COLORADO

Department of Regulatory Agencies

Colorado Office of Policy, Research & Regulatory Reform

2019 Sunset Review

Colorado Nurse Practice Act

October 15, 2019

COLORADO
Department of Regulatory Agencies
Executive Director's Office

October 15, 2019

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The Colorado General Assembly established the sunset review process in 1976 as a way to analyze and evaluate regulatory programs and determine the least restrictive regulation consistent with the public interest. Since that time, Colorado's sunset process has gained national recognition and is routinely highlighted as a best practice as governments seek to streamline regulation and increase efficiencies.

Section 24-34-104(5)(a), Colorado Revised Statutes (C.R.S.), directs the Department of Regulatory Agencies to:

- Conduct an analysis of the performance of each division, board or agency or each function scheduled for termination; and

- Submit a report and supporting materials to the Office of Legislative Legal Services no later than October 15 of the year preceding the date established for termination.

The Colorado Office of Policy, Research and Regulatory Reform (COPRRR), located within my office, is responsible for fulfilling these statutory mandates. Accordingly, COPRRR has completed the evaluation of the Colorado Nurse Practice Act. I am pleased to submit this written report, which will be the basis for COPRRR's oral testimony before the 2020 legislative committee of reference.

The report discusses the question of whether there is a need for the regulation provided under Article 38 of Title 12, C.R.S. The report also discusses the effectiveness of the State Board of Nursing in carrying out the intent of the statutes and makes recommendations for statutory changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Patty Salazar
Executive Director

COLORADO

Department of Regulatory Agencies

Colorado Office of Policy, Research & Regulatory Reform

2019 Sunset Review

Colorado Nurse Practice Act

SUMMARY

What is regulated?

Nursing is a health-care profession that is responsible for the ongoing care of sick, injured, disabled and dying patients. A nurse is trained to promote and maintain health, and a nurse may practice independently or under the supervision of a medical provider. Nurses are licensed at different levels, depending on their level of education: licensed practical nurses (LPNs), registered nurses (RNs) and advanced practice nurses (APNs).

Why is it regulated?

The Board of Nursing (Board) in the Division of Professions and Occupations ensures that nurses are at least minimally competent. This is especially important since a nurse may harm a patient by failing to adequately assess or monitor a patient's condition; by administering the wrong medication or the wrong dose of a medication; by using medical equipment improperly; by failing to communicate with other health-care providers; and by failing to use proper infection controls. Moreover, an APN may harm a patient by misdiagnosing an illness, failing to provide appropriate treatment and failing to refer to another health-care provider when necessary. In all of these cases, a patient may be seriously injured or die as a result of substandard care. Substandard care in the practice of nursing may also extend hospital stays and increase health-care costs.

Who is regulated?

In fiscal year 17-18, the Board licensed 8,953 LPNs and 78,995 RNs (including APNs).

How is it regulated?

Only those licensed under the Nurse Practice Act (Act) may practice practical or professional nursing and represent themselves as LPNs or RNs, respectively. An LPN must complete a one-year program in practical nursing that is approved by the Board and pass the National Council Licensure Examination (NCLEX) for Practical Nurses in order to be licensed. The qualifications required to be licensed as an RN are similar to those of an LPN; however, an RN must obtain either an associate or a bachelor's degree in professional nursing and pass the NCLEX for RNs. An RN may obtain specialized education and certification in order to be placed on the Advanced Practice Registry and practice specialized nursing as an APN. An APN, who meets specific requirements, may also prescribe medications and controlled substances.

What does it cost?

In fiscal year 17-18, the total expenditures to oversee the program were approximately $4.2 million and there were 9.6 full-time equivalent employees dedicated to the program.

What disciplinary activity is there?

In fiscal year 17-18, the Board took the following disciplinary actions against LPN licenses: 1 denial, 21 revocations, 1 suspension, 10 stipulated agreements and 17 letters of admonition; and the Board took the following disciplinary action against RN licenses: 13 denials, 60 revocations, 98 stipulated agreements and 59 letters of admonition.

KEY RECOMMENDATIONS

Continue the Act for seven years, until 2027.
It is especially important to ensure that nurses are at least minimally competent. A nurse may harm a patient by failing to adequately assess or monitor a patient's condition; by administering the wrong medication or the wrong dose of a medication; by using medical equipment improperly; by failing to communicate with other health-care providers; and by failing to use proper infection controls. In all of these cases, a patient may be seriously injured or die as a result of substandard care. Substandard care in the practice of nursing can also extend hospital stays and increase health-care costs.

Limit the requirement that an APN maintain an articulated plan for safe prescribing to the period of provisional prescriptive authority only.
While developing the articulated plan may be a worthwhile exercise for a new prescriber, once an APN has full prescriptive authority, it is no longer necessary. It is already the standard of practice for an APN to consult with and refer to other health-care providers when necessary, and APNs are required to maintain professional certification in their role and population focus, and renewal requirements for certification include continued competency.

METHODOLOGY

As part of this review, Colorado Office of Policy, Research and Regulatory Reform staff attended Board meetings; interviewed stakeholders, officials with state and national professional associations, and Division staff; and reviewed Colorado statutes, rules and the laws of other states.

MAJOR CONTACTS MADE DURING THIS REVIEW

American Association for Colleges of Nursing
American Association of Nurse Practitioners
American Nurses Association
Children's Hospital
Colorado Academy of Family Physicians
Colorado Association of Nurse Anesthetists
Colorado Attorney General's Office
Colorado Dept. of Health Care Policy & Financing
Colorado Dept. of Human Services
Colorado Dept. of Public Health & Environment
Colorado Hospital Association
Colorado Medical Society
Colorado Mental Health Institute at Fort Logan
Colorado Nurses Association
Colorado Organization of Nurse Leaders
Colorado Society of Anesthesiologists
Colorado State Board of Nursing
Colorado State University, Pueblo
Denver College of Nursing
Denver Health and Hospital Authority
Division of Professions and Occupations
Emily Griffith Technical College
Home Care Association of Colorado
Kaiser Permanente
Leading Age Colorado
Metropolitan State University of Denver
National Council of State Boards of Nursing
Peer Assistance Services
Trinidad State University
University of Northern Colorado

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are prepared by:
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Background

Introduction

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) within the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are based on the following statutory criteria:

I. Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;

II. If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;

III. Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;

IV. Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;

V. Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;

VI. The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;

VII. Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;

VIII. Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

[1] Criteria may be found at § 24-34-104, C.R.S.

IX. Whether the agency through its licensing or certification process imposes any sanctions or disqualifications on applicants based on past criminal history and, if so, whether the sanctions or disqualifications serve public safety or commercial or consumer protection interests. To assist in considering this factor, the analysis prepared pursuant to subsection (5)(a) of this section must include data on the number of licenses or certifications that the agency denied based on the applicant's criminal history, the number of conditional licenses or certifications issued based upon the applicant's criminal history, and the number of licenses or certifications revoked or suspended based on an individual's criminal conduct. For each set of data, the analysis must include the criminal offenses that led to the sanction or disqualification; and

X. Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Sunset reports are organized so that a reader may consider these criteria while reading. While not all criteria are applicable to all sunset reviews, the various sections of a sunset report generally call attention to the relevant criteria. For example,

- In order to address the first criterion and determine whether a particular regulatory program is necessary to protect the public, it is necessary to understand the details of the profession or industry at issue. The Profile section of a sunset report typically describes the profession or industry at issue and addresses the current environment, which may include economic data, to aid in this analysis.
- To ascertain a second aspect of the first sunset criterion--whether conditions that led to initial regulation have changed--the History of Regulation section of a sunset report explores any relevant changes that have occurred over time in the regulatory environment. The remainder of the Legal Framework section addresses the third sunset criterion by summarizing the organic statute and rules of the program, as well as relevant federal, state and local laws to aid in the exploration of whether the program's operations are impeded or enhanced by existing statutes or rules.
- The Program Description section of a sunset report addresses several of the sunset criteria, including those inquiring whether the agency operates in the public interest and whether its operations are impeded or enhanced by existing statutes, rules, procedures and practices; whether the agency performs efficiently and effectively and whether the board, if applicable, represents the public interest.
- The Analysis and Recommendations section of a sunset report, while generally applying multiple criteria, is specifically designed in response to the tenth criterion, which asks whether administrative or statutory changes are necessary to improve agency operations to enhance the public interest.

These are but a few examples of how the various sections of a sunset report provide the information and, where appropriate, analysis required by the sunset criteria. Just as not all criteria are applicable to every sunset review, not all criteria are specifically highlighted as they are applied throughout a sunset review.

Types of Regulation

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Coloradans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

Regulatory programs involving businesses are typically in place to enhance public safety, as with a salon or pharmacy. These programs also help to ensure financial solvency and reliability of continued service for consumers, such as with a public utility, a bank or an insurance company.

Activities can involve auditing of certain capital, bookkeeping and other recordkeeping requirements, such as filing quarterly financial statements with the regulator. Other programs may require onsite examinations of financial records, safety features or service records.

Although these programs are intended to enhance public protection and reliability of service for consumers, costs of compliance are a factor. These administrative costs, if too burdensome, may be passed on to consumers.

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review on COPRRR's website at: www.dora.colorado.gov/opr.

The functions of the State Board of Nursing (Board) as enumerated in Article 38 of Title 12, Colorado Revised Statutes (C.R.S.),[2] shall terminate on July 1, 2020, unless continued by the General Assembly. During the year prior to this date, it is the duty of COPRRR to conduct an analysis and evaluation of the Board pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed regulation should be continued and to evaluate the performance of the Board and the Division of Professions and Occupations (Division). During this review, the Board must demonstrate that the program serves the public interest. COPRRR's findings and recommendations are submitted via this report to the Office of Legislative Legal Services.

[2] House Bill 19-1172 recodified Article 38 and placed it in Article 255. In order to avoid confusion and erroneous citations and references, this sunset report consistently refers to the statutory provisions as they existed during the sunset review when they were located in Article 38, C.R.S. A table with the citations as they have been recodified is located in Appendix B.

Methodology

As part of this review, COPRRR staff attended Board meetings; interviewed stakeholders, officials with state and national professional associations, and Division staff; and reviewed Colorado statutes, rules and the laws of other states.

Although COPRRR was able to review detailed data related to a limited number of files during this review, COPRRR was unable to review complete complaint files because the Director of the Division (Director) did not provide the case files to COPRRR pursuant to section 12-38-116.5(9), C.R.S., and corresponding legal advice from the Office of the Attorney General.

COPRRR relies on access to complaint files to gain a better understanding of the actual harm related to the practice under review, which informs recommendations for changes to the Act and to the administration of the program. Moreover, COPRRR also relies on these files to determine whether final dispositions of complaints are in the public interest or self-serving to the profession.

Profile of the Profession

In a sunset review, COPRRR is guided by the sunset criteria located in section 24-34-104(6)(b), C.R.S. The first criterion asks whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation.

In order to understand the need for regulation, it is first necessary to understand what the profession does, where they work, who they serve and any necessary qualifications.

Nursing is a health-care profession that is responsible for the ongoing care of sick, injured, disabled and dying patients.[3] A nurse is trained to promote and maintain health, and a nurse may practice independently or under the supervision of a medical provider.[4]

Nurses are licensed at different levels, depending on their level of education:[5]

- Licensed practical nurses (LPNs),
- Registered nurses (RNs), and
- Advanced practice nurses (APNs).

[3] Encyclopædia Britannica. *Nursing*. Retrieved November 20, 2018, from https://www.britannica.com/science/nursing
[4] Merriam Webster. *Nurse*. Retrieved November 20, 2018, from https://www.merriam-webster.com/dictionary/nurse
[5] ANA Enterprise. *What Is Nursing and What Do Nurses Do?* Retrieved October 30, 2018, from https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/

Licensed Practical Nurses

In 2018, there were 728,900 jobs in the United States for LPNs, sometimes referred to as licensed vocational nurses or LVNs.[6]

LPNs work under the supervision of an RN, and they provide basic and routine care. LPNs are typically responsible for checking vital signs and monitoring the condition of patients; performing basic nursing duties, such as dressing wounds and changing bandages; and ensuring that patients are comfortable, well-nourished and hydrated.[7]

LPNs may also administer medications in some settings.[8]

The specific duties of LPNs depend on the work setting and the state where they work. Some states, including Colorado, allow LPNs to administer medication or start intravenous drips. In other states, LPNs cannot perform these tasks. The level of supervision required for LPNs also varies from state to state.[9]

LPNs may work in several different settings, such as:[10]

- Nursing homes,
- Extended care facilities,
- Hospitals,
- Physician offices, and
- Private homes.

LPNs must complete a one-year program in practical nursing that is approved by a state board of nursing. These programs are often found in technical schools and community colleges, and the coursework covers subjects such as:[11]

- Nursing,
- Biology, and
- Pharmacology.

LPNs also complete clinical training through the nursing education programs.[12]

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[6] U.S. Bureau of Labor Statistics. *Licensed Practical and Licensed Vocational Nurses.* Retrieved September 26, 2019, from https://www.bls.gov/ooh/healthcare/print/licensed-practical-and-licensed-vocational-nurses.htm
[7] ANA Enterprise. *What Is Nursing and What Do Nurses Do?* Retrieved October 30, 2018, from https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/
[8] ANA Enterprise. *What Is Nursing and What Do Nurses Do?* Retrieved October 30, 2018, from https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/
[9] U.S. Bureau of Labor Statistics. *Licensed Practical and Licensed Vocational Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/licensed-practical-and-licensed-vocational-nurses.htm
[10] U.S. Bureau of Labor Statistics. *Licensed Practical and Licensed Vocational Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/licensed-practical-and-licensed-vocational-nurses.htm
[11] U.S. Bureau of Labor Statistics. *Licensed Practical and Licensed Vocational Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/licensed-practical-and-licensed-vocational-nurses.htm
[12] U.S. Bureau of Labor Statistics. *Licensed Practical and Licensed Vocational Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/licensed-practical-and-licensed-vocational-nurses.htm

Registered Nurses

The vast majority of nurses are RNs. In 2018, there were over 3 million jobs for RNs in the United States.[13]

RNs provide critical care to patients. They are typically responsible for performing physical examinations and taking patient histories, providing health-related education and counseling, administering medications and coordinating care with other health-care providers.[14] RNs may also supervise other health-care practitioners, such as LPNs, nurse aides and home health aides.[15]

RNs may work in settings, such as:[16]

- Hospitals,
- Physician offices,
- Home health services,
- Nursing care facilities,
- Outpatient clinics, and
- Schools.

There are three routes to becoming an RN: a bachelor's degree in nursing, an associate degree in nursing or graduation from another approved nursing program.[17] The coursework in these programs cover subjects such as:[18]

- Anatomy,
- Physiology,
- Microbiology,
- Chemistry,
- Nutrition, and
- Psychology and other social and behavioral sciences.

RNs also complete clinical training through the nursing education programs.[19]

[13] U.S. Bureau of Labor Statistics. *Registered Nurses.* Retrieved September 26, 2019, from https://www.bls.gov/ooh/healthcare/print/registered-nurses.htm
[14] ANA Enterprise. *What Is Nursing and What Do Nurses Do?* Retrieved October 30, 2018, from https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/
[15] U.S. Bureau of Labor Statistics. *Registered Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/registered-nurses.htm
[16] U.S. Bureau of Labor Statistics. *Registered Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/registered-nurses.htm
[17] U.S. Bureau of Labor Statistics. *Registered Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/registered-nurses.htm
[18] U.S. Bureau of Labor Statistics. *Registered Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/registered-nurses.htm
[19] U.S. Bureau of Labor Statistics. *Registered Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/registered-nurses.htm

Advanced Practice Nurses

In 2018, there were 240,700 jobs for APNs in the United States.[20]

APNs provide primary and preventative care to patients. Typical responsibilities for APNs include diagnosing and treating minor illnesses and injuries, prescribing medication and managing chronic disease.[21] When necessary, APNs consult with physicians and other health-care providers.[22]

The scope of practice of APNs depends on the state in which they are licensed. Most states allow APNs to prescribe medications, order medical tests and diagnose health conditions.[23]

APNs work in several different settings, such as:[24]

- Hospitals,
- Physician offices, and
- Clinics.

There are several types of APNs:[25]

- Nurse anesthetists, who administer anesthesia, pain management and emergency services;
- Nurse midwives, who provide gynecological and low-risk obstetrical care to women; and
- Nurse practitioners, who provide primary care to patients or specialize in fields such as geriatrics, pediatrics or psychiatry and mental health.

Clinical nurse specialists are another type of APN who provide direct care to patients in a specialized nursing field, such as pediatrics.[26]

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[20] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved September 26, 2019, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[21] ANA Enterprise. *What Is Nursing and What Do Nurses Do?* Retrieved October 30, 2018, from https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/

[22] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[23] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[24] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[25] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[26] U.S. Bureau of Labor Statistics. *Registered Nurses.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/registered-nurses.htm

APNs must obtain a master's degree from an accredited program in the nursing field they are specializing in although some obtain a doctorate.[27] The coursework in APN programs covers subjects such as:[28]

- Anatomy,
- Physiology,
- Pharmacology, and
- Subjects related to the specialty.

In order to be accepted into an APN education program, a candidate must first be licensed as an RN.[29]

All Types of Nurses

The sixth sunset criterion requires COPRRR to evaluate the economic impact of regulation. One way this may be accomplished is to review the expected salary of the profession and the projected growth in the profession.

In May 2018, the median annual wages for nurses were:

- $46,240 for LPNs,[30]
- $71,730 for RNs,[31] and
- $113,930 for APNs.[32]

As baby boomers age and the incidence of chronic health conditions increase, employment of nurses is expected to grow faster than other occupations.[33] Between 2018 and 2028, the number of jobs in nursing is expected to grow by:

- 11 percent for LPNs,[34]

[27] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm
[28] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm
[29] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm
[30] U.S. Bureau of Labor Statistics. *Licensed Practical and Licensed Vocational Nurses.* Retrieved September 26, 2019, from https://www.bls.gov/ooh/healthcare/print/licensed-practical-and-licensed-vocational-nurses.htm
[31] U.S. Bureau of Labor Statistics. *Registered Nurses.* Retrieved September 26, 2019, from https://www.bls.gov/ooh/healthcare/print/registered-nurses.htm
[32] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved September 26, 2019, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm
[33] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved October 30, 2018, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm
[34] U.S. Bureau of Labor Statistics. *Licensed Practical and Licensed Vocational Nurses.* Retrieved September 26, 2019, from https://www.bls.gov/ooh/healthcare/print/licensed-practical-and-licensed-vocational-nurses.htm

- 12 percent for RNs,[35] and
- 26 percent for APNs.[36]

In evaluating the need for regulation, COPRRR also takes into consideration regulation in other states.

All states require nurses to be licensed in order to practice. To be licensed, a nurse must graduate from a relevant nursing program and pass a national examination. Some states have additional requirements, such as passage of a criminal history background check, and the scopes of practice for nurses vary from state to state.

Colorado and 30 other states participate in an interstate nurse licensure compact, in which a nurse who is licensed in one of the compact states may practice in any of the other participating states without having to obtain an additional license.[37] The compact does not fall under the purview of this sunset review.

Professional certification is also available for nurses, and in some cases may be required in order to work in certain specialty areas. In Colorado, APNs are required to obtain professional certification.

The State Board of Nursing also regulates certified nurse aides (CNAs) and licensed psychiatric technicians (LPTs). This report does not consider the regulation of CNAs or LPTs since CNAs are the subject of a separate sunset report this year and LPTs were the subject of a sunset report in 2018.

[35] U.S. Bureau of Labor Statistics. *Registered Nurses.* Retrieved September 26, 2019, from https://www.bls.gov/ooh/healthcare/print/registered-nurses.htm
[36] U.S. Bureau of Labor Statistics. *Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners.* Retrieved September 26, 2019, from https://www.bls.gov/ooh/healthcare/print/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm
[37] National Council of State Boards of Nursing. *Nurse Licensure Compact.* Retrieved November 20, 2018, from https://www.ncsbn.org/nurse-licensure-compact.htm

Legal Framework

History of Regulation

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by the sunset criteria located in section 24-34-104(6)(b), Colorado Revised Statutes (C.R.S.). The first sunset criterion questions whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen that would warrant more, less or the same degree of regulation.

One way that COPRRR addresses this is by examining why the program was established and how it has evolved over time.

In 1905, the Colorado General Assembly created the State Board of Nurse Examiners (BNE) to maintain a registry of professional nurses in order to protect the public from unsafe, incompetent or unethical practice. The duties of the BNE included administering examinations, issuing licenses and revoking the licenses of those who violated the law.

In 1957, the BNE was expanded from five to nine members and was granted the power to accredit nursing education programs in the state. Further, the legislature adopted the American Nurses Association's model definition of nursing, which established that some nursing tasks could be performed without physician supervision. The model definition specifically prohibited nurses from diagnosing and prescribing medications. In 1973, however, the definition was expanded to include diagnosis.

State regulation of practical nurses began in 1957, with passage of Senate Bill 57-125. The bill created the Practical Nursing Practice Act and vested licensing authority with a Board of Practical Nursing (BPN). Ten years later, the Practical Nursing Practice Act was changed to grant licensed practical nurses (LPNs) authority to administer, under the direction of a professional nurse, selected treatments and medications prescribed by a physician or a dentist.

In response to a 1978 sunset recommendation, the General Assembly passed Senate Bill 80-105, merging the BNE and the BPN into a single Board of Nursing (Board). With the passage of this bill, regulation of professional and practical nurses was placed under the authority of a unified board, and a uniform Nurse Practice Act (Act) was put into place.

With the enactment of the 1980 version of the Act, the definition of the practice of professional nursing was revised to include independent nursing functions and delegated medical functions. Further, the new Act granted LPNs the authority to supervise other health-care personnel.

In 1994, the General Assembly passed House Bill 94-1081, which created a registry for advanced practice nurses (APNs). The bill authorized title protection for all APNs, including the four sub-categories of certified nurse midwife, clinical nurse specialist, certified nurse anesthetist and nurse practitioner.

The 1994 sunset review of the Board culminated in the passage of House Bill 95-1007. The bill made numerous changes to the Act, most notably, formalizing the process whereby APNs could prescribe medication. Under the bill, APNs meeting specified educational and experiential requirements could apply to the Board for prescriptive authority. While this authority was limited, it allowed APNs to prescribe certain medications without physician supervision.

In 1999, the General Assembly passed Senate Bill 99-046, which directed the Board president to divide the Board into two inquiry panels. These panels were to meet as frequently as needed to review complaints against licensees, dismiss or order investigation of such complaints, take disciplinary actions and determine whether to grant or deny licensure to applicants with criminal convictions. Historically, the Board met quarterly to consider matters related to licensing, discipline, education and policy. This relatively infrequent meeting schedule, coupled with a high number of licensees and a correspondingly high number of complaints, resulted in considerable administrative delay. The creation of a panel system was intended to streamline the Board's regulatory activities.

In 2001, the General Assembly enacted House Bill 01-1023, which created a new "retired-volunteer" license type. This license type allowed nurses over the age of 65 who intended to practice nursing on a volunteer basis to renew their licenses for a reduced fee. The age limit was later changed to 55.

Senate Bill 06-020 laid the groundwork for the implementation of the Nurse Licensure Compact, a mutual recognition model of nurse licensure that allowed a nurse licensed in one participating state to practice in all participating states on the basis of that license. The Board was vested with the authority to administer the provisions of the Nurse Licensure Compact in Colorado.

COPRRR conducted a sunset review in 2009, and the legislature subsequently made the following changes to the Act:

- Expanded the authority of the Board to impose fines,
- Expanded APNs' prescriptive authority to include controlled substances, and
- Required APNs in independent practice to maintain professional liability insurance.

Additionally, the legislature created the Nurse-Physician Advisory Task Force for Colorado Healthcare in order to improve collaboration and communication between the practices of nursing and medicine.

In the 11 intervening years, the General Assembly enacted 21 bills that amended the Act. The most significant of these amendments:

- Provided APNs with broad prescriptive authority related to opioid antagonists;
- Limited an APN's ability to prescribe opioids to certain patients to a seven-day supply; and
- Provided the Board with the authority to participate in the Enhanced Nurse Licensure Compact (Compact), which, as of July 21, 2017, requires all applicants for a nursing license to undergo a state and national fingerprint-based criminal history record check.

Legal Summary

The second and third sunset criteria question

> Whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms, and whether agency rules enhance the public interest and are within the scope of legislative intent; and
>
> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters.

A summary of the current statutes and rules is necessary to understand whether regulation is set at the appropriate level and whether the current laws are impeding or enhancing the agency's ability to operate in the public interest.

During the 2019 legislative session, and as part of a larger effort to recodify portions of Title 12, C.R.S., the General Assembly passed, and the Governor signed, House Bill 1172. Effective October 1, 2019, this bill recodified the Act (section 12-38-101, *et seq.*, C.R.S.) and moved it to Article 255. Notwithstanding this recodification and to avoid confusion and erroneous citations and references, this sunset report consistently refers and cites statutory provisions as they existed during the sunset review when they were located in Article 38. A table with the citations as they have been recodified may be found in Appendix B.

The State Board of Nursing (Board), located in the Division of Professions and Occupations (Division) in the Department of Regulatory Agencies, is charged with enforcing the Act, which includes rulemaking authority.[38]

[38] § 12-38-108(1)(j), C.R.S.

The eighth sunset criterion questions whether the scope of practice of the regulated profession contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action.

When considering this criterion, it is first necessary to examine the current scope of practice as it is defined in the Act.

Practical nursing is defined in the Act as:[39]

- Caring for the ill, injured or infirm;
- Teaching and promoting preventative health;
- Acting to maintain life and health;
- Administering treatment and medication prescribed by a dentist, physician, physician assistant or podiatrist; and
- Performing delegated medical functions.[40]

LPNs may only practice under the supervision of a dentist, physician, podiatrist or professional nurse with the authority to practice in Colorado.[41] However, LPNs may supervise other LPNs or health-care providers.[42]

Professional nursing, in contrast, is defined as performing independent nursing care by promoting health, providing supportive or restorative care, disease prevention, diagnosis and treatment of human disease, ailment, pain, injury, deformity, and physical or mental condition using specialized knowledge, judgment and skill involving the application of biological, physical, social and behavioral science principles.[43]

Specifically, professional nursing includes the following services:[44]

- Evaluating health by collecting and assessing health data,
- Teaching and counseling about health,
- Providing therapy and treatment to support and restore life and well-being,
- Performing delegated medical functions,
- Referring patients to medical or community agencies for additional evaluation or treatment, and
- Reviewing and monitoring treatment plans.

Advanced practice nursing is defined as an expanded scope, role and population focus in professional nursing, which includes prescriptive authority as defined by the Act.[45]

[39] § 12-38-103(9)(b), C.R.S.
[40] § 12-38-103(9)(b), C.R.S.
[41] § 12-38-103(9)(a), C.R.S.
[42] § 12-38-103(9)(c), C.R.S.
[43] § 12-38-103(10)(a), C.R.S.
[44] § 12-38-103(10)(b), C.R.S.
[45] §§ 12-38-103(8.5)(a) and (b), C.R.S.

An APN is a registered nurse (RN), licensed to practice as a professional nurse with specialized education, who is approved by the Board to be included on the Advanced Practice Registry.[46]

LPNs and RNs may practice independently.[47] APNs are licensed RNs, so this authority necessarily includes APNs.

Rather than list specific tasks that RNs can perform, the Board has developed an algorithm to determine whether a task falls within a professional nurse's scope of practice. The scope of practice algorithm is located in Appendix A of the report. LPNs are only allowed to expand their scope of practice by completion of a Board approved intravenous therapy training program.

An RN has the ability to delegate any professional nursing task to an individual. However, an RN may only delegate medication selection to an individual who is otherwise authorized by law to select medication.[48] Additionally, any delegated task may not require the individual to exercise the judgement of a nurse.[49]

If an RN delegates a task, it must be, according to the nurse's judgement, safely performed by the individual and consistent with the health and safety of the patient.[50] The RN is solely responsible for determining the level of supervision required of any individual who is delegated a professional nursing task and must consider the following:[51]

- The nature of the nursing task,
- The training and skill of the individual,
- The stability of the patient's condition, and
- Whether the task has a predictable outcome.

The scope of practice of an APN is based on the specific role and population focus of the APN and the education of the APN. The scope of practice of an APN includes, among other things, performing acts of advanced assessment, diagnosing, treating, ordering, selecting, administering and dispensing diagnostic and therapeutic measures. Prescribing is only within an APN's scope of practice if this authority is granted by the Board.[52]

[46] § 12-38-103(1.5), C.R.S.
[47] § 12-38-128, C.R.S.
[48] § 12-38-132(1), C.R.S.
[49] § 12-38-132(2), C.R.S.
[50] § 12-38-132(3), C.R.S.
[51] § 12-38-132(4), C.R.S.
[52] 3 CCR 716-1 § 1.14-F, State Board of Nursing Rules.

State Board of Nursing

The fifth sunset criterion questions whether the composition of the agency's board adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.

One way that COPRRR addresses this is by examining the composition of the Board.

The Board consists of 11 members appointed by the Governor:[53]

- Two LPNs,
- Seven RNs, and
- Two public members.

The Board members who are RNs must have been employed for at least three years in their respective nursing professions, which must include:[54]

- One employed in nursing education,
- One employed in practical nursing education,
- One employed in home health care,
- One registered as an APN,
- One employed in nursing service administration,
- One employed as a staff nurse in a hospital, and
- One employed as a staff nurse in a nursing facility.

All board members who are nurses must be licensed and actively practicing nursing related to their respective roles on the Board.[55]

Board members may serve no more than two consecutive four-year terms.[56]

At a minimum, the Board must hold quarterly meetings.[57]

The Board has explicit statutory authority to appoint advisory committees. Each advisory committee must include at least three individuals with expertise in the particular subject matter under consideration.[58]

The Director of the Division (Director) must consult with the Board prior to appointing the Board's program director and other necessary program staff, and at least one member of the Board must serve on any panel convened to interview candidates for the position of program director.[59]

[53] § 12-38-104(1)(a), C.R.S.
[54] § 12-38-104(1)(a), C.R.S.
[55] §§ 12-38-104(1)(a)(I) and (II), C.R.S.
[56] § 12-38-104(1)(c), C.R.S.
[57] § 12-38-106, C.R.S.
[58] § 12-38-109, C.R.S.
[59] § 12-38-107, C.R.S.

Licensing Authority

The Board is authorized to examine and approve licenses to practice nursing.[60] The Board may delegate this authority to the program director.[61] The Board is also required to facilitate the licensure of nurses under the Compact, as authorized in Part 38 of Article 60 of Title 24, C.R.S., by:[62]

- Appointing a qualified individual to serve on the Interstate Commission of Licensure Compact Administrators (Interstate Commission),
- Participating in the coordinated licensure system,
- Requiring applicants for licensure under the Compact to undergo a state and national fingerprint-based criminal history record check,
- Notifying the Interstate Commission of any adverse action taken by the Board, and
- Approving payment of assessments levied by the Interstate Commission.

Only those licensed as practical nurses may practice practical nursing or use the title "licensed practical nurse" or the abbreviation "LPN."[63]

The qualifications required to be licensed as an LPN are:[64]

- Graduation from a program in practical nursing that is either approved by the Board or meets the Board's standards, and
- Passage of an examination prepared or approved by the Board.

Only those licensed as professional nurses may practice professional nursing or use the title, "registered nurse" or the abbreviation, "RN."[65]

The qualifications required to be licensed as an RN are similar to those of an LPN, except an RN must graduate from a program in professional nursing.[66]

The Board may issue a license by endorsement to an applicant who is licensed in another jurisdiction and has qualifications substantially equivalent to those required by Colorado.[67]

For RNs who have additional education in nursing, the Board must maintain an Advanced Practice Registry.[68]

[60] § 12-38-108(1)(b)(I), C.R.S.
[61] § 12-38-108(1)(c), C.R.S.
[62] § 12-38-108(1)(m), C.R.S.
[63] § 12-38-103(8)(a), C.R.S.
[64] § 12-38-112(1), C.R.S.
[65] § 12-38-103(11)(a), C.R.S.
[66] § 12-38-111(1), C.R.S.
[67] § 12-38-111(2), C.R.S.
[68] § 12-38-111.5(1), C.R.S.

In order to be included on the registry, an applicant must:[69]

- Complete a graduate degree in nursing, and
- Obtain national certification in an advanced practice specialty.

An applicant may be included on the registry by endorsement if the individual has been recognized by another state as an APN and has been practicing as an APN for at least two of the five years prior to the application, or if the applicant possesses an appropriate graduate degree and national certification.[70]

Only a nurse on the Advanced Practice Registry may use the title, "advanced practice nurse" or the abbreviation, "APN," and depending on the nurse's advanced practice specialty, the following titles, "certified nurse midwife," "clinical nurse specialist," "certified registered nurse anesthetist" or "nurse practitioner," and the respective abbreviations, "CNM," "CNS," "CRNA" or "NP."[71]

An APN who practices independently must maintain professional liability insurance of at least $500,000 per claim and $1.5 million for all claims in a year.[72]

An APN may prescribe prescription drugs or controlled substances if he or she is listed on the Advanced Practice Registry, has a license in good standing, has met any requirements of the Board,[73] and has a minimum of three years of clinical experience as a professional nurse.[74]

If an APN meets the above requirements, the Board may grant provisional prescriptive authority. In order to gain full prescriptive authority, an APN must complete 1,000 hours of experience mentored by a physician or an advanced practice nurse with full prescriptive authority and experience in prescribing. An APN's prescriptive authority is limited to his or her area of expertise.[75] If an APN fails to demonstrate competence, complete the required mentorship or develop an articulated plan, an APNs' provisional prescriptive authority expires in three years.[76]

An APN with prescriptive authority must develop an articulated plan for safe prescribing practices that documents how he or she intends to collaborate with physicians and other health-care practitioners and that guides the APN's prescriptive practice.[77]

[69] §§ 12-38-111.5(4)(c) and (d), C.R.S.
[70] § 12-38-111.5(4)(e), C.R.S.
[71] § 12-38-111.5(3), C.R.S.
[72] § 12-38-111.8(1), C.R.S.
[73] § 12-38-111.6(1), C.R.S.
[74] § 12-38-111.6(4.5)(a)(VII), C.R.S.
[75] § 12-38-111.6(4.5)(b), C.R.S.
[76] §§ 12-38-111.6(4.5)(b)(I)(D) and (II), C.R.S.
[77] § 12-38-111.6(4.5)(b)(II), C.R.S.

Specifically, the articulated plan must outline:[78]

- A mechanism for consultation or referral related to prescribing,
- A quality assurance plan,
- Decision support tools, and
- Documentation of ongoing continuing education in pharmacology and safe prescribing.

The articulated plan must be signed by the APN's mentor, kept on file, reviewed annually and updated as necessary.[79]

The Board is required to conduct random audits of articulated plans.[80]

An APN with prescriptive authority must maintain national certification in his or her area of expertise.[81]

An RN is not required to have prescriptive authority in order to administer anesthesia.[82]

An LPN or an RN with a license in good standing who is at least 55 years of age may apply for a retired volunteer license as long as he or she no longer provides nursing care for compensation.[83] The retired volunteer license must be provided at a reduced cost, of no more than 50 percent of the cost of a full nursing license.[84]

An individual with a retired volunteer license is immune from civil liability for nursing care provided within his or her scope of practice, except when injury or death is caused by gross negligence or willful and wanton misconduct of the licensee. However, this does not limit the Board's ability to take disciplinary action against the licensee.[85]

As long as an applicant is licensed in another jurisdiction, the Board may issue a temporary license to practice for a period of four months to an applicant for a license by endorsement.[86]

The Board may also issue a permit to practice for a period of two years to an individual who is licensed in another jurisdiction and participating in a nursing training or educational program. However, the practice of nursing must be limited to

[78] § 12-38-111.6(4.5)(b)(II), C.R.S.
[79] § 12-38-111.6(4.5)(b)(II), C.R.S.
[80] § 12-38-111.6(4.5)(e), C.R.S.
[81] § 12-38-111.6(4.5)(b)(IV), C.R.S.
[82] § 12-38-111.6(8)(c)(II), C.R.S.
[83] §§ 12-38-112.5(2) and (3), C.R.S.
[84] § 12-38-112.5(7), C.R.S.
[85] § 12-38-112.5(6), C.R.S.
[86] § 12-38-115(1), C.R.S.

the training or educational program.[87] Permits are intended for nursing students who have attended schools that do not include clinical training in their curricula.[88] Permits are not required for students who are participating in clinical training through an approved in-state nursing program.[89]

The Board may also issue a permit to practice nursing to someone who is under the supervision of a professional nurse.[90] An individual with a permit to practice nursing may only practice under supervision and direction of a licensed RN.[91]

The Board may require licensees to complete up to 20 hours of continuing education every two years.[92] At this time, the Board does not require continuing education.

An educational program must be approved by the Board in order to prepare individuals for licensure as LPNs or RNs. These programs must cover content that is fundamental to the knowledge and skills required for practical or professional nursing, including principles of biological, physical, social and behavioral sciences.[93]

Disciplinary Authority

The Board has the authority to investigate and conduct hearings concerning complaints against licensees.[94] The grounds for discipline include:[95]

- Procuring or attempting to procure a license by fraud, deceit, misrepresentation, misleading omission or a material misstatement of fact;
- Being convicted of a felony or any crime that would constitute a violation of the Act;
- Willfully or negligently acting in a manner inconsistent with the health and safety of a patient;
- Having a license suspended or revoked in another jurisdiction;
- Violating the Act or aiding or knowingly permitting someone to violate the Act;
- Negligently or willfully practicing nursing in a manner that fails to meet the generally accepted standards of practice;
- Negligently or willfully violating an order or rule of the Board;
- Falsifying or negligently making incorrect entries or failing to make essential entries on patient records;
- Excessively using or abusing alcohol, habit-forming drugs, controlled substances or other similar drugs or diverting drugs, except if the individual is

[87] § 12-38-115(3), C.R.S.
[88] 3 CCR 716-1 § 1-7.1, State Board of Nursing Rules.
[89] 3 CCR 716-1 § 1-7.2(B), State Board of Nursing Rules.
[90] § 12-38-115(3.5), C.R.S.
[91] § 12-38-115(4), C.R.S.
[92] § 12-38-127, C.R.S.
[93] §§ 12-38-116(1) and (2), C.R.S.
[94] § 12-38-108(1)(h), C.R.S.
[95] § 12-38-117(1), C.R.S.

participating in a substance abuse program, the Board has discretion to not discipline the licensee;

- Having a physical or mental disability that renders the individual unable to practice nursing with reasonable skill and safety to patients and which may endanger the health and safety of patients;
- Violating a patient's confidentiality;
- Engaging in criminal conduct if the conduct relates to the individual's employment as a nurse;
- Willful and repeated ordering, or performance without clinical justification, of demonstrably unnecessary laboratory tests or studies;
- Administering treatment without clinical justification which is demonstrably unnecessary;
- Failing to consult with or refer to other health-care providers when doing so is consistent with the standard of care;
- Ordering or performing any service, X-ray or treatment without clinical justification and contrary to the generally accepted standards of practice;
- Committing insurance fraud;
- Prescribing, distributing or administering a controlled substance, as defined in state or federal controlled substances acts;
- Dispensing, injecting or prescribing an anabolic steroid without medical necessity;
- Administering, dispensing or prescribing a habit-forming drug other than in the legitimate course of practice;
- Being disciplined in another jurisdiction for conduct that would be grounds for discipline under the Act;
- Willfully failing to respond in a materially factual and timely manner to a Board complaint; and
- Failing to report a criminal conviction to the Board within 45 days.

Anyone may file a complaint against a nurse authorized to practice in Colorado.[96] The Board president must divide the Board into two five-member panels, each of which acts as an inquiry and a hearing panel. Each inquiry panel refers cases that require formal hearings to the other panel or to an administrative law judge (ALJ).[97]

When investigating a licensee, the Board may conduct a criminal history record check.[98] The Board or an ALJ has subpoena authority and the authority to compel witnesses.[99]

The Board is authorized to deny, revoke, suspend, limit or refuse to renew a license to practice nursing if it uncovers conduct that is grounds for discipline. The Board may also place a licensee on probation or impose a fine.[100]

[96] § 12-38-116.5(3)(a)(II), C.R.S.
[97] § 12-38-116.5(1), C.R.S.
[98] § 12-38-108(1)(l)(B), C.R.S.
[99] § 12-38-116.5(13), C.R.S.
[100] § 12-38-108(1)(b.5), C.R.S.

Anyone who practices practical or professional nursing without a license commits a class 2 misdemeanor, punishable by 3 to 12 months imprisonment, a fine between $250 and $1,000, or both, for the first offense and a class 6 felony, punishable by one to two years imprisonment, a fine between $1,000 and $100,000, or both, for any subsequent offense.[101]

When the Board finds a complaint that demonstrates misconduct that does not warrant formal action but should not be dismissed without merit, the Board may issue a letter of admonition.[102]

When the Board finds a complaint that does not warrant formal action and should be dismissed but there are indications of conduct that could lead to serious consequences if not corrected, the Board may issue a confidential letter of concern.[103]

The Board may issue a cease and desist order against anyone who is an imminent threat to the health and safety of the public or is acting without the authority to practice nursing in this state.[104]

The Board also has the authority to seek injunctive relief against anyone violating the Act,[105] and the Board may seek enforcement of a final action of the Board through a court of competent jurisdiction.[106]

All final actions by the Board may be reviewed by the Court of Appeals.[107]

Section 12-38-116(9)(a), C.R.S., describes the Board's restrictions related to open meetings and open records,

> Investigations, examinations, hearings, meetings, or any other proceedings of the board conducted pursuant to the provisions of this section shall be exempt from the open meetings provisions of the "Colorado Sunshine Act of 1972" contained in part 4 of article 6 of title 24, C.R.S., requiring that proceedings of the board be conducted publicly, and the open records provisions of article 72 of title 24, C.R.S., requiring that the minutes or records of the board with respect to action of the board taken pursuant to the provisions of this section be open to public inspection.

[101] §§ 12-38-123(1) and (2), C.R.S.
[102] § 12-38-116.5(3)(c)(IV), C.R.S.
[103] § 12-38-116.5(3)(c)(III), C.R.S.
[104] § 12-38-116.5(15)(a), C.R.S.
[105] § 12-38-108(1)(i), C.R.S.
[106] § 12-38-116.5(12), C.R.S.
[107] § 12-38-116.5(12), C.R.S.

Program Description and Administration

In a sunset review, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) is guided by sunset criteria located in section 24-34-104(6)(b), Colorado Revised Statutes (C.R.S.). The third, fourth and fifth sunset criteria question:

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures practices and any other circumstances, including budgetary, resource and personnel matters;
>
> Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively; and
>
> Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates.

In part, COPRRR utilizes this section of the report to evaluate the agency according to these criteria.

The State Board of Nursing (Board), located within the Division of Professions and Occupations (Division), is entrusted with regulating the practice of practical and professional nursing and to approve practical and professional nursing education programs. Practical nurses are typically referred to as licensed practical nurses (LPNs) and professional nurses are typically referred to as registered nurses (RNs). Licensed RNs may complete advanced education and certification in order to be additionally registered as advanced practice nurses (APNs).

The Board also regulates certified nurse aides and psychiatric technicians. However, both of these license types have separate practice acts and undergo separate sunset reviews.

The Board consists of 11 members appointed by the Governor:[108]

- Two LPNs,
- Seven RNs, and
- Two public members.

[108] § 12-38-104(1)(a), C.R.S.

The Board members who are RNs must have been employed for at least three years in their respective nursing professions, which must include:[109]

- One employed in nursing education,
- One employed in practical nursing education,
- One employed in home health care,
- One registered as an APN,
- One employed in nursing service administration,
- One employed as a staff nurse in a hospital, and
- One employed as a staff nurse in a nursing facility.

All board members who are nurses must be licensed and actively practicing nursing related to their respective roles on the Board.[110]

The Board meets four times a year to discuss policy issues, consider approval of nursing education programs and conduct rulemaking. The Board is also divided into two panels, which meet monthly to review licensing, complaint and disciplinary cases.

Table 1 illustrates the Board expenditures and full-time equivalent (FTE) employees associated with the regulation of LPNs and RNs over a five-year period.

Table 1
Expenditures and Staffing

Fiscal Year	Total Program Expenditures	FTE
13-14	$3,878,559	11.30
14-15	$3,504,697	11.30
15-16	$3,639,509	11.30
16-17	$3,622,811	10.60
17-18	$4,160,810	9.60

The fluctuations in program expenditures are primarily due to legal services. In some years, more cases were referred to the Office of Expedited Settlement Services (ESP), which helps to reduce legal fees. Also, expenditures for leased space and information technology increased expenditures in fiscal years 16-17 and 17-18. The reduction in FTE resulted from reorganization and process improvement projects that were intended to streamline processes and increase program efficiency.

[109] § 12-38-104(1)(a), C.R.S.
[110] §§ 12-38-104(1)(a)(I) and (II), C.R.S.

The FTE numbers in Table 1 do not include employees in the centralized offices of the Division, which provide licensing, administrative, technical and investigative support to the program. However, the cost of those employees is reflected in the total program expenditures.

In fiscal year 18-19, there were 9.45 FTE dedicated to the Board, including a:

- Program Director (Program Management II, 0.60 FTE), responsible for the overall management of the program;
- Assistant Program Director (Administrator IV, 0.70 FTE), responsible for supervising staff for intake, compliance and follow-up activities and providing staff support to the Nurse Aide Advisory Committee (NAAC);
- Administrative Manager (Technician IV, 0.50 FTE), responsible for Board and constituent communication, managing the rulemaking process and providing staff support at Board meetings;
- Intake Team Leader (Technician IV, 0.70 FTE), responsible for initiating complaint intake, assessing responses to complaints and producing Board meeting packets;
- Compliance Specialist (Technician IV, 0.70 FTE), responsible for processing priority Board orders and tracking compliance with Board orders;
- Enforcement Manager (Technician IV, 0.70 FTE), responsible for managing Board follow-up activities and hearing processes; following up on initial decisions; executing certain Board stipulations, ESP and the Office of the Attorney General referrals; and supervising the enforcement specialist;
- Education Manager (Health Professional VI, 0.80 FTE), responsible for inspection and compliance of nursing education programs and supervising the Compliance Specialist for nurse aide training programs;
- Compliance Manager (Compliance Specialist IV, 0.70 FTE), responsible for peer assistance compliance monitoring, probation monitoring and supervising one Compliance Specialist;
- Complaint Manager (Technician V, 0.50 FTE), responsible for supervising the intake team;
- Practice Specialist (Administrative Assistant III, 0.40 FTE), responsible for responding to constituency questions related to nursing practice and processing advanced practice applications referred by the Licensing Section;
- Administrative Assistant III (0.80 FTE), responsible for intake for NAAC and processing enforcement activities;
- Administrative Assistant III (0.75 FTE), responsible for intake for Board Panel A and processing enforcement activities;
- Administrative Assistant III (0.80 FTE), responsible for intake for Board Panel B and processing enforcement activities; and
- Administrative Assistant III (0.80 FTE), responsible for following up on letters of concern, letters of admonition and dismissals.

Table 2 provides, for the five fiscal years indicated, the license fees for LPNs.

Table 2
Fees
Licensed Practical Nurses

Fiscal Year	Examination	Endorsement	Renewal	Reinstatement
13-14	$65	$20	n/a*	$75
14-15	$65	$20	$60	$75
15-16	$65	$20	n/a	$75
16-17	$65	$20	$96	$111
17-18	$65	$20	n/a	$111

*Not applicable

In fiscal year 16-17, the LPN renewal and reinstatement fees were increased to address a low fund balance.

Table 3 provides, for the five fiscal years indicated, the license fees for RNs.

Table 3
Fees
Registered Nurses

Fiscal Year	Examination	Endorsement	Renewal	Reinstatement
13-14	$65	$20	$80	$95
14-15	$65	$20	$80	$95
15-16	$56	$20	$87	$102
16-17	$65	$20	$139	$154
17-18	$65	$20	$139	$154

Renewal and reinstatement fees for RNs were increased in fiscal year 15-16 and 16-17 to address a negative fund balance.

Licenses are renewed every two years on September 30. LPN licenses are renewed in even years, and every year, half of the RN licenses renew, and the other half renew the following year. If a license is not renewed, an LPN or RN must reinstate his or her license in order to practice.

LPNs and RNs are also required to pay a surcharge on their license fees, which is $40 in fiscal year 19-20, to fund a peer assistance program for nurses who have health conditions or substance abuse problems that require evaluation and monitoring in order to allow the licensees to continue to practice safely. The fees reported in Table 2 and Table 3 do not include the surcharge.

Licensing

The eighth sunset criterion questions whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action.

In part, COPRRR utilizes this section of the report to evaluate the program according to this criterion.

An individual must be licensed by the Board in order to practice as an LPN or an RN.

An LPN must complete a one-year program in practical nursing and pass an examination approved by the Board in order to be licensed. The qualifications required to be licensed as an RN are similar to those of an LPN; however, an RN must obtain either an associate or a bachelor's degree in professional nursing.

In order to obtain a license, an applicant must complete and submit an application and supporting documentation to the Division's Licensing Section. A licensing specialist reviews the application and notifies the applicant of any deficiencies. Once the application is complete, a licensing specialist evaluates the application to ensure the applicant meets the requirements. If all the requirements are met, the license is issued. If not, the licensing specialist notifies the applicant in writing, and the application is kept on file for one year.

An application with any issues, such as one or more felony convictions, is sent to one of the Board panels for consideration. The Board may approve or deny the application, and it may also open an investigation.

Colorado participates in the Enhanced Nurse Licensure Compact (Compact), in which a nurse that is licensed in Colorado under the Compact may practice in other Compact states. Currently, 31 states have joined the Compact.

If a nurse does not qualify for a license under the Compact, he or she may qualify for a single-state license issued by Colorado. A nurse may not qualify for a Compact license for the following reasons:

- The applicant has a felony conviction,
- The applicant has a misdemeanor conviction related to patient care,
- The applicant is currently under disciplinary action, or
- The applicant does not have a social security number.

Table 4 provides the total number of single-state licenses issued to nurses.

Table 4
Single-State Licenses

Year	LPN	RN
13-14	30	462
14-15	76	646
15-16	95	1,059
16-17	122	2,182
17-18	115	3,187

The number of single-state licenses issued to LPNs and RNs has steadily increased over the five-year period reported here. The reason for the increase is unknown. However, the Division has noted an increase in the number of telehealth nurses working in non-compact states or another country who seek single-state licenses. Additionally, anyone with a felony conviction or a misdemeanor is ineligible for a license under the compact.

The following licensing tables reflect the total number of nurses licensed in Colorado including those licensed under the Compact.

Table 5 shows the number of LPNs from fiscal year 13-14 to fiscal year 17-18.

Table 5
Number of Licenses
Licensed Practical Nurses

Fiscal Year	Examination	Endorsement	Renewal	Reinstatement	Active Licenses*
13-14	407	315	n/a**	68	9,385
14-15	379	377	7,620	103	8,478
15-16	368	416	n/a	75	9,193
16-17	351	434	7,539	102	8,297
17-18	327	368	n/a	52	8,953

*As of June 30
**Not applicable

The number of LPNs with active licenses fluctuated considerably over the five-year period. Since fiscal year 13-14, the number of LPNs dropped approximately five percent. This decrease is consistent with data presented in the sunset review that was completed in 2008, which also showed the number of LPNs fluctuating considerably from year to year. Over the years, the number of LPNs in Colorado has fallen by about 12 percent since fiscal year 06-07 and 15 percent since fiscal year 03-04.

The decrease in licensed LPNs is likely attributed to health-care facilities and medical practices moving away from hiring LPNs. Today, LPNs primarily work in long-term care.

In order to administer intravenous therapy (IV), an LPN must demonstrate additional competency to the Board. As of August 29, 2019, there were 3,198 LPNs with IV authority.

Table 6 shows the number of licenses issued to RNs from fiscal year 13-14 to fiscal year 17-18.

Table 6
Number of Licenses
Registered Nurses, Including Advanced Practice Nurses

Fiscal Year	Examination	Endorsement	Renewal	Reinstatement	Active Licenses
13-14	2,388	3,584	30,358	619	68,323
14-15	2,039	4,082	30,245	597	71,204
15-16	2,278	4,867	31,297	1,035	73,509
16-17	2,671	5,306	32,679	764	76,241
17-18	2,500	4,408	34,692	608	78,995

Over the five-year period under review, the number of actively licensed RNs increased steadily. From fiscal year 13-14 to fiscal year 17-18, the number of actively licensed RNs increased by about 16 percent.

APNs are licensed RNs with advanced degrees, either master's degrees or doctorates, and national, professional certification.

Table 7 provides the number of APNs by specialty as of August 1, 2018.

Table 7
Advanced Practice Nurses

Type	Number
Nurse Practitioners	5,543
Clinical Nurse Specialists	597
Certified Nurse Midwives	458
Certified Registered Nurse Anesthetists	935

By far, nurse practitioners make up the largest category of APNs in Colorado. Approximately 74 percent of APNs are nurse practitioners, 12 percent are certified registered nurse anesthetists, 8 percent are clinical nurse specialists and 6 percent are certified nurse midwives.

Table 8 provides the total number of APNs with full and provisional prescriptive authority by specialty, as of March 19, 2019.

Table 8
Advanced Practice Nurses
With Prescriptive Authority

Type	Full	Provisional
Nurse Practitioners	3,865	1,001
Clinical Nurse Specialists	125	17
Certified Nurse Midwives	280	76
Certified Registered Nurse Anesthetists	21	12

Most nurse practitioners and a majority of certified nurse midwives in Colorado have prescriptive authority, but only roughly a quarter of clinical nurse specialists do. Since certified registered nurse anesthetists do not require prescriptive authority to administer anesthetics, most do not obtain it.

Examinations

The eighth sunset criterion questions whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action.

In part, COPRRR utilizes this section of the report to evaluate the program according to this criterion.

In all states, graduates of nursing programs must pass the National Council Licensure Examination (NCLEX) in order to obtain a license. The NCLEX examinations are developed by the National Council of State Boards of Education.[111] The purpose of the NCLEX examinations is to determine whether graduates of practical and professional nursing programs have the knowledge, skills and abilities for the safe and effective practice of entry-level nursing.[112]

[111] National Council of State Boards of Nursing. *History*. Retrieved March 8, 2019, from https://www.ncsbn.org/history.htm
[112] *NCLEX Candidate Bulletin*, National Council of State Boards of Nursing (2019), p. 2.

The NCLEX examinations are computer-based, adaptive examinations.[113] Rather than requiring an examinee to answer a certain number of questions correctly, an adaptive examination targets an examinee's ability in relation to a passing standard. A computer program does this by estimating the examinee's ability after each question is answered and then poses the next question based on this estimate. As the examination progresses, the examinee's ability becomes more defined. Once the computer program determines that the examinee meets or falls below the passing standard with a 95 percent certainty and after a sufficient number of test items have been administered to adequately assess main content areas, the examination ends. An examinee may also fail if he or she either reaches the maximum number of questions or runs out of time, and the final ability estimate falls below the passing standard.[114]

Graduates of practical nursing schools must pass the NCLEX for practical nurses (NCLEX-PN), and graduates of professional nursing schools must pass the NCLEX for RNs (NCLEX-RN).

The NCLEX-PN covers the following four content areas:

1. Safe and effective care environment, which includes,
   - Coordinated care (18 to 24 percent of items), and
   - Safety and infection control (10 to 16 percent of items);
2. Health promotion and maintenance (6 to 12 percent of items);
3. Psychosocial integrity (9 to 15 percent of items); and
4. Physiological integrity, which includes,
   - Basic care and comfort (7 to 13 percent of items),
   - Pharmacological therapies (10 to 16 percent of items),
   - Reduction of risk potential (9 to 15 percent of items), and
   - Physiological adaptation (7 to 13 percent of items).

In the NCLEX-RN, the four content areas and percentage of items from each category are slightly different:

1. Safe and effective care environment, which includes,
   - Coordinated care (17 to 23 percent of items), and
   - Safety and infection control (9 to 15 percent of items);
2. Health promotion and maintenance (6 to 12 percent of items);
3. Psychosocial integrity (6 to 12 percent of items); and
4. Physiological integrity, which includes,
   - Basic care and comfort (6 to 12 percent of items),
   - Pharmacological and parenteral[115] therapies (12 to 18 percent of items),
   - Reduction of risk potential (9 to 15 percent of items), and
   - Physiological adaptation (11 to 17 percent of items).

[113] *NCLEX Candidate Bulletin*, National Council of State Boards of Nursing (2019), p. 2.
[114] *NCLEX Candidate Bulletin*, National Council of State Boards of Nursing (2019), pp. 14-15.
[115] Parenteral means administering drugs or nutrients by intravenous or intramuscular injection.

The length of the NCLEX-PN is between 85 and 205 questions, and the time limit to complete the examination is five hours. The length of the NCLEX-RN is between 75 and 265 questions, and the time limit to complete the examination is six hours. Both examinations draw from a large pool of questions, and most of the questions are multiple choice.[116]

Both examinations are offered at Pearson Vue testing centers located in:[117]

- Colorado Springs,
- Greenwood Village, and
- Westminster.

The examination fee for both the NCLEX-RN and the NCLEX-PN is $200.[118]

Table 9 provides the number of NCLEX-PN examinations administered to Colorado applicants for LPN licensure and the pass rates from 2013 to 2017. The data represent first-time test takers only.

Table 9
NCLEX-PN
First-Time Test Takers

Calendar Year	Number of Examinations	Pass Rates
2013	387	95%
2014	398	93%
2015	349	93%
2016	326	95%
2017	346	89%

The pass rates for the NCLEX-PN are relatively high, which may indicate a high level of preparation on behalf of the examinees.

[116] *NCLEX Candidate Bulletin*, National Council of State Boards of Nursing (2019), p. 2.
[117] National Council of State Boards of Nursing. *Test Center Search (Colorado)*. Retrieved March 8, 2019, from https://wsr.pearsonvue.com/testtaker/registration/SelectTestCenterProximity/NCLEXTESTING?conversationId=1767791
[118] *NCLEX Candidate Bulletin*, National Council of State Boards of Nursing (2019), p. 3.

Table 10 provides the number of NCLEX-RN examinations administered to Colorado applicants for RN licensure and the pass rates from 2013 to 2017. The data represent first-time test takers only.

Table 10
NCLEX-RN
First-Time Test Takers

Calendar Year	Number of Examinations	Pass Rates
2013	2,092	87%
2014	2,160	87%
2015	2,009	88%
2016	2,113	88%
2017	2,108	90%

Similar to the NCLEX-PN, the pass rates for the NCLEX-RN are also relatively high, which may indicate a high level of preparation on behalf of the examinees.

Complaint and Disciplinary Activity

The seventh sunset criterion requires COPRRR to examine whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession.

In part, COPRRR utilizes this section of the report to evaluate the program according to this criterion.

The Board receives complaints from patients and their families, medical professionals and other governmental or law enforcement agencies, and the Board may open a complaint on its own initiative. All complaints are reviewed by the two inquiry panels of the Board. If the Board finds that a licensee has violated the Act or the Board rules, the Board is authorized to take the appropriate disciplinary action.

Although COPRRR was able to review detailed data related to a limited number of files during this review, COPRRR was unable to review complete complaint files because the Director of the Division (Director) did not provide the case files to COPRRR pursuant to section 12-38-116.5(9), C.R.S., and corresponding legal advice from the Office of the Attorney General. COPRRR relies on access to complaint files to gain a better understanding of the actual harm related to the practice under review, which informs recommendations for changes to the Act and to the administration of the program. Moreover, COPRRR also relies on these files to determine whether final dispositions of complaints are in the public interest or self-serving to the profession.

Table 11 illustrates, over a five-year period, the number and type of complaints and investigations of LPNs opened by the Board.

Table 11
Licensed Practical Nurse Complaints

Type	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
License by Fraud or Deceit	1	1	1	0	1
Felony Conviction	12	17	5	5	11
Acting in a Manner Inconsistent with Patient Health and Safety	45	48	42	35	78
Suspended or Revoked Nurse or Health-Care Provider License	1	1	5	2	0
Violating the Act or Permitting a Violation	9	8	5	8	5
Failing to Meet Standard of Practice	56	50	59	40	83
Violating Board Order	3	10	13	24	15
Falsifying, Negligently Entering or Failing to Enter Patient Records	20	9	9	7	10
Excessive Use or Abuse of Alcohol or Drugs or Diverting Controlled Substances	20	32	32	17	43
Physical or Mental Disability Impairs Practice	3	9	11	4	8
Violating Patient Confidentiality	1	0	2	0	0
Criminal Conduct	20	26	7	6	10
Unnecessary Tests or Procedures	1	1	2	0	0
Prescription or Distribution of a Controlled Substance to Self or Family	1	4	0	2	3
Administering, Dispensing or Prescribing Habit-Forming Drug or Controlled Substance Outside of Legitimate Practice	0	1	1	0	2
Discipline from Another State or Territory	0	5	7	3	4
Willful Failure to Respond to a Complaint	1	1	6	2	3
Failing to Submit Renewal Questionnaire	0	1	0	0	1
Unlicensed Use of Title	0	3	2	5	1
Unlicensed Practice	0	5	0	1	1
Failing to Report Criminal Conviction	2	6	0	2	0
Total	**196**	**238**	**209**	**163**	**279**

The leading cause for a complaint against an LPN concerns failing to meet the generally accepted standard of practice, followed by acting in a manner inconsistent with the health and safety of persons under his or her care. A high number of complaints also concerns excessively using or abusing alcohol, habit-forming drugs or controlled substances or diverting controlled substances.

Table 12 illustrates, over a five-year period, the number and type of complaints and investigations of RNs opened by the Board.

Table 12
Registered Nurse Complaints

Type	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
License by Fraud or Deceit	3	20	70	3	21
Felony Conviction	17	129	21	62	74
Acting in a Manner Inconsistent with Patient Health and Safety	148	209	171	197	250
Nurse or Health-Care Provider License Suspended or Revoked	8	15	21	5	6
Violating the Act or Permitting a Violation	17	11	59	50	17
Failing to Meet Standard of Practice	181	262	267	259	318
Violating Board Order	17	34	134	69	112
Falsifying, Negligently Entering or Failing to Enter Patient Records	51	55	31	20	30
Excessive Use or Abuse of Alcohol or Drugs or Diverting Controlled Substances	69	149	181	146	170
Physical or Mental Disability Impairs Practice	5	59	18	31	41
Violating Patient Confidentiality	0	5	5	0	3
Criminal Conduct	64	252	31	26	43
Abuse of Health Insurance	0	0	0	0	0
Unnecessary Tests or Procedures	1	3	5	6	2
Fraudulent Insurance Act	0	0	0	1	0
Prescription or Distribution of a Controlled Substance to Self or Family	13	25	18	1	13
Prescribing, Dispensing or Injecting Anabolic Steroid for Hormonal Manipulation.	1	0	0	3	0
Administering, Dispensing or Prescribing Habit-Forming Drug or Controlled Substance Outside of Legitimate Practice	6	7	11	4	10
Discipline from Another State or Territory	15	22	18	14	13
Willfully Failing to Respond to a Complaint	4	13	24	2	7
Failing to Submit Renewal Questionnaire	2	1	0	2	0
Unlicensed Use of Title	2	2	26	15	10
Unlicensed Practice	0	7	30	8	22
Failing to Report Criminal Conviction	4	19	9	27	7
Violating Prescriptive Authority	4	19	9	4	18
Total	**632**	**1,318**	**1,159**	**955**	**1,187**

The complaint numbers for both LPNs and RNs increased significantly in fiscal year 14-15 because, previously, the Board did not open complaints when applications with problems such as felony convictions were sent to the Board for consideration.

Like LPNs, the leading cause for complaints against RNs concerns failing to meet the generally accepted standard of practice, followed by acting in a manner inconsistent with the health and safety of persons under his or her care, and a high number of complaints concerns excessively using or abusing alcohol, habit-forming drugs or controlled substances and diverting controlled substances.

If there is a violation of the Act, the Board may pursue sanctions necessary to protect the public including: revocation or suspension of a license, a stipulated agreement, a letter of admonition or a fine. If the Board determines there is no violation of the Act, then the Board may dismiss the complaint. When the Board uncovers conduct that does not rise to the level of unprofessional conduct but the complaint should not be dismissed outright, the Board may send a letter of concern.

When the Director determines that disciplinary action is appropriate, the Director may utilize ESP within the Division to settle a disciplinary matter. ESP was established to resolve disciplinary issues without a formal hearing. When a case is referred to ESP, the ESP staff obtains the parameters concerning the level of discipline that the Board determines is warranted and attempts to settle the case.

Over the five-year period under review, the ESP Office resolved 753 cases related to LPNs and RNs. If the respondent does not agree to the terms offered through the ESP process, the Board may refer the case to the Attorney General's Office for formal proceedings against the nurse's license.

Table 13 provides, for the period under review, the total number of final agency actions related to LPNs.

Table 13
Final Agency Actions
Licensed Practical Nurses

Type of Action	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
Denials	1	0	3	5	1
Revocations	5	8	3	17	21
Suspensions	6	1	2	0	1
Stipulations	12	6	14	19	10
Letters of Admonition	21	14	23	31	17
Total Disciplinary Actions	**45**	**29**	**45**	**78**	**50**
Dismissals	11	44	20	28	36
Letters of Concern	26	37	18	39	20
Total Dismissals	**37**	**81**	**38**	**67**	**56**

The total number of disciplinary actions in Table 13 and Table 14 do not necessarily align with the total number of complaints in Table 11 and Table 12, respectively, since a single complaint may involve multiple allegations and cases may not be closed in the same year in which they are opened.

Approximately 22 percent of complaints against LPNs resulted in disciplinary action. Over the five-year period, the Board took the following actions against LPN licenses: 54 revocations, 10 suspensions, 61 stipulated agreements and 106 letters of admonitions.

Table 14 provides, for the period under review, the total number of final agency actions related to RNs.

Table 14
Final Agency Actions
Registered Nurses

Type of Action	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
Denials	1	4	3	2	13
Revocations	31	22	40	76	60
Suspensions	20	1	2	4	0
Stipulations	51	52	54	76	98
Letters of Admonition	76	38	39	67	59
Total Disciplinary Actions	**179**	**119**	**138**	**250**	**230**
Dismissals	92	268	201	366	276
Letters of Concern	73	153	233	165	133
Total Dismissals	**165**	**421**	**434**	**531**	**409**

Approximately 17 percent of complaints against RNs resulted in disciplinary action. Over the five-year period, the Board took the following disciplinary actions against RN licenses: 229 revocations, 27 suspensions, 331 stipulated agreements and 27 letters of admonition.

The Division could not account for the increase in the number of disciplinary actions against LPNs and RNs in fiscal year 16-17.

Fining Activity

The Board may issue a fine of between $250 and $1,000 for a violation of the Act or the Board rules. According to Board rules, the Board may issue fines for practicing on an expired license, failing to comply with the terms and conditions of a final agency order or stipulated agreement, practicing outside of his or her role or scope of specialty and population focus or in other circumstances in which a licensee has benefited financially from a violation of a Board rule or the Act.[119] The Board has established a fining structure for such violations in rule.

Table 15 demonstrates the total number and amount of fines issued each year between fiscal year 15-16 and fiscal year 17-18.

Table 15
Fines Issued

Fiscal Year	Number	Total Amount
15-16	1	$500
16-17	1	$1,000
17-18	10	$5,250

While the Board had statutory authority prior to fiscal year 15-16, it did not implement a fining matrix until that year and subsequently did not issue any fines. Fining activity increased in fiscal year 17-18 when the Board increased fining related to unlicensed practice.

The Board issued fines for the following reasons:

- Unlicensed practice;
- Falsifying, making incorrect entries or failing to make essential entries on patient records;
- Violating an order, rule or regulation related to the practice of nursing;
- Practicing on an expired license;
- Failing to respond to a Board complaint in a timely manner; and
- Failing to accurately complete a questionnaire upon renewal.

[119] 3 CCR 716-1 § 3, State Board of Nursing Rules.

Nursing Education Programs

The Board approves practical and professional nursing programs that prepare students for licensure as LPNs and RNs. The program content must deliver the knowledge and skills necessary for the practice of clinical nursing at the practical or professional level.

There are four phases to the application process for nursing programs:

- In Phase I, an applicant must submit an application describing the nursing program, the rationale, the legal authority, a feasibility study and resources to support the proposal. Once the Board approves the initial application in Phase I, an applicant moves on to Phase II.

- In Phase II, an applicant must describe the curriculum, the administration, policies, resources available to support the curriculum, a program evaluation and a records maintenance plan. Once the Board approves an applicant in Phase II, the applicant is granted interim approval.

- In Phase III, an applicant must submit semi-annual reports regarding the progress of implementing the nursing program. Within 180 days of the program's start, it must undergo a site visit by Board staff to verify the nursing program is compliant with Board rules. A nursing program must also submit a program data and analysis report within nine months after graduation of the first cohort.

- In Phase IV, a nursing program with interim approval must demonstrate compliance with the Board rules through a self-study report and request full approval by the Board within one year after graduation of the first cohort.

Once a nursing program has full Board approval, it must complete the following steps to maintain Board approval:

- Submit an annual report on an online, electronic form approved by the Board;
- Maintain NCLEX pass-rates for first-time test takers at or above 75 percent over an eight quarter average;
- Undergo a site visit every five years to demonstrate compliance with the Board rules if the program does not have national accreditation and is not progressing timely; and
- Progress to national accreditation within four years of achieving full Board approval.

The Board also approves training courses for LPNs to obtain additional competency in IV therapy. In order to establish an IV therapy training course, an applicant must submit an application that documents how the program will meet the requirements outlined in the Board rules. Once an IV therapy training course has been approved by the Board, it must submit an annual report documenting its compliance with the Board rules in order to maintain continued approval.

Table 16 illustrates the total number of approved practical and professional nursing programs in Colorado as of August 2019.

Table 16
Practical and Professional Nursing Programs

Program Type	Approved Programs
Practical Nursing, Traditional One-Year	9
Practical Nursing with Exit Option to Associate Degree in Professional Nursing	12
IV Therapy Training for LPNs	7
Professional Nursing Associate Degree, Traditional	15
Professional Nursing Associate Degree for Existing LPNs	8
Professional Nursing Associate Degree for Paramedics	1
Professional Nursing Bachelor's Degree, Traditional	12
Professional Nursing (Accelerated/2nd Degree) Bachelor's Degree	6
Professional Nursing Bachelor's Degree for Existing LPNs	1

Colorado has several options for nursing programs, from one-year programs in practical nursing to become an LPN to four-year programs to become an RN and many intermediate options in between. For example, an LPN can complete a one-year program and enter into practical nursing for a few years before returning to obtain an associate or bachelor's degree in professional nursing and qualify for an RN license. Others may chose a practical nursing program in which they may graduate in a year and seek LPN licensure or continue their education in order to obtain associate degrees in professional nursing. Likewise, an RN who already has an associate degree may enter into an accelerated programs for a bachelor's degree in professional nursing. There is also one program for paramedics who have already obtained some clinical skills and knowledge and are interested in furthering their education to obtain associate degrees in professional nursing.

The Division conducts inspections of nursing programs as needed to ensure that programs meet Board standards set in rule.

Table 17 shows the total number of inspections conducted by the Board over a five-year period.

Table 17
Inspections

Fiscal Year	Total
13-14	1
14-15	1
15-16	3
16-17	2
17-18	1

The number of inspections fluctuates from year to year because the Board staff only conducts inspections when necessary. Typically, inspections are conducted as part of the approval process for new nursing programs. Board staff may also conduct inspections if programs are struggling to obtain accreditation in order to provide additional support to the programs. Finally, Board staff conducts inspections when programs are failing to comply with the Board standards, such as when a high rate of graduates are failing to pass the NCLEX.

The Board has the authority to approve or deny a nursing program's application. Once a program has full Board approval, if an applicant does not meet the standards set by the Board, it may offer the program conditional approval or withdraw approval.

Anyone may file a complaint against a nursing program, including students, faculty, members of the community, and the Board may initiate a complaint on its own motion.

In general, the Board receives complaints against nursing programs for:

- Lacking accurate, non-discriminatory or consistently applied policies;
- Providing inaccurate or inconsistent information about the program requirements;
- Failing to deliver at least 50 percent of clinical training in a health-care facility;
- Failing to adhere to generally accepted recruiting standards;
- Failing to provide adequate support for students who were readmitted who had failed the program;
- Failing to provide faculty support and guidance as promised in the syllabus;
- Engaging in unprofessional behavior as a faculty member;
- Hiring unqualified faculty;
- Providing inadequate laboratory resources;
- Failing to provide a curriculum that teaches the knowledge, skills and competencies necessary for safe nursing practice; and
- Having a toxic teaching or learning environment.

The Board may also open a complaint on its own motion if a nursing program is failing to meet Board standards such as obtaining national accreditation or if over 25 percent of its students fail to pass the NCLEX over a two-year period.

Table 18 illustrates the total number of complaints against practical and professional nursing programs in Colorado from fiscal year 13-14 to fiscal year 18-19.

Table 18
Complaints & Disciplinary Actions
Practical and Professional Nursing Programs

Type of Complaint	Practical	Professional	IV Authority
Number of Complaints	7	24	1
Number of Programs Complained Against	2	9	1
Program Closures	0	2	0
Conditional Approval	1	0	0
Total Disciplinary Actions	**1**	**2**	**0**
Total Dismissals	6	22	1
Final Agency Actions	**7**	**24**	**1**

Over a six-year period, the Board withdrew approval of two professional nursing programs and granted one practical nursing program conditional approval. The Board withdrew the approval of one professional nursing program because over 25 percent of its students failed to pass the NCLEX for over two years and, at one point, 75 percent of the program's students failed the examination. The program was also not progressing toward national nursing accreditation as required by the Board. The Board withdrew approval of another professional nursing program for also having low pass rates, failing to progress toward national accreditation and failing to provide any clinical training in a setting in which the students gained practical experience providing care to actual patients. Additionally, the Board provided conditional approval to a practical nursing program after it failed to provide any clinical training in a setting in which the students gained practical experience providing care to actual patients.

While the Board received one complaint against an LPN training program for IV authority, it did not take any action against this program. Overall, the Board dismissed 29 complaints against nursing programs.

Collateral Consequences – Criminal Convictions

The ninth sunset criterion requires COPRRR to examine whether the agency under review, through its licensing processes, imposes any sanctions or disqualifications based on past criminal history, and if so, whether the disqualifications serve public safety or commercial or consumer protection interests.

In part, COPRRR utilizes this section of the report to evaluate the program according to this criterion.

The Board has the authority to deny, revoke or suspend a license. The Board may also require an applicant or a licensee to enter into a stipulated agreement in which the licensee is subject to requirements such as probation, continuing education, substance abuse treatment and monitoring, or other requirements to ensure the licensee is competent to practice. In Tables 17 and 18, these are referred to as conditional licenses.

A licensee may voluntarily agree to an interim cessation of practice with the Board until a complaint is resolved. Since an interim cessation of practice is voluntary, it is not considered a suspension or a disciplinary action. However, interim cessation of practice may ultimately lead to a revocation.

Table 19 illustrates, over a five-year period, the number and type of license disqualifications or conditional licenses entered into with LPNs that were based on criminal conduct.

Table 19
Collateral Consequences
Licensed Practical Nurses

Nature of Disqualifications	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
Denials	0	0	1	1	0
Revocations	3	5	6	4	9
Suspensions	0	0	2	1	5
Interim Cessation of Practice	0	0	0	0	2
Conditional Licenses	0	2	1	1	1
Total	**3**	**7**	**10**	**7**	**17**

The Board revoked LPN licenses for criminal conduct related to:

- Identity theft,
- Driving while impaired,
- Drug diversion,
- Possession of controlled substances, and
- Obtaining controlled substances by fraud or deceit.

The Board suspended several LPN licenses for criminal conduct such as:

- Criminal neglect,
- Medicaid fraud,
- Child abuse,
- Drug diversion, and
- Possession of controlled substances.

In several of these cases, the license suspensions likely resulted in revocations.

Typically, conditional licenses were issued to LPNs based on alcohol- or substance abuse- related criminal conduct, such as driving while under the influence of drugs or alcohol and possession of narcotics.

Two LPNs agreed to interim cessation of practice agreements, one was related to possible drug diversion, missing medications at work and a refusal to take a drug test and another was related to driving while impaired along with being impaired at work and a drug screen for cocaine. An interim cessation of practice agreement may later result in a revocation.

Table 20 illustrates, over a five-year period, the number and type of license disqualifications or conditional licenses entered into with RNs that were based on criminal conduct.

Table 20
Collateral Consequences
Registered Nurses

Nature of Disqualifications	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
Denials	0	1	1	1	4
Revocations	15	10	14	38	22
Suspensions	1	1	7	13	9
Interim Cessation of Practice	1	0	1	8	4
Conditional Licenses	6	6	12	14	7
Total	**23**	**18**	**35**	**74**	**46**

The Board revoked RN licenses based on criminal conduct, such as:

- Drug possession,
- Obtaining drugs through fraud,
- Drug diversion,
- Domestic violence and assault,

- Vehicular assault related to driving while under the influence,
- Assault with a deadly weapon,
- Child abuse, and
- Sexually assaulting patients.

It also denied RN licenses based on criminal conduct, such as felony fraudulent use of unemployment and identity theft.

Further, the Board suspended RN licenses based on criminal conduct related to:

- Domestic violence,
- Drug diversion,
- Sexual assault of a child and child abuse,
- Sexual misconduct with patients, and
- Murder.

In several of these cases, the license suspensions likely resulted in revocations.

Like LPNs, conditional licenses were often issued to RNs based on criminal conduct related to substance abuse, such as driving while under the influence of drugs or alcohol. Conditional licenses were also issued to RNs for criminal possession of narcotics, assault and obtaining controlled substances through fraud.

Several RNs agreed to interim cessation of practice agreements, typically based on drug diversion or drug use. However, one of these cases was based on physical and verbal abuse and neglect of an at-risk person and another case was based on physical and verbal abuse and neglect of a minor. An interim cessation of practice agreement may later result in a revocation.

Analysis and Recommendations

The final sunset criterion questions whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest. The recommendations that follow are offered in consideration of this criterion, in general, and any criteria specifically referenced in those recommendations.

Recommendation 1 – Continue the Nurse Practice Act for seven years, until 2027.

The laws that govern the practice of nursing are located in Article 38 of Title 12, Colorado Revised Statutes (C.R.S.) (Act). The State Board of Nursing (Board), which is housed in the Division of Professions and Occupations (Division) in the Department of Regulatory Agencies, is entrusted with the enforcement of the Act.

Sunset reviews are guided by statutory criteria found in section 24-34-104, C.R.S., and the first criterion asks whether regulation is necessary to protect the health, safety and welfare of the public.

The Act protects the public by ensuring that nurses are qualified to practice practical or professional nursing.

Nurses are licensed at different levels, depending on their level of education:[120]

- Licensed practical nurses (LPNs), or
- Registered nurses (RNs).

An LPN must complete a one-year program in practical nursing that is approved by the Board and pass the National Council Licensure Examination (NCLEX) for Practical Nurses in order to be licensed.

The qualifications required to be licensed as an RN are similar to those of an LPN; however, an RN must obtain either an associate or a bachelor's degree in professional nursing and pass the NCLEX for RNs.

Advanced practice nurses (APNs) are licensed RNs with advanced education and private, professional certification.

[120] ANA Enterprise. *What Is Nursing and What Do Nurses Do?* Retrieved October 30, 2018, from https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/

Nurses provide care to sick, injured, disabled and dying patients.[121] Nurses are trained to promote and maintain health, and nurses may practice independently or under the supervision of a medical provider.[122]

It is especially important to ensure that nurses are at least minimally competent. A nurse may harm a patient by failing to adequately assess or monitor a patient's condition; by administering the wrong medication or the wrong dose of a medication; by using medical equipment improperly; and by failing to communicate with other health-care providers. In all of these cases, a patient may be seriously injured or die as a result of substandard care. A nurse may also injure someone if they do not use necessary precautions when caring for patients. For example, if a nurse does not use proper infection controls, a patient may suffer a serious infection which could result in the loss of a limb or worse. Substandard care in the practice of nursing can also extend hospital stays and increase health-care costs.

The potential harm of an APN is similar to that of a physician since an APN may diagnose and treat illnesses and injuries, and some APNs may prescribe medication, including controlled substances. An APN may harm a patient by misdiagnosing an illness, failing to provide appropriate treatment and failing to refer to another health-care provider when necessary.

Over a five-year period, the Board received 288 complaints against LPNs and 1,287 complaints against RNs for failing to meet the generally accepted standards of practice.

Licensure is the appropriate level of regulation since a nurse may harm a patient through negligent or inattentive care. Nurses also have access to patient information, patient belongings and patient medication, and patients are vulnerable to abuse, theft and exploitation by a nurse. Unfortunately, drug diversion and theft are problems in the nursing profession. For instance, a nurse may substitute a pain reliever, such as acetaminophen, for a narcotic that a patient needs for pain management after an operation.

Over a five-year period, the Board received 144 complaints against LPNs and 715 complaints against RNs related to excessive use or abuse of drugs or alcohol or diverting controlled substances. During this same period, the Board received 248 complaints against LPNs and 975 complaints against RNs for acting in a manner inconsistent with the health and safety of patients. The Board also received 55 complaints against LPNs and 187 complaints against RNs for falsifying, negligently entering or failing to enter patient records.

[121] Encyclopædia Britannica. *Nursing*. Retrieved November 20, 2018, from https://www.britannica.com/science/nursing
[122] Merriam Webster. *Nurse*. Retrieved November 20, 2018, from https://www.merriam-webster.com/dictionary/nurse

The Act protects the public by vesting the Board with the authority to discipline nurses who violate the Act or the Board rules.

Over a five-year period, the Board took the following disciplinary actions against LPNs:

- Denied 10 licenses,
- Revoked 54 licenses,
- Suspended 10 licenses,
- Entered into 61 stipulated agreements, and
- Issued 106 letters of admonition.

Over the same five-year period, the Board took the following disciplinary actions against RNs:

- Denied 23 licenses,
- Revoked 229 licenses,
- Suspended 27 licenses,
- Entered into 331 stipulated agreements, and
- Issued 279 letters of admonition.

The sunset criteria question:

- Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether complaint, investigation and disciplinary procedures adequately protect the public; and
- Whether final dispositions of complaints are in the public interest or self-serving to the profession.

Although COPRRR was able to review detailed data related to a limited number of files during this review, COPRRR was unable to review complete complaint files because the Director of the Division (Director) did not provide the case files to COPRRR pursuant to section 12-38-116.5(9), C.R.S., and corresponding legal advice from the Office of the Attorney General.

COPRRR relies on access to complaint files to gain a better understanding of the actual harm related to the practice under review, which informs recommendations for changes to the Act and to the administration of the program. Moreover, COPRRR also relies on these files to determine whether final dispositions of complaints are in the public interest or self-serving to the profession. Since COPRRR was unable to review complaint files, a seven-year continuation is recommended.

As regulation is necessary to protect the public, the General Assembly should continue this program for seven years, until 2027.

Recommendation 2 – Amend the Act so that "failure to act within the limitations created by an illness or other health condition" is grounds for discipline and authorize the Board to enter into a confidential agreement with a nurse to address a health condition that impacts his or her ability to practice safely.

Nurses can become ill and suffer injuries, and some of these conditions may impact their ability to practice nursing safely.

To determine if a nurse has a health condition that impacts his or her ability to practice, the application for initial licensure asks the following question:[123]

> In the last five years, have you been diagnosed with or treated for a condition that significantly disturbs your cognition, behavior or motor function, and that may impair your ability to practice as a practical [or professional] nurse safely and competently including but not limited to bipolar disorder, severe major depression, schizophrenia or other major psychotic disorder, a neurological illness or sleep disorder?

The renewal application asks a similar question. If a nurse answers in the affirmative, his or her application may be denied or license revoked, or the Board may require the nurse to enter into a stipulated agreement that limits his or her practice, which is a public disciplinary action.

However, the nurse did not really do anything wrong; the underlying reason for his or her disciplinary action is due to a protected, confidential medical situation.

The second sunset criterion questions whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest.

The General Assembly should revise the Act so that failing to act within the limitations created by a physical or mental condition or disability is grounds for discipline, as opposed to simply having such a condition or disability. Additionally, the nurse must be required to notify the Board of the illness, condition or disability in a manner and period of time determined by the Board.

One way to help ensure that nurses act within the limitations created by an illness or health condition, thus avoiding discipline, is to authorize the Board to enter a into confidential agreement with such a practitioner whereby the practitioner agrees to limit his or her practice.

[123] Division of Professions and Occupations, Board of Nursing. *Application for Original License by Examination: Practical Nurse* (December 2015) and *Application for Original License by Examination: Registered Nurse* (December 2017).

Rather than taking disciplinary action against the licensee, the Board should instead be granted the authority to enter into a confidential agreement with the licensee in which the licensee voluntarily agrees to limit his or her practice so that he or she may continue to practice safely, within the limits of the illness, condition or disability, and failing to comply with the terms of the confidential agreement would be grounds for discipline.

However, this process should not be employed for nurses who are using or abusing drugs or alcohol. Practicing with such a condition constitutes a separate statutory violation, and this recommendation is not intended to address drug or alcohol abuse. Moreover, the Board already has an alternative to discipline program related to drugs and alcohol, which this recommendation is not intended to alter.

Therefore, the General Assembly should amend the Act so that failing to act within the limitations created by a health condition is grounds for discipline, and it should also authorize the Board to enter into confidential agreements with practitioners to address conditions that may impact a nurse's ability to practice safely. These should be based on similar provisions in other practice acts, and the alternative to discipline program related to drugs and alcohol should be retained.

Recommendation 3 – Add to the grounds for discipline, "engaging in a sexual act with a patient during the course of patient care or within six months immediately following the termination of the licensee's professional relationship with the patient."

Several practice acts for health-care providers include among the prohibited acts:

> Engaging in a sexual act with a patient during the course of patient care or within six months immediately following the termination of the licensee's professional relationship with the patient. "Sexual act", as used in this paragraph, means sexual contact, sexual intrusion or sexual penetration as defined in section 18-3-401, C.R.S.[124]

The reason this conduct is prohibited for most health-care providers is to reduce the risk of the provider exploiting the patient due, in part, to the power differential in a patient-provider relationship.

Essentially, a relationship may be exploited when a patient relies on a nurse to administer the care necessary for the patient to stay alive, to heal from injuries or to manage health conditions. In some cases, a patient may idolize a nurse and see him or her as a savior. In other cases, such as home care, a nurse may be the only social contact that the patient has on a regular basis. Often, a patient may be in a

[124] § 12-36-117(1)(r), C.R.S.

vulnerable position, such as a patient in a psychiatric ward, a patient with a brain injury or someone who is heavily medicated.

The third sunset criterion questions whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes.

Currently, the practice act does not explicitly prohibit having sex with a patient during or within the six months following the end of the professional relationship. While the Board may be able to discipline a nurse for having a sexual relationship with a patient when they are being treated, it may be more difficult to discipline a nurse for this conduct when they are off duty or a month or so after the nursing care has ended.

However, the power differential still exists when the patient is no longer being cared for by the nurse. It takes time for the patient to stop idolizing the nurse. It is for this reason that a six-month waiting period after the professional relationship has ended is typically required.

In order to enhance public protection, the General Assembly should add to the grounds for discipline, "engaging in a sexual act with a patient during the course of patient care or within six months immediately following the termination of the licensee's professional relationship with the patient."

Recommendation 4 – Require licensees and insurance carriers to report any malpractice settlements or judgments to the Board.

Currently, licensees are not required to report to the Board any malpractice settlements that are entered into on their behalf, or malpractice judgments that have been entered against them.

Malpractice cases often provide important information about whether a practitioner is competent to practice. If the underlying facts of a case demonstrate that harm was caused by substandard practice, the Board should be able to determine whether any steps are necessary to protect the public. Under the current requirements, unless a consumer files a complaint, the Board may not have any knowledge of a case.

Other health-care professions, including acupuncturists, dentists, physicians and podiatrists,[125] have provisions that require reporting malpractice settlements and judgments to the respective regulatory authority. As health-care providers, nurses should have the same requirement.

As self-reported information is not always reliable, it would be reasonable to also require the insurance companies who write professional liability insurance for nurses

[125] §§ 10-1-120, 10-1-124, 12-29.5-104(5), and 12-35-129(1)(q) and (r), C.R.S.

to also report settlements and judgments. This is how other such requirements in other practice acts are structured.

The third sunset criterion questions whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes.

It is important for the regulatory authority, in this case the Board, to have knowledge of malpractice settlements and judgments because the information provided by an insurance company could help protect the public in case a nurse is unsafe to practice.

In order to create a more effective regulatory program, the General Assembly should require nurses and insurance companies who underwrite professional liability insurance for nurses to report any malpractice settlements or judgments to the Board within 30 days.

Recommendation 5 – Align the language related to drug and alcohol use in 12-38-117(1)(i), C.R.S., with the language in several other practice acts.

Currently, the Act includes in the grounds for discipline: "Excessively *uses* or *abuses* alcohol, habit-forming drugs, controlled substances, as defined in section 18-18-102 (5), C.R.S., or other drugs having similar effects…."[126]

This language would be improved if it were aligned with language in other practice acts. For example, the Medical Practice Act prohibits, "habitual or excessive *use* or *abuse* of alcohol, a habit-forming drug or a controlled substance as defined in section 18-18-102 (5), C.R.S."

In *Colorado State Board of Medical Examiners v. Davis*, 893 P.2d 1365 (Colo. App. 1995), the Colorado Court of Appeals held that disciplinary action based on excessive use of alcohol or a controlled substance does not require current addiction or use of alcohol or controlled substances at the time of the disciplinary hearing.

The third sunset criterion questions whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes.

A clear law makes for better compliance and enforcement. Changing the language would ensure the Board has the authority to take action against a nurse who may no longer be safe to practice based on excessive use or abuse of drugs or alcohol.

Therefore, the General Assembly should align language in the grounds for discipline in 12-38-117(1)(i), C.R.S., with the Medical Practice Act.

[126] § 12-38-117(1)(i), C.R.S.

Recommendation 6 – Require licensees to report an adverse action or the surrender of a license within 30 days.

A licensee who has been convicted of a crime is currently required to report the conviction to the Board. However, they are not required to report other adverse actions which could be just as important for public protection purposes.

Other practice acts require additional reporting in order to protect the public against practitioners who are unsafe to practice. For example, the Medical Practice Act prohibits:

- Failing to report to the [Colorado Medical Board], within 30 days after an adverse action, that an adverse action has been taken against the licensee by another licensing agency in another state or country, a peer review body, a health-care institution, a professional or medical society or association, a governmental agency, a law enforcement agency or a court for acts or conduct that would constitute grounds for disciplinary or adverse action as described in this [Medical Practice Act]; and

- Failing to report to the [Colorado Medical Board], within 30 days, the surrender of a license or other authorization to practice medicine in another state or jurisdiction or the surrender of membership on any medical staff or in any medical or professional association or society while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as described in this [Medical Practice Act].

Consequently, if a physician is disciplined by a professional association, for example, or they surrender their license to practice medicine in another state, they are required to report this to the Medical Board within 30 days. Nurses, however, lack a similar requirement. At this time, nurses are only required to report criminal convictions.

Because nurses are not required to report other adverse actions, the Board may not find out until a nurse renews his or her license that the nurse has been disciplined by a professional organization or surrendered a license to practice in another state. During that time, the nurse may continue to practice here in Colorado even though he or she may not be safe to practice.

The third sunset criterion questions whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes.

While the Board is not required to take action based on an adverse action by another entity or jurisdiction, the Board should review the underlying facts of an adverse action to determine whether the nurse presents a danger to his or her patients.

In order to better protect the public, the General Assembly should add, to the grounds for discipline, the requirement to report an adverse action or the surrender of a license within 30 days, consistent with sections 12-36-117(1)(y) and (z), C.R.S., in the Medical Practice Act.

Recommendation 7 – Amend section 12-38-117(1)(z), C.R.S., to require nurses to report a criminal conviction within 30 days.

Section 12-38-117(1)(z), C.R.S., requires nurses to report a criminal conviction to the Board within 45 days. However, other practice acts, such as the Medical Practice Act, require licensees to report criminal convictions within 30 days.

The third sunset criterion questions whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes.

If someone has been convicted of a crime and they are a danger to their patients, the Board needs to take action as soon as possible. It is reasonable to allow a licensee some time in between the conviction and reporting it to the Board, but 45 days delays the Board's ability to act and puts the public at risk of harm for longer than necessary.

In order to create a more effective regulatory program, the General Assembly should amend section 12-38-117(1)(z), C.R.S., to require nurses to report a criminal conviction within 30 days.

Recommendation 8 – Limit the requirement that an APN maintain an articulated plan for safe prescribing to the period of provisional prescriptive authority only.

APNs in Colorado may obtain full prescriptive authority once they have completed 1,000 hours of prescribing practice under the mentorship of a physician or another APN with full prescriptive authority. During the mentorship period, the APN is granted provisional prescriptive authority and is required to complete an articulated plan for safe prescribing.

The articulated plan, which must be signed by the mentor, requires the APN to outline:

- Specific resources and contacts in case of issues related to prescribing,
- Specific resources or contacts to refer patients who are outside the APN's scope of practice or in case of an emergency,
- Specific mechanisms that will be used to evaluate the quality of prescribing practices,
- Specific decision support tools that will be used in prescribing, and
- Ongoing continuing education courses in pharmacology and safe prescribing.

The articulated plan is required to be signed by the mentor, retained on file, updated annually and provided to the Board upon request.

The first criterion questions whether regulation is necessary to protect the public health, safety and welfare.

Unlike physicians, APNs are not required to complete an internship or a residency program upon graduation. APNs are required to complete three years of professional nursing in order to obtain prescriptive authority, but this does not include a prescribing period under the supervision or mentorship of another experienced prescriber. The mentorship period, therefore, allows for a transition period in between practicing without prescriptive authority and practicing with full prescriptive authority, and the articulated plan provides guidelines for safe prescribing during this transition.

The second criterion questions whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest.

According to stakeholders, once an APN has full prescriptive authority, updating the articulated plan is largely an unnecessary administrative task. It is already the standard of practice for an APN to consult with and refer to other health-care providers when necessary. This is also mandated in statute[127]and failure to do so is further specifically prohibited in the grounds for discipline.[128]

Colorado also requires APNs to maintain professional certification in their role and population focus,[129] and renewal requirements for certification include continued competency. For example, the American Academy of Nurse Practitioners Certification Board requires, in addition to other requirements, 100 hours of advanced continuing education every five years, which must include at least 25 hours of advanced practice pharmacology.[130]

While developing the articulated plan may be a worthwhile exercise for a new prescriber, once an APN has full prescriptive authority, it is no longer necessary.

Therefore, the General Assembly should limit the requirement for an APN to maintain and update an articulated plan for safe prescribing to the period of provisional prescriptive authority. Doing so will not compromise public protection.

[127] § 12-38-111.5(6), C.R.S.
[128] § 12-38-117(1)(n), C.R.S.
[129] § 12-38-111.6(4.5)(c)(III), C.R.S.
[130] American Academy of Nurse Practitioners Certification Board. *Renewal Requirements.* Retrieved August 9, 2019, from https://www.aanpcert.org/recert/ce

Recommendation 9 – Replace the title, "advanced practice nurse" and the corresponding abbreviation, "APN" with the title, "advanced practice registered nurse" and the abbreviation, "APRN" and update references throughout the Act and in other statutes.

Under section 12-38-111.5, C.R.S., a nurse who is included in the Advanced Practice Registry may use the title, "advanced practice nurse" or the abbreviation, "APN," among other titles and abbreviations.

However, the preferred title is, "advanced practice registered nurse" and the corresponding abbreviation, "APRN." This title is commonly used at the national level and in most other states.

The tenth sunset criterion questions whether administrative or statutory changes are necessary to improve agency operations to enhance the public interest.

The title, "advanced practice registered nurse," is preferred by the nursing profession because it more clearly indicates that these nurses are, in fact, RNs with advanced education. Building the term, "registered" into the title highlights that the education, training and, therefore, the scope of practice includes that of an RN.

Since most other states, national organizations and federal agencies use this title, it would be less confusing for consumers and other health-care providers if Colorado also adopted this title.

Therefore, the General Assembly should replace the title, "advanced practice nurse" and the corresponding abbreviation, "APN" with the title, "advanced practice registered nurse" and the corresponding abbreviation, "APRN" and update references to this title throughout the Act and in other statutes.

Recommendation 10 – Authorize the Board to conduct random audits of articulated plans rather than require it.

Currently, the Board is required to conduct random audits of articulated plans to ensure APNs with prescriptive authority are compliant.

This requirement creates an inflexible regulatory program in which the Board does not have the ability to create a more efficient process if it determines that doing so will not compromise public protection.

For instance, the Board may determine, after reviewing compliance with this requirement, that random audits are unnecessary and instead only require an APN to submit an articulated plan for Board review if the Board receives a complaint. Doing so, in this case, may be a more efficient use of state resources while still ensuring that the public is protected.

At a later date, the Board may recognize a pattern of noncompliance with articulated plans and problems with prescribing and, consequently, reinstate random audits.

The third and fourth sunset criteria ask:

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, and
>
> Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively.

It would be more efficient to provide the Board with the authority to conduct random audits if necessary, rather than require them.

Therefore, the General Assembly should change the requirement for the Board to conduct random audits so that the language is permissive.

Recommendation 11 – Repeal the age limitation to obtain a retired volunteer license.

The Board currently has the authority to issue a retired volunteer license to a nurse who no longer accepts compensation for nursing tasks. The benefit of the volunteer license is that the license fee is reduced by at least 50 percent. However, at this time, the volunteer license is limited to someone who is 55 years of age or older.

The volunteer license benefits Coloradans by encouraging nurses and charitable organizations to provide free health care to the public. There simply is no reason to limit the age that someone may provide free health-care services and, in exchange, obtain a license for a reduced fee.

The third sunset criterion questions whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes.

The age limit on this license is unnecessary and it should be repealed. Doing so may increase access to health care for indigent and underserved populations by encouraging more nurses to volunteer their services.

Therefore, the General Assembly should repeal the age limit on the retired volunteer license type and repeal the requirement to be retired and references to the term, “retired.”

Recommendation 12 – Repeal the requirement for the Director to consult with the Board prior to appointing a program director and other program staff.

The Director is required by statute to consult with the Board when appointing a program director and other program staff. Although the Director may consult with a board or commission when making an appointment, it is unusual to place such an obligation on the Director in statute. Typically, the Director may choose whether to consult with a board or commission.

The third and fourth sunset criteria ask:

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, and
>
> Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively.

The Board performs an important role for the state, but it should not be in the position of hiring Division staff. The Board consists of volunteer members, appointed by the Governor, who engage with the program staff at monthly and quarterly meetings; Board members do not engage with program staff on a day-to-day basis, and they do not otherwise have a role in hiring or managing staff.

Additionally, the statute does not require the Director to appoint anyone selected by the Board. The Director is merely required to consult with the Board. So, it is at best a specious requirement.

For all these reasons, the General Assembly should repeal this requirement.

Recommendation 13 – Repeal the requirement for at least one Board member to sit on the panel to interview the program director.

Currently, the Act requires at least one Board member to sit on any panel convened by the Department of Personnel to interview candidates for the position of program director. While provisions like this occasionally exist in state government, it is extremely unusual.

The third and fourth sunset criteria ask:

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, and
>
> Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively.

The oversight of the Division staff is the responsibility of the Director who has knowledge of the day-to-day activities of the program director. Creating a provision in which the Board has a role in hiring Division staff blurs these lines.

Therefore, the General Assembly should repeal the requirement for at least one Board member to sit on the panel to interview the program director.

Recommendation 14 – Repeal, "willfully" and "negligently" from sections 12-38-117(1)(c), 12-38-117(1)(f), and 12-38-117(1)(g), C.R.S., in the grounds for discipline.

Several sections of the grounds for discipline include the language, "willfully" and "negligently":

- **Section 12-38-117(1)(c), C.R.S.,** prohibits a nurse from *willfully* or *negligently* acting in a manner inconsistent with the health or safety of persons under his care;
- **Section 12-38-117(1)(f), C.R.S.,** prohibits a nurse from *negligently* or *willfully* practicing nursing in a manner which fails to meet generally accepted standards for such nursing practice; and
- **Section 12-38-117(1)(g), C.R.S.**, prohibits a nurse from *negligently* or *willfully* violating any order, rule or regulation of the Board pertaining to nursing practice or licensure.

The term, "willful" implies that an act was intentional. However, regulatory oversight focuses on whether a regulated professional has violated the Act or the rules, which could harm consumers, not whether the violation was intentional. As such, the Board should be able to pursue formal discipline if a violation of the Act or rules has occurred, without having to prove the violation was intentional.

Similarly, the term, "negligently" involves a higher standard than appropriate for the Board to take action against a licensee. For example, acting inconsistently with the health and safety of the patients, in and of itself, should be grounds for discipline. Failing to meet the generally accepted standards of practice should be grounds for discipline, and violating an order or rule of the Board should be grounds for discipline. The Board should not also be required to prove that the practitioner acted negligently in doing so.

The third and fourth sunset criteria ask:

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, and
>
> Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively.

Repealing these terms will create a more efficient regulatory program, which could help to reduce legal fees and potentially lower license fees. It will also align the Act with other practice acts, such as the Medical Practice Act, in which these elements are not required to be proven for the regulatory authority to take action.

In order create a more efficient regulatory program, the General Assembly should repeal the terms, "willfully" and "negligently" from sections 12-38-117(1)(c), 12-38-117(1)(f), and 12-38-117(1)(g), C.R.S., in the grounds for discipline.

Recommendation 15 – Repeal the requirement that a letter of admonition be sent by certified mail.

Section 12-38-116.5(3)(c)(IV), C.R.S., requires the Board to send a letter of admonition via certified mail. While this delivery method allows Division staff to verify that a delivery attempt was made, it does not guarantee that the licensee actually receives the letter. The licensee can decline to sign for or pick up the letter, and then claim he or she never received it. This defeats the purpose of sending a letter by certified mail.

Sending a letter by certified mail also costs more than sending one by first-class mail or emailing it.

This requirement should be repealed. The Board requires licensees to notify the Board of a change of address within 30 days, which may be submitted in writing or through the Board's online system. If the Board is notified of an address change as required, it is very unlikely that the licensee would not receive a properly addressed letter of admonition.

The third and fourth sunset criteria ask:

> Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, and
>
> Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively.

Repealing this requirement would save money and streamline the administrative process for letters of admonition without compromising the Board's enforcement authority.

Therefore, the General Assembly should repeal the requirement that a letter of admonition be sent by certified mail.

Recommendation 16 – Make technical amendments to the Act.

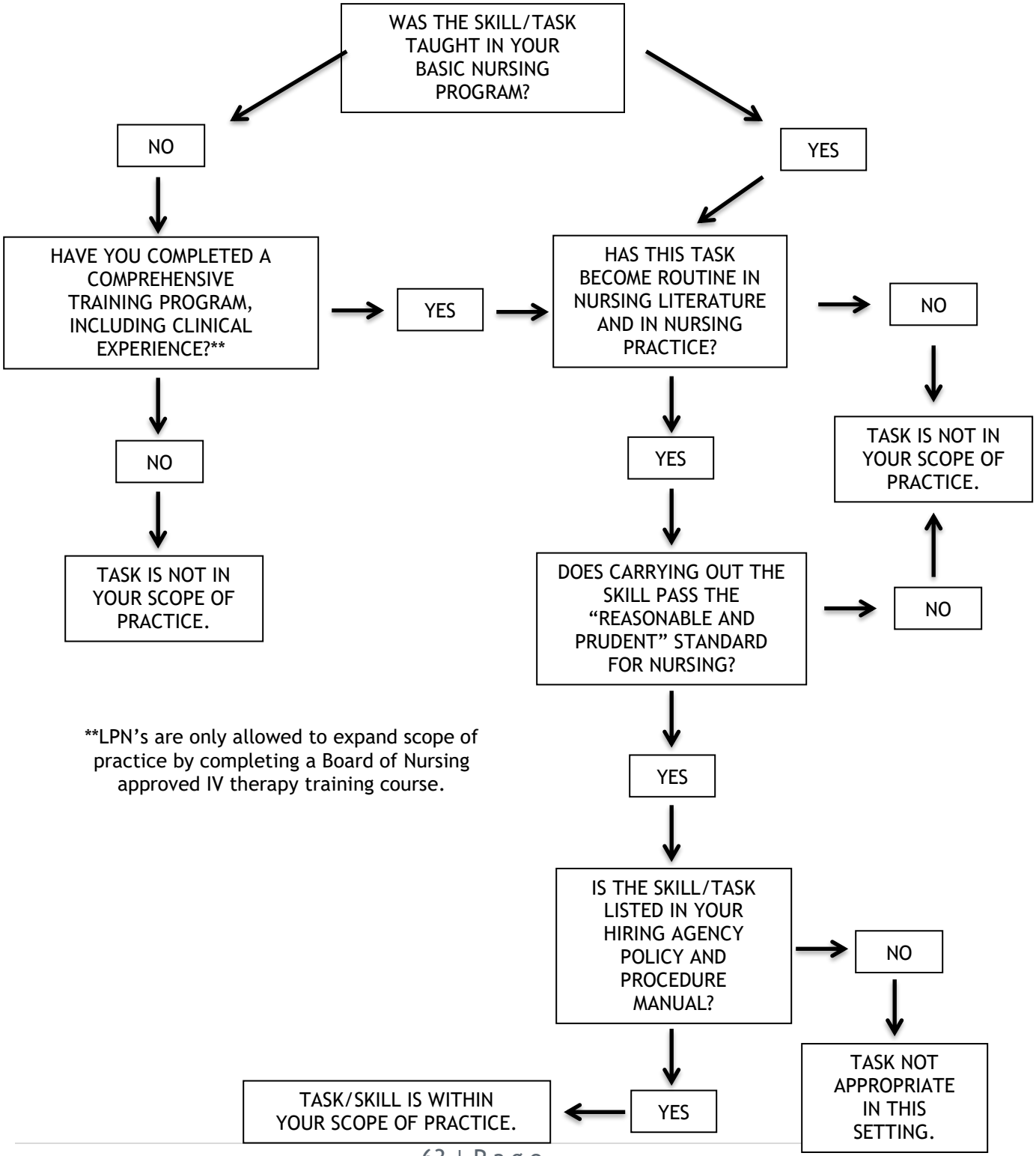
The Act has been in place for many decades. As with any law, it contains instances of outdated, duplicative and confusing language, and the Act should be revised to eliminate obsolete references and to reflect current terminology and administrative practices. These changes are technical in nature, so they will have no substantive impact on the regulation of the practice of nursing.

The General Assembly should make the following technical changes:

- **Section 12-38-117(1)(i), C.R.S.** Create two separate grounds for discipline, one for, "excessively uses or abuses alcohol, habit-forming drugs, controlled substances..." and another for, "diverting controlled substances..." since these are decidedly different types of violations.
- **Sections 12-38-108(1)(b.5), 12-38-111(3), 12-38-112(3), 12-38-112.5(8), and 12-38-118(2), C.R.S.** Replace the terms, "refuse," "refuse to renew" and "refuse to issue" with, "deny" since the Board either approves or denies a license; the term, "refuse" does not have a commonly-understood definition.
- **Section 12-38-117, C.R.S.** Replace the phrase, "physical or mental disability" with "physical condition or mental health disorder" in order to modernize the language.
- **Section 12-38-116(4), C.R.S.** Repeal as obsolete.

Appendix A – Scope of Practice Algorithm for Professional Nurses (RNs)

Is This Task Within My Scope of Practice?



**LPN's are only allowed to expand scope of practice by completing a Board of Nursing approved IV therapy training course.

Appendix B - Title 12 Recodification Table

This table shows provisions of Article 38 of Title 12 of the Colorado Revised Statutes that were relocated as a result of the passage of House Bill 19-1172, concerning an organizational recodification of Title 12.

Prior to October 1, 2019	October 1, 2019 and Thereafter	Prior to October 1, 2019	October 1, 2019 and Thereafter
12-38-101	**12-255-101**	12-38-116.5(2)	12-255-119(2)
12-38-102	**12-255-102**	12-38-116.5 IP(3)(a)(I)	12-255-119 IP(3)(a)(I)
12-38-103 IP	**12-255-104 IP**	12-38-116.5(3)(a)(I)(A)	12-255-119(3)(a)(I)(A)
12-38-103(1.5)	12-255-104(1)	12-38-116.5(3)(a)(I)(B)	12-255-119(3)(a)(I)(B)
12-38-103(2)	12-255-104(2)	12-38-116.5(3)(a)(I)(C)	12-255-119(3)(a)(I)(C)
12-38-103(3)	12-255-104(3)	12-38-116.5(3)(a)(I)(D)	12-255-119(3)(a)(I)(D)
12-38-103(4)	12-255-104(4)	12-38-116.5(3)(a)(II)	12-255-119(3)(a)(II)
12-38-103(5)	12-255-104(5)	12-38-116.5(3)(a)(III)	12-255-119(3)(a)(III)
12-38-103(7.4)	Repealed	12-38-116.5 IP(3)(b)	12-255-119 IP(3)(b)
12-38-103(7.8)	12-255-104(6)	12-38-116.5(3)(b)(I)	12-255-119(3)(b)(I)
12-38-103(8)(a)	12-255-104(7)	12-38-116.5(3)(b)(II)	12-255-119(3)(b)(II)
12-38-103(8.5)(a)	12-255-104(8)(a)	12-38-116.5(3)(b)(III)	12-255-119(3)(b)(III)
12-38-103(8.5)(b)	12-255-104(8)(b)	12-38-116.5 IP(3)(c)	12-255-119 IP(3)(c)
12-38-103(8.5)(c)	12-255-104(8)(c)	12-38-116.5(3)(c)(I)	12-255-119(3)(c)(I)
12-38-103 IP(9)(a)	12-255-104 IP(9)(a)	12-38-116.5(3)(c)(II)	12-255-119(3)(c)(II)
12-38-103(9)(a)(I)	12-255-104(9)(a)(I)	12-38-116.5(3)(c)(III)	12-255-119(3)(c)(III)
12-38-103(9)(a)(II)	12-255-104(9)(a)(II)	12-38-116.5(3)(c)(IV)(A) to (3)(c)(IV)(C)	12-255-119(3)(c)(IV)
12-38-103(9)(a)(III)	12-255-104(9)(a)(III)	12-38-116.5(3)(c)(V)(A)	12-255-119(3)(c)(V)
12-38-103 IP(9)(a)(IV)	12-255-104 IP(9)(a)(IV)	12-38-116.5(3)(c)(V)(B)	Repealed
12-38-103(9)(a)(IV)(A)	12-255-104(9)(a)(IV)(A)	12-38-116.5(4)(a)	12-255-119(4)(a)
12-38-103(9)(a)(IV)(B)	12-255-104(9)(a)(IV)(B)	12-38-116.5(4)(b)	12-255-119(4)(b)
12-38-103(9)(b)	12-255-104(9)(b)	12-38-116.5(4)(c)(I)	12-255-119(4)(c)(I)
12-38-103(9)(c)	12-255-104(9)(c)	12-38-116.5(4)(c)(II)	12-255-119(4)(c)(II)
12-38-103(10)(a)	12-255-104(10)(a)	12-38-116.5(4)(c)(III)	12-255-119(4)(c)(III), IP(4)(c)(IV)
12-38-103 IP(10)(b)	12-255-104 IP(10)(b)	12-38-116.5(4)(c)(III)(A)	12-255-119(4)(c)(IV)(A)
12-38-103(10)(b)(I)	12-255-104(10)(b)(I)	12-38-116.5(4)(c)(III)(B)	12-255-119(4)(c)(IV)(B)
12-38-103(10)(b)(II)	12-255-104(10)(b)(II)	12-38-116.5(4)(c)(III)(C)	12-255-119(4)(c)(IV)(C)
12-38-103(10)(b)(III)	12-255-104(10)(b)(III)	12-38-116.5(4)(c)(III)(D)	12-255-119(4)(c)(IV)(D)
12-38-103(10)(b)(IV)	12-255-104(10)(b)(IV)	12-38-116.5(4)(c)(IV)	12-255-119(4)(c)(V)
12-38-103(10)(b)(V)	12-255-104(10)(b)(V)	12-38-116.5(4)(c)(V)	12-255-119(4)(c)(VI)
12-38-103(10)(b)(VI)	12-255-104(10)(b)(VI)	12-38-116.5(4)(c)(VI)	12-255-119(4)(c)(VII)
12-38-103(11)(a)	12-255-104(11)	12-38-116.5(4)(d)	12-255-119(4)(d)

Prior to October 1, 2019	October 1, 2019 and Thereafter	Prior to October 1, 2019	October 1, 2019 and Thereafter
12-38-103(12)	12-255-104(12)	12-38-116.5(4)(e)	12-255-119(4)(e)
12-38-103(13)(a)	12-255-104(13)	12-38-116.5(5)	12-255-119(5)
12-38-104	**12-255-105**	12-38-116.5(6)	12-255-119(6)
12-38-104 IP(1)(a)	12-255-105 IP(1)(a)	12-38-116.5(7)	12-255-119(7)
12-38-104(1)(a)(I)	12-255-105(1)(a)(I)	12-38-116.5(8)(a)	12-255-119(8)(a)
12-38-104 IP(1)(a)(II)	12-255-105 IP(1)(a)(II)	12-38-116.5(8)(b)	12-255-119(8)(b)
12-38-104(1)(a)(II)(A)	12-255-105(1)(a)(II)(A)	12-38-116.5(8)(c)	12-255-119(8)(c)
12-38-104(1)(a)(II)(B)	12-255-105(1)(a)(II)(B)	12-38-116.5(8)(d)	12-255-119(8)(d)
12-38-104(1)(a)(II)(C)	12-255-105(1)(a)(II)(C)	12-38-116.5(9)(a)	12-255-119(9)(a)
12-38-104(1)(a)(II)(D)	12-255-105(1)(a)(II)(D)	12-38-116.5(9)(b)	12-255-119(9)(b)
12-38-104(1)(a)(II)(E)	12-255-105(1)(a)(II)(E)	12-38-116.5(10)	12-255-119(10)
12-38-104(1)(a)(II)(F)	12-255-105(1)(a)(II)(F)	12-38-116.5(11)	12-255-119(11)
12-38-104(1)(a)(III)	12-255-105(1)(a)(III)	12-38-116.5(12)	12-255-119(12)
12-38-104(1)(b)	12-255-105(1)(b)	12-38-116.5(13)(a)	12-255-119(13)
12-38-104(1)(b.5)	12-255-105(1)(c)	12-38-116.5(13)(b)	Repealed
12-38-104(1)(c)(I)	12-255-105(1)(d)(I)	12-38-116.5(14)	Repealed
12-38-104(1)(c)(II)	12-255-105(1)(d)(II)	12-38-116.5(15) to (19)	12-255-119(14)
12-38-104(1)(c)(III)	12-255-105(1)(d)(III)	**12-38-117**	**12-255-120**
12-38-104(1)(d)	12-255-105(1)(e)	12-38-117 IP(1)	12-255-120 IP(1)
12-38-104(1.5)	12-255-105(2)	12-38-117(1)(a)	12-255-120(1)(a)
12-38-104(3)	Repealed	12-38-117(1)(b)(I)	12-255-120(1)(b)(I)
12-38-105	12-255-105(3)	12-38-117(1)(b)(II)(A)	12-255-120(1)(b)(II)(A)
12-38-106	12-255-105(4)	12-38-117(1)(b)(II)(B)	12-255-120(1)(b)(II)(B)
12-38-107	**12-255-106**	12-38-117(1)(c)	12-255-120(1)(c)
12-38-108	**12-255-107**	12-38-117(1)(d)	12-255-120(1)(d)
12-38-108 IP(1)	12-255-107 IP(1)	12-38-117(1)(e)	12-255-120(1)(e)
12-38-108(1)(a)	12-255-107(1)(a)	12-38-117(1)(f)	12-255-120(1)(f)
12-38-108(1)(b)(I)	12-255-107(1)(b)(I)	12-38-117(1)(g)	12-255-120(1)(g)
12-38-108(1)(b)(II)	12-255-107(1)(b)(II)	12-38-117(1)(h)	12-255-120(1)(h)
12-38-108(1)(b.5)	12-255-107(1)(c)	12-38-117(1)(i)	12-255-120(1)(i)
12-38-108(1)(c)	12-255-107(1)(d)	12-38-117(1)(j)	12-255-120(1)(j)
12-38-108(1)(d)	12-255-107(1)(e)	12-38-117(1)(k)	12-255-120(1)(k)
12-38-108(1)(f)	12-255-107(1)(f)	12-38-117(1)(l)	12-255-120(1)(l)
12-38-108(1)(g)	12-255-107(1)(g)	12-38-117(1)(m)(I)	12-255-120(1)(m)(I)
12-38-108(1)(h)	12-255-107(1)(h)	12-38-117(1)(m)(II)	12-255-120(1)(m)(II)
12-38-108(1)(i)	12-255-107(1)(i)	12-38-117(1)(n)	12-255-120(1)(n)
12-38-108(1)(j)	12-255-107(1)(j)	12-38-117(1)(o)	12-255-120(1)(o)
12-38-108 IP(1)(k)	12-255-107 IP(1)(k)	12-38-117(1)(p)	12-255-120(1)(p)
12-38-108(1)(k)(I)	12-255-107(1)(k)(I)	12-38-117(1)(q)	12-255-120(1)(q)
12-38-108(1)(k)(II)	12-255-107(1)(k)(II)	12-38-117(1)(r)	12-255-120(1)(r)
12-38-108(1)(k)(III)	12-255-107(1)(k)(III)	12-38-117(1)(s)	12-255-120(1)(s)
12-38-108(1)(k)(IV)	12-255-107(1)(k)(IV)	12-38-117(1)(t)	12-255-120(1)(t)
12-38-108(1)(k)(V)	12-255-107(1)(k)(V)	12-38-117(1)(u)	12-255-120(1)(u)

Prior to October 1, 2019	October 1, 2019 and Thereafter	Prior to October 1, 2019	October 1, 2019 and Thereafter
12-38-108(1)(k)(VI)	12-255-107(1)(k)(VI)	12-38-117(1)(v)	12-255-120(1)(v)
12-38-108(1)(k)(VII)	12-255-107(1)(k)(VII)	12-38-117(1)(w)(I)	12-255-120(1)(w)(I)
12-38-108(1)(l)(I)(B)	12-255-107(1)(l)(I)	12-38-117(1)(w)(II)	12-255-120(1)(w)(II)
12-38-108(1)(l)(II)	12-255-107(1)(l)(II)	12-38-117(1)(x)	12-255-120(1)(x)
12-38-108 IP(1)(m)	12-255-107 IP(1)(m)	12-38-117(1)(y)	12-255-120(1)(y)
12-38-108(1)(m)(I)	12-255-107(1)(m)(I)	12-38-117(1)(z)	12-255-120(1)(z)
12-38-108(1)(m)(II)	12-255-107(1)(m)(II)	12-38-117(1)(aa)	12-255-120(1)(aa)
12-38-108(1)(m)(III)	12-255-107(1)(m)(III)	12-38-117(1)(bb)	12-255-120(1)(bb)
12-38-108(1)(m)(IV)	12-255-107(1)(m)(IV)	**12-38-118**	**12-255-121**
12-38-108(1)(m)(V)	12-255-107(1)(m)(V)	12-38-118(1)(a)	12-255-121(1)(a)
12-38-108(1.1)(a)	12-255-107(2)	12-38-118 IP(1)(b)	12-255-121 IP(1)(b)
12-38-108(2)	12-255-107(3)	12-38-118(1)(b)(I)	12-255-121(1)(b)(I)
12-38-108(3)	12-255-107(4)	12-38-118(1)(b)(II)	12-255-121(1)(b)(II)
12-38-108.5	12-255-107(5)	12-38-118(2)(a)(I)	12-255-121(2)(a)(I)
12-38-109	**12-255-108**	12-38-118(2)(a)(II)	12-255-121(2)(a)(II)
12-38-110	**12-255-109**	12-38-118(2)(a)(III)	12-255-121(2)(a)(III)
12-38-110(1)	12-255-109(1)	12-38-118 IP(2)(b)	12-255-121 IP(2)(b)
12-38-110(2)	12-255-109(2)	12-38-118 IP(2)(b)(I)	12-255-121 IP(2)(b)(I)
12-38-111	**12-255-110**	12-38-118(2)(b)(I)(A)	12-255-121(2)(b)(I)(A)
12-38-111 IP(1)	12-255-110 IP(1)	12-38-118(2)(b)(I)(B)	12-255-121(2)(b)(I)(B)
12-38-111(1)(a)	12-255-110(1)(a)	12-38-118(2)(b)(I)(C)	12-255-121(2)(b)(I)(C)
12-38-111(1)(b)	12-255-110(1)(b)	12-38-118(2)(b)(II)	12-255-121(2)(b)(II)
12-38-111(1)(d)	12-255-110(1)(c)	12-38-118(2)(c)	12-255-121(2)(c)
12-38-111(1)(e)	12-255-110(1)(d)	12-38-118(3)	12-255-121(3)
12-38-111(2)	12-255-110(2)	12-38-118(4)	12-255-121(4)
12-38-111(3)	12-255-110(3)	12-38-118(5)	12-255-121(5)
12-38-111.5	**12-255-111**	12-38-118 IP(6)(a)	12-255-121 IP(6)(a)
12-38-111.5(1)	12-255-111(1)	12-38-118(6)(a)(I)	12-255-121(6)(a)(I)
12-38-111.5(3)	12-255-111(2)	12-38-118(6)(a)(II)	12-255-121(6)(a)(II)
12-38-111.5(4)(b)	Repealed	12-38-118(6)(a)(III)	12-255-121(6)(a)(III)
12-38-111.5(4)(c)	12-255-111(3)(a)	12-38-118(6)(b)	12-255-121(6)(b)
12-38-111.5(4)(d)	12-255-111(3)(b)	**12-38-118.5**	**12-255-122**
12-38-111.5 IP(4)(e)	12-255-111 IP(3)(c)	12-38-118.5(1)	12-255-122(1)
12-38-111.5(4)(e)(I)	12-255-111(3)(c)(I)	12-38-118.5(2)	12-255-122(2)
12-38-111.5(4)(e)(II)	12-255-111(3)(c)(II)	12-38-118.5(3)	12-255-122(3)
12-38-111.5(5)	12-255-111(4)	12-38-118.5(4)(a)	12-255-122(4)
12-38-111.5(6)	12-255-111(5)	12-38-118.5(5)	12-255-122(5)
12-38-111.5 IP(7)(a)	12-255-111 IP(6)(a)	12-38-118.5(6)(a)	12-255-122(6)(a)
12-38-111.5(7)(a)(I)	12-255-111(6)(a)(I)	12-38-118.5 IP(6)(b)	12-255-122 IP(6)(b)
12-38-111.5(7)(a)(II)	12-255-111(6)(a)(II)	12-38-118.5(6)(b)(I)	12-255-122(6)(b)(I)
12-38-111.5(7)(a)(III)	12-255-111(6)(a)(III)	12-38-118.5(6)(b)(II)	12-255-122(6)(b)(II)
12-38-111.5 IP(7)(b)	12-255-111 IP(6)(b)	**12-38-121**	**12-255-123**
12-38-111.5(7)(b)(I)	12-255-111(6)(b)(I)	12-38-121(1)	12-255-123(1)

Prior to October 1, 2019	October 1, 2019 and Thereafter	Prior to October 1, 2019	October 1, 2019 and Thereafter
12-38-111.5(7)(b)(II)	12-255-111(6)(b)(II)	12-38-121(2)	12-255-123(2)
12-38-111.6	**12-255-112**	**12-38-122**	**12-255-124**
12-38-111.6(1)	12-255-112(1)	12-38-122(1)	12-255-124(1)
12-38-111.6(2)(a)	12-255-112(2)(a)	12-38-122(2)	12-255-124(2)
12-38-111.6(2)(b)	12-255-112(2)(b)	12-38-122(3)	12-255-124(3)
12-38-111.6(3)(a)	12-255-112(3)(a)	12-38-122(4)	12-255-124(4)
12-38-111.6(3)(d)(I)	12-255-112(3)(b)(I)	**12-38-123**	**12-255-125**
12-38-111.6(3)(d)(II)	12-255-112(3)(b)(II)	12-38-123(1), (1)(a)	12-255-125(1)
12-38-111.6 IP(4.5)(a)	12-255-112 IP(4)(a)	12-38-123(2)	12-255-125(2)
12-38-111.6(4.5)(a)(I)	12-255-112(4)(a)(I)	**12-38-124**	**12-255-126**
12-38-111.6(4.5)(a)(II)	12-255-112(4)(a)(II)	**12-38-125**	**12-255-127**
12-38-111.6(4.5)(a)(III)	12-255-112(4)(a)(III)	12-38-125 IP(1)	12-255-127 IP(1)
12-38-111.6(4.5)(a)(IV)	12-255-112(4)(a)(IV)	12-38-125(1)(a)	12-255-127(1)(a)
12-38-111.6(4.5)(a)(VI)	12-255-112(4)(a)(V)	12-38-125(1)(b)	12-255-127(1)(b)
12-38-111.6(4.5)(a)(VII)	12-255-112(4)(a)(VI)	12-38-125(1)(c)	12-255-127(1)(c)
12-38-111.6 IP(4.5)(b)	12-255-112 IP(4)(b)	12-38-125(1)(d)	12-255-127(1)(d)
12-38-111.6(4.5)(b)(I)(A)	12-255-112(4)(b)(I)(A)	12-38-125(1)(e)	12-255-127(1)(e)
12-38-111.6(4.5)(b)(I)(A.5)	12-255-112(4)(b)(I)(B)	12-38-125(1)(f)	12-255-127(1)(f)
12-38-111.6(4.5)(b)(I)(B)	12-255-112(4)(b)(I)(C)	12-38-125(1)(g)	12-255-127(1)(g)
12-38-111.6(4.5)(b)(I)(C)	12-255-112(4)(b)(I)(D)	12-38-125(1)(h)(I)	12-255-127(1)(h)
12-38-111.6(4.5)(b)(I)(D)	12-255-112(4)(b)(I)(E)	12-38-125(1)(i)(I)	12-255-127(1)(i)
12-38-111.6 IP(4.5)(b)(II)	12-255-112 IP(4)(b)(II)	12-38-125(1)(j)	12-255-127(1)(j)
12-38-111.6(4.5)(b)(II)(A)	12-255-112(4)(b)(II)(A)	12-38-125(1)(k)	12-255-127(1)(k)
12-38-111.6(4.5)(b)(II)(B)	12-255-112(4)(b)(II)(B)	12-38-125(1)(l)	12-255-127(1)(l)
12-38-111.6(4.5)(b)(II)(C)	12-255-112(4)(b)(II)(C)	12-38-125(1)(m)	12-255-127(1)(m)
12-38-111.6(4.5)(b)(II)(D)	12-255-112(4)(b)(II)(D)	12-38-125(1)(n)(I)	12-255-127(1)(n)(I)
12-38-111.6(4.5)(b)(III)	12-255-112(4)(b)(III)	12-38-125(1)(n)(II)	12-255-127(1)(n)(II)
12-38-111.6(4.5)(b)(IV)	12-255-112(4)(b)(IV)	12-38-125(1)(n)(III)	12-255-127(1)(n)(III)
12-38-111.6 IP(4.5)(c)	12-255-112 IP(4)(c)	12-38-125(1)(o)	12-255-127(1)(o)
12-38-111.6(4.5)(c)(I)	12-255-112(4)(c)(I)	**12-38-125.5**	**12-255-128**
12-38-111.6(4.5)(c)(II)	12-255-112(4)(c)(II)	12-35-125.5 IP(1)	12-255-128
12-38-111.6 IP(4.5)(c)(III)	12-255-112 IP(4)(c)(III)	12-38-125.5(1)(a) to (6)	Repealed
12-38-111.6(4.5)(c)(III)(A)	12-255-112(4)(c)(III)(A)	**12-38-126**	12-255-127(2)
12-38-111.6(4.5)(c)(III)(B)	12-255-112(4)(c)(III)(B)	**12-38-127**	**12-255-129**
12-38-	12-255-112(4)(c)(III)(C)	**12-38-128**	12-255-127(3)

Prior to October 1, 2019	October 1, 2019 and Thereafter	Prior to October 1, 2019	October 1, 2019 and Thereafter
111.6(4.5)(c)(III)(C)			
12-38-111.6(4.5)(d)	12-255-112(4)(d)	**12-38-129**	Repealed
12-38-111.6(4.5)(e)	12-255-112(4)(e)	**12-38-130**	12-255-127(4)
12-38-111.6(7)	12-255-112(5)	**12-38-131**	**12-255-130**
12-38-111.6(7.5)(a)	12-255-112(6)(a)	12-38-131(1)	12-255-130(1)
12-38-111.6(7.5)(a)(I) to (7.5)(d)	Repealed	12-38-131(2)(a)	12-255-130(2)(a)
12-38-111.6(7.5)(e)	12-255-112(6)(b)	12-38-131(2)(b)	12-255-130(2)(b)
12-38-111.6(8)(a)	12-255-112(7)(a)	12-38-131 IP(3)(a)	12-255-130 IP(3)(a)
12-38-111.6(8)(b)	12-255-112(7)(b)	12-38-131(3)(a)(I)	12-255-130(3)(a)(I)
12-38-111.6(8)(c)(I)	12-255-112(7)(c)(I)	12-38-131(3)(a)(II)	12-255-130(3)(a)(II)
12-38-111.6(8)(c)(II)	12-255-112(7)(c)(II)	12-38-131(3)(a)(III)	12-255-130(3)(a)(III)
12-38-111.6(9)	12-255-112(8)	12-38-131(3)(a)(IV)	12-255-130(3)(a)(IV)
12-38-111.6(10)	12-255-112(9)	12-38-131(3)(a)(V)	12-255-130(3)(a)(V)
12-38-111.6(11)	12-255-112(10)	12-38-131(3)(a)(VI)	12-255-130(3)(a)(VI)
12-38-111.6(12)	12-255-112(11)	12-38-131(3)(b)	12-255-130(3)(b)
12-38-111.8	**12-255-113**	12-38-131(3)(c)	12-255-130(3)(c)
12-38-111.8(1)	12-255-113(1)	12-38-131 IP(3)(d)	12-255-130 IP(3)(d)
12-38-111.8(2)	12-255-113(2)	12-38-131(3)(d)(I)	12-255-130(3)(d)(I)
12-38-111.8(3)	12-255-113(3)	12-38-131(3)(d)(II)	12-255-130(3)(d)(II)
12-38-111.8(4)	12-255-113(4)	12-38-131(3)(d)(III)	12-255-130(3)(d)(III)
12-38-112	**12-255-114**	12-38-131(3)(d)(IV)	12-255-130(3)(d)(IV)
12-38-112 IP(1)	12-255-114 IP(1)	12-38-131(3)(e)	12-255-130(3)(e)
12-38-112(1)(a)	12-255-114(1)(a)	12-38-131(3)(f)	12-255-130(3)(f)
12-38-112(1)(b)	12-255-114(1)(b)	12-38-131(4)	12-255-130(4)
12-38-112(1)(d)	12-255-114(1)(c)	12-38-131(5)	12-255-130(5)
12-38-112(1)(e)	12-255-114(1)(d)	12-38-131(6)	12-255-130(6)
12-38-112(2)	12-255-114(2)	12-38-131(7)	12-255-130(7)
12-38-112(3)	12-255-114(3)	**12-38-132**	**12-255-131**
12-38-112.5	**12-255-115**	12-38-132(1)	12-255-131(1)
12-38-112.5(1)	12-255-115(1)	12-38-132(2)	12-255-131(2)
12-38-112.5 IP(2)	12-255-115 IP(2)	12-38-132(3)	12-255-131(3)
12-38-112.5(2)(a)	12-255-115(2)(a)	12-38-132 IP(4)	12-255-131 IP(4)
12-38-112.5(2)(b)	12-255-115(2)(b)	12-38-132(4)(a)	12-255-131(4)(a)
12-38-112.5(3)	12-255-115(3)	12-38-132(4)(b)	12-255-131(4)(b)
12-38-112.5(4)	12-255-115(4)	12-38-132(4)(c)	12-255-131(4)(c)
12-38-112.5(6)	12-255-115(5)	12-38-132(4)(d)	12-255-131(4)(d)
12-38-112.5(7)	12-255-115(6)	12-38-132(5)	12-255-131(5)
12-38-112.5(8)	12-255-115(7)	12-38-132(6)	12-255-131(6)
12-38-112.5(9)	12-255-115(8)	**12-38-132.3**	**12-255-132**
12-38-114	**12-255-116**	12-38-132.3(1)	12-255-132(1)
12-38-115	**12-255-117**	12-38-132.3(2)	12-255-132(2)
12-38-115(1)	12-255-117(1)	**12-38-132.5**	**12-255-133**
12-38-115(3)	12-255-117(2)	12-38-132.5 IP(1)	12-255-133 IP(1)

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12-38-115(3.5)	12-255-117(3)	12-38-132.5(1)(a)	12-255-133(1)(a)
12-38-115(4)	12-255-117(4)	12-38-132.5(1)(b)	12-255-133(1)(b)
12-38-115(5)	12-255-117(5)	12-38-132.5 IP(2)	12-255-133 IP(2)
12-38-116	**12-255-118**	12-38-132.5(2)(a)	12-255-133(2)(a)
12-38-116(1)	12-255-118(1)	12-38-132.5(2)(b)	12-255-133(2)(b)
12-38-116 IP(2)	12-255-118 IP(2)	12-38-132.5(2)(c)	12-255-133(2)(c)
12-38-116(2)(a)	12-255-118(2)(a)	12-38-132.5 IP(3)	12-255-133 IP(3)
12-38-116(2)(b)	12-255-118(2)(b)	12-38-132.5(3)(a)	12-255-133(3)(a)
12-38-116 IP(3)	12-255-118 IP(3)	12-38-132.5(3)(b)	12-255-133(3)(b)
12-38-116(3)(a)	12-255-118(3)(a)	12-38-132.5(3)(c)	12-255-133(3)(c)
12-38-116(3)(b)	12-255-118(3)(b)	12-38-132.5 IP(4)	12-255-133 IP(4)
12-38-116(4)	12-255-118(4)	12-38-132.5(4)(a)	12-255-133(4)(a)
12-38-116.5	**12-255-119**	12-38-132.5(4)(b)	12-255-133(4)(b)
12-38-116.5(1)(a)	12-255-119(1)(a)	12-38-132.5(4)(c)	12-255-133(4)(c)
12-38-116.5(1)(b)	12-255-119(1)(b)	**12-38-133**	**12-255-134**
12-38-116.5(1)(c)	12-255-119(1)(c)	12-38-133(1), (2)	12-255-134
12-38-116.5(1)(d)	12-255-119(1)(d)		