

## **National Council of State Boards of Nursing (NCSBN) Updates**

### **Summary:**

The following information from the NCSBN website highlights new products and decisions of NCSBN. Also included is the 2010 Environmental Scan by NCSBN. This is provided for your information.

In addition, this item will provide Board members and staff an opportunity to update the Board regarding activities of the NCSBN committees on which they serve.

### **New Products and Services:**

- *Consumer Education Initiative*

The National Council of State Boards of Nursing (NCSBN) has launched a new educational campaign that explains the work of boards of nursing to consumers. It includes a link to a commercial produced by NCSBN and aired nationally.

<https://www.ncsbn.org/2314.htm>

- *Information for Consumers can be found on a new Consumer Page*

<https://www.ncsbn.org/2055.htm>

- *NCSBN Embarks on Landmark Multi-Site Simulation Study to Examine the Use of Simulation in Nursing Education*

“The NCSBN is conducting a landmark, national, multi-site, longitudinal study of simulation use in prelicensure nursing programs throughout the country. Collaborating with learning institutions across the U.S., the NCSBN is embarking on a new research initiative exploring the role and outcomes of simulation in pre-licensure clinical nursing education. The study will begin Fall 2011.”

<https://www.ncsbn.org/2094.htm>

- *The NCSBN Board of Directors voted to raise the passing standard for the NCLEX-PN Examination at its meeting on Dec. 8, 2010*

NCSBN Board of Directors voted on Dec. 8, 2010, to raise the passing standard for the NCLEX-PN Examination. The new passing standard is -0.27 logits on the NCLEX-PN logistic scale. The new passing standard will take effect on April 1, 2011, with the *2011 NCLEX-PN Test Plan*.

<https://www.ncsbn.org/2365.htm>

- *Innovations in Nursing Education*

NCSBN has adopted model rules for supporting innovation in nursing education. A toolkit is provided with links to the model rules. Included are myths and realities about regulatory barriers and recommendations for Boards of Nursing.

<https://www.ncsbn.org/1927.htm>

- *Transition to Practice*

Background on this study was provided at the October 2010 Board Meeting. At that meeting the Board approved agency application to participate in the study, however, we were unable to enlist a sufficient number of hospitals to volunteer. Information about the study can be found at this link.

<https://www.ncsbn.org/363.htm>

- *Environmental Scan*

This report provides an overview of the current and emerging issues facing boards of nursing and depicts present trends in the regulatory environment. This report is designed to help Boards prepare for future changes. **(See Attachment A).**

**Recommendation:**

No action required.

Environmental  
Scan

2010

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**Annual review of emerging issues and  
trends that impact nursing regulation**

National  
Council of  
State Boards  
of Nursing

## **The 2010 NCSBN Environmental Scan**

### **Introduction**

This report provides an overview of the current and emerging issues facing boards of nursing and depicts present trends in the regulatory environment. While this report appears to be a synopsis of the past year, the purpose of an environmental scan is to assist with future planning. By understanding the current social, political and financial influences in the macroenvironment, NCSBN, as well as boards of nursing can better make decisions regarding the future of the organization. Challenges can be anticipated and decisions can be proactive instead of reactive.

This report serves to impart new knowledge and communicate the “state” of the boards of nursing across the United States. It also provides information from Associate Members in Canada. The report cites current statistics, describes workforce trends, summarizes major government reports and federal and state legislation, and provides data that can be used to address a variety of regulatory issues. It is divided into categories that represent the regulatory environment.

The report provides the most up to date and accurate information available in each of the environmental categories. It should be noted, that some statistics, while published in 2010, reflect data collected in 2008 or 2009, depending on the source. These data were the outcomes of major studies and their importance and ability to influence the future of nursing warranted their inclusion.

Data concerning boards of nursing were taken from *Annual State Reports* collected by NCSBN, meeting minutes, web surveys, informal conversations and other methods. Numbers of boards cited throughout the report are estimates and names of state boards affected by an issue or participating in an initiative are not inclusive since the data contained herein is taken from a variety of sources and boards differed on the type of information they supplied on annual state reports and other documents. While some variances exist, the information provided affords an overview of important events, issues and trends facing regulators as the second decade of the 21<sup>st</sup> Century begins.

It is hoped that this environmental scan will provide NCSBN and state boards of nursing with new knowledge and new insight on which to base decisions for the future of NCSBN and nursing regulation.

## THE NURSING WORKFORCE

This report begins with a profile of the national nursing workforce to give a current picture of the number and characteristics of the nurses being regulated by boards of nursing. This information was taken from the newly released *National Sample Survey of Registered Nurses* performed every four years by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). These data were collected in 2008, but published in 2010. While there are several sources that provide these types of data, this is a well-recognized survey and most likely to be quoted and used in the next few years by both government, professional organizations and non-profit agencies, therefore, regulators are being supplied with some of the most important statistics from this resource.

*Figure 1*

<b>The National Workforce Statistics (2004 and 2008)</b>		
<i>(From the newly released 2008 National Sample Survey of Registered Nurses)</i>		
	<b>2004</b>	<b>2009</b>
Total number of RNs	2,909,357	3,063,162
Total employed* RNs	2,442,593	2,596,399
Total employed RNs per 100,000 population*	825	854

\*The number of employed RNs per 100,000 population is a ratio used to determine the rate of growth of the U.S. RN workforce. The lowest numbers of employed RNs per 100,000 population were in Utah (598), Nevada (618), and California (638), while the largest numbers were in the District of Columbia (1,868), South Dakota (1,333), and North Dakota (1,273) (The U.S. Department of Health and Human Services Health Resources and Services Administration, 2010).

### National Profile of Nurses

- Estimated number of licensed RNs in the U.S.: 3,063,162
- Estimated number of RNs employed in the U.S.: 2,596,399 (84.3%). The total number has risen by 153, 806 RNs since 2004. This is an increase of 5.3%.
- Number of registered nurses receiving initial licensure from 2004-2008: 444,668.
- Number of registered nurses allowing their licenses to lapse from 2004-2008: 291,000.
- Number of internationally educated nurses (IENs) in the U.S.: 165,539 (This number represents 5.4 % of all licensed RNs in the U.S.).
- Number of IENs employed in 2008: 146,097 (5.6% of U.S. nursing workforce). Nurses from the Philippines continue to comprise just over 50 percent of all IENs. Canada (12%) and India (9.6%) are next in terms of highest numbers contributing to the U.S. workforce.

- Number of registered nurses estimated to reside in compact states: 824,662.
- Percentage of compact state RNs that work and reside in the same state: 96%.
- Percentage of compact state RNs that work in a compact state that is not their home state: 1.6%.
- Percentage of RNs that have a compact license and work in a non-compact state: 2.4%.  
(The U.S. Department of Health and Human Services Health Resources and Services Administration , 2010)

**Figure 2 The Compact State Workforce**

Licensure in a Compact State	Number	Percent
Live and work in same Compact State	791,444	96.0
Live in one Compact State and work in another Compact State	13,537	1.6
Live in a Compact State and work in non-Compact State	19,681	2.4
Total	824,662	100.0

(Table taken from: The U.S. Department of Health and Human Services Health Resources and Services Administration, 2010)

**Additional Statistics about the Nursing Workforce**

- Median age of RNs: 46 years (2004: 46 years).
- Percentage of RNs under age 30: 10.6%.
- Percentage of RNs who belong to an ethnic minority group: 16.8% (2004: 12.2%).
- Percentage of male RNs since the year 2000: 9.6% (prior to 2000: 6.2%).
- Most common employment setting for RNs: Hospitals.
- Percentage of RNs employed as a staff nurse: 66.3%.
- Percentage of RNs with a graduate degree who work as a staff nurse: 20%.
- Percentage of RNs who work at least 40 hours per week: Over 30%.
- Percentage of RNs who work paid overtime of at least 7.5 hours per week: 27.5%.

(U.S. Department of Health and Human Services Health Resources and Services Administration, 2010)

**Trends Shaping the Composition of the Workforce in 2010: Age and Diversity**

Expansion of the nursing workforce continues with estimates of 3.1 million RNs in the U.S. According to HRSA, more nurses were employed in 2008 than any other year since 1980. For the first time in decades, the average age of RNs has not increased. One factor contributing to this is the increased number of younger RNs -under age 30 joining the workforce. The profession continues to diversify in terms of minorities and males. Hospitals continue to be the most common employment setting for RNs ( U.S. Department of Health and Human Services Health Resources and Services Administration, 2010).

The fact that there are several sources of nursing workforce data and none of them can provide the exact count of nurses across the U.S. enforces the need for boards of nursing to collect workforce data and have a central repository for access by regulators as well as other agencies and the public.

### **Workforce Issues: Boards of Nursing**

The following are state workforce trends reported by boards of nursing for 2010:

- Increase in the number of licensees both by examination and endorsement
- Shortage of positions for new graduates
- Hospitals in the District of Columbia are hiring nursing assistants in lieu of LPNs

### **Other Issues Related to Workforce**

In late December of 2009, three of the largest nursing unions in the United States, the National Nurses United (NNU), California Nurses Association (CNA) and United American Nurses, merged to form the largest medical professionals union in the country (Robert Wood Johnson Foundation, 2009).

NCSBN's national employer survey of professional and practice issues (2009-2010) revealed fewer vacancies for RN positions, but an increase in overtime use by hospitals (Budden, 2010).

### **Workforce Initiatives**

*The Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the IOM*

This initiative, begun in July of 2009, consisted of a task force and research team that developed a set of comprehensive recommendations, Included are ones that address the *nursing* shortage and the capacity of nursing education programs (RWJF, 2009). The Task force consisted of 14 experts from various disciplines and industries. Based on expert opinion, input from Town Hall Meetings and a major research initiative, the outcome of this is four key messages:

1. *Nurses should practice to the full extent of their education and training.*
2. *Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.*
3. *Nurses should be full partners with physicians and other health care professionals in redesigning health care in the United States.*
4. *Effective workforce planning and policy-making require better data collection and an improved information infrastructure.*
5. *Encourage life-long learning* (IOM and Robert Wood Johnson Foundation, 2010, p. S-3).

Specific Aspects of the report that relate to regulation:

1. The report recommends the elimination of regulatory barriers particularly related to scope of practice. The report specifically states that scope of practice regulation should be aligned with the Consensus Report for APRN Regulation
2. Boards of nursing and others such as the federal government and health care organizations should support transition to practice programs
3. Innovative strategies for nursing education
4. Collection of workforce data

5. Need for life-long nursing in throughout the profession

## **Legislation Related to Workforce**

### *Federal legislation*

The most significant legislation to emerge out of the 111<sup>th</sup> Congress is the *Patient Protection and Affordable Care Act (The Affordable Care Act)*. This legislation reforms health care in the U.S. and promises to insure an additional 30 million Americans. This will place a significant burden on the current workforce across all the health professions. Offsetting this are a number of grants that focus on nursing education and expansion of the nursing workforce

The Affordable Care Act contains \$159.1 million in grants to be distributed in health care workforce training programs. The purpose of these grants is to strengthen and expand the U.S. primary care workforce. This includes the following grants:

- Nursing Workforce Development programs will receive \$106 million in grants to support all levels of nursing education (see nursing education legislation for further information).
- Nurse Education, Practice, Quality and Retention (\$29.9 million) this grant supports 108 infrastructure grants that will increase the nursing pipeline, encourage career mobility, prepare an increased number of nurses at the baccalaureate level, and provide continuing education training to improve the quality of patient care.

(United States Department of Health and Human Services Agency for Health Resources and Services Administration, 2010)

(For a complete list of all provisions related to nursing in the *Affordable Care Act* see the AARP Center to Champion Nursing Website.

[http://assets.aarp.org/www.aarp.org/\\_cs/health/nursingandhealthreformtable.pdf](http://assets.aarp.org/www.aarp.org/_cs/health/nursingandhealthreformtable.pdf) )

### *State legislation*

Alaska passed legislation that would limit mandatory overtime for nurses.

## **NURSING EDUCATION**

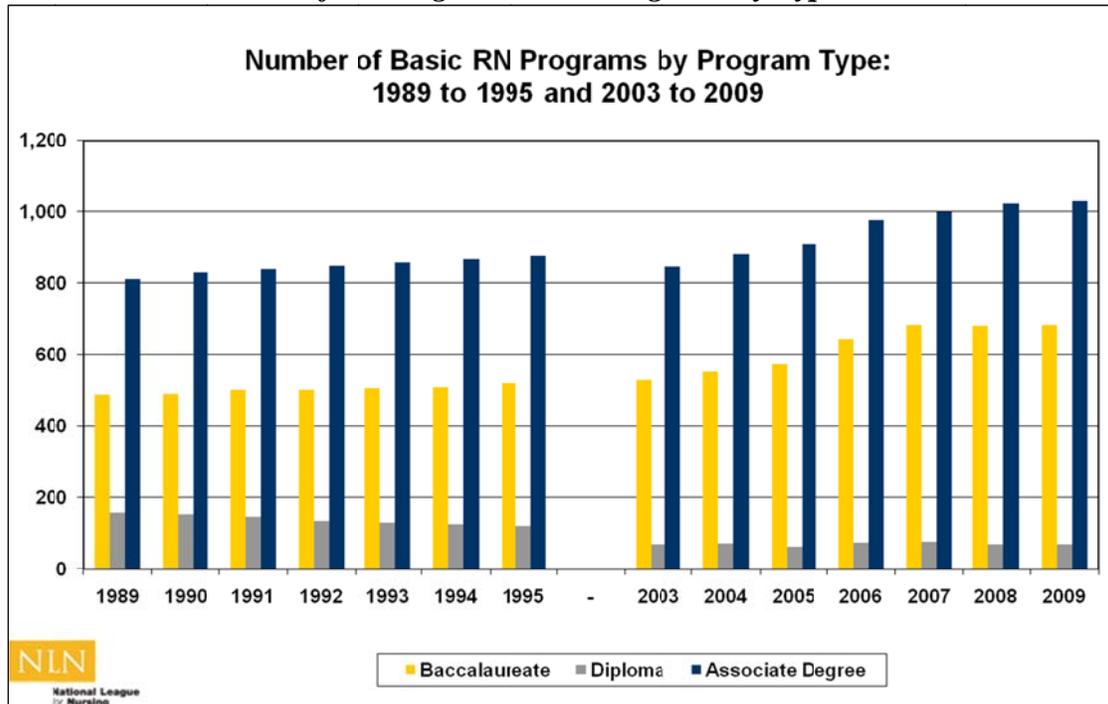
The following depicts the current data and trends related to nursing education. The information has been obtained from recent reports issued by the National League for Nursing (NLN) and the American Association of the Colleges of Nursing (AACN).

### **Nursing Programs**

- According to the most recent NLN data available, during the 2008-2009 academic year, 40% of all applicants to RN programs were accepted into a nursing education program, 35% were unqualified and 25% were qualified, but not accepted (NLN, Nursing Student Demographics, 2010).
- As depicted below in Figure 3, there has been a steady rise in prelicensure nursing programs since 2003; however, this growth has leveled off with no increase seen in 2009 (NLN, 2010).

- A growing trend in nursing education is the Doctor of Nursing Practice (DNP) Program. Thirty-six states along with the District of Columbia have schools offering DNP education. There are 120 DNP programs currently enrolling students at schools of nursing and an additional 161 programs are in the planning stages. From 2008 to 2009, the number of students enrolled in DNP programs increased from 3,415 to 5,165 (Rosseter, 2010).

**Figure 3** *Number of Nursing Education Programs by Type*



(NLN, Nursing Student Demographics, 2010)

### Faculty

The most recent and comprehensive data available on the current status and trends related to faculty are reported in the *2010-2011 Special Survey on the Vacant Faculty Positions* (Fang and Tracy, 2010). Out of 556 respondents from U.S. Colleges of Nursing, 303 respondents (54.5%) stated they had vacancies and needed additional faculty. Faculty related data include:

- Total budgeted positions: 12,783.
- Total number of vacancies: 880 (6.9%) This number, referred to as the “national vacancy rate” is up slightly from 6.6 percent in 2009.
- Total number of filled positions: 11,903 (93.1%).
- Mean number of vacancies: 1.6 per school.
- Range of number of vacancies: 1 to 16.
- Number of schools with no faculty vacancies, but need additional faculty: 112 (20.1%).
- Number of schools with no faculty vacancies that do not need additional Faculty: 141 (25.4%).
- Between 200 and 300 doctoral faculty and 220-280 Masters prepared faculty will be eligible for retirement every year through 2012 (AACN, 2010).

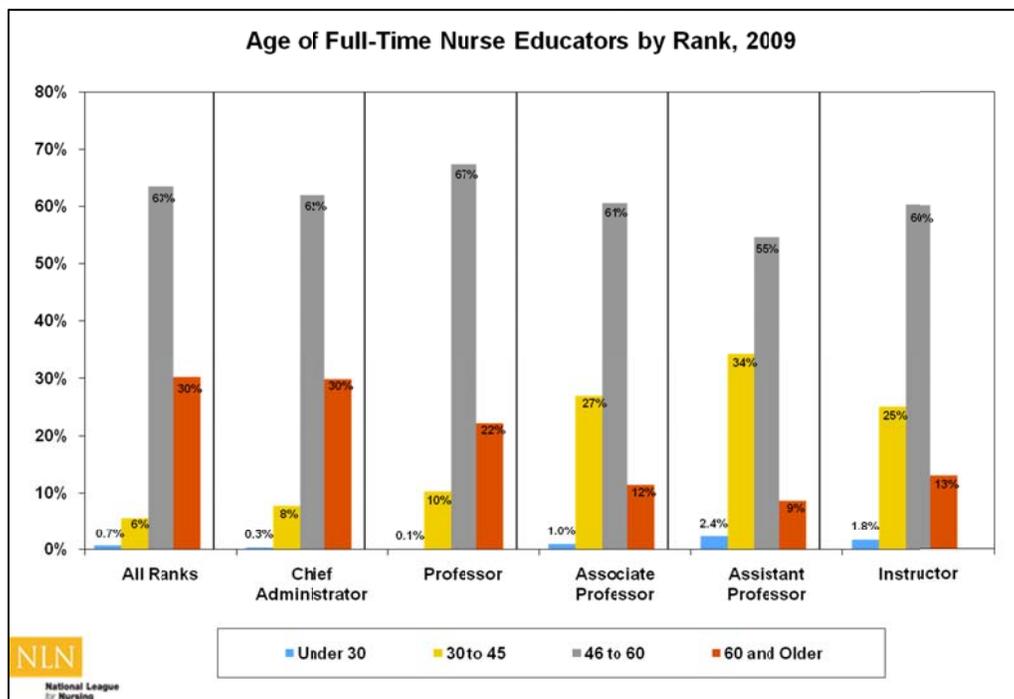
- The percentage of full-time educators age 60 and over rose significantly from only 9% in 2006 to almost 16% in 2009. Overall, almost 76% of full-time faculty were over the age of 45 in 2009 (NLN, 2010).

Most critical issues confronting schools of nursing regarding faculty recruitment and retention (N = 544):

- Limited pool of doctorally prepared faculty (30.4%)
- Noncompetitive salaries (30.2%)
- Finding faculty with the right specialty mix (18.5%)
- Finding faculty willing/able to teach clinical courses (4.7%)
- Finding faculty willing/able to conduct research (3.6%)
- High faculty workload (2.9%)

(Tracy and Fang, 2010)

**Figure 4**



(NLN, Nurse Educator Demographics, 2010)

As depicted in Figure 4, the largest age group contributing faculty to the nursing education workforce is the 46-60 year old age bracket. This by itself is not disconcerting as this age bracket is where most faculty traditionally fall. What is of concern are the small numbers of individuals in the 30-45 year age bracket that have chosen a career path in nursing education. At this time, these numbers are not of the proportion that will be needed by nursing programs once senior faculty retire.

### Students

- Type of education most commonly reported for RNs in the United States: The Associate Degree in Nursing (ADN).
- Percentage of nursing students receiving the ADN (2004-2008): 45.4%.

- Percentage of nursing students receiving Bachelor's or graduate degrees: 34.2%.
- Percentage of nursing students receiving a Diploma from a hospital-based program: 20.4%.
- Percentage of nursing students having an academic degree prior to initial nursing degree: Over 21%.

(The U.S. Department of Health and Human Services Health Resources and Services Administration , 2010)

### *Minority Enrollment*

Minority student enrollment in nursing programs is increasing. Of significance is the rise in the number of Hispanic students enrolled in nursing education programs. Despite this, Hispanics still comprise only 7% of all prelicensure nursing students. In contrast, Hispanics make up 12% of all 4-year college students (Kaufman, 2010).

### *Age of the Student Population*

One in three students enrolled in nursing education programs last year was over the age of 30. This points to an emerging trend depicting a younger nursing student population. An analysis of these data indicate that students enrolled in baccalaureate programs in 2008-2009 were significantly younger than the general four-year college student population. Only 14% of BSN students were reported to be over age 30, compared with almost 22% of four-year college students. The opposite is noted in ADN programs with 49% of ADN students being over the age of 30. This significantly surpasses the number of students over age 30 in U.S. two-year colleges where only about 25% of the student population is age 30 or older (Kaufman, 2010).

### *Gender Enrollment*

The percentage of men enrolled in basic nursing programs in 2008-2009 reached an all time high at 13.8%. (Kaufman, 2010)

## **Education Issues: Boards of Nursing**

### *U.S. Member Boards*

At least nine boards report an increase in new nursing education program applications during FY10. These range from LPN to MS programs. The majority cited an increase in LPN and ADN programs. Idaho approved its first two certified medication aide programs.

One board, Virginia, reported school closures. Arkansas reported that there has been a closure of some LPN programs due to the lack of availability of jobs.

In South Dakota, all associate degree programs (with the exception of two tribal colleges) have BSN completion programs. In Washington State, by 2012, all LPN programs will be required to articulate with an associate degree program and associate degree programs will be required to have an articulation agreement with baccalaureate programs.

The Governor of California temporarily suspended all state LPN programs being offered in vocation technical schools for budgetary reasons. This left only three proprietary schools that offered LPN education. During the 2010 legislative session, funding was allocated to reopen six of the schools in January of 2011.

Boards also report the following:

- A shortage of clinical sites/difficulty with clinical placement.
- A decrease in the number of faculty.
- Rejection of qualified students for admission into nursing programs.
- New York reports a bill has been introduced to advance the education of RNs to the baccalaureate degree.
- HB1209 in Florida, which was adopted last year, went into effect in 2010. This removed the authority of the board of nursing to oversee nursing education. The board of nursing will only be required to do initial program approval. If a nursing program's NCLEX scores fall below 10% of the nation's average, the program is automatically terminated.
- Several states are revising rules for program approval and/or standards for nursing education programs.

#### *Canadian Associate Members*

As of 2010, the provinces of Alberta, British Columbia, Manitoba and Ontario are requiring all new nurses entering practice to have a baccalaureate degree.

#### **Trends Related to Nursing Education**

Trends related to nursing education include: an increase in the number of nursing education programs, increase in applicants coupled with insufficient numbers of faculty and aging faculty nearing retirement.

#### **Legislation**

##### *Federal legislation*

##### *The Patient Protection and Affordable Care Act*

- Advanced Education Nursing (\$42 million) supports 153 infrastructure grants to increase advanced education to train nurses as primary care providers and/or nursing faculty.
- Advanced Education Nursing Traineeship (\$16 million) supports 351 schools of nursing and individuals preparing for careers as nurse specialists, requiring advanced education.
- Nurse Anesthetist Traineeship (\$1.3 million) funds 83 nurse anesthetist training programs to provide traineeships that pay tuition, books, fees, and a living stipend for registered nurses who have completed at least 12 months in a master's or doctoral nurse anesthesia program.
- Nurse Education, Practice, Quality and Retention (\$29.9 million) supports 108 infrastructure grants to expand the capacity of the nursing pipeline, promote career mobility for individuals in nursing, prepare more nurses at the baccalaureate level, and provide continuing education training to enhance the quality of patient care.
- Faculty Development: Integrated Technology into Nursing Education and Practice Initiative (\$2.5 million) supports nine grants for faculty development projects in information and other technologies to expand the capacity of collegiate schools of nursing to educate students for 21st century health care practice.

(United States Department of Health and Human Services Agency for Health Resources and Services Administration, 2010)

### *State legislation*

On September 30, 2010, California Governor Arnold Schwarzenegger signed into law Assembly Bill 867, allowing the California State University system to establish a Doctor of Nursing Practice (DNP) Pilot Program. Prior to this, the state of California only allowed schools affiliated with the University of California system to offer doctoral degrees in nursing.

Kentucky also passed legislation that would permit state public universities to open advanced practice doctoral programs in nursing.

Arizona passed legislation that would establish a pilot program for innovative nursing and allied health education at state community colleges.

### **PROFESSIONAL CERTIFICATION/CONTINUED COMPETENCE**

Over 35% of RNs hold some type of professional certification. The most common certification for RNs is basic life support (31%). The professional certifications held by the most RNs are in the following clinical or management specialty areas: critical care, maternal/neonate, oncology, case management, general surgery, and medical/surgical areas.

**Figure 5**

Registered nurse certifications* Type of certification	Total (number)	Total (percent)
Total registered nurses with certifications	1,094,838	35.7
Life support/resuscitation (BLS, ALS, BCLS, CPR, NRP, and others)	956,472	31.2
Trauma nursing/emergency medicine (TNCC, ATCN, ATN, EMT, ENPC, and others)	125,008	4.1
Critical care	58,320	1.9
Maternal/neonate	43,123	1.4
Oncology	36,175	1.2
Case management	31,106	1.0
General surgery	28,599	0.9
Medical/surgical	26,594	0.9

(The U.S. Department of Health and Human Services Health Resources and Services Administration , 2010)

### **Continued Competence: Boards of Nursing**

Continued competence continues to be a focus of discussion across the U.S. Pressure is being exerted on boards of nursing by the AARP, state nurses association and other groups to enact measures related to continued competence.

Three boards have addressed continued competence in FY2010:

- Montana: new rules were finalized for CEs for RNs and LPNs.
- Virginia: continued competence requirements have been proposed for licensure renewal and will go through the regulatory process.

- Washington: instituted continued competence requirements for license renewal. These include:
  - Participation in active practice. 531 hours every three years.
  - Self-assessment and reflection
  - Continuing nursing education. 45 hours every three years. (Washington, 2010)
- Texas: implemented a jurisprudence and ethics CE course.

The State of Hawaii has been exploring continuing education and other methods of continued competence.

## **STATE BUDGETS**

The FY2010 recession was the worst economic downturn in U.S. history since the 1930s and this had a major impact on boards of nursing. As a result of the financial crisis, 48 states and the District of Columbia have experienced severe budget shortfalls. In these states, revenues fell short of the amount needed to provide state services. Only Montana and North Dakota were exempt from financial shortfalls. The largest gap was faced by California with a \$45,500,000,000 deficit (McNichol, 2010). The next highest gap experienced during 2010 was New York whose deficit reached \$21,000,000,000.

The outlook for 2011 and 2012 does not predict improvement. Budgets will continue to be sharply constrained throughout 2011. Shortfalls are expected to reach \$125 billion dollars. States will continue to struggle to identify needed revenue to support programs and services. These 2011 and 2012 shortfalls will add to the gaps states closed in their fiscal year 2010 budgets. It is predicted that two states, Alaska and Arkansas, will not experience shortfalls during FY11 (McNichol, 2010).

### **.Impact on Boards of Nursing**

Most states report experiencing the impact of state budget shortages. Boards of nursing are reporting that large state budget deficits are affecting staffing, out of state travel and board programs. Board staff are required to take unpaid mandatory furlough days and board of nursing funds are being swept to help alleviate state revenue shortages. Restriction of wage increases, hiring freezes, budget cuts and travel restrictions are some of the measures being imposed upon boards by their state governments. Some boards, especially those belonging to umbrella agencies, were forced to operate on minimal staff in an effort to decrease costs.

### **Trends Related to State Budgets**

Trends in state budgets include severe deficits and cuts in spending often placing a hardship on boards of nursing who must contend with funds being swept, mandatory furlough days and limited staffing to name just a small portion of the issues they are dealing with as a result of the states' financial crisis

## **ACCESS TO HEALTH CARE, QUALITY AND PATIENT SAFETY**

Patient protection can be viewed from many aspects. From the protection provided by regulatory boards that promotes safe practitioners to the protection provided by other agencies that provides access, quality of care, and patient safety. All of these functions overlap and boards of nursing have had a particular interest in all three areas of health care. Therefore, the current data and

trends are included in this report along with summaries of several government reports issued in 2010.

### **Access to Care**

The statistics from the Center for Disease Control (CDC) indicate that 43.6 million Americans are uninsured (14.8%). The number of uninsured in the U.S. increased from 45.7 million persons in 2007 to 46.3 million in 2008. While this is a small, non-statistically significant increase (15.3% to 15.4%), the declining economy and severe job loss in 2009 and 2010 has likely impacted these rates and the current number of uninsured is most likely significantly higher. In 2009, the unemployment rate grew from 7.6% in January to 10.0% in December 2009 (Robert Wood Johnson Foundation, 2010). These numbers peaked even further during 2010.

In terms of access to care, last year, 17% of adults 18 years of age and older were without a usual place of health care (U.S. Department of Health and Human Services, Center for Disease Control, National Center for Health Statistics, 2010).

Minorities are much more likely to be uninsured. Almost one-fifth (19.1%) of African-Americans and nearly one-third (30.7%) of Hispanics were uninsured last year. This can be compared to an uninsured rate of 17.6% for Asians and 10.8% for non-Hispanic whites; however, the percentage of people without health insurance is increasing most rapidly among non-Hispanic whites (Robert Wood Johnson Foundation, 2010).

Last year, NCSBN's environmental scan reported on the 2009 priorities outlined in the Agency for Healthcare Research and Quality (AHRQ) annual report, *The National Healthcare Disparities Report*. This document is a Congressional mandate and provides an annual summary of the progress being made towards closing the gaps in health care delivery to Americans across the country in diverse groups. In 2010, the report was not issued. In lieu of the report, the Institute of Medicine (IOM) was asked to provide guidance as to how the *National Healthcare Disparities Report* may have greater impact on reducing inequity in the U.S. healthcare system. The IOM issued their report in April of 2010. Further information on this can be found at <http://www.iom.edu/Reports/2010/Future-Directions-for-the-National-Healthcare-Quality-and-Disparities-Reports.aspx>

The *National Healthcare Disparities Report* issued in 2009, reported healthcare disparities related to race, ethnicity and socioeconomic status. Although there are differences related to condition and population, disparities were noted in almost all aspects of health care, including:

- Health care quality: effectiveness, patient safety, timeliness and patient centeredness.
- Health care utilization.
- Levels and types of care: preventive care, treatment of acute conditions and management of chronic diseases.

(U.S. Department of Health and Human Services Agency for Healthcare Research and Quality, 2009) It is not anticipated that significant changes to these data occurred in 2010.

Rural areas remain underserved. Twenty percent of the population resides in rural communities and only 9% of physicians serve those communities. The estimated underserved population living in primary care health professional shortage areas (HPSAs) as of September, 2008, was 11.8%. This translates to 6,033 Primary Care HPSAs with 64 million people living in them. It would take an additional 16,336 practitioners to meet their need for primary care providers. The

state with the highest underserved population is Louisiana (34.4%). The state with the lowest number of underserved is New Jersey (1.7%) (Kaiser Health News, 2010).

### **Quality of Care**

Congress also mandates AHRQ to provide an annual report on health care delivery and the status of health care quality in the U.S., the *National Healthcare Quality Report (NHQR)*. This document was also reviewed by the IOM and their recommendations for this report can be found on the website above (listed for the National Healthcare Disparities Report).

The following themes emerged from the 2009 report:

- *Health care quality is suboptimal and continues to improve at a slow pace.*
- *Reporting of hospital quality is leading improvement, but patient safety is lagging.*
- *Health care quality measurement is evolving, but much work remains.*
- *Disparities persist in health care quality and access.*
- *Measurable improvement was noted in fewer than half of the 38 patient safety measures studied. The study found that patient safety measures on average declined by nearly 1% annually in each of the last six years. (AHRQ, 2009)*

As part of the *Affordable Care Act*, the government is calling for higher quality in services with an emphasis on primary care. In an effort to achieve this goal, the federal government is asking for assistance from the states as well as the private sector. Section 3011 of the *Affordable Care Act* requests the Secretary of the Department of Health and Human Services (HHS) to establish a “national quality strategy, including a comprehensive strategic plan and the identification of priorities to improve the delivery of health care services, patient health outcomes, and population health.” This document will include the following contents: 1) agency-specific plans and benchmarks; 2) coordination among agencies; 3) strategies to align public and private payers; and 4) alignment with meaningful use of health information technology (IT). During the fall of 2010, a draft document was released for public comment. The final report is expected to be presented to Congress January 1, 2011. The *Affordable Care Act* also calls for a parallel National Prevention and Health Promotion Strategy due to Congress in March of 2011. (U.S. Department of Health and Human Services, 2010). These reports are important because they are an effort by the federal government to align quality and affordability and will outline the government priorities for health care in the years ahead. A summary will be provided in NCSBN’s 2011 Environmental Scan.

### **Patient Safety**

A recently released study by the Office of the Inspector General is a profound study of patient safety and indicates that an alarming number of adverse events continue to plague the health care system. Results indicate that 13.5% of Medicare patients experienced an adverse event while hospitalized in October of 2008. This percentage translates to 134,000 Medicare patients experiencing at least one adverse event while hospitalized. Of those harmed, 13.1% of patients experienced an adverse event that fell into one of the four most serious categories of patient harm. An estimated 1.5% of the patients (approximately 15,000) died as a result of an adverse event. An additional 13.5% experienced adverse events during their hospital stays that resulted in temporary harm. Investigators ascertained that 44% of all events were preventable. Of significance was the fact that the preventable events were linked most commonly to “medical

errors, substandard care, and lack of patient monitoring and assessment.” The additional costs to Medicare from these events are an estimated \$324 million (Levinson, 2010).

The Commonwealth Fund conducted a comparative study examining access to and quality of U.S. health care with six other countries. Results indicated that the U.S. health care system ranked at the bottom or next-to-last on five indicators of a high performance health system. The indicators measured were: quality, access, efficiency, equity, and healthy lives. In terms of trends, the same study was also conducted in 2007, 2006 and 2004 and the U.S. has shown no improvement over time. The U.S. is repeatedly rated last on dimensions of access, patient safety, coordination, efficiency, and equity (The Commonwealth Fund, 2010).

### **Trends in Health Care Access and Patient Safety**

Disparities in health care persist without significant gains. Individuals in low socioeconomic groups, those with lower education, low levels of literacy, living in rural areas and ethnic minorities remain underserved. Patient safety continues to be a major concern.

### **Patient Safety: Boards of Nursing**

To better analyze practice complaints and how they relate to systems errors, boards are continuing to adopt the principles of Just Culture. The Ohio Board of Nursing held a daylong conference and invited stakeholders and legislators to educate them on the Just Culture principles. North Carolina has implemented Just Culture pilot programs.

### **Legislation**

#### *State legislation*

New York passed legislation that will require facilities to disclose nursing quality indicators and information regarding nurse staffing and patient outcomes to the public.

## **NURSING PRACTICE/ADVANCED PRACTICE**

### **Advanced Practice Nurses**

- Number of registered nurses educated as APRNs: 250,527.
- Number of registered nurses employed as APRNs: 220,494.
- Largest group of APRNs: Nurse Practitioners (CNSs are the second largest group, but their numbers are decreasing. The NSSRN states that CNSs are the only group of APRNs whose numbers are declining) (The U.S. Department of Health and Human Services Health Resources and Services Administration , 2010).

### **APRN Consensus Model**

Two year after the NCSBN Delegate Assembly approved the model legislative language for the APRN Consensus Model, jurisdictions have made efforts toward enacting new legislative language in their states to promote uniformity.

- Two boards are/have adopted regulations that will give CNSs APRN status and title protection.
- Colorado is implementing legislation that repeals collaborative practice agreements and replaces them with an 1800 hour preceptorship for “provisional prescriptive authority”

followed by an additional 1800 hour mentorship and an “articulation” that reinforces safe prescribing.

- Arkansas is requiring pharmacotherapeutics as a CE for APRNs with prescriptive authority.
- Alaska has new regulations that allow APRNs to delegate injection of certain medications and vaccines to certified medical assistants.
- Iowa has been examining the role of CRNAs in chronic pain management.
- Kentucky, Hawaii and Colorado passed major legislation adopting the Consensus Model for APRN Regulation. An additional six other boards introduced APRN legislation in 2010 with varying results.

### **Other APRN Issues**

A significant increase of the number of primary care providers will be needed to provide the care outlined the Affordable Care Act. This has implications for Nurse Practitioners who are capable of contributing these services, but are often hindered by scope of practice barriers.

This past year scope of practice panels (panels consisting of physicians, pharmacists and other professionals) were proposed through legislation or discussed at the state level. These panels would make determinations about expansion of a non-physician’s scope of practice. The proposed panels would be unbalanced and heavily weighted towards physicians’ viewpoints. Given the AMA’s opposition to the expansion of scope of practice, boards of nursing and other state and national nursing organizations are opposing the passage of legislation that would establish a Scope of Practice Panel.

Four states had legislation introduced in 2010 that would establish a scope of practice panel in the state: Connecticut, New Mexico, West Virginia, and Texas. None were enacted; however, concern remains that the AMA will continue to introduce bills in the upcoming sessions.

The Citizen’s Advocacy Center(CAC) has weighed in on this issue and in a white paper supports the expansion of scope of practice and urges other consumer groups to provide their support also. They also describe the establishment of an impartial panel/board to determine a state’s and a profession’s need for expansion of scope of practice (Le Buhn, 2010).

AARP has also pledged its support expansion of scope of practice for APRNs.

### **Legislation Related to APRN Practice**

#### *State Legislation*

Colorado passed legislation that allows the board of nursing to determine the “appropriate graduate degree for APRNs” and allows them to register in the state as an APRN if he/she is an APRN in another state, holds certification and has a graduate degree.

Colorado also passed legislation that removes an APRN’s ability to declare a patient terminally ill for the end of life decisions and delegates this responsibility solely to the physician.

Maryland passed legislation authorizing the board of nursing to establish continuing education (CE) requirements for renewal of Nurse Practitioner certificates. It also repeals the requirement that the Board of Physicians approve the scope of practice for nurse practitioners.

## **Registered Nurses and Practical/Vocational Nurses**

The following position statements, advisory rulings and interpretive guidelines were issued by boards of nursing:

### Kentucky

- Administration of Etomidate in pre-hospital emergency situations for rapid sequence induction when an MD is not present
- Administration of Etomidate in a medication facilitated intubation
- APRN prescribing for self and family
- APRN performance of colonoscopies

### Massachusetts

- Use of vagal Nerve Stimulator Magnet
- Procedural Sedation and/or mild to moderate sedation/analgesic
- Verification of orders

### Ohio

- RN role in bariatric procedures, specifically gastric band adjustments

### Oklahoma

- RN verify PICC line catheter tip placement by x-ray
- Artificial rupture of amniotic membranes
- Adjustment rate of elastomeric pumps

### Northern Mariana Islands

- Due to federalization of hospitals, foreign nurses can no longer work in those institutions. Currently, they are trying to recruit nurses from the U.S. mainland.

### *Associate Members*

#### Ontario

- Allows all nurses to “dispense a drug” and “treat by means of psychotherapy” an individual’s serious disorder of thought or cognition.

#### Manitoba

- RNs working in specific settings with certain patient populations have the authority to order screening and diagnostic tests and prescribe drugs. This pertains to nurses working with travel health, STDs, reproductive health and TB.

## **Legislation Related to RN and LPN Practice**

### *State Legislation*

Hawaii passed legislation defining the “practice of nursing” and directs the board of nursing to adopt the provisions contained within the NCSBN Model Act.

## **DISCIPLINE**

### **Emerging issues and trends for boards of nursing**

- Boards continue to be interested in the Just Culture movement and are adopting principles for determining board action in disciplinary cases.
- Boards are reporting an increase in applicants for licensure who have criminal convictions.
- Three Boards are implementing alternative to discipline for practice remediation/early remediation to address substandard care programs: Washington, Pennsylvania, and Vermont.
- Four boards reported adoption/ implementation of legislation/regulations that will allow them to begin or expand criminal background and/or fingerprint checks: The District of Columbia, Georgia, Mississippi, and Kentucky. Nevada will begin fingerprinting on renewal and North Carolina will be requiring criminal background checks for reinstatement.
- Texas is instituting criminal background checks for students prior to entry into nursing programs.
- Louisiana passed legislation that will allow the RN board the authority to share information with other regulatory or law enforcement agencies upon written request.
- Missouri changed their mandatory reporting law to include nursing homes and physician offices. The law will now require all employers to report to the board of nursing any nurse that is terminated or resigns in lieu of termination for practice violations.
- North Carolina has contracted with the Citizens Advocacy Center to conduct an external review of the operations of the alternative to discipline program for chemical dependency.
- Boards are reporting an increased number of cases regarding confidentiality, boundary issues and issues related to social networking.

### **Legislation**

#### *State Legislation*

Maine established an alternative to discipline program for chemically dependent nurses in 2010.

## **LICENSURE**

- The Missouri Board is issuing one license that will be valid through the nurses' entire career. There is no expiration date or compact status on the card and directs inquiries regarding verification to Nursys.
- The trend towards online renewal continues with more boards using this technology and having the majority of licensees renew over the board of nursing or agency Website.
- Boards are also becoming cardless and there are an increased number of boards becoming paperless.
- Oregon has adopted an auto-verification system for employers. Subscribers will receive automatic updates on changes to the status of a license, including discipline information for a prescribed list of licensees. North Carolina has also adopted an employer notification system.
- Tennessee reports an increase in LPN applicants for endorsement from questionably fraudulent schools.
- Boards in general are reporting an improvement in technology and new equipment to assist with licensure and other processes. These include: new license management systems,

automated systems for licensing and enforcement, VPN, E-license systems, data dashboards and other systems to improve efficiency and public protection.

### **Other Licensure Issues**

NCSBN's national survey of employers indicated that 14% of employers in the year surveyed had discovered a nurse in their institution practicing without a license (Budden, 2010).

### **Legislation**

#### *State legislation*

Arizona and Illinois both passed legislation requiring all licensed professionals to disclose their title, type of professional license and field of practice on all advertisement.

Illinois passed legislation that allows health care providers, licensed in another state, to provide voluntary services at a free clinic without holding a licensed in Illinois.

## **SUMMARY**

The year 2010 presented a rapidly changing environment for boards of nursing. Passage of legislation that would transform the U.S. health care system has numerous implications in the coming years for regulators. State budget crises impacted almost every board in the country and challenged boards to be conservative and innovative in their use of resources. These financial shortfalls show little chance of resolving in the next few years.

The issue of advanced practice and the adoption of the Consensus Model for APRN Regulation brought both successes and failures. While some states successfully passed legislation aligning state practice acts/regulations with the Consensus Model others faced opposition and will have to rethink strategies for the upcoming year. Medicine continues to pursue its opposition to APRN independent practice despite a growing shortage of primary care physicians and outcries from consumer groups such as the AARP and CAC. Patient safety continues to be one of the most significant problems in the U.S. health care system and boards are seeing an increase in discipline with new types of issues emerging such as confidentiality and social networking. The shortage of nurses noted over the last few years has, in many states, turned into a shortage of positions for new graduates in 2010.

On the horizon are also new opportunities and hope for the future. For the first time in 30 years the median age of nurses plateaued and the majority of students enrolled in baccalaureate nursing programs are under the age of 30. The shortage of nurses, in some areas, has resolved at least temporarily. The IOM report on the Future of Nursing opens new doors and possibilities for the future of RNs and APRNs.

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