<table>
<thead>
<tr>
<th>Session</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session I</td>
<td>Finance Committee Forum</td>
<td>1</td>
</tr>
<tr>
<td>Session II</td>
<td>Examination Committee Forum</td>
<td>7</td>
</tr>
<tr>
<td>Session III</td>
<td>Keynote Address</td>
<td>11</td>
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<tr>
<td>Session IV</td>
<td>Bylaws Committee Forum</td>
<td>39</td>
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<tr>
<td>Session V</td>
<td>Disciplinary Resources Advisory Panel Forum</td>
<td>47</td>
</tr>
<tr>
<td>Session VI</td>
<td>Practice, Regulation &amp; Education (PR&amp;E) Committee Forum</td>
<td>51</td>
</tr>
<tr>
<td>Session VII-A</td>
<td>NPDB-HIPDB Updates</td>
<td>63</td>
</tr>
<tr>
<td>Session VII-B</td>
<td>HIPDB Update</td>
<td>77</td>
</tr>
</tbody>
</table>
Finance Committee Forum

Presented by:
Ruth Ann Terry, MPH, RN
NCSBN Treasurer

Robert Clayborne, MBA, CPA
NCSBN Director, Finance
Finance Committee Report
Presented by: Ruth Ann Terry, Treasurer

Finance Committee Charge
- Financial Policies
- Budget
- Financial Statements
- Audit
- Investments
- Liability Insurance

Finance Strategy

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Planning</td>
<td>- Internal source of funds</td>
</tr>
<tr>
<td></td>
<td>- Financial stability</td>
</tr>
<tr>
<td></td>
<td>- Financial resource allocation aligned with mission</td>
</tr>
<tr>
<td>Investment Management</td>
<td>- Optimum return on investments</td>
</tr>
<tr>
<td>Internal Control Risk</td>
<td>- Asset protection</td>
</tr>
<tr>
<td>Management</td>
<td></td>
</tr>
</tbody>
</table>
**Navigation Planning Targets – Reserve**

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

**Reserve Compared to Operating Expense in $000’s**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Reserve</th>
<th>Operating Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY-06</td>
<td>50,000</td>
<td>60,000</td>
</tr>
<tr>
<td>FY-07</td>
<td>60,000</td>
<td>70,000</td>
</tr>
<tr>
<td>FY-08</td>
<td>70,000</td>
<td>80,000</td>
</tr>
</tbody>
</table>

**Navigation Planning Targets – Stability**

*Financial Stability*
- Annual operating revenues equal or exceed expenses over the long term.
Where it Comes From

- Investments: 5%
- Learning Extension: 2%
- NURSYS: 4%
- Other Revenue: 1%

Where It Goes

- E-Learning: 2%
- Program Services: 13%
- NURSYS: 3%
- NCLEX: 65%
- Technology: 7%
- Admin Services: 2%
- Communications: 3%
- Governance: 2%
- Occupancy: 3%

Financial Planning Targets – Resource Allocation

- Budget aligned with mission and strategic plan
### Session I: Finance Committee Forum

**Mission**

- Strategic Initiatives

**Internal Operations**

<table>
<thead>
<tr>
<th>Functional Areas</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>1,141</td>
<td>30,334</td>
<td>1,443</td>
<td>2,247</td>
<td>2,391</td>
</tr>
<tr>
<td>Finance</td>
<td>295</td>
<td>1,132</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,141</td>
<td>30,334</td>
<td>1,443</td>
<td>2,247</td>
<td>2,391</td>
</tr>
</tbody>
</table>

**External Operations**

<table>
<thead>
<tr>
<th>Functional Areas</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure</td>
<td>1,365</td>
<td>1,312</td>
<td>1,240</td>
<td>1,020</td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>5,939</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,365</td>
<td>1,312</td>
<td>1,240</td>
<td>1,020</td>
<td></td>
</tr>
</tbody>
</table>

**Program Services**


**Finance**

- Beginning Reserve: $68,320
- Cash from Operations: $14 million short-term operating reserve.
- Cash from Investments: $65 million long-term reserve.
- Ending Reserve: $69,200

**Stability**

- Budgeted revenues exceed operating expenses. Focus on operating expense budget that can be supported by primary revenue source over the longer term.
- Operating budget linked to mission with consideration for impact on financial reserves.

**Resource Allocation**

- Policy guides effective investment strategy
- Investment returns equal benchmarks

**Optimum Return on Investments**

- Returns equal long-term goal: 5.1% last 5 years
Return Compared to Price Index and Budget

Return Compared to Benchmarks

Internal Control and Risk Management

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

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

Questions
Examination Committee Forum

Presented by:
Sheila Exstrom, PhD, RN
Nebraska, Area II, Chair
Anne Wendt, PhD, MSN, RN, CAE
NCSBN Director, NCLEX® Examinations
2007 Examination Committee Report
Sheila Exstrom, PhD, RN, Chair
NCSBN Examination Committee

Recommendation to the Delegate Assembly

- Adopt the proposed changes to the 2008 NCLEX-PN® Test Plan

Rationale for Recommendations for the 2008 NCLEX-PN® Test Plan

- 2006 PN Practice Analysis Study
  - Empirical data collected from newly licensed nurses
  - Report of Findings from the 2006 PN Practice Analysis Linking the NCLEX-PN® Examination to Practice (NCSBN, 2007)

- Expert Judgment
  - Examination Committee
  - Practice Analysis Panel of Experts
  - Member Boards
  - NCSBN NCLEX Examinations Staff
  - Pearson VUE Test Development Staff
Proposed 2008 NCLEX-PN® Test Plan

- Current overall format retained
- Minor edits to maintain currency
- “Client Needs” structure retained

Recommendations

- Physiological Integrity
  - Pharmacological Therapies: This subcategory has been retained and the suggested addition of “parenteral therapies” has been removed.

Recommended Revisions

- Coordinated Care – (new bulleted concepts added)
  - Collaboration with Interdisciplinary Team
  - Confidentiality/Information Security
  - Information Technology
  - Performance Improvement (Quality Improvement)
  - Staff Education
Recommended Revisions

- Safety and Infection Control (new bulleted concepts added):
  - Internal and External Disaster Plans
  - Ergonomic Principles
  - Accident/Environment Prevention
  - Restraint and Safety Devices
- Pharmacological Therapies (new bulleted concepts added):
  - Contraindications and Compatibilities
  - Dosage Calculations

Item Allocation Percentages

<table>
<thead>
<tr>
<th>2005 PN Test Plan Categories</th>
<th>Percentage of Items</th>
<th>2008 PN Test Plan Categories</th>
<th>Percentage of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe and Effective Care Environment</td>
<td>11-17%</td>
<td>Safe and Effective Care Environment</td>
<td>12-18%</td>
</tr>
<tr>
<td>- Coordinated Care</td>
<td>8-14%</td>
<td>- Coordinated Care</td>
<td>8-14%</td>
</tr>
<tr>
<td>Health Promotion and Maintenance</td>
<td>7-13%</td>
<td>Health Promotion and Maintenance</td>
<td>7-13%</td>
</tr>
<tr>
<td>Physiological Integrity</td>
<td>8-14%</td>
<td>Physiological Integrity</td>
<td>8-14%</td>
</tr>
<tr>
<td>- Basic Care and Comfort</td>
<td>11-17%</td>
<td>- Basic Care and Comfort</td>
<td>11-17%</td>
</tr>
<tr>
<td>- Pharmacological Therapies</td>
<td>9-15%</td>
<td>- Pharmacological Therapies</td>
<td>9-15%</td>
</tr>
<tr>
<td>- Reducing Risk Potential</td>
<td>10-14%</td>
<td>- Reducing Risk Potential</td>
<td>10-14%</td>
</tr>
<tr>
<td>- Physiological Adaptation</td>
<td>12-18%</td>
<td>- Physiological Adaptation</td>
<td>11-17%</td>
</tr>
</tbody>
</table>

Proposed Timeline for Implementation of 2008 PN Test Plan

- October 2006 – Examination Committee reviews PN practice analysis results and makes recommendations for the test plan.
- November 2006 – Proposed test plan is sent to Member Boards for feedback.
- April 2007 – Examination Committee presents the proposed test plan at the NCSBN Midyear Meeting.
- April 2007 – Examination Committee reviews feedback on the test plan and submits recommendations to the Delegate Assembly.
Proposed Timeline for Implementation of 2008 PN Test Plan

- **August 2007** – Delegate Assembly action is provided.
- **September 2007** – PN test plan is published and placed on the NCSBN Web site.
- **September 2007** – Panel of Judges meets to recommend the passing standard.
- **December 2007** – NCSBN Board of Directors evaluates the passing standard.
- **April 2008** – Implementation of the test plan and passing standard.

Questions
Keynote Address:
Transforming Nursing Practice Through Integrated Information Technology

Presented by:
Bill Felkey, MS
Professor, Auburn University
Transforming Nursing Practice through Integrated Information Technology

Bill G. Felkey
Professor of Pharmacy Care Systems
Auburn University
felkebg@auburn.edu

How do you feel about adopting new Technology?
Session III:
Keynote Address

Getting Rid of the Bubba Link

IPv4 = 4.3 billion 2/3rd used
IPv6 = 3.4 x 10^38
6.5B = 5 x 10^28

Ubiquitous Internet
The Connected Healthcare Community
- RHIO-based
- IT systems are connected via a shared architecture
- Collaborative Care Model
- All providers have access to up-to-date patient information

Unavoidable Technologies
- Electronic Medical Record (EMR)
- CPOE and HIE
- Laptops and PDAs
- Wireless
- Internet-based resources
- Internet reporting of outcomes
- Email with patients and other providers

Migrating from Paper to Electronic Data

"feels like picking everything from a huge menu"
- "feels like filling in a form"
- "feels like typing or dictating"
- "the way I do it now"
There is still a fuzziness about the terms “Electronic Medical Record” and “Electronic Health Record.”

There is still a fuzziness about the terms “Electronic Medical Record” and “Electronic Health Record.”

**e-Health Stages of Maturity**

**TRANSFORM**
Transform the enterprise by seamlessly integrating all process through end-to-end, Web-based interactions with customers and business partners.

**INTEGRATE**
Integrate the automation of numerous transactions in an effort to automate entire business functions.

**TRANSACT**
Deploy robust self-service capabilities and online transactions.

**INTERACT**
Engage the community by providing relevant information and enabling the community to interact with the site and the organization.

**PUBLISH**
Build Web awareness and presence with customers and employees by publishing static information.
"System-ness" Approach

- Health care delivery is an ecosystem of which informatics (the use of computers and other information technology) is a part.
  - The California Senate and Assembly Committees on Health should create regulations for the design, measurement, and control strategies that integrate the components of the system in ways that will bridge the quality chasm to improve safety and quality.

IOM Workshop, Washington, DC, 2006

Health Decision Support

- Represents a range of mechanisms to inform providers, patients, family members, and other caregivers at the time of decision making in relation to health actions.
  - These decisions and actions occur in all health care settings and in all places where individuals, families, and other caregivers make decisions about health management.
  - The California Senate and Assembly Committees on Health should identify essential elements required to achieve availability of decision support in these contexts.
  - The California Senate and Assembly Committees on Health should also describe obstacles to achieving availability of health decision support and propose ways to mitigate these obstacles.

IOM Workshop, Washington, DC, 2006

Workforce Issues

- The introduction of informatics and automation inevitably changes clinical work processes. The California Senate and Assembly Committees on Health should create legislation that promotes:
  - How informatics and automation can relieve burdens on scarce health care providers
  - How individuals and families can safely take on appropriate responsibilities for health management
  - How the Internet can be used safely and appropriately to manage health information
  - How requirements for workforce roles and training will change as the healthcare system evolves, and an evolutionary process for that change occurs

IOM Workshop, Washington, DC, 2006
Interoperability

- What are the needs, gaps and the critical path to reach the goals of system-ness?
- Previous IOM reports focused on three categories: adoption, interoperability, and connectivity:
  - Adoption: practitioner and organization cooperation
  - Interoperability (technical issues)
  - Connectivity (physical networks and rules for moving information)

IOM Workshop, Washington, DC, 2006

Resistance?

“That it will ever come into general use, notwithstanding its value, is extremely doubtful because its beneficial application requires much time and gives a good bit of trouble, both to the patient and to the practitioner because its hue and character are foreign and opposed to all our habits and associations.”

From The London Times in 1834
Commenting on...
the "stethoscope"

Where Do Errors Occur?

Ordering 39%
Transcribing 12%
Preparing 11%
Administering 38%

(Leape LL et al. Systems analysis of adverse drug events. JAMA 1995;274:35-43.)
Error Rates by Dosage Form

<table>
<thead>
<tr>
<th>Dosage Form</th>
<th>Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral solid</td>
<td>1.4%</td>
</tr>
<tr>
<td>Injection</td>
<td>1.9%</td>
</tr>
<tr>
<td>Inhaled</td>
<td>2.8%</td>
</tr>
<tr>
<td>Oral liquid</td>
<td>2.4%</td>
</tr>
<tr>
<td>Oral solution</td>
<td>3.4%</td>
</tr>
<tr>
<td>Oral suppository</td>
<td>3.9%</td>
</tr>
<tr>
<td>Oral liquid</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

No significant difference, \( p = .06 \)

Reality Therapy

Handwriting example

Bates, 2001
Vocera

Integrate Manage Deliver Display

It's the Data Delivery, Not the Device

The Right Information To the Right People At the Right Time & Place In the Right Format

Mobile Patient Data Delivery
Information Technology to Improve Patient Safety

- Electronic medical records (EMR)
- Electronic orders and prescribing: Computerized Physician Order Entry (CPOE)
- Electronic decision-support tools
- Handheld devices (PDAs)
- Barcode and RFID Technology

Patricia L. Hale, Ph.D., M.D. Medical Informatics Subcommittee ACP-ASIM

Literature Review

There is conflicting information on how CPOE affects errors in the transcribing/ordering stage of the medication use process.

- “POE combined with eMAR eliminated all physician and nursing transcription errors.”
- “We found that a widely used CPOE system facilitated 22 types of medication error risks.”
- “We also reported errors that were caused by CPOE, notably errors in potassium chloride ordering, but also other errors.”


Electronic Decision Support Systems

- Information systems that provide the best evidence-based medical knowledge at the time of care

Patricia L. Hale, Ph.D., M.D. Medical Informatics Subcommittee ACP-ASIM
Electronic Decision Support Systems

- Other types of Decision Support Systems are:
  - Algorithms
  - Guidelines
  - Order sets/standing orders
  - Trend monitors
  - Co-sign enforcers

Patricia L. Hale, Ph.D., M.D. Medical Informatics Subcommittee ACP-ASIM

Modify Prescribing Practices

Results - Frequency
Recommendations (Ondansetron)

Week
% of Orders

p value <0.001 at -4 and 4 weeks
(Thach, 2002)

The Digital Peripheral Brain

- Personal Information Management
- Compendia
- Calculators and Converters
- Documentation and Tracking
- Practice Guidelines
- Patient Oriented Utilities and Document Management
- Classification and Coding
- Appraisal
Informatics Skills Inventory

http://pharmacy.auburn.edu/informatics_survey/

Effect of Bar Code System Excl. Wrong Time Errors

Ref: Flynn et al. 2003

RFID Advantages Over Barcode

- The advantage of RFID is that it does not require direct contact or line-of-sight scanning.
- RF signals communicate through many materials including clothing
- RFID can store much more data than a typical barcode.
- Some RFID tags can both transmit and record data.
Patient Self Care Benefit

WorldDoc “Helping you with your Health Decisions”

<table>
<thead>
<tr>
<th>Patient Self Care Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Self Care Benefit</strong></td>
</tr>
<tr>
<td><strong>WorldDoc</strong> “Helping you with your Health Decisions”</td>
</tr>
<tr>
<td><strong>Drive contains searchable pdf file with:</strong></td>
</tr>
<tr>
<td>- An image of the patient for positive identification</td>
</tr>
<tr>
<td>- A digitized copy of the Health Plan ID card</td>
</tr>
<tr>
<td>- Personal Information</td>
</tr>
<tr>
<td>- Medical History</td>
</tr>
<tr>
<td>- Family Medical History</td>
</tr>
<tr>
<td>- Physician providers with contact information</td>
</tr>
<tr>
<td>- Current medication (name, dosage and frequency)</td>
</tr>
</tbody>
</table>

Portable Medical Record

Drive contains searchable pdf file with:

- An image of the patient for positive identification
- A digitized copy of the Health Plan ID card
- Personal Information
- Medical History
- Family Medical History
- Physician providers with contact information
- Current medication (name, dosage and frequency)

Consider Information Therapy Prescriptions (lx)

- Provider Prescribed
- Take 2 URL’S and call me in the morning
- System Prescribed
- Co-producer Prescribed

www.healthwise.org
Well.At.Home

"Reminds patients of their scheduled activities, such as taking medications and physiologic measurements."

"Provides patients with health education tailored to their clinical situation based on orders."

"Collects information from patients about compliance with the orders, their comprehension of the educational information, and their clinical status."

"Contains a system of "clinical alerts" allowing the agency to identify specific events that need to be brought to a clinician’s attention."

Digital scale
Sphygmomanometer
Glucometer
Pulse oximeter
Electrocardiogram
Respiration
Thermometer

CCI

MediMonitor
McDonald's has electronic order verification
...decreases errors and improves service.
Imagine if…

Customer: Cohen, Stu
Age: Over 40
Alert: Big Mac Combo
You've ordered a Big Mac Combo with large fries. Your last cholesterol level was too high.
Downsizing to a medium fry is recommended.

Real-Time Sensors
Next Generation Pacemakers/Defibrillators
"Pacemakers & Defibrillators"
Roadmap evolving towards enhanced wireless transceivers:
- Patient control defibrillation
- Wireless Home Monitoring 24/7 by the Health Care Professional

Next Generation Pacemakers/Defibrillators

Data Base Monitoring Critical Alerts
MDKeeper Continuous Monitoring

- GPRS
- GSM
- No sensors
- Help calling
- Could be a platform for other device control

HIS Challenges

- Can be exceedingly expensive
- Technology seen as “fix” for more fundamental problems
- Suboptimal or poor design
- Response time, downtime, crashes, viruses, and hardware failures
- Deferred improvement, waiting for the new to be developed

HIS Challenges (cont.)

- Losses in clinician time, efficiency and redistribution of tasks
- Poor interconnectivity and integration
- Volatile, vendor-driven marketplace
- Poor marketplace memory of failed implementations
- Underdeveloped mechanism for continuous learning
- CDSS often not standardized, untested, poor signal to noise ratio
HIS Challenges (cont.)

- Can cause errors, and these can be large scale
- Tendency to over-rely on info from computer rather than the patient
- Lack of integration for medication reconciliation across the continuum
- Increasing information overload from sheer volume without reliable filters

Status of Wireless Standards

The Wireless Grid Standards Jungle

Easier to Attack: Growing Security Threats

New & Easier Attack Tools
- AirJack
- WEPRecover
- WiGLE.net

Increasing Sophistication of Attacks

Growing Sophistication

Knowledge Required by Intruder

New & Easier Tools make it very easy to attack the Network
Security (HIPAA)

Multidisciplinary Approach to Care Wireless 5 “Rights”
- Right provider
- Right intervention
- Right facility
- Right patient
- Right time

Case: KM is a 27 YOWF hospitalized for cellulitis due to a leg injury sustained when the steps she was standing on collapsed. C & S results indicate susceptibility to vancomycin. The attending writes for vancomycin per pharmacy.

Regulator Connectivity
- Federal/DEA
- State/NCSBN
- CMS Rules Changes
Session III:
Keynote Address

Telehealth

Information Appliances

Desktop Footprint?
New Additions

On the Other Hand

Biometric Authentication
Semantic Web

Search Engines
Summary

- Medical errors are due to SYSTEM problems.
- Electronic Resources can be useful in decreasing medical errors... but only if they are implemented and used correctly.

Why Should Regulators Keep Up?

- EMRs enabled changes could moderate unsustainable health care cost growth and improve quality
- The market is not working well
- The government is the largest employer and health care payer
- Incentives will be most effective now
  - Opportunity to steer adoption toward standardized, interoperable systems
  - High leverage from pay-for-use incentives
Bill G. Felkey
Professor
Pharmacy Care Systems
Auburn University
felkebg@auburn.edu
http://pharmacy.auburn.edu/pcs/
Bylaws Committee Forum

Presented by:
Charlene Kelly, PhD, RN
Nebraska, Area II, Chair Bylaws Committee
Proposed Revisions to the Bylaws Overview of Conceptual Changes
Bylaws Committee FY07

Associate Members (AM)

- Allow a new category of membership for nursing regulatory bodies from other countries or territories.
- AMs would be approved by the Delegate Assembly.
- AM membership fee would be approved by the Delegate Assembly.
- AMs would not have membership voting rights at Delegate Assembly.
- AMs could serve on all committees except for the NCLEX Examination, Finance, Bylaws and Leadership Succession Committee. Would be able to vote on committees.

Rationale

- Consistent with strategic plan and vision as it relates to globalization of regulatory nursing standards.
- Provides greater diversity of input into regulatory best practices.
- Increases input, involvement, networking and sharing of regulatory information and issues both nationally and internationally.
- Increases the openness of the organization.
Advanced Practice Boards of Nursing (APBON)

- Allow APBON to be Member Boards of NCSBN.
- Membership would be approved by the Delegate Assembly.
- All boards of nursing would retain two votes per Member Board.

Rationale

- Will provide the opportunity for advanced practice boards who are now disenfranchised to have the same input as boards of nursing who currently regulate advanced practice nursing.
- Membership approval will follow the same process by Delegate Assembly as all other Member Boards.
- Currently four states have separate RN and LPN/VN boards; thus four votes per state, which has not been a problem.
- If board proliferation becomes a problem it can be addressed through a bylaw change at that time.

Rationale

- Currently only two states have a separate advanced practice board of nursing that could qualify for membership at this time.
- A state medical board could not be a member unless they had a majority of nurses on their board.
- Membership has the authority to not accept questionable board as a member.
Board of Directors (BOD)

- Increases composition from nine to eleven members.
- Three officers, four Area directors, four directors-at-large
- All positions are two year terms.
- Board positions will be staggered.
- Board member could not serve more than four consecutive years in one position.

Area members will continue to vote for their Area director.
Directors-at-large will be elected by the entire membership.
BOD would approve test service (test plans approved by Delegate Assembly).
Gives the same basis for removal of a board member to both the Delegate Assembly and the Board of Directors.

Rationale:

- Increasing the number of board members increase membership participation and improves continuity, spreads the additional work of the Board regarding committee liaisons and attendance at external meetings.
- Having all terms two years improves continuity and opportunity for participation by members.
- The purpose of Area directors is to guarantee geographical representation on the Board of Directors.
- Area directors legally represent the organization as a whole.
Rationale:

- Approving the test service is a business decision that appropriately resides with the board of directors to "transact the business and affairs" of the organization.
- Deletes specific causes for removal of a board member by the Board of Directors and replaces with language that is more discretionary and better protects the organization. Appeal process in place.

National Council of State Boards of Nursing

- Change title to NCSBN.

Rationale

- Change is consistent with how NCSBN is known externally and reflected in the organizational logo.

Executive Director

- Change title to Chief Executive Officer.

Rationale

- Change is consistent with the common title in nonprofit organizations.
Practical Nurse

- Change all references from practical nurse to practical/vocational nurse.

Rationale
- Consistent with language used across states.

Standing Committees

- Change Examination Committee to NCLEX Examination Committee.
- Designate NCLEX Examination and Finance as the standing committees of the organization.
- Change “provide general oversight” to “advise the board of directors” for the NCLEX Examination Committee.
- Deletes reference to approval of item development panels.

Rationale
- The common practice in nonprofit organizations is to have the least amount of standing committees.
- Standing committees typically are committees whose function and purpose do not change and are essential to the operation of the organization.
- The Examination Committee and the Finance Committee are essential to the operation of the organization.
- The current structure allows for any and all work to be done through the use of special committees.
- Not having status as a standing committee does not mean the work is not important.
Rationale

- The membership should be assured that all necessary work will get done.
- Issues related to practice, education and regulation will be addressed and facilitated through the use of special committees.
- The current work of the PR&E committee is important and will continue through the use of special committees which will allow for increased membership involvement and will provide for supplemental expertise and diversity for each project.
- The increase of emerging practice, regulation and education issues are more than one committee can address in a timely manner.

Rationale

- Increases the use of special committees thereby increasing membership participation.
- Coordination and prevention of duplicative work among committees can be facilitated.
- Approval of item development panels, an operational function, will remain with the NCLEX Examination Committee and staff; not necessary for bylaws; the current Examination Committee is in support of this change.
- Bylaws committee can be convened when needed.
- Resolutions committee can be convened informally for Delegate Assembly as it has been in the past.

Dissolution

- Change voting percentage from 75% to a majority for dissolution.

Rationale

- Majority vote is consistent with current Pennsylvania law whereas 75% is in violation of Pennsylvania law.
Leadership Succession Committee

Leadership Succession Committee replaces the Committee on Nominations.

Composed of eight members all elected by the Delegate Assembly.

The chair will be appointed by the Board of Directors from the elected members of the committee.

Four positions designated: one past Board of Director member, one current or former committee chair, a board member of a Member Board and an employee of a Member Board.

Four positions will represent each of the four geographic areas.

Leadership Succession Committee

Term is two years. May serve two terms.

Terms will be staggered.

Charge is:
- Recommend strategies for the ongoing sustainability and advancement of the organization through leadership succession planning.
- Present a slate of candidates through a determination of qualifications and geographic distribution for inclusion on a ballot for the election of the Board of Directors and the Leadership Succession Committee.

Rationale

Provides structure within the organization to ensure leadership development and succession.

Organizational leadership is a strategic process.

Organizational leaders are developed through careful planning, cultivation, orientation, education and involvement.

Organizational leadership builds upon the diversity and expertise of the membership.

Continues to allow for nominations from the floor.
Disciplinary Resources Advisory Panel
Forum – Pain Management

Presented by:
Sandra Evans, MAEd, RN
Idaho, Area I, Chair

Vickie Sheets, JD, RN, CAE
NCSBN Director, Practice and Regulation
Disciplinary Resources Advisory Panel Forum

2007 DRAP Charge

- Advise NCSBN staff regarding the content of a 2007 Investigator-Attorney Workshop.
- Complete a pain management statement that addresses the regulatory management of nurses being treated for pain or pain and chemical dependency as well as the accepted standards of pain management.
- Complete a feasibility study for an investigator certification program.

Why Pain Management?

Pain is a universal experience that has implications for board decision making.

- Licensing requirements
- Ongoing competence issues
- Discipline issues
Pain Management and Regulation

- 2007: Develop general statement
  - Identify regulatory issues
  - Concise
  - Identify board of nursing role

- 2008: Complete detailed resources
  - Separate resource for each issue
  - Includes model policies and guidelines and background material

Regulatory Issues Identified

- Regulatory implications of nurse administered pain management
- Regulatory implications of APRN’s and pain management
- Regulatory implications when a nurse may be unsafe to practice due to pain and/or treatments of pain
- Regulatory implications when a chemically dependent nurse is treated for pain

Questions & Discussion

- Have we identified the right issues?
- Have we identified the appropriate board role?
- When does pain affect a nurse’s ability to practice nursing safely?
- How does regulation impact the patient who is receiving pain therapy?
- Should NCSBN approach other professional regulatory association regarding joint papers and/or projects?
Questions & Discussion

- What are the challenges your board faces in implementing its disciplinary role?
- What would help?
- What kinds of resources are most needed to support your board’s discipline activities?
- What kinds of topics?
- Should we be using more Webcasts and other technology for outreach?

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Practice, Regulation & Education (PR&E) Committee Forum – 2005
Medication Assistant Delegate Assembly Resolution

Presented by:
Brenda Jackson, PhD, MSN, RN
Texas, Area III, Chair
Nancy Spector, PhD, RN
NCSBN Director, Education
2005 Delegate Assembly Resolution:

"Resolved that NCSBN conduct a job analysis, develop a model medication administration curriculum, and conduct a feasibility study for administering a competency examination for medication assistive personnel. The results of the job analysis, course and feasibility study shall be reported to the 2006 Delegate Assembly."

At 2006 Delegate Assembly:

- Progress on job analysis and feasibility study was presented.
- Medication assistant-certified (MA-C) curriculum was presented and comments were taken back to PR&E.
Report of Findings from the 2006 Job Analysis of Medication Assistants

Practice Regulation and Education Committee (PR&E)
- Provided direction for the survey.
- Reviewed and recommended edits to activity statements and survey form.
- Recommended survey instrument pilot tested.
- Survey conducted in April/May 2006.
- Results reported to PR&E in September 2006.

Subject Matter Experts (14)
- Used summary of MA daily activity logs.
- Used activity statements from other job analyses, job descriptions, orientations, policies and procedures, and a draft of NCSBN's Medication Assistant Certified Curriculum.
- Developed a category structure.
- Created a list of activity statements performed by MAs.
Employment Settings Sampled

- Long-term care facilities (56%)
- Assisted living facilities (32.5%)
- Rehabilitation facility (11.1%)
- Developmental disabilities facility (8.8%)
- Residential facility (8.2%)
- Home health (7.4%)
- Psychiatric or mental health facility (6.4%)

Employment Settings Sampled

- Hospice (5.7%)
- Group home (5.4%)
- Hospital (3.0%)
- Community-based or ambulatory care (2.9%)
- Correctional facility (2.6%)
- School (2.6%)
- Daycare (adult or child) (1.6%)
- Other (4.9%)

Results

- N = 7,000 (mailed)
- N = 1,433 (returned)
- N = 1,288 (analyzable)
- Analyzable Response Rate = 22.5%
MA Demographics
- Gender = 91.9% Female
- Average age = 43 years
- Ethnicity:
  - 64.6% White/non-Hispanic
  - 20.4% African American
  - 6.9% Hispanic
- Years of Experience:
  - 20.8% 1 year or less
  - 38.1% 2 to 5 years
  - 12.2% more than 15 years

MA Preparation
- 49.8% received training from their employer.
- 89.4% were required to complete specific medication assistant training.
- The majority had 60 hours or less of classroom training and 40 hours or less of clinical training.
- 77.1% said that being a certified nursing aide/assistant was an additional prerequisite to become an MA.
- 67.6% said a high school diploma/GED was required.

MA Work Setting
- The majority of respondents:
  - Worked in long-term care facilities (56.1%)
  - Worked 8 hours per shift (53.6%)
  - Worked an average 28.89 hours each week
  - Cared for clients aged 65 to 85 years (77.8%)
  - Cared for clients with behavioral/emotional conditions (66.9%), stable chronic conditions (59.9%) and those at the “end of life” (52.0%)
  - Administered medication to an average of 28 clients per shift.
Activity Statements

- Total of 104 activity statements
- Reliability estimate of 0.98 for the survey instrument
- 79.5% of respondents thought the activities were representative of their practice

Applicability of Activity to Practice Setting

- Activities performed by the fewest respondents were:
  - “Administer medications by nasogastric (NG) tube” (89.10% not performed)
  - “Mix insulin from two different vials for client” (88.08% not performed)
- Activities performed by the most respondents were:
  - “Maintain infection control procedures (e.g., hand washing, standard/universal precautions, personal protective equipment [PPE])” (1.50% not performed)
  - “Maintain clean work environment” (1.43% not performed)

Frequency of Activity Performance

- Activities that received the lowest total group mean frequency ratings were:
  - “Perform Cardiopulmonary Resuscitation (CPR)” (0.3)
  - “Initiate emergency care for a client who is choking” (0.5)
- Activities that received the highest total group mean frequency ratings were:
  - “Use six ‘rights’ when administering medications (right drug, right dose, right client, right time, right route, right documentation)” (3.78)
  - “Maintain infection control procedures (e.g., hand washing, standard/universal precautions, personal protective equipment [PPE])” (3.87)
Importance of Activity Performance

Activities with the lowest importance rating were:
- “Participate in performance improvement/quality assurance activity (e.g., collecting data, serving on performance improvement committee)” (2.96)
- “Use restraints according to agency policy” (2.97)

Activities with the highest importance rating were:
- “Maintain infection control procedures (e.g., hand washing, standard/universal precautions, personal protective equipment [PPE])” (3.94)
- “Use six ‘rights’ when administering medications (right drug, right dose, right client, right time, right route, right documentation)” (3.96)

Subgroup Analyses

Years of Experience:
- The mean importance ratings were similar across years of experience.

Work Setting:
- The mean importance ratings for most of the activity statements were similar for the various work settings.

NCSBN Geographic Area:
- The mean importance ratings for the activity statements were consistent based on NCSBN’s four geographic Areas.

Conclusion

A nonexperimental, descriptive study was conducted to explore the importance and frequency of activities performed by medication assistants. Results of this study can be used to determine medication assistant practice across various work settings.
Model Medication Assistant-Certified (MA-C) Curriculum

Purpose:
Provide boards with literature-based curriculum for medication assistants that will assist boards in their mission of protecting the public.

Curriculum will allow for uniformity in education of MA-C across boards and other agencies that regulate this role.

Goal:
Provide document reflective of what is occurring in practice where MA-Cs are being utilized.

Overview

Licensed nurse is responsible for:

- Understanding delegation
- Supervision
- Assessment of clients
- Judgment
- Conversion/Calculations
- Medications through selected routes
MA-C Requirements

- Educated as CNA
- Graduate of high school or GED
- Able to read, write and speak English
- Basic math skills
- 18 years or older
- Successfully passing 80 hours of didactic and 40 hours of supervised clinical exams
- CPR certification

Curriculum includes:

- Definitions
- Modules
  - Objectives
  - Content outline
  - Evaluation criteria
  - Suggested references
- Quick reference for major content areas

Five Modules include:

- Medication Fundamentals
- Safety
- Communication and Documentation
- Medication Administration
- Ethical and Legal
Changes Since 2006 Delegate Assembly

- Hours designated, though can be adjusted for your state
- Added definitions
- Additional references
- Evaluation criteria more detailed

Changes Since 2006 Delegate Assembly

- Added a quick reference to the medication assistant curriculum for the instructors to use.
Changes Since 2006 Delegate Assembly

- Added a visual model to describe the nurse's role for working with the MA-C.

Nurse's Role in Medication Administration

Staff are currently in the process of exploring strategic options to develop or acquire a medication assistant testing program. As part of this process the feasibility of the examination program is being considered.
NPDB-HIPDB Updates

Presented by:
Shari Campbell, DPM, MSHS, LCDR, USPHS, Practitioner Data Banks Branch, Bureau of Health Professions, Health Resources and Services Administration
Overview

- NPDB - HIPDB Background
- Data
- Compliance Activities
- System Updates
- New Initiatives

NPDB - HIPDB

Background
NPDB-HIPDB Purpose

- The intent is to protect the public, improve the quality of health care and deter fraud and abuse in the health care system by providing information about past adverse actions of practitioners, providers, or suppliers to authorized health care entities and agencies.

Who reports to the NPDB-HIPDB?

NPDB
- Medical Malpractice Insurers
- State Medical and Dental Licensing Authorities
- Hospitals and other Health Care Entities
- Professional Societies with formal peer review
- Self-Insured Organizations
- Drug Enforcement Agency (DEA)
- HHS Office of Inspector General

HIPDB
- Federal and State Government Agencies
- Health Plans

Who queries the NPDB-HIPDB?

NPDB
- Hospitals and other Health Care Entities
- State Medical and Dental Licensing Authorities
- Professional Societies with formal peer review
- Practitioners (self-query only)
- Researchers (non-identifiable statistical information)

HIPDB
- Federal and State Government Agencies
- Health Plans
- Practitioners, Providers and Suppliers (self-query only)
- Researchers (non-identifiable statistical information)
What is reportable to the NPDB-HIPDB?

**NPDB**
- Medical Malpractice Payments
- Adverse Actions (physicians and dentists)
- License
- Clinical Privileges*
- Professional Society Membership*
- Medicare and Medicaid Exclusions (all practitioners)
- DEA Actions (all practitioners)

**HIPDB**
- Licensure Actions
- Medicare and Medicaid Exclusions and other exclusions from Federal or State Health Care Programs
- Health Care Related Criminal Convictions, or Civil Judgments
- Other Adjudicated Actions or Contract Terminations

*other practitioners may be reported

What is in the HIPDB?

**Practitioner Reports**

- State Licensure 101,313
- State & Fed Exclusions 6,617
- Judgments or Convictions 13,600
- DEA Actions 2,393
- Health Plan 1,503
- SIA 465

Cumulative Data as of 12/31/06
What is in the HIPDB?

**Organizations**

- State Licensure: 10.8%
- Data & Fed Exclusions: 2.2%
- Judgments or Convictions: 0.8%
- Gov't Admin: 4.8%
- Health Plan: 1.5%
- DEA: 0.1%

Cumulative Data as of 12/31/06

Who queries the HIPDB?

- Self-Queries: 5.7%
- Gov't Hospitals: 15.6%
- Health Plans: 64%
- Government Health Prog: 1.2%
- State Boards: 8%
- Other Service Providers: 5%

2006 Data

Types of Reports on Nurses (Professional and Para-professional)

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<th>2006</th>
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<td>Health Plan</td>
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<td>TOTALS</td>
<td>16791</td>
<td>19166</td>
<td>4680</td>
<td>40639</td>
</tr>
</tbody>
</table>

Note: Professional Nurses include: RN, NP, all clinical specialists
Para-professional Nurses include: LPN, CNA, NA
Types of Reports on Nurses
(Professional and Para-professional)

Note: Professional Nurses include: RN, NP, all clinical specialists
Para-professional Nurses include: LPN, CNA, NA

Nurse Licensure Actions

Nurse Exclusion Actions
Compliance Activities

- Convey the importance of timely reporting
  - Holding Policy Forums and talking with leadership of composite State licensing boards
  - Presenting to Associations/Federations of State licensing boards
  - Presenting to State Association Medical Staff Services

- Regulations
  - NPDB: Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended and its implementing regulations (45 CFR Part 60)
  - HIPDB: Section 1128E of the Social Security Act as added by Section 221(A) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 CFR Part 61)

Compliance Activities

- Monitor Timely Reporting
  - Compare actions documented on State Licensing Board web sites to actions reported to the NPDB and/or HIPDB
  - Identify and contact States that have not reported any actions to the NPDB and/or HIPDB

- Review reports that are filed and later voided

- Review a limited number of report narratives to determine if they are legally sufficient:
  - Must include enough information so that future queriers knowing nothing about the events giving rise to the report will have an understanding of what the subject practitioner is alleged to have done, the nature of the action taken and the reasons for the report

Compliance Activities

- Compare NPDB payment reports to the NAIC summary payment reports (Supplement A to Schedule T)
- Review Medical Malpractice Payment Reports that mention High-Low agreements in the narrative to determine if the payment was made for the benefit of the:
  - Practitioner (reportable)
  - Insurer to avoid the risk of a higher payment when the finder of fact ultimately determines that the practitioner had no liability (not reportable)
- These reporters are asked to void the report

- Monitor the eligibility of Data Bank Registrants
- Monitor for violation of Confidentiality Rules
NPDB - HIPDB

System Updates

August 17, 2007 System Release
- Addition of new codes that will allow reporting of multi-state privilege actions related to Nurses Licensure Compact Agreement.
- All State Boards of Nursing received a letter explaining the process for reporting multi-state privilege actions in June 2007.

Recent System Updates
- Ability to correct a Revision-to-Action Report (IQRS and ITP)
- Increase all Report Narratives and Subject Statements to 4,000 Characters
  - Display most recent Entity Information
    - Section A will be expanded to include the most recent reporter name and address if it has changed since the submission date
  - Addition of another option to Automatic Reinstatement Data Element (IQRS and ITP)
  - Currently, an entity can select only “yes” or “no” in response to whether a reinstatement is automatic at completion of the adverse action period
    - Add a third response option:
      - Yes
      - Yes, with conditions (requires a Revision to Action Report when status changes)
      - No
Recent System Updates

- Limit Registration Renewal Grace Periods
  - There will be a limit of three months or four (4) grace renewals, whichever is longer, in which the entity is permitted access to the system without actually renewing.
  - Once the limit is passed, the system will permit the user to renew only. There will not be a grace period provided to use the system while the renewal is mailed and processed.

- Grace Period For Expired Entity Registrations
  - The system considers an entity to be “inactive” once their registration expires. Report change notifications are not sent to inactive entities.
  - To prevent an entity with an expired registration from missing report change notifications, a 90 day grace period will be established.

NPDB - HIPDB

New Initiatives

- Proactive Disclosure Service (PDS)
- Section 1921: expansion of the NPDB

Proactive Disclosure Service (PDS)

- The intent of PDS is to protect the public and improve the quality of health care by providing information to entities as soon as it is received by the Data Banks.
  - Average querier receives a new Data Bank report in 302 days.
  - Opened as a Prototype on May 1, 2007
    - Prototype status expected to last 18 months for evaluation purposes.
The Current Query Process

- Hospitals, other health care entities, including MCOs, State and Federal agencies query the Data Bank by requesting information on a routine schedule.
- A seamless, secure internet system permits a user to query one or both Data Banks.
- Users query in preparation for reappointment or during the re-credentialing process (typically every 2 or 3 years).
- The query fee is $4.75 per name, per Data Bank.

The PDS Process

- A subscription service that notifies the subscriber of new information on any of their enrolled practitioners within one business day of Data Banks receipt of the information.
- Notification is sent via email; the entity must log in to retrieve the information.
- Offered as an alternative to and not a replacement of the current querying method.
- Report format, information and data reported to the Data Banks will not change.
- Can use PDS for NPDB, HIPDB or both.
- Annual subscription fee is $3.25 per enrollee, per Data Bank.

PDS Enrollment

- When a practitioner is first enrolled in the PDS, the enrollment confirmation will include all reports on the practitioner to ensure the entity is aware of all existing reports in the Data Banks.
  - This is included in the price of PDS
PDS Characteristics

- Notification of a new or updated Data Bank Report:
  - Within one business day
  - Via e-mail (without subject identifying information)
- Data Bank report availability:
  - Report disclosures will be available on the IQRS for 45 days in PDF format
  - All reports in the Data Bank(s) for each enrolled practitioner will be available upon demand

PDS Characteristics

- Subscribing to the service:
  - A 12-month subscription period for each enrollee (practitioner)
  - The subscription expires on the last day of the same month of the following year
    - i.e., all practitioners enrolled in May 2007 regardless of the exact date of enrollment will have a subscription expiration date of May 31, 2008

Section 1921

- A provision of the Social Security Act as amended by Section 5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987, as amended by the Omnibus Budget Reconciliation Act of 1990.
- Enacted to provide protection to program beneficiaries from questionable health care practitioners and to improve the anti-fraud provisions of Medicare and Medicaid.
Section 1921

Notice of Proposed Rule Making
- Published in the Federal Register March 21, 2006
- Projected to be Final in the Fall of 2007
- Expands the NPDB

Major reports Added by Section 1921
- Adverse actions or findings by private accrediting organizations
- Adverse licensure actions taken against all health care practitioners
  - Broader than issues related to professional competence and conduct
  - Adds the same type of licensure actions currently reported to the HIPDB

Section 1921

Access
- Entities that are currently allowed to query the NPDB will have access to Section 1921 reports
- Entities given access to the NPDB through Section 1921 will be allowed to query ONLY for Section 1921 reports

Access with Section 1921

NPDB & Section 1921
- Hospitals and other Health Care Entities
- State Medical and Dental Licensing Authorities
- Professional Societies with formal peer review
- Practitioners (self-query only)
- Researchers (non-identifiable statistical information)

Section 1921 Only
- State Medicaid Fraud Control Units
- Agencies administering Federal and State Health Care Programs
- U.S. Comptroller General
- U.S. Attorney General and other law enforcement officials
Reference Information

- Web Site - www.npdb-hipdb.hrsa.gov
- NPDB and HIPDB Guidebooks
- Interactive Training
- Brochures and Fact Sheets
- Statistics
- Annual Reports
- Instructions for Reporting and Querying
- Customer Service Center - 1-800-767-6732
  (1-800-SOS-NPDB)

Contact Information

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scampbell@hrsa.gov
Healthcare Integrity and Protection Data Bank (HIPDB)

Presented by:
Vickie Sheets, JD, RN, CAE
NCSBN Director, Practice and Regulation
Transition to HIPDB Codes

- NCSBN provided eight HIPDB Update Webinars for Member Board entry staff and supervisors.
- NCSBN provided two conference calls focusing on HIPDB policy issues for executive officers and board attorneys.
- Conversion implemented June 18, 2007.

NCSBN Resources

- NCSBN Web site: www.ncsbn.org
  - HIPDB Resource Pack
  - HIPDB Update Webinar PowerPoint
  - Code Transition Worksheets
  - Privilege Action Worksheet
  - Updated Resource Packet
NCSBN Resources

- NCSBN Staff Resources
  - Vickie Sheets
  - Policy Issues
    312-526-3631 | vsheets@ncsbn.org
  - Nursys Administrator
    nursysadmin@ncsbn.org
- Additional Webinars are available upon request by a Member Board.

HIPDB Resources

- NPDB-HIPDB
  - www.npdb-hipdb.gov
- NPDB-HIPDB Handbook
  - Tutorials
  - "What's New"
  - Federal statutes and rules
  - FAQ and other written materials
- NPDB-HIPDB Help Desk
  - 1.800.767.6732