jurisdiction:_____ Person Completing Survey:_____

Telephone number:_____

PLEASE RETURN COMPLETED SURVEY BY: FRIDAY, JUNE 19, 1998

You may reply by e-mail or fax (FAX: 312-787-6898) **to** Tom Vicek, Director of Administrative Services

Thank you for your assistance.

Attachment E3

Multistate Discipline Process

The proposed multistate discipline process is described generically below. It could be adapted to the particular statutes, rules, procedures and traditions of each jurisdiction. There are ten critical steps to this process. The work group recommends that the same process used by each jurisdiction for licensure actions be followed for privilege actions. It will be important that participants in the process articulate whether the license (in the home state) or the privilege (in the remote state) is under review.

Step # 1 - Complaint receipt
Jurisdictions vary as to who receives complaints and the requirements for making a complaint (e.g., only written complaints, signed by complainant, or written plus verbal or anonymous complaints). Boards are encouraged to review these procedures as to whether the possibility of remote state action against the practice privilege will influence the manner in which complaints are accepted for review.

Step #2 - Identification of nurse
The information system will be an important resource to support discipline processes in party states and, upon receipt of complaint, should be checked to determine the nurse's status in the state. Important questions to answer at this point:

- Is the person identified in the complaint a nurse licensed in the state receiving the complaint?
- For party states, is state receiving the complaint the state of the individual's residence?
- For party states, is this person practicing under the privilege granted through licensure in another party state?
- For nonparty states, if a person is not licensed, is it possible that this person is practicing nursing without the required nonparty state license?

Step #3 - Evaluation of face value of complaint
Complaints need to be reviewed at their face value to determine if additional investigation is warranted. Questions to consider at this point:

- If the identified person is not a nurse, should the complaint be referred to another board or agency?
- Would the alleged behavior, if true, provide grounds for disciplinary or privilege action?

Step #4 - Complaint review/analysis
The compact language (Article V, Section a) requires the reporting of "significant current investigative information yet to result in a remote state action." Complaints which reach this step in the disciplinary process are considered to be significant current investigative information, so should be reported to the information system at this point.

Boards vary as to what level of staff and board involvement occurs in the disciplinary process. Most states provide for some level of staff review and analysis of complaints to determine the priority of the case. Some cases, even though the behavior may fit the language of the grounds for discipline, may not be serious enough to rise to the level of board action on license or privilege. Most jurisdictions have developed some type of administrative mechanism, e.g., sending a letter of concern to the nurse while dismissing the allegations, to handle such complaints. Most jurisdictions track these types of concern letters or dismissed allegations for the purpose of identifying patterns of behavior (i.e., one occurrence of a behavior is not acted upon, but two or three incidents would be pursued). The compact will improve party

boards' ability to track these dismissed allegations and allow party states to identify patterns of behavior from multiple allegations that occur in multiple states.

Complaints identified for further discipline processing require additional fact gathering before they can be resolved.

Step #5 - Fact gathering and report preparation
Again, states vary as to the levels of fact gathering and the personnel involved. Some states immediately refer cases to investigators. In others, preliminary fact gathering may be performed by board discipline staff. Still others refer all complaints to their attorney for review and determination of whether or not additional investigation is needed.

Regardless of who obtains the information, whether done in person, via telephone or by requesting particular records or documentation, the following activities are typically involved in the process of fact gathering:

- Interview - nurse
- Interview - complainant
- Interviews - other witnesses
- Record review
- Site visit
- Background check
- Previous employment
- Waivers to medical record, or treatment records
- Subpoenas
- Other investigative activities

The job of the fact gatherer is to serve as the eyes and ears of the board and to report the facts objectively, fairly, concisely and thoroughly. This information is reported to the board and serves as the basis for decision-making for both licensure and privilege actions.

Step #6 - Is emergency action needed?
The disciplinary process takes time, so boards need to have procedures in place to act quickly in emergency situations. Such action can be initiated at any point in the process, should an imminent danger to the public be identified. In party states, the home state may choose to use summary (temporary or emergency) suspension if so authorized in state law. The compact (Article VI, Section c) authorizes all party states to issue cease and desist orders to limit or revoke a nurse's authority to practice in the state.

Step #7 - Charging decision
Reports developed through the fact gathering step are reviewed by person(s) authorized by board (or board in some states) and charging decision made. This important step in the discipline process is another example of variation among states. In some states, boards are involved in the determination of probable cause, while in other jurisdictions, board attorneys and staff make initial decisions regarding whether cases should be pursued based upon general direction provided by board policy. The question is, *"Is there reasonable belief in the existence of facts warranting board action?"* If the investigation does not support the finding of probable cause, the complaint would be dismissed. If it is determined that a discipline ground has been violated, but that situation does not warrant board action, the case may be dismissed with some sort of advisory or warning. If there is probable cause that action is warranted, appropriate documents are prepared and are filed following the procedures prescribed by the state.

Step #8 - Informal or formal proceedings
The format and drafting of official documents, whether or not negotiated settlements are pursued, and the procedures and conduct of hearings are state specific. Whether through formal or informal proceedings,

the goal is to determine: 1) findings of fact, 2) whether or not the proven facts constitute a violation of the grounds for discipline, and 3) what licensure or privilege remedy should result.

Step #9 - Board decision

Regardless of whether informal or formal proceedings are utilized, the final decision falls upon the board in most jurisdictions. In negotiated settlements, the board must focus on whether the proposed remedy is congruent with the facts admitted or stipulated. In the hearing process, the board must focus on the allegations in the charging document and determine, based on the evidence presented, whether the state has proven the charges. Regardless of who presides, most boards of nursing have this decision-making responsibility in the administrative hearing process. The board must consider the standard of proof in the jurisdiction and whether the burden of proof is upon the applicant (if seeking licensure or privilege) or the board (in other cases). The board has to answer the following questions:

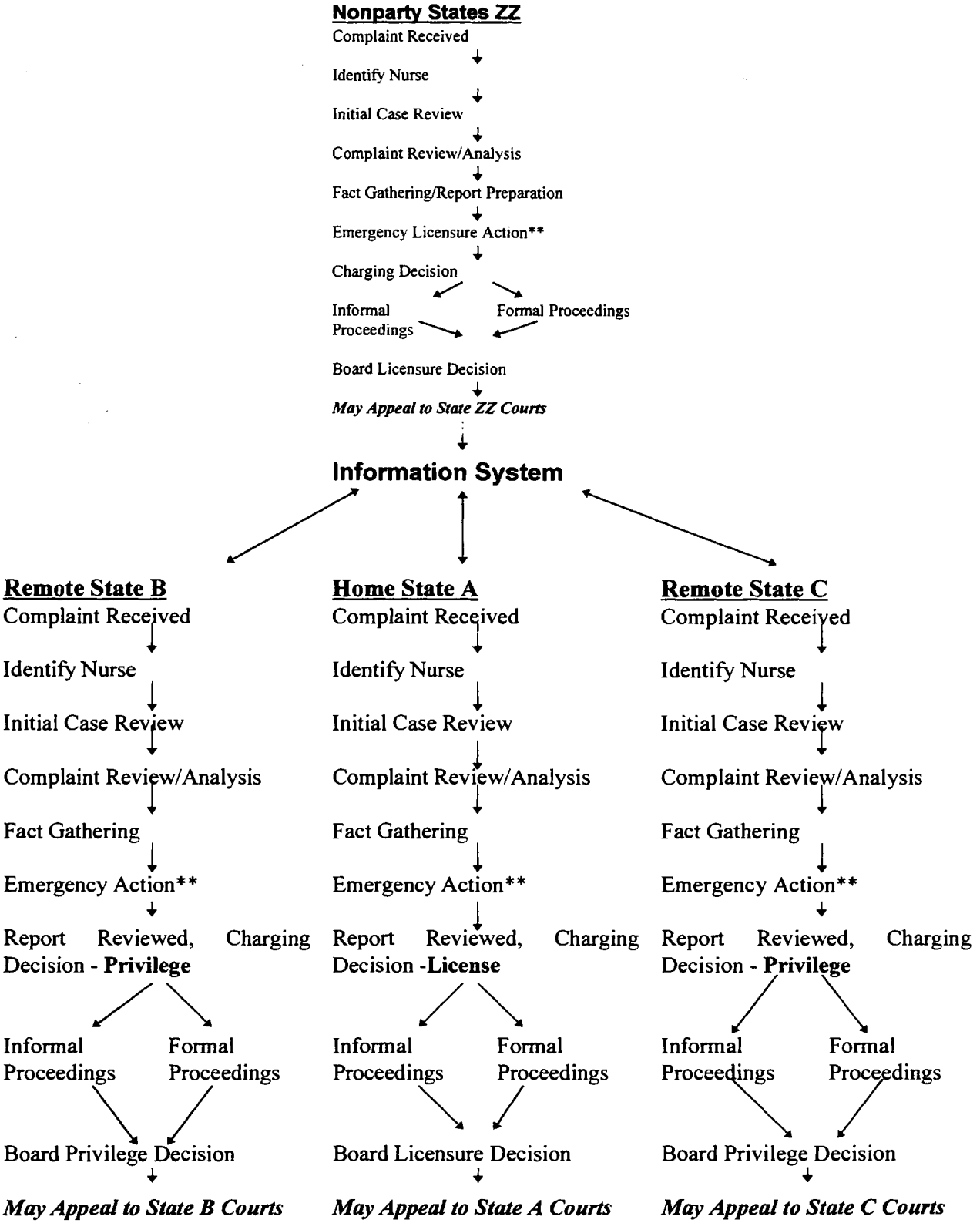
- Are the charges proven by the state? Do facts support the charges in the charging document?
- Is licensure discipline or privilege action warranted? Was there a violation? What was the severity of risk? What was the patient outcome? Are there special circumstances or other mitigating factors?
- What discipline is warranted? The threshold question: should the nurse should be out of practice to protect the public? What was the seriousness of the violations? What were the mitigating and aggravating factors? What are the prospects of rehabilitation? If it is determined the nurse should be out of practice, for how long? What would demonstrate readiness to return to practice? If the nurse is allowed to continued practice, what safeguards are necessary to assure public protection?

The remedy selected is determined based on the answers to those questions. The filing of documents and implementation of resulting orders would file the procedures of the state taking action.

Step #10 - Opportunity for appeal

Nurses have the opportunity to appeal decisions by the board of nursing. State procedures may vary, typically appeals go first to the district court or its equivalent. A court may review the agency's governing statutes to determine if it acted within its authority. Courts cannot retry the matter, but rather determine whether or not a board properly exercised powers conferred upon it by statute. The court cannot substitute its own decision in judicial review, but rather is expected to affirm the decision of the board or remand the case for further proceedings.

Multistate Discipline Process



***May be initiated at any point in process as needed*

Attachment E4

Discipline Case Scenarios

Scenario: Endorsement to nonparty state after remote state action

Jane Doe is licensed in Home State A and practices in Remote State B. Her practice privilege is revoked in Remote State B, and State A chose not to take action against her license (or is backlogged in taking action).

In the meantime, Jane files an endorsement application with Nonparty State C. State C's laws permit denial based on another state's disciplinary action against a license. Remote State B's action limited Jane's practice privilege, but there is no licensure action.

State C would not be able to automatically deny Jane Doe's application based on Remote State B's action. Instead, State C would need to obtain the investgative information and independently prove the underlying facts of the case.

Comments: This situation is like those states which currently do not have a discipline ground for taking action based on action in another state. All nonparty states could be affected in this scenario depending on the wording statutes related to out-of-state discipline. States that do not plan to enter into an interstate compact need to be alerted to evaluate their statutes for amendments necessary to deal with endorsements coming from compact states. Work group suggests all boards consider inserting in grounds for discipline taking action on the basis of licensure or privilege action in another state.

Scenario: Frequent moving by probationers, alternative program participants

Traveling nurses and nurses engaged in telemedicine may make frequent "temporary moves" in a practice location while maintaining a permanent address in one home state. The problem arises if probationers (or alternative program participants) practice in multiple party states without those states being aware that they are practicing there. As a result, the nurse practices without the necessary monitoring.

Even if the home state's probation terms or contract require notifying the home state of practice in other states, a violation would be difficult to detect. The remote state would not become aware of the individual's practice in the remote state unless a complaint arose. While employers in the remote state should check licensure status, it is not done consistently.

Comments: One approach would be to stress the employer checking licensure status, and incorporate this in the education and information sharing regarding multistate practice. (The work group suggests using chief nursing officer, or supervisor, as person responsible for this verification, and tie to potential for aiding unlicensed practice if fail to verify.)

Informing employers and remote states regarding practice sites should be included in alternative program agreements. Responsibility should be on the nurse.

Scenario: Inconsistency in penalty for similar offenses in same facility

Sue Smith lives and works in a border town in State A, her home state. Jill Jones works in the same facility in State A, which is her remote state, and resides in State B, her home state. Smith and Jones both are found to be diverting drugs for self-use.

Smith enters State A's Alternative Program, complies with the program, and avoids disciplinary action. Jones has her license revoked by State B and can no longer practice.

Comments: This situation is similar to what can happen currently in the Veterans Administration or military system. Variations in the availability of alternative programs will continue under the compact.

Scenario: Falsifying state of residency

An RN chooses to keep State A as her home state long after moving to Party State B. She keeps a post office box address in her original Home State A because she knows that State A has lower renewal fees, more lenient disciplinary rules, and a restricted budget that slows the discipline process.

During an investigation of practice in State B, this RN moves frequently to other party states and commits additional offense, making it difficult to locate her and coordinate and complete an investigation.

Comments: Residency requirements will be critical to articulate in the rules. Suggest looking at IRS requirements and such particular states: FL, AK, NV, TX, LA. Also, be specific in rules on the time frame for notifying new home state (suggest 30 days).

The information system, which will include tracking of complaints and investigations, should provide an excellent tool to assist in this type of mobile problematic nurse.

Scenario: Collection of cost recovery by remote state

After extensive investigative and prosecution costs, Remote State A revokes Jane Doe's practice privileges and orders her to pay $5,500 in cost recovery. Jane Doe returns to practice in Home State B while awaiting possible disciplinary action there. In the meantime, Remote State A sends collection notices to Jane Doe for cost recovery, and she ignores the notices. Without the risk of action against her license by State A, Jane Doe has no incentive to pay her cost recovery bill.

Comments: Collection leverage could be added if home states consistently helped to enforce cost recovery to remote states by making cost recovery compliance a term of probation or a term of reinstatement. Also, consider making a ground for discipline (perhaps as unprofessional conduct) failure to comply with any terms or conditions of a remote state. The sanction for not complying would be suspension of license.

Scenario: Seeking licensure in party sate after revocation in home state

Jill Jones' license is revoked by her Home State A after a practice violation. Her family relocates to Party State B and she wishes to re-enter the nursing field two years later. She has returned to school and completed extensive remedial education. How would Jones' new Home State B evaluate her reinstatement request? Would she be required to move back to her former Home State A and comply with its reinstatement process, including possible probation time?

Comments: Work group suggests that while Jones would have to apply to State B, she would be likely directed to work with State A to clear the action. The compact provides authority to complete pending investigations; would this be applicable to completion of actions as well? This is another example of where the information system has potential to assure that Jones is upfront with information regarding prior discipline.

Scenario: Changing home states to avoid action against license

Sue Smith commits numerous medication errors in Home State A and feels certain that she will have her license revoked. Before State A can take action, she relocates to Party State B and makes it her home state. When State A finalizes its investigation, it has become the remote state and can only take action to revoke Smith's practice privilege, not her license. Her new Home State B then proceeds to begin action against her license, so she decides to move again to another state.

Comments: This situation is covered in the compact, which allows completion of pending investigations even if a nurse relocates.

Scenario: Confidentiality laws may prohibit party state information exchange

Home states and remote states may not be able to share information about participation in alternative programs, complaint information, or other key data that could have public safety implications. For example, if Jane Doe enters her Home State A's alternative program, State A may not be at liberty to tell Remote State B about Doe's status. Jane Doe may be working in Remote State B without anyone's knowledge since the employer in Remote State B would not be told of her alternative program involvement when they verify license status with Home State A.

Comments: Alternative program agreements should include requirement to report participation to employer and any remote state where practicing, planning to practice. This may be difficult to achieve, particularly with privately contracted programs, but the work group believes that the information system ought to include fields available to party states tracking alternative program participation.

Scenario: Moving to compact states after discipline in nonparty state

Jill Jones resides and works in nonparty State A. Prior to State B joining an interstate compact, Jones held a license in State B and continues to maintain the license in a current, active status through that individual state. Nonparty State A revokes Jones' license and she moves to State B, which becomes her home state. Jones can work not only in Home State B, but all party states, until Home State B takes action base on State A's action. Remote states where she practices will not know to initiate revocation of practice privileges because they may not know that Jones is present and practicing in their states.

Comments: State A's action should be picked up through the DDB, and State B would need to make a determination regarding license there.

Scenario: Inconsistent fingerprinting requirements

Home State A requires fingerprints of applicants, which results in reports of subsequent convictions in that state for the lifetime of the nurse. However, the nurse actually practices in Remote State B. The nurse has not been fingerprinted in Remote State B, and Home State A would have no way to learn of past or subsequent criminal convictions committed in Remote State B.

Comments: This is a complex issue that may need to be ultimately resolved through a uniform requirement. Some of the problems include access to criminal information, prohibitions against sharing information obtained from the FBI, and lack of uniform interpretation and application of criminal law regarding what are considered "serious convictions." FBI report is most important. Could an applicant or licensee waiver authorize the dissemination of the information?

Best approach may be to develop model application screening procedures. Also need to consider how to deal with licensees with convictions, and how best to identify (e.g., questions on renewal applications, periodic or random background checks, etc.).

Another issue is how to define "conviction" - does it include guilty pleas, nolo contrendre, set asides, etc.? Questions to take to criminologist working with Discipline Resources Subcommittee.

Work group identified need to review underlying conduct, not just felony convictions.

Nevada does have the authority to do fingerprint check during the course of an investigation, or as part of renewal (have not used latter).

Scenario: Trying to use multistate privilege in state where previously revoked

Nurse's license is revoked by State A (party state). She is also licensed in State ZZ (nonparty state). She returns to State ZZ, where she is allowed to keep her ZZ license. Then, nurse moves on to State B (party state) and applies for licensure by endorsement. State B grants a limited license to nurse. Nurse then tries to practice in State A (party state) again on the basis of her State B license. What happens?

Comments: Conflict of laws between State A and State B. How does the previous State A revocation affect a subsequent privilege to practice?

Scenario: Out-of-state consultant (or short-term director of nursing services, instructor, camp nurse)
Why Important: Many nurses perceive "giving advice" as not practicing "hands-on nursing."

Comments: Practice interpreted broadly, beyond "hands-on." Compact gives authority to nurse in a party state to practice in other party states. Need for education, dissemination of information.

Scenario: Federal nurses (military, Veterans Administration, Indian Health Service)
Why Important: Scope issues raised in current federal practice on basis of "license somewhere"; also questions about where home state would be.

Comments: How residency is defined may address. Many scope issues exist under current system. This is another place that the information system may assist. Need for education, networking, working with federals to bring on board.

Scenario: Home health nurses/agencies
Why Important: Home health nurses may have clients in multiple sites at same time, and may be in border communities. Investigations tend to be complex, will be more challenging if need to collaborate and coordinate multiple jurisdictions.

Comments: Coordination of investigation resources, use information system to support multistate cases. Information system can be big help to identify patterns early. May be opportunities to "help out" sister states.

Scenario: Drug diversion (see alternative program discussion)
Why Important: Will be significant issue because this is population that seeks "geographic cure."

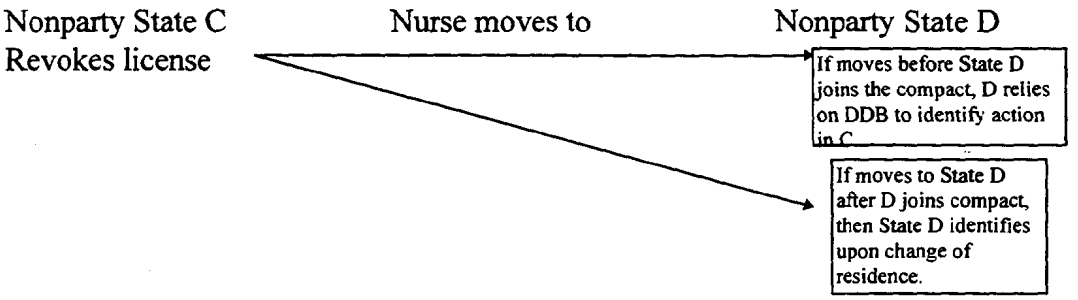
Comments: Potential for better tracking with information system..

Scenario: What does revocation or restriction of multistate privilege mean? How long does it last?
Nurse's license is revoked by State A (party state). She is also licensed in State ZZ (nonparty state). She returns to State ZZ, where she is allowed to keep her ZZ license. Then, nurse moves to State B (party state) and applies for licensure by endorsement. State B grants a limited license to practice. Nurse then tries to practice in State A (party state) again on basis of her State B license. What happens?

Comments: Two questions were identified by work group:
1. How does the previous State A revocation affect a subsequent privilege to practice?
2. What does revocation or restriction of multistate privilege mean? How long does it last?

Scenario - What happens if nurse moves between states of licensure, after revocation in one of those states?
Nurse licensed in both Nonparty State C and Nonparty State D. State C revokes her license. She then moves to Nonparty State D. What happens if Nonparty State D joins the compact and becomes a party state?

Comments: Timing of the effectiveness of the compact is operative in this situation. If the nurse moves before State D joins compact, State D must rely on the DDB monthly report to flag her license as having disciplinary action in State C. If moves to State D after State D joins compact, then State D would have the opportunity, in addition to the DDB monthly report, to identify the action in State C upon notification of change of residence.



State A - party	State B- party	State C - party	State D - nonparty	State E - party
			Nurse lives in D, can choose to maintain licenses in States A, B, C and E.	
			If moves to State A, State A is state of residence and so surrenders licenses in States B, C and E. She can choose to maintain license in Nonparty State D.	

Attachment E5

Summary of Findings and Recommendations MSR Discipline Work Group # 1

Factors to Consider in Planning for Discipline under Mutual Recognition

- This is an opportunity to improve interstate communication and cooperation regarding disciplinary cases, to the benefit of the public
- Majority of discipline cases will continue to be managed intrastate
- Not all multistate cases will require coordinated investigations or be appropriate for concurrent actions, many of the less serious cases can continue to be acted on sequentially
- For those multistate cases involving high risk behavior, where consumers are placed at serious risk of harm, MR cases need to be moved to the front of the queue, managed expeditiously with coordinated investigations and concurrent proceedings/actions
- Communication and information sharing, as authorized in the interstate compact, are critical to assure public protection
- Member Boards need to carefully examine perceived barriers collaboration, identify the source (whether a statute, a rule, a policy, or a tradition) and explore creative and innovative ways to get over, around or under the barrier

Desired Outcome of Multistate Discipline

Enhancement of public protection through a multistate discipline process

Suggested Evaluation Process for Discipline Process

- Identify desired outcomes
- Select measurable indicators (how do you know you have achieved the desired outcome?)
- Determine who is/are the evaluator(s)
- Determine when do you evaluate (ongoing, periodic, at conclusion)
- Identify available evaluation mechanisms and select one that can meet the criteria listed below

Selected Evaluation Criteria

1. Support and enhance ability of boards to identify cases and determine the facts of a complaint - *case finding, jurisdiction issues, accurate information, useable information (valid, reliable, verifiable)*

2. Information is shared within identified time parameters - *information is shared within identified time parameters, appropriate time frames at various level of process*

3. Cost effective - *decrease duplication of efforts, shared costs, maximize coordination of resources, and recovery of costs*

4. Sanctions protect the public - *information sharing, identify potential multistate problems earlier, tracking of cases and effective remedies (including monitoring)*

5. Enforceable - *applicable procedures are followed; due process provided; process and decision-making stands up on appeal; specified requirements are met (e.g., if reports are required, reports are received or jurisdiction can take further action - go to court for enforcement if necessary; if cost recovery stipulated, costs are paid or jurisdiction can take further action)*

Recommendations Regarding Information Sharing

- The work group identified the need for levels of information access:
  - ⇒ Party states would have the highest level of access, having access to all information including complaint and investigation. They would be subject to mandatory information sharing per the compact.
  - ⇒ Nonparty states would have access to final discipline actions through the DDB, access to basic identification information (perhaps at charge). Need to promote continued reporting to DDB, and sharing of nurse information with system.
  - ⇒ Employers/other authorized to have access - work group suggests that employers could, for a fee, have direct access to selected elements of the information system, including basic nurse identification information and final discipline action (DDB).
  - ⇒ Nurse identifiers to include names, Social Security number, address (and address history), school(s) and year(s) of graduation, consider including mother's maiden name.
  - ⇒ Work group also discussed possibility of nurse credentialing service that could be used to offset costs of system.
- The work group discussed two approaches to tracking complaints/investigations:
  - ⇒ Flagging system - certain level of access to information system would have access to fields indicating if complaint received, investigation in process, how case resolved without action (to track patterns of behavior which individually would not rise to level of board licensure or privilege action) and board action on licenses, board action on multistate privilege in remote state. Responsibility would be on boards to follow up by contacting involved board for more information.
  - ⇒ Investigative Information available on-line - limited access screen which would track the nature of the complaint, investigative details, process, actions.
  - ⇒ The work group identified the need for the DDB to include privilege revocations and limitations.

  The work group recommends that the first approach, the tracking by flagging, be used. Their rationale involved considering the staff time needed to input additional fields, their prediction that investigators or others using the information would still call the state reporting the complaint or investigation for more information. Earlier communication between investigators regarding cases would hopefully promote early collaboration and coordination of investigations.
- Failure to report - if a party state fails to promptly report or update complaint/investigation/final resolution information, would be referred to Compact Administrators Group.
- Alternative Programs - agreement between alternative program and nurse to include requirement that nurse apply for privilege to practice in a remote state; failure to do so would be added to grounds for discipline.
- Other alternative program issues - what about states where boards do not know who is in program? *See MSR Alternative Program Report.*
- Suggest rule that would require reporting of who is in alternative program.
- Need to address the differences between states regarding at what point in an investigation that information can be shared. Even though there is compact language requiring sharing of significant investigative information, some attorneys question still whether or not the compact would supersede state law in this area.

Other information suggestions - look for Web browser software that would screen for similarities of fields, cue words regarding actions. Interesting suggestion for graduate student research project: send a mock case to all Member Boards, and ask for them to code as to type of allegations and remedies. Compare and analyze.

Recommendations - Investigations

- Multistate services to provide support in a number of practice and discipline related areas.
- How to promote early collaboration re discipline cases?
  - ⇒ Raise awareness
  - ⇒ Let know resources and support available
  - ⇒ Success stories - spread the word

- ⇒ Information system for early tracking
- ⇒ Networking opportunities - have available lists of investigators, attorneys and board staff who work with discipline

- Education piece - building coalitions, promote working together to make best use of resources
- Develop ways of communicating what needed by a board requesting an investigation
- Compile particulars regarding investigations, e.g., Miranda, licensure issues, peace officer status, subpoenas, etc.

Suggested Discipline Rule Content and Guidelines for Mutual Recognition

Key question - where does process for taking privilege action belong? Work group identified two possibilities:

#1 - *In the compact rules* - since compact authorizes the multistate privilege, as well as cease/desist and privilege restriction/revocation, use the compact administrator rules to identify the process, especially for cease/desist orders.

#2 - *In Model Nursing Practice Act and Rules* - Member Boards could incorporate use in jurisdiction's nursing practice act and rules. But, since compact language also refers to remote state laws as to sanction, therefore, best place to detail process is in *Model Nursing Practice Act* and *Model Nursing Administrative Rules.*

Work group leaned toward latter, concern expressed regarding too broad a delegation to the compact administrator rule making if in compact rules. This issue needs further consideration and discussion by the attorney group if possible.

Suggested Rule Content	Suggest Guidelines
Define "promptly" - as within 30 days	
Define "significant" - as important enough to move forward (does not include complaints that are found to be non-jurisdictional, frivolous, not a violation of a ground for discipline)	Develop grid, severity scale, tools to assist in initial complaint evaluation
Define "public" - as information available to anyone with access to the information system.	Query - where does media fit in? Guidelines would be assistive
Define "non-public/private" so that it would address information only available to party states *(see MSR Alternative Program definition)*	
Define "confidential" - *see MSR Alternative Program Work Group definition*	
The work group recommends that temporary permits do not authorize the multistate privilege	
Require that remote state action on multistate privilege in that state to be promptly reported to DDB. If remote state actions not promptly reported, would be reviewed by Compact Administrators Group. The 30-day time frame is consistent with current NPDB time frame for MD/DDS discipline action reporting. Expect to be same for NPDB and HIPDB	How do other states become aware of privilege action? DDB Monthly Discipline Report.

Include a sentence to assure that party states address in alternative program agreements that nurses monitored in program obtain permission to practice in remote states	Alternative program "how" in guidelines

Recommendations for State Nursing Practice Acts

Revise grounds for discipline to include:

- Ground to take disciplinary action on the basis of privilege action in another state
- Ground (or add to definition of unprofessional conduct) for failure to comply with scope and standards of practice in a remote state
- Ground for failure alternative program participant to request permission to practice remote state
- (If not already in grounds) Ground for failure to comply with alternative program agreement/contract

Recommendation for Discipline Support Services

The work group suggested the creation of discipline support services, to operate under the direction of the Compact Administrators Group. The support services would provide a variety of services to the Member Boards which choose to use the services. These services were envisioned to offer monitoring services for both discipline and alternative programs, investigative support (consultation, orientation and training, other resources) and possibly practice inquiry (an 800 number to screen and respond to practice inquiries per participating state algorithms). In brainstorming how such services could be funded, the work group suggested that development and start-up costs might be funded by private foundation grant. Financial support for ongoing services could come from the boards contracting for services, or creating a special fund created by each state contributing "a quarter a nurse," or recovering costs from the licensee who is disciplined or monitored. The work group asked how to obtain authority - could it be contracted service? Some other suggestions to implement:

- Use pool of regional investigators
- Promote partnering - investigator pairs with local investigator (access to subpoenas, knows law); encourage networking, promote communication
- Only upon request of board dealing with complaint

Attachment E6

Summary of Findings and Recommendations MSR Alternative Program Work Group

Factors to Consider in Planning for Alternative Programs under Mutual Recognition

The work group discussed how alternative programs could be accommodated within mutual recognition. The following factors were identified as needing careful consideration in planning any approach:

- Some states have alternative programs, some do not.
- Who is to know about alternative program participation (implications if remote state knows and home state does not)?
- Most alternative programs currently require licensure in the program states.
- How many programs require licensure in the program state?
- How many programs currently require notice from the nurse if nurse moves to another state?
- What are reporting implications for programs which accept "true volunteers" (nurses who self report, perhaps at the urging of another, but without any practice or legal considerations) as well as board-referred nurses?
- What are the monitoring implications?
- Should alternative program participants be restricted to the home state? (Or program state?)
- Should there be limits on the number of remote states an alternative program participant is allowed to practice in?
- What is the impact of mandatory reporting requirements?

Development of Process for Accommodating Alternative Programs in Mutual Recognition

The compact specifies in Article V(f) *"Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of licensure action and that such participation shall remain non-public if required by the party state's laws. Party states must require nurses who enter any alternative program to agree not to practice in any other party state without prior authorization from such other party state."*

Suggested Process - The work group developed the following process for a program participant to request authorization to practice in a remote state:

- Program agreements need to include provision that nurse participant must restrict practice to the program state. Like other changes in employment, nurse must consult the program regarding any change of practice. Permission of the participant's alternative program would be required based on whether an employment opportunity is acceptable within the terms of the contract for supervision, stability, limitations, etc.
- Nurse submits written request to remote state for permission to practice while participating in alternative program in another party state, to include statement regarding proposed practice, employment, setting, and statement that such practice is consistent with terms of current alternative program agreement.
- Copies of written request would be sent to alternative program and home state board of nursing.
- Written request would include a consent for release of records from alternative program to the remote state (allows remote state to validate compliance, terms of agreement, and compliance history).

Authorization Decision - The remote state board of nursing (or its designee) would make the authorization decision. Considerations for remote state decision-making include:

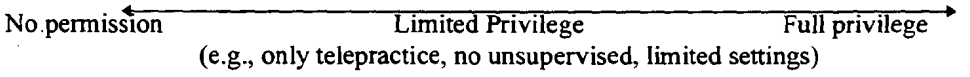
- Has nurse been compliant in the alternative program (with terms of agreement/contract)?
- Length of time in recovery, in program.
- Current practice restrictions (both potential employer and board issue).

- Setting type and nature (e.g., telepractice vs. physical presence).
- Are there legal charges pending or convictions?
- What is current relapse evaluation, current recovery evaluation? (Referral to independent evaluator might be requested by remote board for further considerations of the practice request.) Note: such a referral might not be needed for some situations, e.g., telepractice where the nurse remains in the home state, but absolutely needed for situations involving physical presence in the remote state.

Recommended Time Frames, Compliance

- Nurse needs to be in a stable recovery.
- 12 consecutive months of 100 percent compliance with terms of agreement/contract (no missed drug screens, aftercare completed or new position will not interfere with completion, minimum six months' successful work history.
- Home state restrictions remain in place - alternative program agreement/contract terms prevail.

Options for Remote State Responding to Request - the remote state would have a range of options for responding to requests. These would include:



Each state would determine the how for giving permission. Some boards might use informal meetings with designated board representatives. Others might authorize collaboration between alternative programs. Still others might use either informal or formal discipline processes. The method of issuing the permission would also be determined by the state. Some boards might use a letter of authorization. Some might require a nurse to have an agreement with the state alternative program or other type of informal agreement. Some states might issue an order.

Monitoring - How would monitoring be conducted if an alternative program participant practiced in a remote state? The work group determined that this was another area where interstate collaboration and coordination would best serve the public and the nurse. The work group:

- recommends that the locus of monitoring be determined on a case-by-case basis, considering factors such as where employment is located, where therapeutic and support activities are located, resource considerations (for board and/or programs, as well as nurse) and geographic considerations.
- emphasizes the importance that the monitoring state must agree to notify the remote state in the event of relapse, other non-compliance or completion of program.

Can Nurses Enter Remote State Alternative Programs? - The work group discussed at length where can a nurse participate in an alternative program. Home state only? Or, should there be opportunity to participate in a remote state program? A complaint could go to either home or remote state.

- Home state could refer to home state alternative program and/or to discipline.
- Remote state would have the option of revoking privilege and/or referring to an alternative program - home state? Remote state? Both?
- There would be fiscal, as well as policy considerations.

The work group recommends that offering the opportunity for non-resident nurses to participate in an alternative program be seriously considered. Since most programs currently require licensure in the program state to participate, the state nursing practice act may need to be amended to allow a nurse who is a non-resident but eligible for privilege to participate in an alternative program. The decision as to which state is best suited to provide the primary monitoring should be a collaborative decision between the programs and the nurse, based on factors such as where employment is located, where therapeutic and support activities are located, resource considerations (for board and/or program, as well as nurse), and geographic considerations. (See below for discussion of how this

coordination might be accomplished.) The primary monitoring state must agree to notify the other state in the event of relapse, other non-compliance or completion of program.

Clearly, there would be financial implications. One approach suggested was to charge all program participants for services, with a higher fee for non-residents.

Information Sharing

Article VIII (b) *"The compact administrator of each party state shall furnish to the compact administrator of each other party state any information and documents including, but not limited to, a uniform data set of investigations, identifying information, licensure data, and disclosable alternative program participation information to facilitate the administration of the Compact."* The work group recommends that this information sharing be accomplished by a flagging system within the central information system.

- Flag on central system that a nurse is a participant in an alternative program
- Also list states (drop down list of alternative programs)
- Mechanism to remove flag after successful program completion
- Access to flags available to designated representative(s) of party states only
- Authority to flag restricted to designated representatives of party states (authority here from compact that supersedes current public record laws)
- For any nonparty state access, would need to consider implications for public records laws in state, perhaps could charge for nonparty state access?

The work group's rationale is public safety. Board staff need to know if dealing with an individual who is in the alternative program (is drug behavior a factor of the case?), and program staff need to know that program participant has had a complaint (indicative of problem with program compliance?). The work group identified an elegant computer solution to promote information sharing: *Program written so that if both alternative program flag and complaint flags present, report would be generated to both board discipline and alternative program staff.*

Discipline/Alternative Program Coordinator

The work group talked at length about how a Discipline/Alternative Program Coordinator could offer multiple services to Member Boards, assisting with both discipline and alternative program needs. This partly reflects a clearinghouse concept, having information and resources available so the pieces are in place for use by Member Boards as needed.

Attachment E7

Report of Board Committee on Compact Administration

Relationship to Organization Plan

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

Objective G.....Develop strategies for implementing a mutual recognition model for nursing regulation.

Recommendations to the Board of Directors

1. Affirm the aim of the National Council with respect to the Compact Administrators Group (CAG), as stated in the conclusion.
2. Approve the objectives and the structure of the Interim CAG.

Background

The Board Committee on Compact Administration, in collaboration with the staff Leadership Team, has developed ideas about the potential structure and functions for the Compact Administrators Group (CAG). The results of the discussion are presented below.

Interim Group

The objectives of the group are:

(1) To develop suggested policies and procedures
(2) To solicit inputs from future party and nonparty states
(3) To develop the official CAG structure, relationships, decision-making processes, and funding mechanisms

With respect to the first need, the development of policies and procedures might need to be preceded by creation of a lexicon of compact-related terms. The policies and procedures should include ways of relating to nonparty states and their licensees. In looking forward to the official CAG, it would be desirable for the interim group to define, and have input into developing, support services and resources for use by the CAG and/or National Council related to discipline, licensure, and information.

With respect to soliciting inputs, the interim group is suggested to be inclusive of all Member Board perspectives so that all feel that their needs are heard. At the same time, in anticipation of its future function, the interim group must have the interests of those states enacting compact legislation as primary focus.

The third need includes the development of governance, decision-making, staffing and funding structures, as well as definition of the CAG's future relationship to the National Council.

Communication opportunities for the interim group could include face-to-face meetings at the Annual Meeting (compact administration forum, Executive Officer Network), and others in FY99. In addition, written updates in current vehicles should occur; perhaps a special letter to executive officers for "CAG Updates" could be instituted and/or an electronic forum, such as a "chatroom." Continual feedback opportunities should be presented to Member Boards/executive officers. A committee of the Board was felt to be the best mechanism to develop the initial "CAG Plan" for presentation and feedback.

Official Compact Administrators Group

The parameters of the CAG's authority, based on the compact, are:

1. Shared jurisdiction – recognition of license, multistate privilege
2. Shared discipline – multistate problems
3. Shared information – to support #1, 2
4. Shared administration of the compact – the infrastructure necessary to perform #1, 2, 3

The official CAG will begin functioning no earlier than January 1, 2000, when the first compacts take effect. The functions of the group will include agreeing upon common language for rules/regulations and policies/procedures, and deciding how to consistently approach interactions with nonparty states and their licensees. The group will be responsible for self-governance and self-funding, in accord with its status as autonomous decision-making entity over compact-related matters. As such, it will have to determine needs for staff support and other resource requirements, calculate a fee and a method of payment.

Conclusion

The Board Committee on Compact Administration feels that the Interim Group is crucial to the goal of establishing the Compact Administrators Group as a semi-autonomous entity operating within the general framework of the National Council. *The aim is that the National Council may be the choice for supplying the needs of the official CAG, based on quality and cost advantages.* As the transition goes forward, frequent, open communication among future compact administrators and nonparty state Member Boards is essential.

Attachment E8

Volunteer Groups in the Mutual Recognition Plan

Board of Directors
Tom Neumann, WI, *President*
Margaret Howard, NJ, *Vice-President*
Charlene Kelly, NE, *Treasurer*
Joey Ridenour, AZ, *Area I Director*
Lorinda Inman, IA, *Area II Director*
Julia Gould, GA-RN, *Area III Director*
Anna Yoder, MA, *Area IV Director*
Gregory Howard, AL, *Director-at-Large*
Laura Poe, UT, *Director-at-Large*

Multistate Regulation (MSR) Task Force
Joan Bouchard, OR, *Chair*
Kathy Apple, NV
Iva Boardman, DE
Shirley Brekken, MN
Shirley Camp, GA-RN
Faith Fields, AR
Miriam Limo, PA
Ida Rigley, ND
Sharon Weisenbeck, KY
Laura Poe, *Board Liaison*

Operations Work Group
Myra Broadway, ME
Sandra Evans, ID
Patsy Johnson, KS
Sulinda Moffett, OK
Ruth Ann Terry, CA-RN
Faith Fields, *MSR Task Force Liaison*
Ida Rigley, *MSR Task Force Liaison*

Fiscal Work Group
Dorothy Fulton, AK
Bette Lindberg, MA
Carol Osman, NC
Nancy Wilson, WV-PN
Charlene Kelly, *Board/MSR Liaison*

Finance Committee
Charlene Kelly, NE, *Treasurer and Chair*
Lanette Anderson, WV-PN
Sandra Evans, ID
Barbara Morvant, LA-RN
Ellen Toker, PA

Discipline Comment Group
Susan Brank, CA-RN
Carolyn Bryan, ND *
Robert Buck, NV *
Donna Mooney, NC
Evelyn Polk, GA-RN *
James Smith, NE *
Jane Werth, AZ *
Emmaline Woodson, MD
Iva Boardman, *MSR Task Force Liaison*
* also member of MSR Discipline Work Group

Board Attorney Comment Group
Tom Abram, Vedder Price
Dale Atkinson, Atkinson & Atkinson
William England, HCFA
Nathan Goldman, KY
Trent Kelley, WA
Fred Knight, AR
Janice Lanier, OH
Terry Prendergast, SD
Elizabeth Saindon, Arent Fox
Linda Siderius, CO
Joelle Stein, MA
Robert Waters, Arent Fox
Shirley Camp, *MSR Task Force Liaison*
Sharon Weisenbeck, *MSR Task Force Liaison*

Executive Officers' Network
Donna Dorsey, MD, *Chair*
Dorothy Fiorino, OH, *Vice-Chair*

Policy Futures Panel
Patty Hayes, WA, *Chair*
Judi Crume, AL
Donna Dorsey, MD
Marcia Rachel, MS
Diana Vander Woude, SD

Information System User Group
Susan Boone, OH
Michael Coleman, NC
Mary Griffith, AZ
Mark Majek, TX-RN
Milene Sower, NY
Shirley Brekken, *MSR Task Force Liaison*

Nursing Practice and Education Committee
Jan Zubieni, CO, *Chair*
Nancy Bafundo, CT
Marjorie Bronk, TX-VN
Kenneth Lowrance, TX-RN
Toma Nisbet, WY
Linda Seppanen, MN
Cynthia Van Wingerden, VI

Attachment F

Computerized Clinical Simulation Testing (CST®) Project Overview

Contents

Introduction

The purpose of CST is to evaluate nursing competence in application of the clinical decision-making process to the management of client care. CST is not designed to test fine details of factual knowledge (e.g., identification of specific low sodium foods; steps in a procedure), ability to teach, psychomotor skills, communication or interpersonal skills, delegation or supervision decisions, or, ethical or moral behaviors. It differs from the current NCLEX® multiple-choice question examination in that a CST examination presents neither questions nor answer options. This new testing methodology is designed to evaluate application of the clinical decision-making process to client care through a series of interactive client care scenarios.

The CST system operates via computer in a Windows environment. At the beginning of each CST case, a brief description of the current client situation, including the case day, time and location, is presented. Following the introduction, the examinee advances to the client-care screen. From this screen, the user can either open components of the client's chart for review or specify, through free-text entry, desired nursing activities to implement for the patient or the family/significant other. Examinees are free to perform any nursing actions in any sequence, and at any time they desire. Other than reviewing components of the chart, all nursing actions (assessment, diagnosis, intervention, and consultation) are requested through free-text entry. When each action is implemented, a client response is received and simulated time moves forward. Once confirmed by the examinee, the nursing action is implemented and cannot be retracted. As the examinee proceeds through a case, the client's condition changes in response to nursing action (or non-action) and the unfolding of the underlying health problem. At the end of the case, the participant is prompted to select the three client problems/nursing diagnoses that were most relevant in the case.

Clinical Decision-Making in CST

For the purposes of the CST Research Study, clinical decision-making is defined as the use of rational and/or intuitive processes to identify, consider, and specify problem and action alternatives for the purpose of assisting clients to meet their needs for: psychosocial integrity; physiological integrity; health promotion and maintenance; and a safe, effective care environment. Most would agree that evidence of competence in clinical decision-making can be captured through observation of actions performed by the decision maker. In CST, evidence of clinical

decision-making competence is captured when examinees specify problems and actions (assessments and interventions) that are taken with, or on behalf of, the client during an unprompted, time sensitive, dynamic, interactive simulation, during which feedback related to specified nursing actions is received. Inferences about the examinee's ability to analyze and interpret client data can be made based on the accuracy of problem identification and the appropriateness, as well as the timing and sequencing, of observed actions.

Evidence of clinical decision-making competence can be captured using CST, based on the following examinee actions and action characteristics that can be elicited:

a) *Assessment*: Specification of assessment/data collection actions over time
b) *Problem identification/Nursing diagnosis*: Specification of problems/nursing diagnoses
c) *Intervention*: Specification of intervention actions over time and in response to client condition changes
d) *Evaluation*: Specification of follow-up assessment/data collection actions
e) *Intervention modification*: Specification of follow-up intervention actions based on client responses
f) *Prioritization*: time and sequence of all specified nursing actions recorded
g) *Efficiency*: beneficial, neutral, and unnecessary actions recorded
h) *Safety*: risky or inappropriate actions recorded

The full scope of nursing actions available in CST, with its unprompted, dynamic and temporal nature, contribute to the realism of the testing environment. Based on the description of CST, arguments may be made, both pro and con, regarding the extent to which CST might be able to capture evidence of the use of the intuitive processes involved in decision-making. However, such a determination is beyond the scope of this study.

Chapter I. Origins of the National Council's CST Project

National Council Exposure to National Board of Medical Examiner's (NBME's) Computer Simulation Model (CBX)

The origin of the National Council's CST initiative was based on a series of events that culminated in the conceptualization of CST and its applicability to the evaluation of nurse competency relative to clinical decision-making. These events were as follows:

- Prior to 1985, the National Council's executive director had several interactions with NBME's president regarding NBME's simulation model and its possible adaptation for use in nursing licensure examinations.
- The Board of Directors, in November 1985, had an opportunity to see an example of CBX and discuss, with NBME and National Council staff, its potential uses.
- At the direction of the Board, National Council's executive director, director for nursing practice and education and assistant director of testing services met several times during 1986-87 with high-level NBME staff to further explore the concept of CST and its "adaptability" prior to and during proposal preparation.

Stimulus for CST Proposal Preparation

In 1985, the National Council was in the preparatory phase of exploring the feasibility of using a Computerized Adaptive Testing (CAT) model for the administration of the NCLEX® examinations. Included in this initiative was an exploration of the availability of external funding sources. The W. K. Kellogg Foundation was approached based on its prior support of the National Council, its history of providing significant monetary awards for nursing projects, and its history of providing financial support for NBME's CBX project. Initial discussions with Kellogg in FY86 resulted in the preparation and submission of a funding proposal for the support of CAT. However, prior to January 1986, there were indications that Kellogg may be more interested in providing support for CST since this would be an extension of NBME's initiative and would facilitate Kellogg's directive to NBME that they collaborate with other health professions groups interested in the CBX technology. Subsequently, NBME agreed to collaborate with National Council for the purpose of adapting CBX to support CST. A funding proposal was developed and was submitted to Kellogg in February and resubmitted, following revision, in August 1987. (Note: the original plan was to initiate development of CAT and subsequent to that, to address a CST initiative.)

Initial Project Goals and Timelines

February 1988 — The Kellogg Foundation awarded the National Council a grant of $1,868,954 to support a three-year demonstration project designed to:

- adapt technology developed by NBME for the development and delivery of computer-based clinical simulations for initial nurse licensure
- initiate development of 20 computerized clinical simulations in nursing for future use in nursing licensure examinations
- examine the validity and reliability of CST as a basis for making licensure decisions
- develop and implement a plan for promoting the future use of CST in nursing licensure examinations with Member Boards and the nursing community

June 1988 — Project initiated, once CST Task Force and staff Project Director were in place

August 1991 — Project completed and outcomes reported to W.K. Kellogg and the Delegate Assembly (see results reported, Chapter III)

Chapter II. Delegate Assembly and Board of Directors - Information Provision and Direction

A. Delegate Assembly

August 1987	Delegate Assembly informed of proposal submission to Kellogg Foundation for support of CST.
August 1988	Delegate Assembly approves inclusion of a Goal I, Objective A strategy in the Long Range Plan: Investigate the feasibility of computer simulation testing for initial and continued licensure.
August '88 thru '91	Forums and written reports provided to Delegate Assembly regarding project activities/status.
August 1991	Delegate Assembly directs: *That research and development of CST be continued, with a timeframe of three to four years, and including annual reports to the Delegate Assembly which evaluate progress and implications for future development.* Rationale states: Further research will enable the National Council to determine the usefulness of CST for potential applications (initial licensure, reentry, following discipline, and continued competence) in terms of practical feasibility, psychometric soundness, usefulness to Member Boards, cost/benefit, and timelines required for implementation. Motion adopted by the Delegate Assembly.
August '92 thru '97	Written reports and periodic forums provided to Delegate Assembly regarding project activities/status.
March 1993	At Area Meetings, Member Boards advised of "DOS to Windows" changes being made in NBME software and plans for proceeding with next phase of research and development.
August 1993	Received report that revisions to DOS-based software and orientation system had been completed. Work on databases and case development (to support field testing of new computer model) underway. Results of the field study, originally scheduled for Spring 1992 (delayed due to unanticipated amount of work required to develop the databases), reported.
August 1994	Received report that significant software revisions being made by NBME (i.e., conversion to Windows-based examinee interface) and changes to case and scoring key authoring systems are underway (referred to as Phase II of the project), and that Phase III activities will be initiated when this work is completed in FY96. CST activities during FY95 would focus on database development and CBX/CST system software programming and debugging.
August 1995	Received report outlining work accomplished re: development of supporting databases, the anticipated initiation of CST-specific programming by NBME in August 1995. A detailed timeline for completion of Phase III by August 1999, was provided. Document included in *Book of Reports* described how issues would be resolved related to combining CST and CAT, determining overall pass/fail status, setting a passing standard, determining ideal number of cases per CST exam form, test plan implications, and identifying what should be tested on CAT vs. CST.
August 1997	Received report re: Phase III progress, plans for the pilot study, and for Member Board evaluation of the uses of CST for RN education and evaluation.

B. Board of Directors

January 1986	Board directs that if further discussions with Kellogg indicate the proposal must be modified to include both CST and CAT modalities, direction should be obtained from the Board's Coordinating Committee.
May 1986	Based on feedback from Kellogg that it would not provide financial support for CAT but would consider a CST proposal, the Board directs that the National Council continue to seek external funding for the CAT project and also explore the feasibility of collaborating with NBME.
February 1987	CST proposal submitted to W.K. Kellogg Foundation following approval by the Coordinating Committee of the Board of Directors
1988-89	Board of Directors provides direction to staff and legal counsel regarding continued negotiations with NBME for a software license and maintenance agreement for CST software.
July 1990	Based on preliminary results of pilot study, Board of Directors approves timeline for staff preparation of a funding proposal to be submitted to the Kellogg Foundation to support next phase of CST research and development (proposal to be withdrawn if 1991 Delegate Assembly decision is negative).
May 1992	Board of Directors authorizes continuation of project activities (database revisions and case development) through December 1992, using remaining Kellogg Funds and $42,022 in National Council funds due to delay in Kellogg decision-making re: funding request.
December 1992	Board of Directors receives report that requests for external funding were denied by Kellogg, due to change in funding priorities. The Board: • expressed its commitment to carrying out research and development of CST to establish its psychometric soundness and legal defensibility and directed the Steering Committee and staff to explore funding options, including National Council self funding, and to report back in March 1993 • directed staff and legal counsel to review the structure of the contractual relationship between the NBME and National Council and to negotiate appropriate changes • approved a request for $212,875 for FY93 CST project activities • established a designated fund of $75,000 for performance of a market analysis survey (to be directed at potential external uses of CST)
April 1993	The Board approves the establishment of a designated fund for a five-year CST Project in the amount of $2,965,817. [From 1993 *Book of Reports* report of the Board: "... for the purpose of continued research and development of CST for the period FY94 through FY98, with a review of budget and progress annually. The Board believes that this major commitment is consistent with the National Council's purpose in its bylaws, with its mission, and with Goal I – identified as most important by the Member Boards."]
June 1993	Board of Directors receives report of technical evaluation of NBME's software by National Council-retained SEI, Inc. SEI's report states, "NBME is making good use of current technology to re-engineer their systems...NBME is adhering to a sound software development methodology. SEI believes that collaboration is a good approach." SEI's recommendations: jointly proceed to develop specific requirements for the nursing simulation system; after the requirements phase, evaluate the value of continued collaboration based on the similarity of requirements, since NBME is not staffed or

structured to support two dissimilar systems; and consider some additional software strategies to further enhance the underlying technology. [All of these recommendations were subsequently implemented.]

November 1996 — Board of Directors receives update regarding CST case development progress (i.e., anticipated three-month delay in starting Phase III due to delay in completing software programming) and plans for CST software placement in schools to prepare graduates for participation in Phase III CST Pilot Study.

February 1997 — Board of Directors adopted the proposed communications plan for FY97.

November 1997 — Board of Directors (1) receives reports from Director of Testing Services and from CST staff re: research, operational and policy issues related to CST; and (2) receives report that National Council staff had been recently informed by NBME staff that Phase III case development activity timeline needed to be shortened by approximately three months to accommodate preparation of Sylvan administration software.

December 1997 — Board of Directors approves "Go-No Go Criteria" for proceeding with CST Pilot Study in Spring 1998.

February 1998 — Board of Directors (1) informed that all "Go-No Go Criteria" had been met and pilot study to be implemented in April 1998; and (2) in response to report on progress in negotiations with NBME, directed staff and legal counsel to hold face-to-face meeting with NBME President and relevant staff to discuss test service issues.

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

Chapter III. 1990-91 Field Test Results

The results of the study, as summarized below, suggested that CST can be developed, administered, and scored; that it may test something different from what is tested with multiple-choice questions; and that reliable estimates of examinee performance can be obtained with an administration of approximately six to eleven cases.

Key outcomes:

- NBME's computer simulation technology was successfully modified to represent nursing.
- Twenty-seven CST cases were developed and field-tested.
- A pilot study was conducted using a sample of 263 new nursing graduates in three different states. Each testing session consisted of an orientation, five practice cases, and an 11-case examination.
- Study results provided preliminary evidence in support of the validity and reliability of CST with no evidence of a practice effect (that scores improve with practice).
- Intercase reliability estimates ranging from .82 (for six cases) to .89 (for eleven cases), suggesting that the number of cases that would need to be administered falls within this range. [Note: NCLEX multiple-choice question (MCQ) exam reliability coefficients have historically been .88-.90; this range is regarded by most experts as the minimum for high-stakes individual test scores] Internal consistency reliability coefficients (the consistency with which items within a case measure candidate ability) ranged from .69 to .87.
- In evaluating the relationship between performance on CST and on the MCQ NCLEX examination, a correlation of 0.37 was obtained, suggesting that CST and MCQ NCLEX examination may measure different constructs. [The closer to 1.0, the more similar the two instruments; the closer to 0, the more dissimilar they are in what they are tapping.] In addition, subsequent analyses revealed that some examinees who passed the NCLEX examination had very low performance on CST and conversely, some examinees who scored high on CST failed the NCLEX examination, further supporting the hypothesis that CST and MCQ NCLEX examination measure different constructs.
- Preliminary evidence supporting the validity of the scoring system was also found. Expert judgment of a small sample of examinees' performance on a small sample of CST cases resulted in a rank-order of examinees consistent with the rank order of computer-generated CST scores.
- Support for the construct validity of CST as a measure of the clinical decision-making process was provided by experts and by study participants. One piece of evidence was expert judgment that the item maps (scaling of items within a case from easy to hard) represented the appropriate clinical decision-making process for management of a case. Additional evidence was found in the participant responses to the question: What did you like best about CST? The following sample of their responses strongly suggests that they were able to demonstrate their use of clinical decision-making skills. "It allowed me to manage the patient my way."; "[It] tests data collection, planning, decision-making, and evaluation and follow-up of nursing interventions."; "I was able to use more problem-solving and decision-making skills than I would have used on a multiple-choice test."; "CST really stimulated my thinking. I felt as if I was caring for a real patient."; "This is definitely a much better test of good, sound practical thinking than the written multiple-choice exam. People can have a good knowledge base but not be able to apply it. This program tests actual actions, not merely book knowledge."
- Identification of simulation model, database, software and examinee interface changes needed to decrease cueing, improve measurement precision, and increase user friendliness were also identified. These included:
  - changing examinee identification of all patient assessments from list-selected to free-text entry
  - redesigning the supporting databases to support free-text entry of patient assessment requests
  - changing the function of the [Escape] and [Enter] keys to prevent inadvertent early exit from a case
  - reformatting report screens to decrease examinee confusion regarding the nature of information being provided
  - revising the orientation system to reflect the above changes

Chapter IV. Current CST Development and Candidate Interface Processes

The following description is designed to create a mental picture of processes (what they are and how long they take) that must go on before/after administration of a CST case (part I), and during administration (part II).

I. CST Development

A. Case Development:

1. Case Development Process
   a) CST staff: prepare assignments for Case Development Committee (CDC) depending on needs of "case pool"
   b) CDC (four members/case)
      (1) CDC Meeting one: receive case assignments (one or more cases/CDC author), brainstorm case ideas within CDC group, develop rough outline of case
      (2) prepare written case materials (Case introduction, H&P, patient chart, and flow chart (graphical depiction of how case unfolds over time))
   c) CST staff: review CDC materials, contact case authors via phone for any needed clarification, make modifications needed for case programming
   d) NBME staff: format flow chart and H&P
   e) CST staff: prepare/send formatted case materials and case review assignments to CDC
   f) CDC Meeting two: critique flow charts and H&Ps and identify needed changes
   g) CST staff: compile CDC recommended case flow chart and H&P modifications, and list of nursing activity terms to be included in programmed cases
   h) NBME staff: program case
   i) CST staff: review programmed case and case printout and identify needed changes
   j) NBME staff: complete requested programming changes
   k) CDC Meeting three: critique programmed case and identify needed changes
   l) CST staff: compile and submit needed modifications for programming
   m) NBME staff: complete requested programming changes
   n) CST staff:
      (1) review programming changes and case printouts and identify needed modifications
      (2) conduct field testing of cases by new graduates and experienced nurses
      (3) based on 1 & 2 above, submit final request for programming changes to NBME
2. Case Development Resources
   a) National Council Staff resources: During Phase III of the CST Project, approximately 47 staff hours/case were estimated to have been spent on case development. Because of the high complexity of cases, tightened timelines, inadequate time between CDC meetings, and inadequate time for quality assurance checks at each step of the way, it is believed that this is a very crude and exaggerated figure. Also, the above does not reflect that ongoing work on the database that supports CST cases is required. It is projected, based on National Council and NBME experience, that approximately 1,000 hours per year will be needed to support the database.
   b) Expert Reviewers/Consultants: Paid expert reviewers (10 to 12 nurses) each spend approximately one hour reviewing each programmed case for consistency, accuracy, etc.
   c) NBME staff resources: During Phase III of the CST Project, NBME has reported figures ranging from 50-60 staff hours/case. The new plan for case development is designed to reduce that figure to 35-40 staff hours/case. On their medical cases, NBME reportedly spends an average of 35 staff hours/case for case development.

B. Scoring Key Development

1. Scoring Key Development Process
   a) CST staff:
      (1) prepare for Scoring Key Development Committee (SKDC) meeting: in-depth review of programmed cases, case printouts and flow charts
      (2) lead SKDC meeting

b) SKDC (four members/case) Meeting one: develop key by working through case specifying nursing actions, sequence and timing of actions, and the level of importance of the actions that should be taken in the case

c) CST staff: prepare key of SKDC's critical actions and submit for programming

d) NBME staff:

(1) program key and perform quality assurance checks with field test data

(2) score data (run through automated scoring system); submit raw score data to National Council

e) CST/Testing staff:

(1) perform initial data analysis, identify problematic items and unanticipated actions (actions taken by examinees that are not accounted for on scoring key)

(2) prepare for second SKDC meeting: key validation and expert ratings of examinee performance records

f) SKDC Meeting two: Key Validation and Expert Ratings

(1) review and determine disposition of problematic items and unanticipated actions

(2) rate examinee performance records (ratings can be used as a scoring approach and to validate automated scoring system)

g) CST staff: compile needed key programming revisions based on SKDC recommendations for problematic items and unanticipated actions

h) NBME staff: reprogram scoring key and rescore data

i) CST/Testing staff: analyze data, produce score reports

2. Scoring Key Development Resources

a) National Council staff resources (total 13-17 hours per case):

(1) estimated 5 hours CST staff time/key for development, validation, and ratings

(2) National Council staff time/key for compiling textbook validations/citations for items on keys is unknown since this activity has not yet been performed, but is estimated to be 6-10 hours/key

(3) National Council staff data analysis and score report time/case is unknown at this time but estimated to be approximately 2 hours/case in production mode

b) NBME staff resources: report average of 60 staff hours/key for key programming/QA

II. CST Interface: A Candidate Taking a CST Examination

A. Exam

1. Initial exam, message: "click to start case"
2. Exam time:
   a) pilot study: maximum of 30 min/case; maximum of 5.25 hours/exam
   b) future exams: maximum of 20-30 min/case; maximum of 4-6 hours/exam
3. Number of cases:
   a) pilot study exam: 10 cases
   b) future exams: 8 to 12 cases

B. Case

1. Case introduction: two to three sentences describing current status of examinee, click
2. View Client Care screen

a) Chart

(1) Chart sections: Admission H&P, Orders, Progress Notes, Lab Reports, Imaging Reports, Miscellaneous Test Reports

(2) Click on chart section label to review specific section

(3) Frequency of Chart Reviews: the number of chart reviews executed during a case is highly individual to both the examinee and the characteristics of the case. However, it is estimated that a typical examinee may execute 5 to 10 chart reviews and spend from 3 to 10 minutes reviewing chart sections during a case

b) Nursing Activity Box/Free-Text Entry

(1) Free-text entry boxes

(a) text box for free-text entry of nursing activities directed toward the patient

(b) text box for entering nursing activities directed toward family/significant other (not always present in a case)

(2) Executing desired nursing activities
  (a) Click on text box and type in assessment or intervention activity (use of nouns rather than verbs is encouraged)
  (b) System searches for match to entry
    (i) If an alphabetical match not found (about 10-15% of time during earlier testing, hope to reduce): Message to examinee is, "The system does not recognize your request, please try another synonym for your request."
    (ii) If alphabetical match found: List of alphabetically similar words presented
      (a) Click on word/phrase that most closely matches initial request
      (b) Second list of words/phrases related to selected term presented
      (c) Click on word/ phrase that most closely matches request
      (d) Confirmation box appears
      (e) Click on confirmation box
      (f) The clock advances in simulation time, the nursing action is recorded on progress notes section of the chart, and the nursing action cannot be undone
(3) Frequency of free-text entry of nursing activities: the number of nursing activities executed during a case is highly individual to both the examinee and the characteristics of the case. However, it is estimated that approximately 15 to 30 free-text nursing activities/case will be executed during a case
(4) Clock Advances
  (a) Type of clock advances
    (i) Automatic clock advances: occur as nursing actions are confirmed
    (ii) Manual clock advances: performed by examinee and used to move ahead in time to evaluate patient
      (a) Click on Clock Icon, day and time sheet opens
      (b) Click on day and time for desired clock advance
      (c) Time at top of screen displays new time
      (d) Examinee cannot move backwards in time
  (b) Frequency of clock advances: the number of clock advances executed during a case is highly individual to both the examinee and the characteristics of the case. However, it is estimated that, on average, approximately 4 to 6 clock advances would be used to maximize the efficiency of working through a case

c) Ending a case: Case ends when simulation time (varies widely across cases) or real time (20-30 min/case) expires. Case end message: "Thank you for taking care of this patient."

Chapter V. Staffing and Expenditure History

Expenditures

Fiscal Year	Personnel	NBME	Other	Total
1988				42,746
1989	171,751	275,000	30,487	477,238
1990	199,257	450,000	149,205	798,462
1991	158,499	52,800	164,341	375,640
1992	61,634	70,000	128,418	260,052
1993	19,891	152,245	52,780	224,916
1994	165,812	17,606	78,760	262,178
1995	177,542	0	47,490	225,032
1996	194,053	75,000	78,724	347,777
1997	277,605	208,750	150,861	637,216
1998	314,563	260,475	262,615	837,653
1999	342,200	40,000	202,895	585,095
2000	346,000	139,560	104,705	590,265
Totals	**2,428,807**	**1,741,436**	**1,451,281**	**5,664,270**

Funding

1988-1993	Kellogg Foundation	1,968,954
1992-2000	NCSBN (Unrestricted - Designated Funds)	3,695,316
Totals		**5,664,270**

Personnel

Name	Title	Date of Hire
Anna Bersky	CST® Project Director	10/15/89
June Krawczak	CST® Project Associate	10/04/93
Deirdre Ambrose	CST® Program Assistant	10/18/93
Tara Kumar	CST® Content Coordinator	09/30/96
Lorraine Kenny	Research Study Coordinator	03/31/97

Chapter VI. Phase III Pilot Study and Major FY99-00 Milestones

A. Research/Operational Questions

Research Question #1: Does each CST case offer participants the opportunity to demonstrate their competence in application of the clinical decision-making process to management of the client?

a. Does the **clinical situation** depicted reflect "real- life" situations encountered by nurses?
b. To what extent can **client-management activities** used in real-life client encounters be performed in CST?
c. Are CST **case scoring keys** a valid representation of optimal client management? Do they reflect currently accepted standards of practice?
d. What **measurement approaches** (scoring systems) to evaluating participant performance on a case provide valid information about nursing competence in application of the clinical decision-making process?
e. Does the automated scoring system produce participant measures that are consistent with expert ratings of participant transaction lists (record of actions taken by a participant during a CST case)?
f. What difference, if any, is there between individual case scoring keys developed by two independent groups? What is the difference in the measures they produce?
g. What difference, if any, is there between the scoring key developed for a textual presentation of a case and that developed for a case with the addition of audio-visual enhancement? [not being assessed in the pilot test due to inability to prepare cases in time]
h. What impact, if any, does audio-visual enhancement have on participant actions and item performance? [not being assessed in the pilot]

Research Question #2: Does each CST examination (set of 8-12 cases) offer participants the opportunity to demonstrate their competence in application of the clinical decision-making process to the management of a series of clients?

a. What is the relationship between participant ability measures across cases?
b. Do participant ability measures from cases representing similar clinical practice areas (e.g., medical-surgical, pediatrics, obstetrics, psychiatric, etc.) correlate more highly than measures from cases representing different content areas?
c. Do participant ability measures from cases in which there are a preponderance of either assessment or intervention item types correlate more highly with other cases that have a preponderance of the same item type, than with measures from cases that have a preponderance of the other type or a more equal distribution of item types?
d. Do participant ability measures from cases in which there are a preponderance of either assessment or intervention item types correlate more highly with other cases that have a preponderance of the same item type, than with measures from cases that have a preponderance of the other type or a more equal distribution of item types?
e. What is the reliability of each examination form? How many cases are needed to get a reliable estimate of participant performance across cases?

Research Question #3: At what level of measurement (e.g., items, subscores, cases or examination) are pass/fail standards best determined for individual cases and for a combination of cases?

Research Question #4: Does CST contribute to evidence about who is competent to practice safe and effective nursing?

a. Do CST and MCQ testing methodologies measure different components of nursing competence?
b. Do participants who are expected to have more clinical decision-making ability (based on their having more nursing experience and/or more education) perform better on CST than those expected to have less clinical decision-making ability?
c. Is performance on CST related to extraneous factors, such as computer experience, keyboard experience, practice with CST or demographic characteristics?

Research Question #5: What are the implications of using various approaches to combining CST and MCQ test results for determining eligibility for nursing licensure?

a. What is the impact of using different approaches to combining CST and MCQ performance?
b. Which way of combining CST with MCQ performance is most consistent with judges' decisions?

Operational Questions

a. What are the human and fiscal resources required to support case/examination development?
b. How much time will be required to administer CST?
c. What is the candidate cost?
d. How will a two-part examination be administered (all at one time; at two seatings; or "hurdle" (e.g., only take CST if pass CAT; etc.)?
e. How quickly can CST performance be determined and communicated to Member Boards?

B. Major FY99 and FY00 milestones until completion of project

1. *Pilot study related activities*

July 1998	Data collection completed
September 1998	First run of examinee data using initial scoring keys completed
December 1998	Scoring key validation completed
January 1999	Programming of key revisions completed
January 1999	Second run of examinee data through revised scoring key completed
March 1999	Update/progress reports - Area Meetings
August 1999	Update/progress report - Annual Meeting forum
November 1999	Exploration of approaches to standard setting completed
January 2000	Data analysis completed; development of recommendation(s)
March 2000	Draft report presented at Area Meetings
August 2000	Final report presented to Delegate Assembly for decision

2. *Operational activities*

April 1999	Programming of remaining cases, using new approach, completed and experiences used to determine future resource needs [Note: Cases with audio-visual enhancement are not included in this group, but would be developed during the pre-implementation time if a positive decision for implementation is made.]
June 1999	Scoring keys for new cases completed and experiences used to determine future resource needs
Ongoing	Database modifications/additions to support new cases and for preparing case classification tables

Chapter VII. Relationship with the National Board of Medical Examiners

The National Council's relationship with the National Board of Medical Examiners (NBME) began when the W.K. Kellogg Foundation stated its decision not to fund the National Council's proposal for computerized adaptive testing, but invited a proposal for computerized clinical simulation testing since that would build on computerized simulation work done by the NBME and funded by Kellogg. The negotiations with the NBME have been extensive and at times difficult.

In 1988, a letter of agreement was signed with NBME regarding a collaborative project to develop simulation software for nursing, which grants National Council a limited license to use "CBX" software during the project and specifies that at the conclusion, National Council owns the nursing simulation databases and the default National Council databases, as well as videodisc material. In 1989, a license agreement was negotiated which gave precise terms for royalties, annual maintenance fees, and obtaining source code. In 1994, the National Council approached NBME to renegotiate certain terms of the agreement, due to the constraints the original agreement placed on National Council's options for the future. The amendment to the agreement provided for deferred payment of the annual fee until such time as more than $250,000 in gross revenue is earned annually by use of the CST software, provides a $2 million cap for royalty payments (which were uncapped in the original agreement), and makes the acquisition of source code contingent upon payment of a one-time $2 million fee rather than ongoing higher royalties.

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

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

Obligations to NBME

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

Chapter VIII. Unresolved Policy Issues

The essential question around which these issues revolve is "Is CST a viable enhancement to the NCLEX® examination?"

Issues with Mostly-Known Answers

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

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

Issues with Partially-Known Answers

What will the addition of CST to the entry-level RN licensure examination do to the candidate fee?
Unless the length of the multiple-choice question (MCQ) NCLEX-RN examination can be reduced (unlikely, since reliability will need to be maintained), "seat time" is likely to approximately double. Test development costs will include National Council and NBME staff time for case development, programming, database maintenance, scoring services, and contract management (detailed in other parts of this report). Doubling of the test price is a conservative scenario. The operational part of the pilot test will enable more precise estimates of ongoing production costs.

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

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

Issues with Mostly-Unknown Answers

How much will CST add to the measurement quality currently provided by the NCLEX-RN examination?
Probably some incremental validity will be added, based on the outcome of the 1991 CST field test. The pilot research questions will allow some additional description of what CST is tapping.

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

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

Chapter IX. Business Plan for Implementation of CST as a Part of the NCLEX-RN® Examination: Projections of Timelines and Costs

Implementation Analog: The Computerized Adaptive Testing (CAT) Experience

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

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

CST Examination Work

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

CST Integration Work

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

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

** NBME has estimated (in a 4/22/96 letter) its case and key programming costs at $15,000 per case. Multiplied by 220 base cases = $3.3 million. Base case development volunteer time is estimated at 37.1 hours per case which calculates out to $470,000 in travel expenses. These estimates do not include National Council staffing costs.

Projections

At this stage of the CST project, it is very difficult to accurately project the timelines and costs necessary to accomplish an implementation for the entry-level examination program; as more work is accomplished, estimates may become more accurate. However, National Council has developed some experience that can provide guidance. All estimates should be taken with the caveat that they could be high or low and that National Council's and NBME's processes may become more efficient as the project progresses.

Given National Council's current actual case development experience with NBME, staff reports that with two dedicated FTEs, about 32 cases were developed in a year. (This also coincides with NBME's estimate that it plans to build between 25 and 40 CCS cases per year.) For a full CST implementation (not a phase-in of the methodology), it is our best estimate that more than 250 base cases will be needed. This number is contingent on several important policy decisions concerning acceptable case exposure, per candidate case overlap, etc. For the base case production alone, this effort translates into about 8 years' work at current resourcing and case complexity

levels (CST staff believe that up to 50 cases can be produced per year, leading to an estimate of about 5 years work). From the volunteer and staff side, it is projected that 1,021 volunteer days will be needed to produce 220 cases, mathematically this divides out to 4.1 years of every day solid work (250 days per year).

To compare this CST case exposure with the NCLEX examination, each candidate sees an average of 100 items in a 1,500 item pool (approximately 6.7%); each item is seen for one minute and is 1.0% of the candidate's examination experience. This estimated level of case development will mean each candidate will see 8 (or more) cases from a 250 case pool (approximately 3.2%); candidates will likely be thinking about each case for 20 minutes or more and each case is about 12.5% of the candidate's CST examination experience. It is conceptually difficult to compare these exposure figures directly. A higher percentage of the NCLEX item pool is exposed to any candidate, but for a much shorter period of time. Each CST case is a much bigger piece of the candidate's examination experience than any one NCLEX item. An NCLEX item is exposed in the same way to all candidates who take it; a CST case presents with the same background to all candidates, the same history and physical information, and orders are available to all candidates, but candidates will likely progress through the cases on different paths and not see exactly the same things. Consequently, the 250-case pool estimate must be regarded as no more than an "educated guess" at this point. Additionally, with the pace of RN practice changes, development of a case maintenance process to keep the cases current will be very important. To enhance security and stretch the case pool, each base case will also likely need to be configured with between 3 and 5 disguises. This additional workload has not been estimated in this paper.

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

Case development	$3,300,000
Committee travel expenses	470,000
Personnel (FY01 thru 05)	2,000,000
Estimated total	$5,770,000

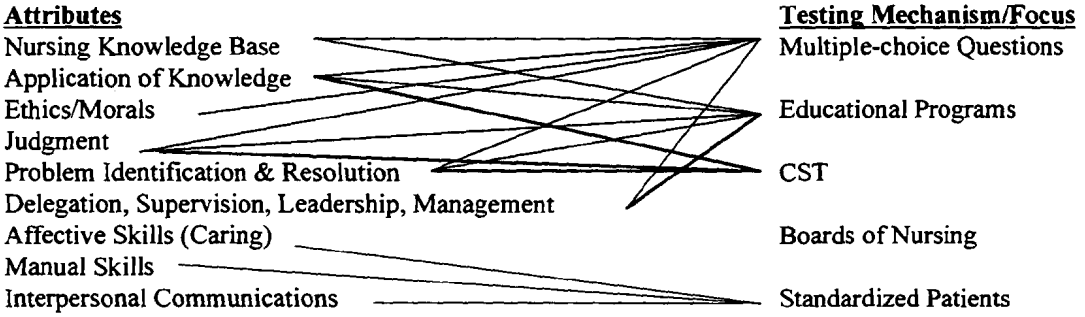
Implementation Realities

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

Chapter X. Next-generation Licensure Examination Options

The licensure examination program is arguably the most important service that National Council provides to Member Boards. It provides a key piece of information on which boards base licensure decisions. Given the great importance of this function, the proper way to consider next generation licensure examination options is in the context of filling the greatest Member Board information need. That is, for entry-level licensure candidates, what is the most important knowledge, skill, and/or ability that is not being adequately assessed currently? What is the key candidate characteristic about which Member Boards do not receive sufficient information? The choice of specific assessment mechanism should not drive the process, rather, it is better to determine what characteristics need to be measured, then determine the best procedures for doing so.

The Examination Committee has not addressed this issue in great detail. The committee has, however, worked on development of a chart (reproduced below) which lists key candidate attributes and potential assessment mechanisms for the attributes.



The development of this chart focused on some of the existing entities from which boards could acquire the needed information about candidates, but the list was not developed to be exhaustive. There are other assessment mechanisms possible for the next-generation entry-level nurse licensure examination program.

Within the limited context of large-scale computerized assessment, there are several operational programs that use creative item types as part of the assessment. Some item types that have been demonstrated to National Council staff include: (1) fill-in the blank items [this has the advantage over multiple-choice questions of being non-cued, free-response entry]; (2) matching items [an advantage here can be that not all choices get used and that there can be many more than four options]; (3) graphic picture manipulation; (4) text selection; and (5) multiple, multiple-choice [e.g., a group of answer-choices that related to a set of questions].

Another possible important enhancement for the next-generation licensure examination could be the inclusion of graphics and/or sound. This media addition could be applied to standard test questions or to new creative item types. High-quality multimedia presentations are no longer futuristic ideals, but are currently being applied to training projects and to some assessments.

The technology of virtual reality assessments is also developing very quickly. There are several companies developing devices for actual and virtual manipulation in a controlled setting (e.g., endoscopes, arthroscopes). Depending on the attributes that most need measurement, the testing volume of the National Council may support the development of these types of devices for important nursing tasks.

Chapter XI. CST® Cases
Market Potential Analysis

Introduction

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

Limitations: Further research may be required to determine:

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

Base Assumptions:

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

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

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

Notes

Notes

Report of the Resolutions Committee/New Business

Committee Members

Sharon Weisenbeck, KY, Area III, *Chair*
Charlet Grooms, OH, Area II
Doris Nuttelman, NH, Area IV
Ruth Ann Terry, CA-RN, Area I
Sandra Evans, ID, Area I, *Finance Committee Liaison*

Staff

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

Relationship to Organization Plan

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

Recommendations to the Board of Directors

No recommendations.

Highlights of Activities

- **Review of resolutions**

No resolutions were submitted by the May 1, 1998, deadline as published in National Council's *Newsletter* to Member Boards. The Resolutions Committee will meet on August 7, 1998, to review resolutions received prior to 2:00 p.m. on August 7, 1998.

- **Resolutions Forum**

All resolutions received will be presented by the committee as part of the Resolutions/New Business Forum, which will be held on Saturday, August 8, 1998.

Meeting Dates

- August 7, 1998

Instructions for Submitting Motions/New Business to the Resolutions Committee During the Annual Meeting

Attached are materials designed to facilitate the submission of resolutions and the review process by the Resolutions Committee. The materials enclosed are:

- Resolutions Committee Operating Policies and Procedures (Attachment A),
- form for introducing new business for consideration by the Resolutions Committee (Attachment B),
- fiscal impact statement (Attachment C), and
- sample motion sheet for use during sessions of the Delegate Assembly (Attachment D).

How To Submit Motions and Resolutions

The form for introducing new business (Attachment B) should be completed and returned to the on-site National Council office, to the attention of the Resolutions Committee, *prior to 2:00 p.m.* on August 7, 1998.

The Resolutions Committee will meet on Friday, August 7, 1998, beginning at 4:00 p.m., to review motions and resolutions. The person(s) submitting a motion or resolution should attend the committee meeting and be prepared to speak to the motion or resolution.

If you have any questions or need assistance with any resolution, please contact Nancy Sylvester, National Council's parliamentarian, who will be in attendance throughout the week.

Resolutions/New Business Submitted Directly to the Delegate Assembly

Delegates also may present any new business directly to the Delegate Assembly when delegates begin to discuss new business, scheduled at the end of the business agenda. The parliamentarian should be consulted when presenting new business.

Attachments

Attachment A

Resolutions Committee Operating Policies and Procedures

Description

The Resolutions Committee is a committee appointed by the President to serve the Delegate Assembly.

Purpose

To expedite the work of the Delegate Assembly.

Functions

1. Receive and analyze all motions submitted to it, without changing intent. The analysis shall consist of:
   a) determination of consistency with National Council articles of incorporation, bylaws, mission, goals, objectives, and policies;
   b) determination of relationship to ongoing programs;
   c) assessment for duplication with other proposed motions;
   d) legal implications;
   e) financial impact.
2. Initiate motions.
3. Present oral and written reports of motions and resolutions. The report for each motion and resolution shall include the following *analyses* performed by the Resolutions Committee:
   a) determination of consistency with National Council articles of incorporation, bylaws, mission, goals, objectives, and policies;
      Consistent
      Not Consistent (with rationale)
   b) determination of relationship to ongoing programs;
      Not in current Organization Plan
      In current Organization Plan (site identified)
   c) assessment for duplication with other proposed motion/s;
      No duplication
      Duplication (motion/s identified)
   d) legal implications;
      None
      Implications identified
   e) financial impact.
      None
      Impact identified

Procedures

Motions and resolutions may be submitted by a delegate(s), structural unit or jurisdiction. A fiscal impact statement must accompany the motion or resolution.

Motions and resolutions may be submitted to the Resolutions Committee until the committee convenes its meeting at the Annual Meeting. Thereafter, the submitter shall present the motion or resolution directly to the Delegate Assembly as new business.

Submitters are encouraged to submit motions and resolutions prior to the deadline as identified below, to allow time for the committee and the submitter to work together on format, wording, clarity, etc., should that be needed, and to have the motion or resolution included in the mailing to Member Boards 45 days before the Annual Meeting.

Courtesy resolutions are proposed by the Resolutions Committee.

Motions and Resolutions for Publication

1. Motions and resolutions must be submitted by the deadline published in the National Council *Newsletter* in order to be reviewed by the Resolutions Committee and mailed to Member Boards 45 days before the Annual Meeting.
2. The Resolutions Committee will meet after the submission date and prior to the deadline for receipt of materials. The committee will review all motions and resolutions and work with submitters should editing, rewriting, or combining of motions and resolutions be necessary. All submitters will be advised of the committee analyses of their motions and resolutions. No motions and resolutions will be amended or revised after committee action and until the report is presented at the Delegate Assembly.
3. Motions and resolutions included in the mailing to Member Boards will be presented at the Resolutions Forum.

Motions and Resolutions Received After the Publication Deadline

1. The deadline for receipt of motions and resolutions at the Delegate Assembly shall appear in the Rules of Conduct for the Delegate Assembly.
2. A meeting of the Resolutions Committee shall be scheduled at the Annual Meeting to review motions and resolutions received prior to the deadline appearing in the Rules of Conduct for the Delegate assembly and not previously reviewed by the Committee. This meeting shall occur as close to the session at which new business will be considered as is consistent with the orderly transaction of the committee's business. [This later meeting schedule will allow greater time for resolutions emerging from network groups, Area meetings, and forums to be prepared for the committee's review.]
3. The person(s) submitting a motion or resolution should attend the committee meeting and be prepared to speak to the motion or resolution.
4. The committee will go into executive session to prepare the motion or resolution for submission to the Delegate Assembly.

Other New Business

1. A motion or resolution not received before the Resolutions Committee meeting at the Delegate Assembly shall be presented directly to the Delegate Assembly as new business.
2. The submitter is responsible for duplication of the resolution for distribution to members of the Delegate Assembly. Each resolution or motion should be accompanied by a written analysis of consistency with National Council mission, goals, objectives; assessment of fiscal impact and potential legal implications. If it is not, the President shall refer the motion or resolution to appropriate committees and/or staff for preparation and dissemination of such analyses prior to a vote on the motion or resolution.

Definitions

- **Motion**

A proposal for consideration by the Delegate Assembly stated in the format, "I move that..." A motion does not contain the rationale in its wording but the rationale may be submitted with the motion and the proposer should be prepared to speak to the motion after seconding to present the rationale.

- **Resolution**

A proposal for consideration by the Delegate Assembly stated in the format, "Whereas ..." [any number of whereas statements present the rationale for the proposal]; "therefore be it resolved ..." [any number of resolved statements defining the action(s) to be taken].

Approved by Board of Directors, May 1990
Revised, January 1996

Attachment B

Form for Introducing New Business for Consideration by the Resolutions Committee at the Annual Meeting

I move that:

Rationale for Motion:

If the motion is made by an individual:

Person making motion:_____

Member Board:_____

❒Board Member
❒Board Staff

Person seconding motion:_____

Member Board:_____

❒Board Member
❒Board Staff

If the motion is made by a committee:

Committee responsible for motion:_____

Name of Committee Chair:_____

Instructions: Complete and return to the on-site National Council office, to the attention of the Resolutions Committee.

Attachment C

National Council of State Boards of Nursing
Fiscal Impact Statement

FISCAL YEAR 1999

TITLE OF MOTION/RESOLUTION: _____

I. SUMMARY*

	FY99	FY00	FY01
Revenue	_____	_____	_____
Out-of-Pocket Expense	_____	_____	_____
Existing Staff Time Expense	_____	_____	_____
Net Revenue/(Expense)	_____	_____	_____

II. PROJECTED DATES:

Beginning: _____

Completion: _____

SUBMITTED BY: _____

_____

* To be calculated by submittor in conjunction with National Council staff.

Attachment D

Sample Motion Sheet

Below is a sample of the motion sheet used by delegates to make motions during the Delegate Assembly. Official motion sheets can be found on delegate tables on-site. They are to be submitted in triplicate.

NATIONAL COUNCIL

National Council
of State Boards of Nursing, Inc.

MOTION NUMBER: _____
MEETING: _____
DATE: _____

I MOVE, _____

ACTION:
- ☐ Amended
- ☐ Adopted
- ☐ Failed
- ☐ Postponed
- ☐ Tabled
- ☐ Withdrawn
- ☐ Referred

MAKER: _____

SECOND: _____

Orientation Manual

Purpose

The purpose of the Orientation Manual is to provide information about the mission, governance and operations of the National Council. It is hoped that this manual will facilitate the active participation of all Delegate Assembly participants as well as Board of Directors and committee members.

Following a brief discussion of the National Council's history, this manual will describe the organization's structure, functions, policies and procedures. More descriptive information on the National Council is available in a published orientation portfolio, available through the communications department.

History

The concept of an organization such as the National Council had its roots as far back as August 1912 when a special conference on state registration laws was held during the American Nurses Association (ANA) convention. At that time, participants voted to create a committee that would arrange an annual conference for persons involved with state boards of nursing to meet during the ANA convention. It soon became evident that the committee required a stronger structure to deal with the scope of its concerns. However, for various reasons, the committee decided to remain within the ANA.

Boards of nursing also worked with the National League for Nursing Education (NLNE) which, in 1932, became the ANA's Department of Education. In 1933, by agreement with the ANA, the NLNE accepted responsibility for advisory services to the State Boards of Nurse Examiners (SBNE) in all education and examination-related matters. Through its Committee on Education, the NLNE set up a subcommittee that would address, over the following decade, state board examination issues and problems. In 1937, NLNE published *A Curriculum Guide for Schools of Nursing*. Two years later, the NLNE initiated the first testing service through its Committee on Nursing Tests.

Soon after the beginning of World War II, nurse examiners began to face mounting pressures to hasten licensing and to schedule examinations more frequently. In response, participants at a 1942 NLNE conference suggested a "pooling of tests" whereby each state would prepare and contribute examinations in one or more subjects that could provide a reservoir of test items. They recommended that the Committee on Nursing Tests, in consultation with representative nurse examiners, compile the tests in machine-scorable form. In 1943, the NLNE board endorsed the action and authorized its Committee on Nursing Tests to operate a pooling of licensing tests for interested states (the State Board Test Pool Examination or SBTPE). This effort soon demonstrated the need for a clearinghouse whereby state boards could obtain information needed to produce their test items. Shortly thereafter, a Bureau of State Boards of Nursing began operating out of ANA headquarters.

The bureau was incorporated into the ANA bylaws and became an official body within that organization in 1945. Two years later, the ANA board appointed the Committee for the Bureau of State Boards of Nurse Examiners which was comprised of full-time professional employees of state boards.

In 1961, after reviewing the structure and function of the ANA and its relation to state boards of nursing, the committee recommended that it be replaced by a council. Although council status was achieved, many persons continued to be concerned about potential conflicts of interest and recognized the often heard criticism that professional boards serve primarily the interests of the profession they purport to regulate.

In 1970, following a period of financial crisis for the ANA, a council member recommended that a free-standing federation of state boards be established. After a year of study by the state boards, this proposal was overwhelmingly defeated when the council adopted a resolution to remain with the ANA. However, an ad hoc committee was appointed later to examine the feasibility of the council becoming a self-governing incorporated body.

At the council's 1977 meeting, a task force was elected and charged with the responsibility of proposing a specific plan for the formation of a new independent organization. On June 5, 1978, the Delegate Assembly of the ANA's Council of State Boards of Nursing voted 83 to 8 to withdraw from the ANA to form the National Council of State Boards of Nursing.

Organizational Mission, Objectives, and Goals

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

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

An organizational chart depicting the relationship between the national Council and Member Boards can be found on page 8.

The National Council has several objectives, one of which is to develop and establish policy and procedure regarding the use of licensure examinations in nursing. Another is to identify and promote desirable uniformity in standards and expected outcomes in nursing education and practice as they relate to the public interest. The National Council also seeks to assess trends and issues that affect nursing, disseminate data relating to nurse licensure and promote continued competence in nursing. To achieve these objectives, it plans and promotes educational programs; provides consultative services for Member Boards and others; and conducts research that addresses education, practice and policy-related issues. Tactics for achieving these goals are developed in accordance with organizational objectives and reflect the National Council's mission. The National Council's organization plan adds short-term activities and resources designed to accomplish the long-range goals and objectives. Tactics to implement goals are developed, assessed and refined each fiscal year and provide the organization with a flexible plan within a disciplined focus. Annually, the Board of Directors and committees participate in evaluating the accomplishment of goals and objectives and the directives of the Delegate Assembly.

Organizational Structure and Function

■ Membership

Membership in the National Council is extended to those boards of nursing that agree to use, under specified terms and conditions, one or more types of licensing examinations developed by the National Council. At the present time, there are 61 Member Boards, including those from the District of Columbia, the Virgin Islands, Puerto Rico, Guam, American Samoa and the Northern Mariana Islands. Boards of nursing may become Member Boards upon approval of the Delegate Assembly, payment of the required fees and execution of a contract for using the NCLEX-RN® examination and/or the NCLEX-PN® examination.

Member Boards maintain their good standing through remittance of fees and compliance with all contract provisions and bylaws. In return, they receive the privilege of participating in the development and use of the National Council's licensure examinations. Member Boards also receive information services, public policy analyses and research services. Member Boards who fail to adhere to the conditions of membership may have delinquent fees assessed or their membership terminated by the Board of Directors. They may then choose to appeal the Board's decision to the Delegate Assembly.

■ Areas

The National Council's membership is divided into four geographic areas. The purpose of this division is to facilitate communication, encourage regional dialogue on relevant issues and provide diversity of board and committee representation. Area directors are elected by delegates from their respective Areas through a majority vote of the Delegate Assembly. In addition, there are two directors-at-large who are elected by all delegates voting at the Annual Meeting. (See Glossary for list of jurisdictions by Area.)

■ Delegate Assembly

The Delegate Assembly is the legislative body of the National Council and comprises delegates designated by the Member Boards. Each Member Board has two votes and may name two delegates and alternates.

The Delegate Assembly meets at the National Council's Annual Meeting, traditionally held in August. Special sessions can be called under certain circumstances. Regularly scheduled sessions are held on a rotation basis among Areas.

At the Annual Meeting, delegates elect officers and members of the Committee on Nominations by majority and plurality vote respectively. They also receive and respond to reports from officers and committees and approve the annual audit report. They may revise and amend the bylaws by a two-thirds vote, providing the proposed changes have been submitted at least 45 days before the session. In addition, the Delegate Assembly adopts the

mission statement, goals and objectives of the National Council, and approves most test-related decisions, including changes in examination fees and test plans.

■ **Officers**

Officers of the National Council include the president, vice-president, treasurer, four Area directors and two directors-at-large. Only members or staff of Member Boards may hold office, subject to exclusion from holding office if other professional obligations result in an actual or perceived conflict of interest.

No person may hold more than one elected office at the same time. The president shall have served as a delegate or a committee member or an officer prior to being elected to office. An officer shall serve no more than four consecutive years in the same officer position.

The president, vice-president and treasurer are elected for a term of two years or until their successors are elected. The president, vice-president and treasurer are elected in even-numbered years.

The four Area directors are elected for a term of two years or until their successors are elected. Area directors are elected in odd-numbered years. The two directors-at-large are elected each year for a one-year term.

Officers are elected by ballot during the annual session of the Delegate Assembly. Area directors are elected by delegates from their respective Areas.

Election is by a majority vote. Write-in votes are prohibited. In the event a majority is not established, the Bylaws dictate the reballoting process.

Officers assume their duties at the close of the session at which they were elected. A vacancy in the office of president is filled by the vice-president. Other officer vacancies are filled by Board appointees until the term expires.

■ **Board of Directors**

The Board of Directors, the administrative body of the National Council, consists of the nine elected officers. The Board is responsible for the general supervision of the affairs of the National Council between sessions of the Delegate Assembly. The Board authorizes the signing of contracts, including those between the National Council and its Member Boards. It also engages the services of legal counsel, approves and adopts an annual budget, reviews membership status of noncompliant Member Boards and renders opinions, when needed, about actual or perceived conflicts of interest.

Additional duties include the adoption of personnel policies for all staff, appointment of committees, monitoring of committee progress, approval of studies and research pertinent to the National Council's purpose, and provision for the establishment and maintenance of the administrative offices.

■ **Meetings of the Board of Directors**

Meeting dates for the year are finalized by the Board of Directors during its post-Annual Meeting Board meeting. All Board meetings are held in Chicago with the exception of the pre- and post-Annual Meeting Board meetings.

Board officers are asked to submit reports and other materials for the meeting at least three weeks prior to each meeting so that they can be copied and distributed with other meeting materials. The call to meeting, agenda and related materials are mailed to Board officers two weeks before the meeting. The agenda is prepared by staff, in consultation with the president, and provided to the membership via the biweekly *Newsletter*.

The agenda is organized around the organization plan (goals and objectives). Items for Board discussion and action are accompanied by a memo or report which describes the item's background and indicates the Board action needed. Motion papers are available during the meeting and are used so that an accurate record will result. Staff takes minutes of the meeting. A summary of the Board's major decisions is also included in the *Newsletter* for Member Boards' information, prior to the release of approved minutes following the next Board meeting.

Resource materials are available to each Board officer for use during Board meetings. These materials, which are updated periodically throughout the year, are kept at the National Council office and include copies of the articles of incorporation and bylaws, organization plan, policies and procedures, contracts, budget, test plan, committee rosters, minutes and personnel manual.

■ **Communications With the Board of Directors**

Communication between Board meetings takes place in several different ways. The executive director communicates weekly with the president regarding major activities and confers as needed with the treasurer about financial matters. Quarterly reports of major activities are prepared by the staff and provided to Board officers.

In most instances, the executive director is the person responsible for communicating with National Council consultants about legal, financial and accounting concerns. This practice was adopted primarily as a way to monitor and control the costs of consultant services.

Conference calls can be scheduled, if so desired by the president. Written materials are generally forwarded to Board officers in advance of the call. These materials include committee or staff memos detailing the issue's background as well as Board action required. Staff prepares minutes of the call and submits them at the next regularly scheduled Board meeting.

Board officers use the National Council letterhead when communicating as representatives of the National Council.

■ **Committee on Nominations**

National Council delegates elect representatives to the Committee on Nominations. The committee consists of four persons, one from each Area, who may be either board members or staff of Member Boards. Committee members are elected to one-year terms. They are elected by ballot with a plurality vote. At the first committee meeting, the members of the committee select a chair.

The Committee on Nominations' function is to consider the qualifications of all candidates for Board of Director office and for the committee itself and to prepare a slate of qualified candidates. During the Delegate Assembly, additional nominations may be made from the floor.

Committees

Many of the National Council's objectives are accomplished through the committee process. Every year, the committees report on their activities and make recommendations to the Delegate Assembly or Board of Directors. At the present time, the National Council has three standing committees: Examination, Finance, and Nursing Practice and Education. Standing committees may be assisted by subcommittees, such as the Education Approval/Accreditation Subcommittee (NP&E) or the NCLEX Item Review Subcommittee (Exam).

Committees and special committees are appointed by the Board of Directors to address special issues and concerns. Examples of special committees include the Unlicensed Assistive Personnel Task Force, Multistate Regulation Task Force and Policy Futures Panel.

Committees are governed by specific policies and procedures which may be found in National Council's policy manual. Committee membership is extended to all current members and staff of Member Boards. In the appointment process, every effort is made to match the expertise of each individual with the needs of the National Council. Also considered is balanced representation whenever possible, among Area, Board members and staff, registered and licensed practical/vocational nurses, and consumers. Consultants provide outside expertise to committees as needed, on a one-time or ongoing basis.

A National Council staff member is assigned to serve each committee. Staff work closely with the committee chairs to facilitate committee work and provide support and expertise to committee members, but they have no formal decision-making role. Agendas for the committee meetings are established by the chair. With staff assistance, the chair prepares the agenda, the call to meeting and any other documents that must be reviewed prior to committee meetings. Staff supervises the mailing of these materials, which are sent to committee members no less than two weeks before the committee meeting.

■ **Examination Committee**

The Examination Committee consists of at least six persons, including one representative from each Area. One of these persons must be a licensed practical/vocational nurse. The committee chair must have served on the committee prior to being appointed chair.

The purpose of the Examination Committee is to develop the licensure examinations and evaluate procedures needed to produce the licensure examinations. Toward this end, it recommends test plans to the Delegate Assembly and suggests research important to the development of licensure examinations.

The Examination Committee provides general oversight of the NCLEX® examination process, including examination item development, security, administration and quality assurance. Other duties include the selection of appropriate item development panels, test service evaluation and preparation of written information about the examinations for Member Boards and other interested parties. The committee also regularly evaluates the licensure examinations by means of item analysis and test and candidate statistics.

One of the National Council's major objectives is to provide psychometrically sound and legally defensible nursing licensure examinations to Member Boards. Establishing examination validity is key to this objective. Users of examinations have certain expectations about what an examination measures and what its results mean; a valid examination is simply one that legitimately fulfills these expectations.

Validating a licensure examination is an evidence-gathering process to determine two things: 1) whether or not the examination actually measures competencies required for safe and effective job performance, and 2) whether or not it can distinguish between candidates who do and do not possess those competencies. An analysis of the job for which the license is given is essential to validation. There are several methods for analyzing jobs, including compilation of job descriptions, opinions of experts, and surveys of job incumbents. Regardless of the method used, the outcome of the job analysis is a description of those tasks that are most important for safe and effective practice.

The results of the job analysis can be used to devise a framework describing the job, which can then be used as a basis for a test plan and for a set of instructions for item writers. The test plan is the blueprint for assembling forms of the test, and usually specifies major content or process dimensions and percentages of questions that will be allotted to each category within the dimension. The instructions for item writers may take the form of a detailed set of knowledge, skills and abilities (KSA) statements or competency statements which the writers will use as the basis for developing individual test items. By way of the test plan and KSA statements, the examination is closely linked to the important job functions revealed through the job analysis. This fulfills the first validation criterion: a test that measures important job-related competencies.

The second criterion, related to the examination's ability to distinguish between candidates who do and do not possess the important competencies, is most frequently addressed in licensure examinations through a criterion-referenced standard setting process. Such a process involves the selection of a cut score to determine which candidates pass and which fail. Expert judges with first-hand knowledge of what constitutes safe and effective practice for entry-level nurses are selected for this process. They are trained in conceptualizing the minimally competent candidate (performing at the lowest *acceptable* level), and they go through a structured process of judging success rates on each individual item of the test. Their pooled judgments result in identification of a cut score. Taking this outcome along with other data relevant to identification of the level of competence, the Board of Directors sets a passing standard which distinguishes between candidates who do and do not possess the essential competencies, thus fulfilling the second validation criterion.

Having validation evidence based on job analysis and criterion-referenced standard setting processes is the best legal defense available for licensing examinations. For most of the possible challenges that candidates might bring against an examination, if the test demonstrably measures the possession of important job-related skills, its use in the licensure process is likely to be upheld in a court of law.

- **Finance Committee**

The Finance Committee is comprised of one representative from each Area and the treasurer, who serves as the chair. The committee's primary purpose is to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. It also reviews financial status on a quarterly basis and provides the Board of Directors with a proposed annual budget prior to each new fiscal year.

- **Nursing Practice and Education Committee**

The Nursing Practice and Education Committee consists of at least one representative from each Area. The committee's purpose is to provide general oversight of nursing practice and education regulatory issues. It periodically reviews and revises the *Model Nursing Practice Act* and *Model Nursing Administrative Rules,* and prepares other position statements and guidelines for presentation to the Delegate Assembly. It also prepares written information about the legal definitions and standards of nursing practice and education which it disseminates to Member Boards and other interested parties. In the recent past, the committee has had a number of subcommittees to study various issues, e.g., continued competence, discipline resources, and accreditation/approval in nursing education.

National Council Staff

National Council staff members are hired by the executive director, to whom they report. Their primary role is to implement the Delegate Assembly's and Board of Directors' policy directives and provide assistance to committees.

The National Council staff is organized into departments for the purpose of meeting the organizational objectives. The Testing Department exists to accomplish the National Council's primary objective, which is to develop and establish examination-related policy and procedure. Other staff members are assigned to the Departments of: Research Services, Communications, Practice and Accountability, Practice and Credentialing, Education and Practice, Public Policy, Administrative Services, Information Technology, Marketing, Member Board Relations and Executive Staff to assist the National Council to meet its other objectives.

General Delegate Assembly Information

Agendas for each session of the Delegate Assembly are prepared by the president in consultation with the Board of Directors and executive director and approved by the Board of Directors. At least 45 days prior to the Annual Meeting, Member Boards are sent the recommendations to be considered by the Delegate Assembly. A *Business Book* is provided to all Annual Meeting registrants which contains the agenda, reports requiring Delegate Assembly action, reports of the Board of Directors and standing committees, annual plan and budget.

Prior to the annual session of the Delegate Assembly, the president appoints the rules, credentials, elections and resolutions committees, as well as the Committee to Approve Minutes. The president must also appoint a timekeeper, a parliamentarian and pages.

The purpose of the Rules Committee is to draft, in consultation with the parliamentarian, rules for the conduct of the specific Delegate Assembly. The Credentials Committee's function is to provide delegates with identification bearing the number of votes to which the delegate is entitled. It also presents oral and written reports at the opening session of the Delegate Assembly and immediately preceding the election of officers and Committee on Nominations. The Elections Committee conducts all elections that are decided by ballot in accordance with the bylaws and standing rules. The Resolutions Committee initiates resolutions if deemed necessary and receives, edits and evaluates all others in terms of their relationship to National Council's mission, goals and fiscal impact to the organization. At a time designated by the president, it reports to the Delegate Assembly.

Minutes of the Delegate Assembly are kept by the parliamentarian. These minutes are then reviewed, corrected as necessary and approved by the Committee to Approve Minutes, which includes the executive director who serves as corporate secretary.

The Delegate Assembly, the legislative body of the National Council, as specified in the bylaws, provides direction to:

- approve all new National Council memberships;
- elect officers and members of the Committee on Nominations;
- receive reports of officers and committees and take action as appropriate;
- establish the fee for the NCLEX examination;
- approve the auditor's report;
- adopt policy and position statements;
- adopt the mission, goals and objectives of the National Council;
- approve the substance of all contracts between the National Council and Member Boards and the National Council and test services;
- establish the criteria for and select the NCLEX examination test service;
- adopt test plans to be used for the development of the NCLEX examination; and
- transact any other business as may come before it.

General Committee Information

■ Committee Appointments

The appointment of representatives of Member Boards to committees of the National Council is a responsibility delegated to the Board of Directors by the bylaws. In order to facilitate this process and ensure a wide representation of Member Boards, board staff and board members, the following procedure is used.

Individuals who wish to be considered for appointment or reappointment to a National Council committee/special committee submit a Committee Volunteer Information Form. The information provided is maintained in the National Council's Volunteer Resource Pool. All information contained in the Pool, along with information about the number of positions available on each committee, is forwarded to the respective Area director for recommendations for appointment or reappointment. Concurrently, committee chairs are asked to provide input as to whether individuals currently serving on committees should be reappointed. The Area directors recommend to the Board of Directors the appointment/reappointment of individuals to vacant positions.

Prior to the Annual Meeting, the Board of Directors evaluates the qualifications of existing and potential committee chairs, makes tentative appointments for committee chairs, and reviews and tentatively approves the committee/special committee appointments that were recommended by Area Directors. During the Board's September meeting, appointments are finalized after considering the need for additional special committees required to accomplish the directives of the Delegate Assembly.

■ Committee Minutes

Minutes are taken at every committee meeting including telephone conference calls. Minute-taking is an extremely important responsibility because minutes serve as records of what took place at the meeting. Although minutes can be opposed by oral testimony, they are, in the vast majority of cases, legally binding once they have been adopted and certified. Thus, it is crucial that they accurately reflect the committee's process and outcomes.

Committee minutes are taken by committee members or staff, who should:

- report the date, place and time of the meeting;
- include a statement that the meeting was duly called;
- indicate the presiding officer, chair or committee member;
- indicate who served as secretary;
- record names of persons present and quorum statistics;
- record the adoption of minutes from the previous meeting;
- record the adjournment time;
- be clear and concise;
- not include every routine document;
- make amendments to the minutes only with the committee's approval; and
- initial any amendments.

Minutes from National Council Board and committee meetings should reflect the topic discussed and the actions that followed.

■ Committee Reports

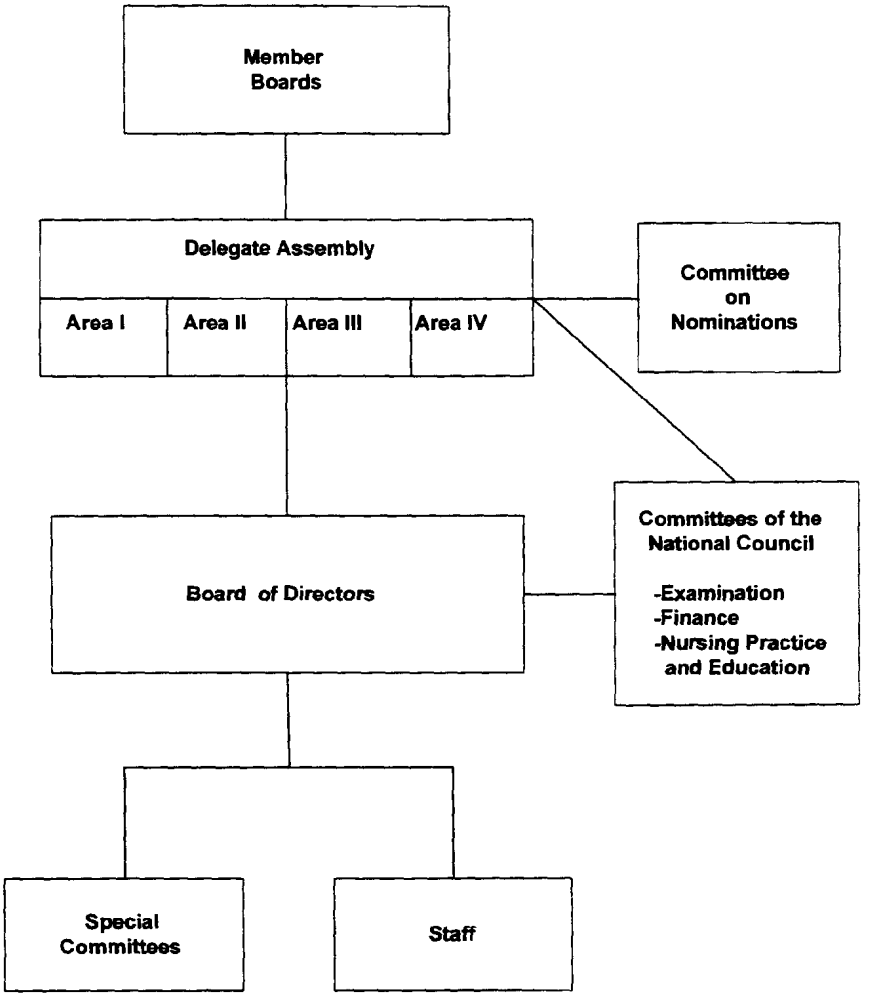
Committees requesting action from the Board submit reports to the National Council office no later than three weeks prior to each Board of Directors' meeting. The reports are written by the committee chair and committee staff person. Staff processes the reports and supervises their mailing.

The first page of the report contains committee recommendation(s). Subsequent pages document the committee's activities in either narrative or outline format. Background and rationale for the committee's recommendation(s) should be clearly stated. The report concludes with a reiteration of the committee's recommendation(s), and fiscal impact and legal comments are indicated.

A summary of every committee meeting is reported to the membership via the *Newsletter* that follows the close of the individual meeting. Committee reports that are submitted to the Board of Directors throughout the year are also posted immediately following each Board meeting on National Council's VIP Web site, a location on the World Wide Web that is accessible by both board members and staff of boards of nursing.

National Council of State Boards of Nursing, Inc.

Organization



6/98

National Council of State Boards of Nursing, Inc. Bylaws

Revision Adopted	*August 29, 1987*
Amended	*August 19, 1988*
Amended	*August 30, 1990*
Amended	*August 1, 1991*
Amended	*August 5, 1994*
Amended	*August 20, 1997*

Article I

■ Name

The name of this organization shall be the National Council of State Boards of Nursing, Inc., hereinafter referred to as the National Council.

Article II

■ Purpose and Functions

Section 1. ***Purpose.*** The purpose of the National Council is to provide an organization through which state boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

Section 2. ***Functions.*** The National Council's functions shall include but not be limited to providing services and guidance to its members in performing their regulatory functions regarding entry into nursing practice, continued safe nursing practice and nursing education programs. The National Council provides Member Boards with examinations and standards for licensure and credentialing; promotes uniformity in standards and expected outcomes in nursing practice and education as they relate to the protection of the public health, safety and welfare; provides information, analyses and standards regarding the regulation of nursing practice and nursing education; promotes the exchange of information and serves as a clearinghouse for matters related to nursing regulation.

Article III

■ Members

Section 1. ***Definition.*** A state board of nursing is the governmental agency empowered to license and regulate nursing practice in any state, territory or political subdivision of the United States of America.

Section 2. ***Qualifications.*** Any state board of nursing that agrees to use one or more National Council Licensing Examinations, hereinafter referred to as the NCLEX® examination, under the terms and conditions specified by the National Council and pays the required fees may be a member of the National Council.

Section 3. ***Admission.*** A state board of nursing shall become a member of the National Council and be known as a Member Board upon approval by the Delegate Assembly, as described in Article VII, payment of the required fees and execution of a contract for using the NCLEX® examination.

Section 4. ***Areas.*** The Delegate Assembly shall divide the membership into numbered geographical Areas. At no time shall the number of Areas be less than three nor more than six. New members shall be assigned to existing Areas by the Board of Directors. The purpose of this division is to facilitate communication, encourage regional dialogue on National Council issues and provide diversity of representation on the Board of Directors and on committees.

Section 5. ***Fees.*** The annual fee shall be $3,000 until determined otherwise by the Delegate Assembly in conjunction with the current contract cycle. The annual fee shall be payable each July 1.

Section 6. ***Privileges.*** Membership privileges include but are not limited to the right to vote as prescribed in these bylaws and the right to assist in the development of the NCLEX® examination, except that a Member Board that uses both NCLEX® examination and another examination leading to the same license shall not participate in the development of the NCLEX® examination to the extent that such participation would jeopardize the integrity of the NCLEX® examination.

Section 7. ***Noncompliance.*** Any Member Board whose fees remain unpaid after October 15 is not in good standing. Any Member Board which does not comply with the provisions of the bylaws and contracts of the National Council shall be subject to immediate review and possible termination by the Board of Directors.

Section 8. ***Appeal.*** Any termination of membership by the Board of Directors is subject to appeal to the Delegate Assembly.

Section 9. ***Reinstatement.*** A Member Board in good standing that chooses to terminate membership shall be required to pay only the current fee as a condition of future reinstatement. Any membership which has been terminated for nonpayment of fees shall be eligible for reinstatement to membership upon payment of the current fee and any delinquent fees.

Article IV

■ Officers

Section 1. ***Enumeration.*** The elected officers shall be a president, a vice-president, a treasurer, two directors-at-large and a director from each Area.

Section 2. ***Qualifications.*** Members and employees of Member Boards shall be eligible to serve as National Council officers until their term or their employment with a Member Board ends. Members of a Member Board who become permanent employees of a Member Board will continue their eligibility to serve.

Section 3. ***Qualifications for President.*** The president shall have served as a delegate or a committee member or an officer prior to being elected to the office of President.

Section 4. ***Directors.*** Each Area shall elect a director. Two directors-at-large shall be elected by the Delegate Assembly.

Section 5. ***Terms of Office.*** The president, vice-president, treasurer and Area directors shall be elected for a term of two years or until their successors are elected. Directors-at-large shall be elected for a term of one year or until their successors are elected. The president, vice-president and treasurer shall be elected in even-numbered years. The Area directors shall be elected in odd-numbered years. Officers shall assume duties at the close of the Annual Meeting of the Delegate Assembly at which they are elected. No person shall serve more than four consecutive years in the same officer position.
* *See Proviso number 1.*

Section 6. ***Limitations.*** No person may hold more than one elected office at one time. No officer shall hold elected or appointed office or a salaried position in a state, regional or national association or body if such office or position might result in a potential or actual, or the appearance of, a conflict of interest with the National Council, as determined by the Committee on Nominations before election to office and as determined by the Board of Directors after election to office. If a current officer agrees to be presented on the ballot for another office, the term of the current office shall terminate at the close of the Annual Meeting at which the election is held.

Section 7. ***Vacancies.*** A vacancy in the office of president shall be filled by the vice-president. The Board of Directors shall fill all other vacancies by appointment. The person filling the vacancy shall serve until the next Annual Meeting.

Section 8. ***Removal from Office.*** A member of the Board of Directors may be removed with or without cause by a two-thirds vote of the Delegate Assembly. The Board of Directors shall remove any member of the Board of Directors from office upon conviction of a felony. A member of the Board of Directors may be removed by a two-thirds vote of the Board of Directors for failure to perform duties of the office. The individual shall be given 30 days' written notice of the proposed removal.

Section 9. ***Appeal.*** An individual removed from office by the Board of Directors may appeal to the Delegate Assembly at its next Annual Meeting. Such individual may be reinstated by a two-thirds vote of the Delegate Assembly.

Section 10. ***Responsibilities of the President.*** The president shall preside at all meetings of the Delegate Assembly and the Board of Directors, assume all powers and duties customarily incident to the office of president, and act as the chief spokesperson for the National Council. The president shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 11. ***Responsibilities of the Vice-President.*** The vice-president shall assist the president, perform the duties of the president in the president's absence, and fill any vacancy in the office of the president until the next Annual Meeting. The vice-president shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 12. ***Responsibilities of the Treasurer.*** The treasurer shall serve as the chair of the Finance Committee and shall assure that quarterly reports are presented to the Board of Directors and Member Boards, and that annual financial reports are presented to the Delegate Assembly. The treasurer shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 13. ***Duties of Area Directors.*** The directors elected from Areas shall preside at Area Meetings of the Member Boards, and shall serve as liaison and resource persons to Member Board members and employees in their respective Areas. The Area directors shall act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Section 14. ***Duties of Directors-at-Large.*** Directors-at-large shall perform such duties as shall be assigned to them by the Board of Directors, and act in conformity with these bylaws and as directed by the Delegate Assembly or Board of Directors.

Article V

■ **Nominations and Elections**

Section 1. ***Committee on Nominations***

a) *Composition.* The Committee on Nominations shall be comprised of one person from each Area. Committee members shall be members or employees of Member Boards within the Area.
b) *Term.* The term of office shall be one year. Members shall assume duties at the close of the Annual Meeting at which they are elected.
c) *Election.* The committee shall be elected by ballot of the Delegate Assembly at the Annual Meeting. A plurality vote shall elect. At the first committee meeting, the members of the committee shall elect, from its membership, a committee chair. The first meeting of the committee shall be held concurrent with the first meeting of the Board of Directors in the subsequent fiscal year.
d) *Limitation.* A member elected or appointed to the Committee on Nominations may not be nominated for an officer position during the term for which that member was elected or appointed.

e) *Vacancy.* A vacancy occurring in the committee shall be filled from the remaining candidates from the Area in which the vacancy occurs, in order of votes received. If no remaining candidates from an Area can serve, the Board of Directors shall fill the vacancy with an individual from the Area who meets the qualifications of Section 1 of this Article.
f) *Duties.* The Committee on Nominations shall consider the qualifications of all nominees for officers and the Committee on Nominations as proposed by Member Boards or by members of the Committee on Nominations, and present a qualified slate of candidates for vote at the Annual Meeting. The committee's report shall be read at the first session of the Delegate Assembly, when additional nominations may be made from the floor. No name shall be placed in nomination without the written consent of the nominee.

Section 2. *Election of Officers.* Election of officers shall be by ballot of the Delegate Assembly during the Annual Meeting. Write-in votes shall be prohibited. Election of all officers except Directors-at-Large: If a candidate does not receive a majority vote on the first ballot, re-balloting shall be limited to the two candidates receiving the highest numbers of votes. In case of a tie on the re-balloting, the choice shall be determined by lot.

Elections of Director-at-Large: If the necessary number of candidates does not receive a majority vote on the first ballot, re-balloting shall be limited to the candidates receiving the highest number of votes (two candidates if one position is to be filled; four candidates if two positions are to be filled). If the necessary number of candidates does not receive a majority vote on the second ballot, re-balloting shall occur among all remaining candidates. If the necessary number of candidates does not receive a majority on the third ballot, the candidate(s) with the most votes shall be declared the winner. If there is a tie between candidates with the most votes, then the choice shall be determined by lot.

Article VI

■ Meetings

Section 1. *Open Meetings.* All meetings called under the auspices of the National Council shall be open to the public with the following exceptions: (a) meetings of the Examination Committee whenever activities pertaining to test items are undertaken; and (b) executive sessions of the Delegate Assembly, Board of Directors and committees, provided that the minutes reflect the purpose of and action taken in executive session.

Section 2. *Participation.*

a) *Right to Speak.* Members and employees of Member Boards shall be given the right to speak at all meetings called under the auspices of the National Council. Only delegates to the Delegate Assembly, members of the Board of Directors and members of National Council committees shall be entitled to make motions and vote in their respective meetings; provided, however, that the Board of Directors, committees and Member Boards may make motions at the Delegate Assembly.
b) *Interactive Communications.* Meetings held with one or more participants attending by telephone conference call, video conference or other interactive means of conducting conference communications constitute meetings where valid decisions may be made. A written record documenting that each member was given notice of the meeting, minutes reflecting the names of participating members and a report of the roll call on each vote shall be distributed to all members of the group and maintained at the National Council Office.
c) *Electronic Communication and Mail.* To the extent permitted by law, business may be transacted by electronic communication or by mail, in which case a report of such action shall be made part of the minutes of the next meeting.
d) *Committees.* Committees may establish such methods of conducting their business as they find convenient and appropriate.

Article VII

■ Delegate Assembly

Section 1. *Composition and Term.* The Delegate Assembly shall be comprised of delegates designated by each Member Board. An alternate duly appointed by a Member Board may replace a delegate and assume all delegate privileges. A National Council officer may not represent a Member Board as a delegate. Delegates and alternates serve from the time of appointment until replaced.

Section 2. ***Voting.*** Each Member Board shall be entitled to two votes. The votes may be cast by either one or two delegates. There shall be no proxy or absentee voting at the Annual Meeting. A Member Board may choose to vote by proxy at any special session of the Delegate Assembly. A proxy vote shall be conducted by distributing to Member Boards a proxy ballot listing a proposal requiring either a yes or no vote. A Member Board may authorize the secretary of the National Council or a delegate of another Member Board to cast its votes.

Section 3. ***Authority.*** The Delegate Assembly, the legislative body of the National Council, shall provide direction for the National Council through adoption of the mission, goals and objectives, adoption of position statements, and actions at any Annual Meeting or special session. The Delegate Assembly shall approve all new National Council memberships; approve the substance of all NCLEX® examination contracts between the National Council and Member Boards; adopt test plans to be used for the development of the NCLEX® examination; select the NCLEX® examination test service; and establish the fee for the NCLEX® examination.

Section 4. ***Annual Meeting.*** The National Council Annual Meeting shall be held at a time and place as determined by the Board of Directors. The Delegate Assembly shall meet each year during the Annual Meeting. The official call to that meeting, giving the time and place, shall be conveyed to each Member Board at least 90 days prior to the Annual Meeting. In the event of a national emergency, the Board of Directors by a two-thirds vote may cancel the Annual Meeting and shall schedule a meeting of the Delegate Assembly as soon as possible to conduct the business of the National Council.

Section 5. ***Special Session.*** A special session of the Delegate Assembly shall be called upon written petition of at least ten Member Boards made to the Board of Directors. A special session may be called by the Board of Directors. Notice containing the general nature of business to be transacted and date and place of said session shall be sent to each Member Board at least ten days prior to the date for which such a session is called.

Section 6. ***Quorum.*** The quorum for conducting business at any session of the Delegate Assembly shall be at least one delegate from a majority of the Member Boards and two officers present in person or, in the case of a special session, by proxy.

Article VIII

- **Board of Directors**

Section 1. ***Composition.*** The Board of Directors shall consist of the elected officers.

Section 2. ***Authority.*** The Board of Directors shall have general supervision of the affairs of the National Council between the meetings of the Delegate Assembly and shall perform such other duties as are specified in these bylaws. The Board shall be subject to the orders of the Delegate Assembly, and none of its acts shall conflict with action taken by the Delegate Assembly. The Board of Directors shall report annually to the Delegate Assembly.

Section 3. ***Meetings of the Board of Directors.*** The Board of Directors shall meet in the Annual Meeting city immediately prior to, and following, the Annual Meeting, and at other times as necessary to accomplish the work of the Board. Special meetings of the Board of Directors shall be called by the president upon written request of at least three members of the Board of Directors. Special meetings may be called by the president. Twenty-four hours or more notice shall be given to each member of the Board of Directors of a special meeting. The notice shall include a description of the business to be transacted.

Article IX

- **Executive Director**

Section 1. ***Appointment.*** The Executive Director shall be appointed by the Board of Directors. The selection or termination of the Executive Director shall be by a majority vote of the Board of Directors.

Section 2. ***Authority.*** The Executive Director shall serve as the chief staff officer of the organization and shall possess the authority conferred by, and be subject to the limitations imposed by the Board of Directors. The Executive Director shall manage and direct the programs and services of the National Council, supervise all administrative services, serve as corporate secretary and shall oversee maintenance of all documents and records of the National Council.

Section 3. ***Evaluation.*** The Board of Directors shall conduct an annual written performance appraisal of the Executive Director, and shall set the Executive Director's annual salary.

Article X

■ **Committees**

Section 1. ***Standing Committees.*** Members of standing committees shall be appointed by the Board of Directors.

a) *Examination Committee.* The Examination Committee shall be comprised of at least six members, including one member from each Area. One of the committee members shall be a licensed practical/vocational nurse. The committee chair shall have served as a member of the committee prior to being appointed as chair. The Examination Committee shall provide general oversight of the NCLEX® examination process, including examination item development, security, administration and quality assurance to ensure consistency with the Member Boards' need for examinations. The Examination Committee shall approve item development panels and recommend test plans to the Delegate Assembly. Subcommittees may be appointed to assist the Examination Committee in the fulfillment of its responsibilities.

b) *Finance Committee.* The Finance Committee shall be comprised of one member from each Area and the treasurer, who shall serve as chair. The Finance Committee shall provide general oversight of the use of the National Council's assets to assure prudence and integrity of fiscal management and responsiveness to Member Board needs. The Finance Committee shall maintain financial policies which provide guidelines for fiscal management, and shall review and revise financial forecast assumptions.

c) *Nursing Practice and Education Committee.* The Nursing Practice and Education Committee shall be comprised of at least one member from each Area. The Nursing Practice and Education Committee shall provide general oversight of nursing practice and education regulatory issues by coordinating related subcommittees.

Section 2. ***Special Committees.*** The Board of Directors shall appoint special committees as needed to accomplish the mission of the National Council. Special committees may be subcommittees, task forces, focus groups, advisory panels or other groups designated by the Board of Directors.

Section 3. ***Committee Membership.***

a) *Composition.* Standing committees shall include only current members and employees of Member Boards. Special committees shall include current members and employees of Member Boards, and may include consultants or other individuals selected for their special expertise to accomplish a committee's charge. In appointing committees, consideration shall be given to expertise needed for the committee work, Area representation and the composition of Member Boards. The president, or president's delegate, shall be an ex-officio member of all committees except the Committee on Nominations.

b) *Term.* The standing committee members shall be appointed for two years or until their successors are appointed. Standing committee members may apply for re-appointment to the committee. Members of special committees shall serve at the discretion of the Board of Directors.

c) *Vacancy.* A vacancy may occur when a committee member resigns or fails to meet the responsibilities of the committee as determined by the Board of Directors. The vacancy may be filled by appointment by the Board of Directors for the remainder of the term.

d) *Committee Functions.*

    1. *Budget.* Standing committees shall submit a budget request for activities prior to the beginning of the fiscal year. Special committees will be assigned a budget to use in accomplishing the charge. Committees shall not incur expenses in addition to the approved budgeted amount without prior authorization of the Board of Directors.

2. *Policies.* Each standing committee shall establish policies to expedite the work of the committee, subject to review and modification by the Board of Directors. Special committees shall comply with general policies established by the Board of Directors.
3. *Records and Reports.* Each committee shall keep minutes. Special committees shall provide regular updates to the Board of Directors regarding progress toward meeting their charge. Standing committees shall submit quarterly reports to, and report on proposed plans as requested by, the Board of Directors. Special committees shall submit a report and standing committees shall submit annual reports to the Delegate Assembly.

Article XI

■ **Special Services Division**

Section 1. ***Purpose.*** The Special Services Division of the National Council shall be the vehicle for conducting activities which are consistent with the purposes of the National Council and which relate to providing services or products primarily to parties other than Member Boards. This Article shall apply solely to activities within the jurisdiction of the Special Services Division.

Section 2. ***Scope of Activities.*** Activities within the jurisdiction of the Special Services Division shall include the development, promotion and distribution of services and products provided primarily to parties other than Member Boards but shall not include (a) the development of examinations and standards for the governmental authorization for nursing practice in Member Board jurisdictions or (b) the development of standards regarding the regulation of nursing practice and nursing education in Member Board jurisdictions. However, with the prior approval of the Board of Directors, the Special Services Division may develop, promote and distribute services or products which include such examinations and standards at the request of one or more Member Boards and/or certifying bodies other than examinations and standards for the initial entry-level licensure of nurses.

Section 3. ***Management Authority.*** The property and activities of the Special Services Division shall be managed by an Executive who shall be appointed by, and serve at the pleasure of, the Board of Directors and who may, but need not, be the same person who serves as the Executive Director of the National Council. The Executive shall be the chief executive officer of the Special Services Division and, subject to such operating policies and guidelines, including such financial policies and limitations, as may be adopted by the Board of Directors from time to time, shall have full authority to direct the activities of the division and to enter into contracts and make other commitments on behalf of the division, which shall be binding upon the National Council.

Article XII

■ **Finance**

Section 1. ***Audit.*** The financial records of the National Council shall be audited annually by a certified public accountant appointed by the Board of Directors. The audit report shall be presented to the Delegate Assembly.

Section 2. ***Fiscal Year.*** The fiscal year shall be from October 1 to September 30.

Article XIII

■ **Indemnification**

Section 1. ***Direct Indemnification.*** To the full extent permitted by, and in accordance with the standards and procedures prescribed by Sections 5741 through 5750 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that he or she is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against expenses (including but not limited to attorney's fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by the person in connection with such action, suit or proceeding.

Section 2. ***Insurance.*** To the full extent permitted by Section 5747 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provision of any future Pennsylvania statute, the corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, agent or representative of the corporation, or performs or has performed volunteer services for or on behalf of the corporation, or is, or was serving at the request of the corporation as a director, officer, employee, agent or representative of another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of Section 1 of this Article.

Section 3. ***Additional Rights.*** Pursuant to Section 5746 of the Pennsylvania Nonprofit Corporation Law of 1988 or the corresponding provisions of any future Pennsylvania statute, any indemnification provided pursuant to Sections 1 or 2 of this Article shall:

a) not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any future bylaw, agreement, vote of members or disinterested directors or otherwise, both as to action in his or her official capacity and as to action in another capacity while holding such official position; and
b) continue as to a person who has ceased to be a director, officer, employee, agent or representative of, or provider of volunteer services for or on behalf of the corporation and shall inure to the benefit of the heirs, executors and administrators of such a person.

Article XIV

■ **Parliamentary Authority**

The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern the National Council in all cases not provided for in the articles of incorporation, bylaws and any special rules of order adopted by the National Council.

Article XV

■ **Amendment of Bylaws**

Section 1. ***Amendment.*** These bylaws may be amended at any Annual Meeting or special session of the Delegate Assembly. A two-thirds vote of the delegates present and voting is required to amend the bylaws, providing that copies of the proposed amendments have been presented in writing to the Member Boards at least 45 days prior to the session. Without previous 45-day notice, the bylaws may be amended by a three-quarters vote of the delegates eligible to vote if, at least five days prior to the meeting, notice is given that amendments may be considered at the Annual Meeting or special session.

Section 2. ***Revision.*** These bylaws may undergo revision only upon authorization and adoption by the Delegate Assembly. A committee for revision, authorized by the Delegate Assembly, shall prepare and present the proposed revision. A two-thirds vote of the delegates present and voting is required to adopt the revision, provided that copies of the proposed revision shall have been submitted in writing to the Member Boards at least 45 days prior to the Annual Meeting or special session at which the action is to be taken.

Proviso to the Bylaws of the National Council of State Boards of Nursing

1. Proviso to Article IV, Section 5:

Any officer currently in office or elected to office at the 1994 Delegate Assembly may serve up to five consecutive years at the same office position.

Proposed Bylaws Amendments

As of July 10, 1998, the only proposed bylaws amendment received was the one being presented by the Board of Directors. It can be found in the Report of the Board of Directors (Tab 9), and is repeated below:

Board of Directors

1. **That Article VII, Section 3, of the National Council Bylaws be amended by deleting the words "goals and objectives" and the words "adoption of" preceding "position statements" so that the sentence would read, "The Delegate Assembly, the legislative body of the National Council, shall provide direction for the National Council through adoption of the mission and position statements, and actions at any Annual Meeting or special session."**

Rationale

The Board of Directors has been engaged in an intensive process over the past two years, leading to the development of six strategic initiatives and 23 outcomes which are directly related to the mission of the organization, as adopted by the Delegate Assembly in 1997. These strategic initiatives and outcomes were presented by the president at each Area Meeting, and seemed to meet with approval in view of the absence of suggestions for improvement or objections. On the last occasion that a new set of goals and objectives (analogous to "strategic initiatives" and "outcomes") was proposed to the Delegate Assembly, the proposal presented by the Board with member and committee input was also adopted without change by the Delegate Assembly. Under the proposed Bylaw amendment, the Board of Directors would develop strategic initiatives and outcomes and report them to the Delegate Assembly annually.

Member Boards continually provide feedback to the Board of Directors via letters, calls, and requests, and are frequently asked for input formally and informally. The resolutions process at the Delegate Assembly provides a formal opportunity for input and direction as well.

Notes

Glossary

AACN
American Association of Colleges of Nursing, or American Association of Critical Care Nurses.

AANA
American Association of Nurse Anesthetists.

AANP
American Academy of Nurse Practitioners.

ACC
ACNM Certification Council, Inc.

ACNM
American College of Nurse Midwives.

AccuFacts
A searchable electronic database of National Council documents that may be distributed to the public. Accessible to Member Boards via NCNET and the public via the National Council's public World Wide Web site.

ADA
Americans with Disabilities Act.

ANA
American Nurses Association.

ANCC
American Nurses Credentialing Center.

AONE
American Organization of Nurse Executives.

APRN (also known as APN or ARNP)
Advanced Practice Registered Nurse. In the National Council's *Model Nursing Practice Act*, this level of nursing practice is based on knowledge and skills acquired in basic nursing education; licensure as a registered nurse; and a graduate degree with a major in nursing or a graduate degree with a concentration in the advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psycho-social assessment, appropriate interventions and management of health care.

Area
One of four designated geographic regions of National Council's Member Boards.

Area I	Area II	Area III	Area IV
Alaska	Illinois	Alabama	Connecticut
American Samoa	Indiana	Arkansas	Delaware
Arizona	Iowa	Florida	District of Columbia
California	Kansas	Georgia	Maine
Colorado	Michigan	Kentucky	Maryland
Guam	Minnesota	Louisiana	Massachusetts
Hawaii	Missouri	Mississippi	New Hampshire
Idaho	Nebraska	North Carolina	New Jersey

Area I	Area II	Area III	Area IV
Montana	North Dakota	Oklahoma	New York
Nevada	Ohio	South Carolina	Pennsylvania
New Mexico	South Dakota	Tennessee	Puerto Rico
N. Mariana Islands	West Virginia	Texas	Rhode Island
Oregon	Wisconsin	Virginia	Vermont
Utah			Virgin Islands
Washington			
Wyoming			

ASI
Assessment Systems, Inc. A wholly owned subsidiary of The Psychological Corporation. The test service for the NNAAP (National Nurse Aide Assessment Program, formerly known as the NACEP) and the Certification Examination for Practical Nurses in Long-Term Care.

Blueprint
The organizing framework for an examination which includes the percentage of items allocated to various categories.

Board Member
An individual who serves on a board of directors (national level) or a board of nursing (state level).

BOD
Board of Directors of the National Council of State Boards of Nursing. (Authority: general supervision of the affairs of the National Council between meetings of the Delegate Assembly.)

Bylaws
The laws which govern the internal affairs of an organization.

CAC
Citizen Advocacy Center.

CAT
Computerized Adaptive Testing.

CCAP
Continued Competence Accountability Profile. It provides a framework for the licensed nurse to document learning needs, learning plans and goals/objectives, strategies for development and evaluation as to whether or not goals/objectives have been achieved. It is an expected activity of all licensed nurses to reflect lifelong learning activities and application to daily practice. The profile is, in essence, the application of the nursing process to one's own competence and professional development and accountability.

CCNA
Council on Certification of Nurse Anesthetists.

CDC
Case Development Committee. A committee of clinical experts that has the responsibility of developing cases for the Computerized Clinical Simulation Testing (CST®) project.

CEPN-LTC
Certification Examination for Practical Nurses in Long-Term Care.

CGFNS
The Commission on Graduates of Foreign Nursing Schools. (An agency providing credentialing services for foreign-educated nurses, as well as a certification program designed to predict success on the NCLEX-RN® examination.)

Chauncey
See The Chauncey Group International, Ltd.

CLEAR
Council on Licensure, Enforcement and Regulation. (An organization of regulatory boards and agencies, headquartered in Lexington, Kentucky.)

CNATS
Canadian Nurses Association Testing Service.

CNM
Certified Nurse Midwife.

CNS
Clinical Nurse Specialist.

CON
Committee on Nominations. The elected committee of the National Council responsible for preparing a slate of qualified candidates for each year's elections. The Committee on Nominations' members serve one-year terms.

CRNA
Certified Registered Nurse Anesthetist.

CSCC
Candidate Services Call Center. Sylvan's national facility for candidate scheduling and inquiry for all their examinations (formerly National Registration Center or NRC).

CST®
Computerized Clinical Simulation Testing.

Delegate Assembly
The registration body of the National Council which comprises 61 Member Boards. Each Member Board is entitled to two votes. (Authority: provides direction through adoption of the mission, goals and objectives; adoption of position statements and actions.)

Department of Education (DOE)
U.S. Department of Education.

Diagnostic Profile
The document sent to failing candidates reflecting their performance on various aspects of the NCLEX® examination by test plan content area.

DIF
Differential Item Functioning or a measure of potential item bias.

Direct Registration
A method of submitting candidate registrations for the NCLEX examination. Registrations are submitted by candidates, with the $88 fee, directly to The Chauncey Group. The option for telephone registration is available for $97.25.

Disciplinary Data Bank (DDB)
A National Council data management system, established in 1981, that serves as a database of disciplinary actions reported by Member Boards.

EC
Examination Committee.

Education Program Reports
See *NCLEX® Program Reports.*

EDWARD
Electronic Document Warehousing And Retrieval Database. System providing guided electronic access to all available nursing practice acts and administrative rules. Available to Member Boards via NCNET.

EIRs
Electronic Irregularity Reports. Reports written by the test center staff on the day of testing regarding any irregularities occurring during NCLEX examination testing. These reports are forwarded by Sylvan overnight to The Chauncey Group and the National Council. The National Council forwards the EIRs to the Member Board where the candidate is seeking licensure.

Electronic Access
Member Boards' direct inquiry of the National Council Disciplinary Data Bank via NCNET for information regarding disciplinary history of action(s) taken against a nurse's license.

ELVIS
Electronic Licensure Verification Information Service. An NCNET online service to provide licensure information to Member Boards as they make licensure endorsement decisions.

ETS/The Chauncey Group
Educational Testing Service is the parent company of The Chauncey Group. The Chauncey Group is the National Council's test service for the NCLEX examinations. The Chauncey Group is located in Princeton, New Jersey, and is engaged in educational and certification testing services.

Experimental Items
Newly written test questions placed into examinations for the purpose of gathering statistics. Experimental items or "tryouts" are not used in determining the pass/fail result.

FARB
Federation of Associations of Regulatory Boards. FARB provides a forum for individuals and organizations to share information related to professional regulation, particularly in the areas of administration, assessment and law.

Fiscal Year (FY)
October 1 to September 30 at the National Council.

HCFA
Health Care Financing Administration. (A unit of the federal government under the Department of Health and Human Services.)

HIPDB
Healthcare Integrity and Protection Data Bank. A national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements for which no finding of liability have been made) against health care providers, suppliers or practitioners as required by the Health Insurance Portability and Accountability Act of 1996.

HRSA
Health Resources and Services Administration. (A unit of the federal government under the Department of Health and Human Services.)

ICN
International Council of Nurses.

ICONS
The Interagency Conference on Nursing Statistics. Members include the American Association of Colleges of Nursing, American Association of Critical Care Nurses, American Organization of Nurse Executives, American Nurses' Association, Bureau of Labor Statistics, Division of Nursing (HRSA), National Center for Health Statistics, National Council of State Boards of Nursing, National League for Nursing and American Association of Nurse Anesthetists.

Insight
A triannual publication discussing issues related to nurse aides and assistive personnel, delegation to unlicensed assistive personnel and the NACEP.

Interprofessional Workgroup
The Interprofessional Workgroup on Health Professions Regulation is an ad hoc group of national federations of regulatory boards and professional associations related to nursing, pharmacy, medicine, chiropractic, dentistry, nursing home administration, social work, physician assistants, optometry, dietetics, laboratory personnel, audiology and speech-language pathology, physical therapy, occupational therapy and respiratory care. The group, which is facilitated by the National Council, was formed to respond to the recommendations of the Pew Taskforce on Healthcare Workforce Regulation.

Issues
A quarterly newsletter published and nationally distributed by the National Council.

Item
A test question.

Item Response Theory (IRT)
A family of psychometric measurement models based on characteristics of examinees' item responses and item difficulty. Their use enables many measurement benefits (see Rasch Model).

Item Reviewers
Individuals who review newly written items developed for the NCLEX-RN and NCLEX-PN® examinations.

Item Writers
Individuals who write test questions for the NCLEX-RN examination, NCLEX-PN examination and NNAAP examination.

Job Analysis
A research study that examines the practice of newly licensed job incumbents (RNs, LPN/VNs) or new nursing assistants. The results are used to evaluate the validity of the test plans/blueprints that guide content distribution of the licensure examinations or the nurse aide competency evaluation.

JRC
Joint Research Committee. This committee consists of three National Council and three Chauncey or ETS staff members, and two external researchers. The committee is the vehicle through which research is funded for the NCLEX examination program. Funding is provided jointly by the National Council and The Chauncey Group.

KSA
Knowledge, skill and ability statements.

Logit
A unit of measurement used in IRT models. The log transformation of an odds ratio creates an equal interval, logit scale on which item difficulty and person ability may be jointly represented.

MNAR
Model Nursing Administrative Rules. (A publication of the National Council.)

MBOS
Member Board Office System. The software used in many Member Board offices to communicate electronically with The Chauncey Group regarding NCLEX examination candidates.

Member Board
A jurisdiction which is a member of the National Council.

MNPA
Model Nursing Practice Act. (A publication of the National Council.)

MR
Mutual Recognition. Mutual recognition for nursing regulation was adopted by the August 1997 Delegate Assembly, and language for an interstate compact that would facilitate mutual recognition was adopted by a special session of the Delegate Assembly in December 1997.

MSR
Multistate Regulation.

NACEP™
Nurse Aide Competency Evaluation Program. (See also NNAAP.)

NAFTA
North American Free Trade Agreement (Canada, Mexico and the United States). Addresses trade in services and contains requirements and encouragement related to harmonization of qualifications for professional practice in the three countries.

NAPNES
The National Association for Practical Nurse Education and Service.

National Council Organization Plan
Mission, goals and objectives of the National Council as adopted by the Delegate Assembly.

NBME
National Board of Medical Examiners. NBME is the technical consultant for CST.

NCBPNP/N
National Certification Board of Pediatric Nurse Practitioners and Nurses.

NCC
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties.

NCIC
National Crime Information Center. A computerized information system operated by the Federal Bureau of Investigation (FBI) for the purpose of exchanging criminal history information among criminal justice agencies.

NCLEX-RN® Examination
National Council Licensure Examination-Registered Nurse.

NCLEX-PN® Examination
National Council Licensure Examination-Practical Nurse.

NCLEX® Program Reports
Published by The Chauncey Group twice per year, the *NCLEX® Program Reports* provide administrators and faculty in nursing education programs with information about the performance of their graduates on the NCLEX examination. Included in the *NCLEX® Program Reports* is information about a program's performance by the *NCLEX® Test Plan* dimensions and by content areas. Data about a program's rank nationally and within the program's state also are included.

NCLEX® Quarterly Reports
The NCLEX® Quarterly Reports summarize the performance of all first-time candidates educated in a given jurisdiction who were tested in a given quarter, and the national group of candidates. They also provide a summary of the preceding three quarters' passing rates. (Previously known as green sheets.)

NCNET
National Council Network. National Council's electronic network for Member Boards, on which a variety of software services are delivered (e.g., EDWARD, DDB, EIRs, SAVHI, etc.).

NCSBN or NC
Abbreviated forms of National Council of State Boards of Nursing, Inc.

Newsletter
A biweekly publication produced by the National Council and distributed to each Member Board. Items included on a regular basis: committee reports; Board of Directors' major actions and minutes; notice of upcoming events; updates to National Council manuals; solicitations for persons to serve in various capacities; information related to the NCLEX examination; and information related to National Council activities.

NFLPN
National Federation of Licensed Practical Nurses.

NIRS©
Nursing Information Retrieval System. A relational database of tables of nursing and medical information that are linked via a simple coding scheme that permits quick and efficient identification and capture of the numerous relationships which exist within and across the tables. It is designed to expedite CST case and scoring key development, quality assurance and the delivery of a CST examination.

NLN
National League for Nursing.

NNAAP
National Nurse Aide Assessment Program. The new nurse aide certification examination developed by the National Council during FY98 that combines the NACEP and ASI's nurse aide certification programs.

NP
Nurse Practitioner.

NP&E
Nursing Practice and Education. (A standing committee of the National Council.)

NPDB
National Practitioner Data Bank. A federally mandated program for collecting disciplinary data regarding health care practitioners. The NPDB began operation in September 1990, receiving required medical malpractice payment reports for all health care practitioners, and required reports of discipline and clinical privilege/society actions regarding physicians and dentists. Mandatory reporting of licensure actions regarding other health care practitioners, including nurses, is required by section 1921 of the Social Security Act (originally enacted in P.L.100-93, section five). Implementation of other health care practitioner reporting to the NPDB has been on hold. Currently, the Health Resources and Services Administration (HRSA) is planning implementation of section 1921. Draft rules governing reporting are expected to be published in August 1998.

NPI
National Provider Identifier. On May 7, 1998, rules were posted in the *Federal Register* proposing a standard for a national health care provider identifier and requirements for its use by health plans, health care clearinghouses and health care providers. This is planned to be a new, unique eight-character alpha-numeric identifier.

NURSYS
A database being developed by the National Council, containing demographic information on all licensed nurses and an unduplicated count of licensees and serving as a foundation for a variety of services, including the disciplinary data bank, licensure verification, interstate compact functions and research on nurses.

OBRA 1987
Omnibus Budget Reconciliation Act of 1987 (contains requirements for nurse aide training and competency evaluation).

Pew Taskforce on Health Care
The Pew Health Professions Commission charged the Taskforce on Health Care Workforce Regulation to identify and explore how regulation protects the public's health and propose new approaches to health care workforce regulation to better serve the public's interest. The task force was composed of eight individuals with legal, policy and public health expertise. Its recommendations were issued in late 1995.

Psych Corp
The Psychological Corporation (TPC). The Psychological Corporation, a wholly owned subsidiary of Harcourt General Corporation, is the parent corporation of ASI. The NACEP test service who is charged to develop and maintain an evaluation for nurse aide competency as mandated by federal legislation (OBRA 1987). Assessment Systems, Inc., producer of another nurse aide exam, was acquired by TPC in 1995.

Psychometrics
The scientific field concerned with all aspects of educational and psychological measurement (or testing), specifically achievement, aptitude and mastery as measured by testing instruments.

Public Policy
Policy formed by governmental bodies. They include all decisions, rules, actions and procedures established in the public interest.

RAP
Research Advisory Panel.

Rasch Measurement Model
The item response theory model used to create the NCLEX examination measurement scale. Its use allows person-free item calibration and item-free person measurement.

Reliability
A test statistic that indicates the expected consistency of test scores across different administrations or test forms. That is, it assesses the degree to which a test score reflects the person's true standing on the trait being measured. The National Council uses the Kuder-Richardson Formula 20 (KR20) statistic to measure the reliability of the NACEP. For adaptively administered examinations, such as the NCLEX examination using CAT, the decision consistency statistic is the more appropriate statistic for assessing precision (see Decision Consistency).

RFP
Request for Proposals.

SAHVI
Storehouse of Administrative, Historical and Volunteer Information. Database that contains comprehensive National Council historical and volunteer information, as well as mailing list data. Portions of the SAVHI database are available to Member Boards via NCNET.

SKDC
Scoring Key Development Committee. Committee of clinical experts which has the responsibility of developing scoring keys for the CST project.

SSD
Special Services Division. A unit of the National Council that develops services and products, the revenue from which will go to support core programs for Member Boards.

Standard Setting
The process used by the Board of Directors to determine the passing standard for an examination, at or above which examinees pass the examination and below which they fail. This standard denotes the minimum acceptable amount of entry-level nursing knowledge, skills and abilities. The National Council uses multiple data sources to set the standard, including a criterion-referenced statistical procedure and a Survey of Professionals. Standard setting is conducted every three years for each NCLEX examination and whenever the test plan or *NACEP Blueprint* changes.

STC
Sylvan Technology Center.

Submission of Reports
A Member Board, upon taking disciplinary action, submits to the National Council Disciplinary Data Bank biographical data about the nurse and information regarding the grounds for and the disciplinary action taken by the board of nursing.

Sylvan
See Sylvan Technology Centers.

Sylvan Prometric
The computer-based testing division of Sylvan Learning Systems.

Sylvan Learning Systems
The Chauncey Group's business partner for the delivery of computerized tests. More than 400 Sylvan Learning Centers nationwide form the core of SLS' business. SLS is a publicly traded corporation headquartered in Baltimore, Maryland.

Sylvan Technology Centers (STCs)
Sylvan Technology Centers are Sylvan Prometric's high-stakes testing centers responsible for the secure delivery of computerized examinations. There are more than 250 STCs in North America. The NCLEX examinations are administered in more than 200 STCs located in the United States and its territories.

Test Plan
The organizing framework for the NCLEX-RN examination and NCLEX-PN examination which includes the percentage of items allocated to various categories.

Test Service
The organization which provides test services to the National Council, including test scoring and reporting. The Chauncey Group, along with Sylvan Prometric, is the test service for the NCLEX examinations, and ASI is the test service for the NNAAP and CEPN-LTC.

The Chauncey Group International, Ltd., or The Chauncey Group
A wholly owned subsidiary of Educational Testing Service (ETS). National Council's test service for the NCLEX examination, located in Princeton, New Jersey.

TPC
See Psych Corp.

Trilateral Initiative for Nursing
A project coordinated by CGFNS and funded by the W.K. Kellogg Foundation to develop a series of papers addressing the following aspects of nursing in each of the three NAFTA countries (Canada, Mexico and the United States): standards of nursing education, approval and accreditation of nursing education programs, licensure/ registration and standards of practice, and nursing specialty certification.

UAP/ULAP
Unlicensed Assistive Personnel.

Validity
The extent to which inferences made using test scores are appropriate and justified by evidence; an indication that the test is measuring what it purports to measure. The National Council assures the content validity of its examinations by basing each test strictly on the appropriate test plan (NCLEX-RN examination or NCLEX-PN examination) or blueprint (NACEP). Each test plan or blueprint is developed from a current job analysis of entry-level practitioners.

VIP
Volunteer Information Program. A site on National Council's World Wide Web page (http://www.ncsnb.org) that can be accessed by board members and staff of boards of nursing.