Department of Regulatory Agencies

Office of Policy, Research and Regulatory Reform

2008 Sunset Review: Nurse Aide Certification Program

October 15, 2008

Consumer Protection

Department of Regulatory Agencies

Executive Director's Office
D. Rico Munn
Executive Director

Bill Ritter, Jr.
Governor

October 15, 2008

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 mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the Colorado Nurse Aide Certification Program. I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2009 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

> The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...
>
> The department of regulatory agencies shall 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 report discusses the question of whether there is a need for the regulation provided under Article 38.1 of Title 12, C.R.S. The report also discusses the effectiveness of the Board of Nursing and Division of Registrations staff 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,

D. Rico Munn
Executive Director

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Department of Regulatory Agencies

2008 Sunset Review:
Nurse Aide Certification Program

Summary

What Is Regulated?
Certified nurse aides (CNAs) assist patients with activities of daily living, take vital signs, assist with housekeeping tasks, escort patients to tests or appointments, and help move patients in and out of bed.

Why Is It Regulated?
Federal law requires the states to regulate CNAs working in long-term care facilities as well as home health aides. State regulation ensures CNAs meet standards of minimal competence, identifies applicants with criminal histories or backgrounds that may disqualify them, and meets the federal registry requirements.

Who Is Regulated?
In fiscal year 06-07 there were a total of 29,911 nurse aides in Colorado.

How Is It Regulated?
The Colorado Board of Nursing (Board) is housed within the Department of Regulatory Agencies, Division of Registrations. The Nurse Aide Advisory Committee (Committee) is appointed by the Board to handle most regulatory functions on its behalf. There are two primary routes to nurse aide certification in Colorado: by examination or by endorsement. To be certified by examination, an applicant must submit an application, pay the application fee, and pass a Board-approved examination and skills evaluation. To be certified by endorsement, an applicant must submit an application, pay the application fee, provide evidence of nurse aide certification in another state, complete an education program, and have no record of any disciplinary action in another state. The Board investigates complaints against CNAs and takes disciplinary action against those who violate the Nurse Aide Practice Act (NAPA).

What Does It Cost?
The fiscal year 06-07 expenditure to oversee this program was $913,644.07 and there were 4.5 full-time equivalent employees associated with this program.

What Disciplinary Activity Is There?
For the period fiscal year 02-03 through fiscal year 06-07, the Board issued 306 disciplinary actions including revocation of certifications, suspension of certifications, letters of admonition and injunctions.

Where Do I Get the Full Report?
The full sunset review can be found on the internet at: www.dora.state.co.us/opr/oprpublications.htm.

Key Recommendations

Continue the regulation of certified nurse aides (CNAs) for 11 years, until 2020.
By and large, the CNA program has been effective. The Board has established an application process that identifies applicants with criminal histories or background that may disqualify them from placement on the CNA registry. The Board investigates complaints against CNAs and takes disciplinary action against those who violate the NAPA. Through these activities, the Board acts in the interest of the public. With the CNA program, the Board certifies applicants meeting minimal standards, removes unsafe CNAs from practice, and meets federal registry requirements. For these reasons, the Board's regulation of CNAs should be continued.

Direct the Board to promulgate rules establishing the education requirements and scope of practice for CNAs with Medication Aide Authority.
Medication aide authority (MAA) for CNAs was established in 2005 to help the long-term care community meet its medication administration needs. To date, not a single CNA has procured this authority, which can be attributed to the limited scope of the MAA and the requirement that education be completed at a community college. With some retooling, however, the MAA could still fill an important niche in Colorado's health care system. As a first step in redesigning the program, the General Assembly should remove from statute the specific language governing the MAA scope of practice and education, experience, and certification requirements. Instead, the General Assembly should empower the Board to promulgate rules addressing these areas. Establishing the requirements in rule allows the Board a measure of flexibility in fleshing out the new requirements, while still giving stakeholders the opportunity to be involved in crafting the new MAA via the public rulemaking process.

Repeal the requirement that proceedings relating to complaints where formal charges were filed be subject to the Colorado Open Records Act (CORA).
Meetings regarding disciplinary proceedings are closed, except for when the Board, through the Committee, has filed a formal complaint against a CNA via the Attorney General's Office (AGO). Removing the requirement that these cases be discussed in open session will in no way reduce the public's access to disciplinary information. Formal complaints prepared by the AGO and all final disciplinary documents would remain part of the public record. Therefore, the requirement that cases where formal complaints were filed be subject to CORA should be eliminated.

Major Contacts Made During This Review

American Association of Retired Persons
Center for People with Disabilities
Colorado Board of Nursing
Colorado Community College System
Colorado Cross-Disability Coalition
Colorado Department of Law
Colorado Health Care Association
Colorado Hospital Association
Colorado Nurse Aide Advisory Committee
Colorado Nurses Association
Home Care Association of Colorado
Visiting Nurses Association

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether or not 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 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:

- 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;
- 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;
- 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 an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- 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;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- 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;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

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

Types of Regulation

Regulation, when appropriate, can serve as a bulwark of consumer protection. Regulatory programs can be designed to impact individual professionals, businesses or both.

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.

Regulation, then, has many positive and potentially negative consequences.

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

As regulatory programs relate to businesses, they can enhance public protection, promote stability and preserve profitability. But they can also reduce competition and place administrative burdens on the regulated businesses.

Regulatory programs that address businesses can involve certain capital, bookkeeping and other recordkeeping requirements that are meant to ensure financial solvency and responsibility, as well as accountability. Initially, these requirements may serve as barriers to entry, thereby limiting competition. On an ongoing basis, the cost of complying with these requirements may lead to greater administrative costs for the regulated entity, which costs are ultimately passed on to consumers.

Many programs that regulate businesses involve examinations and audits of finances and other records, which are intended to ensure that the relevant businesses continue to comply with these initial requirements. Although intended to enhance public protection, these measures, too, involve costs of compliance.

Similarly, many regulated businesses may be subject to physical inspections to ensure compliance with health and safety standards.

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. To facilitate input from interested parties, anyone can submit input on any upcoming sunrise or sunset review via DORA's website at: www.dora.state.co.us/pls/real/OPR_Review_Comments.Main.

The regulatory functions of the Colorado Board of Nursing (Board) relating to Article 38.1 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2009, unless continued by the General Assembly. During the year prior to this date, it is the duty of DORA 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 of certified nurse aides (CNAs) should be continued for the protection of the public and to evaluate the performance of the Board and staff of the Division of Registrations (Division). During this review, the Board must demonstrate that the regulation serves to protect the public health, safety or welfare, and that the regulation is the least restrictive regulation consistent with protecting the public. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly.

Methodology

As part of this review, DORA staff attended Board and Nurse Aide Advisory Committee (Committee) meetings; interviewed Division staff; interviewed Committee members; reviewed Committee records and minutes, including complaint and disciplinary actions; interviewed officials with state and national professional associations; interviewed health care providers; reviewed Colorado statutes and rules; visited CNA education programs; and reviewed the laws of other states.

Profile of the Profession

Nurse aides provide basic, essential care to the nation's sickest and most vulnerable citizens.[2] Nurse aides assist patients with activities of daily living, such as bathing, dressing, grooming, and toileting. They may also take vital signs, assist with housekeeping tasks, escort patients to appointments, and help move patients in and out of bed. A critical element of nurse aide practice is to observe, document and report changes in patients' conditions. Because the care nurse aides provide is basic and ongoing, they often have daily contact with patients. This daily contact makes nurse aides uniquely qualified to observe changes in patients' conditions that might go unnoticed by higher-level health care providers.

Because some patients require round-the-clock care, nurse aides may be required to work nights, weekends, and holidays. The nature of a nurse aide's work—helping to move patients in and out of bed, and spending many hours standing and walking—can be physically demanding. Working with very ill, disoriented, or cognitively impaired patients can also be emotionally draining. On the other hand, helping care for people in need can offer emotional rewards.

Nurse aides are not considered independent practitioners and work under the supervision of a licensed practical nurse (LPN), registered nurse (RN), physician, or other qualified health care provider.

Under federal law, nurse aides whose employers receive reimbursement from Medicare or Medicaid must complete a minimum of 75 hours of state-approved training and pass a competency evaluation. After candidates have met these requirements—plus any additional state requirements—states must list these individuals on the certified nurse aide (CNA) registry. Employers that do not receive federal funds may not require nurse aides to be listed on the registry.

Nurse aide training is offered in high schools, vocational-technical centers, nursing care facilities, and some community colleges. Courses cover body mechanics, nutrition, basic anatomy and physiology, infection control, communication skills, and resident rights.[3]

Median hourly earnings of nurse aides, orderlies, and attendants nationwide were $10.67 in May 2006. The middle 50 percent earned between $9.09 and $12.80 an hour. The lowest-paid 10 percent earned less than $7.78, and the highest-paid 10 percent earned more than $14.99 an hour.[4]

[2] Although the U. S. Department of Labor considers nurse aides and home health aides discrete professions, for the purposes of this section, "nurse aide" refers equally to those employed in the home health setting.
[3] Occupational Outlook Handbook, 2008-2009 Edition, U. S. Department of Labor, Bureau of Labor Statistics. *Nursing, Psychiatric and Home Health Aides*. Retrieved June 9, 2008, from http://stats.bls.gov/oco/print/ocos165.htm
[4] Occupational Outlook Handbook, 2008-2009 Edition, U. S. Department of Labor, Bureau of Labor Statistics. *Nursing, Psychiatric and Home Health Aides*. Retrieved June 9, 2008, from http://stats.bls.gov/oco/print/ocos165.htm

In 2006, there were approximately 1.4 million nurse aides employed in the United States (not necessarily all of these individuals are certified). Employment opportunities for nurse aides are expected to grow at a rate much faster than average over the next decade, due to an aging population as well as the high turnover rate of CNAs employed in long-term care facilities. Further, as hospitals experience increasing pressure to discharge patients, more patients are likely to require rehabilitative care at home or in a nursing facility.

History of Regulation

When the U.S. Congress passed the Omnibus Budget Reconciliation Act of 1987, it mandated that all nurse aides who work in nursing homes and other long-term care facilities that receive funds from Medicare and/or Medicaid receive certain minimal training and testing. Shortly thereafter, Congress imposed similar requirements on home health aides. The federal law also directed each state to create a registry of all nurse aides meeting these training requirements.

In response to the new federal mandate, the Colorado General Assembly created a certification program for nurse aides with the passage of the Nurse Aide Practice Act (NAPA), effective July 1, 1989. The NAPA placed the new program under the authority of the Board, which also regulates RNs, LPNs, and licensed psychiatric technicians (LPTs). Although the federal legislation treated the training and certification of home health aides and nurse aides separately, the NAPA conflated the two, offering a single certification for aides wishing to work in either home health or long-term care settings. The same year, the Board promulgated rules to further define the certification requirements and requirements for nurse aide training programs.[5] The Board was authorized to create an advisory committee to help it fulfill its legislative mandate.

During the 2002 legislative session, the General Assembly passed two bills relating to CNA regulation.

House Bill 02-1090 created the Medication Administration Advisory Committee. The Committee was directed to provide guidance to DORA regarding whether CNAs should be permitted to administer medications.

House Bill 02-1447 created the Direct Care Provider Career Path Pilot Program. This pilot program was intended to offer three tiers of CNA employment, each requiring increasing levels of education, and offering higher levels of responsibility and income potential. This pilot program was repealed by operation of law on July 1, 2008.

[5] *Sunset Review of the Nurse Aide Certification Program*, Department of Regulatory Agencies (2002), p. 4.

A sunset review of the nurse aide certification program was conducted in 2002. The review resulted in Senate Bill 03-134, which made several changes to the NAPA. The composition of the Committee was increased from five to seven members, and the Board was directed to conduct a feasibility study of requiring CNA applicants to submit to fingerprint-based criminal history record checks. Further, the bill separated “abuse” and “neglect” into two different statutory provisions under grounds for discipline, thereby easing federally mandated reporting.

During the 2005 session, the work of the Medication Administration Advisory Committee came to fruition with the passage Senate Bill 05-155, which created a Medication Administration Authority for CNAs. The bill established the scope of the authority, as well as the educational and experiential requirements to qualify for the authority. Another provision in the bill removed the requirement that CNA applicants submit to a criminal history background check as a condition of certification.

Legal Framework

The federal Omnibus Budget Reconciliation Act (OBRA), passed in 1987, enacted sweeping reforms within the long-term care system. The legislation sought to improve the quality of care provided in nursing facilities by establishing standards of nursing care and minimum training and competency requirements for employees in these facilities.

Rules developed to implement the law mandated that long-term care facilities may only employ nurse aides who have completed a training and competency evaluation within four months of hire, or have otherwise demonstrated competence in providing nursing services.[6] Further, the law required that by no later than January 1, 1989, each state must establish a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program.[7] The law directed the secretary of the Centers for Medicare and Medicaid Services (CMS) to establish standards for the approval of nurse aide training programs.[8] Shortly thereafter, similar requirements were enacted for home health aides.

OBRA addressed certified nurse aides (CNAs) and home health aides (HHAs) as separate professions, establishing separate—but very similar—rules for their education and certification. Generally speaking, the rules governing HHAs are less proscriptive than those governing nurse aides. In meeting the mandates of OBRA, however, Colorado established a single certification program to register both CNAs and HHAs. Within Colorado's laws and rules, the term "nurse aide" refers equally to those who work in long-term care and those who work in the home health setting.

The laws encompassing Colorado nurse aide regulation are contained within Article 38.1 of Title 12, C.R.S. These laws are known collectively as the Nurse Aide Practice Act (NAPA). The provisions of the NAPA, and the corresponding rules, largely mirror the federal laws and rules for skilled nursing facilities.

The Colorado Board of Nursing (Board), housed within the Department of Regulatory Agencies (DORA), Division of Registrations, is vested with the authority to enforce the NAPA. Federal Medicaid and Medicare programs provide funding for the certification program. The Colorado Department of Health Care Policy and Financing secures the Medicaid portion of the funding, and the Colorado Department of Public Health and Environment (CDPHE) secures the Medicare portion. These funds are forwarded to DORA to support the program.[9]

[6] 42 C.F.R. §483.75(e)(2).
[7] 42 U.S.C. § 1395i-3(e)(2)(a) and 42 C.F.R. § 483.156.
[8] 42 U.S.C. § 1395i-3(f)(2)(a).
[9] § 12-38.1-103(6), C.R.S.

The Board's duties in relation to CNA certification include:

- Certifying nurse aides to practice in Colorado; [10]
- Promulgating rules and regulations;[11]
- Ensuring compliance with federal laws and rules relating to CNAs;[12]
- Maintaining a registry of all CNAs and a record of all final disciplinary actions taken under the provisions of the Act;[13] and
- Approving CNA training programs.[14]

To assist in the performance of its duties, the Board may designate an advisory committee. Representation on the seven-member Nurse Aide Advisory Committee (Committee) is as follows:[15]

- One CNA;
- One registered nurse (RN) who supervises certified nurse aides;
- One representative of a home health agency;
- One representative of a nursing facility;
- One employee of the CDPHE;
- One family member of a consumer who receives home health services or nursing facility services; and
- One consumer of home health care or nursing facility services.

Committee members are not compensated for their services but are reimbursed for the actual and necessary expenses incurred in the performance of their duties.[16]

Nurse Aide Education Programs and Competency Evaluation

As prescribed in the federal guidelines, the Board is responsible for approving nurse aide education programs. Any institution, facility, agency, home health agency, or individual wishing to establish such a program must apply to the Board. The applicant must demonstrate that it possesses sufficient qualified instructors, including a qualified program coordinator, and sufficient financial and clinical resources to support the program. The organization, administration, and implementation of the program must be consistent and compliant with all state and federal requirements.[17]

[10] §12-38.1-103(1), C.R.S.
[11] § 12-38.1-103(3), C.R.S.
[12] § 12-38.1-103(3), C.R.S.
[13] § 12-38.1-103(4), C.R.S.
[14] § 12-38.1-108(1), C.R.S.
[15] § 12-38.1-110(1), C.R.S.
[16] § 12-38.1-110(1), C.R.S.
[17] Board Rule XI, § 4.2.

Nurse aide training programs must consist of at least 75 hours of instruction, at least 16 of which must consist of supervised practical training. “Supervised practical training” refers to training in a laboratory or other setting in which the trainee performs tasks on an individual under the direct supervision of an RN or a licensed practical nurse (LPN).[18]

The curriculum must cover both knowledge and demonstrable skills applicable to the populations that CNAs serve, and include the following seven areas:[19]

- At least 16 hours of training, prior to any direct contact with a resident, in communication and interpersonal skills; infection control; safety emergency procedures; promoting residents' independence; and respecting residents' rights.
- Basic nursing skills, including taking and recording vital signs; recognizing abnormal changes in body functioning; and caring for residents when death is imminent.
- Personal care skills, including bathing; grooming, including mouth care; dressing; toileting; assisting with eating and hydration; and transfers, positioning, and turning.
- Mental health and social service needs, including awareness of developmental tasks associated with the aging process; how to respond to resident behavior; allowing the resident to make personal choices; and using the resident's family as a source of emotional support.
- Care of cognitively impaired residents, including techniques for addressing the unique needs and behaviors of individuals with dementia; communicating with and understanding the behavior of cognitively impaired residents; appropriate responses to the behavior of cognitively impaired residents; and methods of reducing the effects of cognitive impairments.
- Basic restorative services, including training residents in self-care whenever possible; using assistive devices in transferring, ambulation, eating, and dressing; maintaining range of motion; proper turning and positioning in bed and chair; bowel and bladder training; and care and use of prosthetic and orthotic devices.
- Residents' rights, including providing privacy and maintaining confidentiality; promoting the residents' right to make personal choices; providing assistance in resolving grievances and disputes; maintaining care and security of residents' personal possessions; promoting the resident's right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff; and avoiding the need for restraints in accordance with current professional standards.

The curriculum must be designed to accommodate students with limited literacy skills.[20]

[18] 42 C.F.R. § 483.152(a)(1) and (3) and Board Rule XI, § 5.2.
[19] 42 C.F.R. § 483.152(b), § 12-38.1-108(3), C.R.S, and Board Rule XI, § 5.3.
[20] § 12-38.1-108(2), C.R.S.

Instructors in a training program must meet certain minimum standards. For example, the training of nurse aides must be performed under the general supervision of an RN who possesses a minimum of two years of nursing experience, at least one of which is in long-term care facility services; and instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides.[21]

Nurse aide training programs must ensure that students are under the close supervision of an RN or LPN, and that students do not perform any services for which they have not been trained and found proficient.[22]

The Board must decide whether to approve a nurse aide education program within 90 days of receiving a complete application.[23] The Board must conduct inspections of each nurse aide training program it approves within one year of such approval and every two years thereafter.[24]

Federal regulations prohibit the Board from approving nurse aide education programs that are offered by or in a facility that has been subject to an enforcement action within the previous two years.[25]

The Board must withdraw approval of a program when notified that the Medicare-certified long-term care facility conducting the program has lost its privilege to conduct the program.[26] The Board may withdraw approval if the program falls out of compliance with state or federal requirements, or if the pass rate on the competency evaluation falls below 60 percent over four consecutive quarters.[27]

The Board is prohibited from requiring nurse aide training programs to substantially exceed the requirements established in the federal law.[28]

The primary objective of nurse aide education programs is to prepare students to take a nurse aide competency evaluation that assesses their didactic knowledge and manual skills. The competency evaluation must be offered at least quarterly and cover the following topics: [29]

- Basic nursing skills;
- Personal care skills;
- Recognition of mental health and social services needs;
- Basic restorative services; and
- Resident or patient rights.

[21] 42 C.F.R. § 483.152(a)(5).
[22] 42 C.F.R. § 483.152(a)(4).
[23] 42 C.F.R. § 483.151(c).
[24] § 12-38.1-108(5), C.R.S.
[25] 42 C.F.R. § 483.151(b)(2).
[26] Board Rule XI, § 10.1.
[27] Board Rule XI, Section 10.2B and Board Policy 60-03.
[28] § 12-38.1-108(6), C.R.S.
[29] § 12-38.1-107, C.R.S.

The competency evaluation must address each course requirement, and consist of two parts: a written or oral examination (aides may choose the one they prefer) and a skills demonstration portion. The skills demonstration must consist of a demonstration of randomly selected items drawn from a pool consisting of the tasks generally performed by nurse aides.[30]

Only the state or a state-approved entity that receives neither Medicare nor Medicaid funds may administer the competency evaluation.[31]

Certification

One of the Board's primary duties is to certify qualified applicants. To qualify for certification by competency evaluation, applicants must:

- Submit an application;[32]
- Pay an application fee;[33]
- Provide written evidence that they have not committed any act or omission that would be grounds for discipline or denial of certification;[34]
- Provide evidence of completing an approved nurse aide education program;[35]
- Provide evidence that they are lawfully present in the United States;[36] and
- Pass the competency evaluation.[37]

Typically, applicants must have successfully completed an approved nurse aide training program to be eligible to take the competency evaluation. There are some exceptions to this, however. In some cases, applicants may challenge the nurse aide training program curriculum if they can provide evidence of having received equivalent training elsewhere.[38] Training provided within a practical nursing, professional nursing, or psychiatric technician education program qualifies applicants to take the competency evaluation, as long as the courses taken covered the topics in the required nurse aide curriculum.[39]

[30] 42 C.F.R. § 483.154(b)(1) and (2).
[31] 42 C.F.R. § 483.154(c).
[32] § 12-38.1-104(1), C.R.S.
[33] § 12-38.1-104(2)(a), C.R.S.
[34] § 12-38.1-105(1)(a), C.R.S.
[35] § 12-38.1-105(1)(b), C.R.S.
[36] § 24-34-107(1)(a), C.R.S.
[37] § 12-38.1-107(1)(a), C.R.S.
[38] Board Rule X, § 3.7.
[39] Board Rule X, § 3.8.

The other primary route to certification is by endorsement. To qualify for certification by endorsement, an applicant must:

- Submit an application;[40]
- Pay an application fee;[41]
- Provide written evidence of the following:
    - Having no record of any act or omission that would be grounds for discipline or denial of certification;[42]
    - Nurse aide certification in another state or territory of the United States with requirements that are essentially similar to Colorado's requirements;[43]
    - Completion of an education program meeting the standards in Colorado's laws and rules;[44] and
    - Having no record of abuse, negligence, or misappropriation of resident's property or any disciplinary action taken or pending in any other state or territory against such certification.[45]

Once issued, CNA certificates must be renewed on a schedule determined by the Division Director,[46] currently every two years. At the time of renewal, CNAs must attest that they have performed nursing care services for at least eight hours for pay during the previous 24 months.[47] If a CNA has not provided such care, he or she may provide evidence of having passed the competency evaluation within the past 24 months.[48]

Medication Aide Authority

CNAs may be granted authority to administer medications under certain conditions. To qualify for medication aide authority (MAA), the CNA must:[49]

- Possess a high school diploma or a general equivalency diploma;
- Be at least 18 years of age;
- Be able to read and comprehend English;
- Have worked at least 2,000 hours as a CNA in a nursing facility;

[40] § 12-38.1-106(1), C.R.S.
[41] § 12-38.1-106(1) C.R.S.
[42] § 12-38.1-106(1)(b), C.R.S.
[43] § 12-38.1-106(1)(a), C.R.S.
[44] § 12-38.1-106(1)(c), C.R.S.
[45] § 12-38.1-106(1)(d), C.R.S.
[46] § 12-38.1-109, C.R.S.
[47] Board Rule X, § 5.2.
[48] Board Rule X, § 5.5.
[49] § 12-38.1-110.5, C.R.S.

- Provide evidence of having completed coursework in the following areas:
    - Four credit hours in biology, anatomy, and physiology;
    - One credit hour in pharmacology calculations;
    - Two credit hours in pharmacology;
    - One credit hour in health assessment; and
    - Two credit hours in a medication administration practicum at the facility where the applicant is employed.
- Pass the Board-approved medication administration examination.

Once the MAA has been issued, the CNA may do the following in nursing facilities only:[50]

- Measure and document vital signs prior to administering medications;
- Administer routinely prescribed oral medications which the CNA has personally prepared, according to the manufacturer's instructions and a physician's order; and
- Document the administration of such medications.

CNAs with MAA—sometimes referred to as medication aides—are prohibited from administering Coumadin and its derivatives, controlled substances, non-oral medications, or medications administered on an "as needed" basis.[51]

Medication aides must be supervised by a licensed RN or LPN.[52] Medication aides must report medication administration errors to a supervisor immediately.[53]

An RN must review, on a monthly basis, all medications administered by the medication aide.[54] This review includes frequent and periodic review of the Medication Administration Record to verify that the medication aide is properly performing and documenting medication administration.[55]

Complaints and Enforcement

A critical responsibility of the Board is to assure public protection by revoking, suspending, or admonishing CNAs who are found to have violated the grounds for discipline. The Board may also deny initial certification to a CNA applicant if there is probable cause to believe that the applicant has violated the NAPA. [56]

[50] §12-38.1-110.5(3)(a), C.R.S.
[51] Board Rule XIX, § 9.1.
[52] Board Rule XIX, § 6.1.
[53] § 12-38.1-110.5(3)(b), C.R.S.
[54] Board Rule XIX, § 8.1.
[55] Board Rule XIX, § 8.3.
[56] §§ 12-38.1-111(1) and 12-38.1-112 (1), C.R.S.

Grounds for discipline include:[57]

- Procuring or attempting to procure a license by fraud, deceit, misrepresentation, misleading omission, or material misstatement of fact;
- Having been convicted of a felony or any crime that would constitute a violation of the NAPA;
- Willfully or negligently acting in a manner inconsistent with the health or safety of persons under his or her care;
- Having had a license/certificate to practice as a nurse aide or any other health care occupation suspended or revoked in any jurisdiction;
- Negligently or willfully violating any order, rule, or regulation of the Board;
- Verbally or physically abusing a person under the care of the CNA;
- Habitually abusing or excessively using alcohol or habit-forming drugs;
- Having a diagnosis of a physical or mental disability rendering the CNA unable to practice as a nurse aide with reasonable skill and safety to the patients and which may endanger the health or safety of persons under the care of the CNA;
- Misappropriating patient or facility property;
- Violating the confidentiality, as prescribed by law, of any patient;
- Engaging in any conduct constituting a crime as defined in Title 18, C.R.S., and which conduct relates to employment as a CNA;
- Neglecting a person under the care of the CNA;
- Using any designation in connection with his or her name that tends to imply that he or she is a CNA unless he or she is so certified; and
- Practicing as a nurse aide during a period when the person's certificate has been suspended or revoked.

Any person believing a CNA has violated these grounds for discipline may file a written complaint with the Board.

The Board evaluates complaints and, if appropriate, recommends further investigation. If, after investigation, there is probable cause to believe that a CNA has violated the NAPA, the Board may initiate disciplinary proceedings.[58]

Upon written evidence that the CNA has violated the grounds for discipline, the Board may revoke or otherwise discipline the CNA's certificate.[59] The Board must notify the CNA of the disciplinary action, and the charges giving rise to it, via certified letter within 30 days of the action. The Board must also notify the CNA of his or her right to request a hearing.[60]

[57] § 12-381.111(1), C.R.S.
[58] § 12-38.1-114(2), C.R.S.
[59] § 12-38.1-114(3), C.R.S.
[60] § 12-38.1-114(4), C.R.S.

Within 30 days of being notified of the disciplinary action, the CNA may file a written request for a formal disciplinary hearing.[61] Hearings must be conducted in accordance with the Administrative Procedure Act.[62]

If the CNA fails to file a written request for a hearing within 30 days, the disciplinary action of the Board becomes final.[63]

Upon receiving the results of an investigation, the Board may determine that formal action is not required. In this case, the Board may dismiss the complaint or issue the CNA a confidential letter of concern.[64]

If the Board receives credible evidence—either via a written complaint or otherwise—that a CNA is acting in a manner that poses an imminent threat to the public health and safety, the Board may issue a cease and desist order. The Board may also issue cease and desist orders against anyone found to be practicing as a nurse aide without a certificate.[65]

If the Board finds that a nurse aide has neglected or abused a resident or misappropriated resident property, the Board must permanently include this information on the nurse aide registry.[66]

Any final disciplinary action of the Board is subject to judicial review by the Court of Appeals, in accordance with section 24-4-106, C.R.S.[67]

[61] § 12-38.1-114(5)(a), C.R.S.
[62] § 12-38.1-114(7), C.R.S
[63] § 12-38.1-114(5)(a), C.R.S.
[64] § 12-38.1-114(10.5), C.R.S.
[65] § 12-38.1-114(14(a), C.R.S.
[66] 42 U.S.C. § 1395i – 3(g)(1)(c) and 42 C.F.R. § 483.156(a)(4).
[67] § 12-38.1-116., C.R.S.

Program Description and Administration

The Colorado Board of Nursing (Board) is vested with the authority to regulate certified nurse aides (CNAs) and to approve nurse aide education programs.

Although the official regulatory authority rests with the Board, pursuant to section 12-38.1-110, C.R.S., the Board appoints a Nurse Aide Advisory Committee (Committee), to handle most regulatory functions on its behalf. The Committee meets monthly, typically on the second Thursday of the month.

Statistics of all the Committee's activities, including disciplinary actions, certification activities, and education program approvals, appear on the consent agenda of the Board's quarterly meetings. Rulemaking hearings for rules pertaining to CNA certification are also conducted at the quarterly meetings.

The Division of Registrations (Division) provides administrative and managerial support for the CNA certification program.

Table 1 illustrates, for the five fiscal years indicated, the program's overall expenditures and staffing levels.

Table 1
Agency Fiscal Information

Category	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07
Total Program Expenditures	$757,525.43	$707,574.64	$756,320.06	$957,315.73	$913,644.07
Full-Time Equivalent (FTE) Employees	5.0	4.8	4.0	4.5	4.5

The significant increase in program expenditures from fiscal year 04-05 to 05-06 was due to a one-time refinance of state matching funds for Medicaid.

In July of 2003, the Division of underwent a major reorganization, creating centralized units to handle licensing/certification, customer service, and central intake functions for all Division boards and programs. The above table reflects only those FTE dedicated to the Board for enforcement, inspection, policymaking, and non-routine[68] licensing functions related to CNA regulation.

[68] "Non-routine" refers to applications requiring special Board review, such as those where the applicant was educated in a foreign country, or those where the applicant answers "yes" to one of the background screening questions.

Table 2 shows the fees charged by the program.

Table 2
CNA Certification Program Fees

Original Certification by Endorsement	$10
Medication Aide Authority	$12
Renewal	$40
Late Fee (for renewals after the expiration date)	$15
Reinstatement	$55
Duplicate Certificate	$5

Pursuant to section 24-34-105, C.R.S., fees are subject to change every July 1.

Certification

There are two primary routes to CNA certification in Colorado: by examination and by endorsement. Applicants must complete the appropriate application and submit it with all supporting documentation to the Division's Office of Licensing (Office). 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 for certification. If requirements are met, the certificate is issued. If not, the licensing specialist notifies the applicant in writing, and the application is kept on file for one year.

Table 3 illustrates, for the five fiscal years indicated, the number of new certificates issued by method.

Table 3
New CNA Certificates Issued by Method

Method	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07
Examination	3,404	2,619	3,294	3,871	3,614
Endorsement	603	458	426	681	560
Total	4,007	3,077	3,720	4,552	4,174

The variation in the number of new CNAs from year to year is largely caused by the variation in the number of programs offering CNA training in a given year: if several training programs close from one year to the next, that causes a commensurate decrease in the number of new CNAs.

Table 4 illustrates the total number active CNAs for the five fiscal years indicated.

Table 4
Total Number of CNAs

FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07
23,783	22,214	26,794	25,089	29,911

Again, the variation in the total number of CNAs from year to year is largely caused by the variation in the number of programs offering CNA training in a given year.

All applications for CNA certification require applicants to answer detailed background questions. These questions are intended to identify applicants with criminal convictions, past disciplinary actions with licensing boards, a history of alcohol or drug abuse, and numerous other factors that may affect the applicant's ability to practice as a nurse aide safely. If the applicant answers affirmatively to any of the background questions, the application is subjected to an additional review.

The Board developed a decision tree to facilitate review of these "yes" applications. Office staff has the authority to administratively approve some of these applications within defined parameters. Examples of "yes" applications that staff may administratively approve include those disclosing:[69]

- A single conviction for driving under the influence (DUI) or driving while ability impaired (DWAI) that occurred more than one year ago, absent any other information in the application that would indicate a history of alcohol or drug impairment;
- Up to three misdemeanor convictions or petty offense convictions that occurred more than five years ago, where all terms of probation are completed and none of the convictions involved bodily harm; and
- Traffic offenses that do not involve DUIs, DWAIs or felonies.

If the violations are outside the parameters of authority delegated by the Board, Board staff assigns the application to the Committee. Examples of "yes" applications that must be referred to the Committee include those disclosing: [70]

- One or more felony convictions;
- Conviction(s) involving alcohol within the last year; or
- Any conviction that involved a patient, or took place when the applicant was in a position of trust.

[69] Guidelines for the Handling of Nurse Aide "Yes" Applications, p.2.
[70] Guidelines for the Handling of Nurse Aide "Yes" Applications, p.1.

The Committee reviews the application and decides whether to grant or deny certification at one of its monthly meetings. If the Committee denies the applicant certification, the applicant is entitled to a hearing under the Administrative Procedure Act.

Examinations

Applicants for CNA certification are required to pass a Board-approved competency evaluation that meets federal and state requirements. The Board contracts with a testing vendor, Pearson-Vue, to create, score, and report the results of the examination. The examination, called the National Nurse Aide Assessment Program (NNAAP), consists of a written or oral examination and a skills evaluation. The purpose of the NNAAP examination is to ensure that candidates can safely perform the job of an entry-level nurse aide.

The written examination consists of 60 scored multiple-choice questions and 10 pretest questions. It is offered in a paper-and-pencil format, and candidates are allotted two hours to complete the examination.[71]

Candidates who have trouble reading English may take an oral examination instead of the written examination. The oral examination, which is available in both English and Spanish, consists of 60 multiple-choice questions and 10 multiple-choice word recognition questions. Candidates are allotted two hours to complete the examination.[72]

Table 5 indicates the content areas for the written/oral portion of the NNAAP examination and the percentage of questions in each content area.

Table 5
Content Areas for the Written/Oral Portion of the NNAAP [73]

Subject Area	Percentage of Examination
Physical Care Skills	
Activities of Daily Living	14% (9 questions)
Basic Nursing Skills	35% (21 questions)
Restorative Services	8% (5 questions)
Psychosocial Care Skills	
Emotional and Mental Health Needs	10% (6 questions)
Spiritual and Cultural Needs	4% (2 questions)
Role of the Nurse Aide	
Communication	7% (4 questions)
Client Rights	7% (4 questions)
Legal and Ethical Behavior	5% (3 questions)
Member of the Health Care Team	10% (6 questions)

[71] *Colorado Nursing Assistant Candidate Handbook*, Pearson-Vue (2008), p.12.
[72] *Colorado Nursing Assistant Candidate Handbook*, Pearson-Vue (2008), p.12.
[73] *Colorado Nursing Assistant Candidate Handbook*, Pearson-Vue (2008), p.13.

During the skills evaluation, trained evaluators rate candidates on their performance of the skills. Candidates must demonstrate competency in a total of five skills: hand-washing, and four skills selected at random from a list of 24 skills.[74] These skills include:[75]

- Assisting clients with the use of a bedpan;
- Cleaning and storing dentures;
- Dressing a client with an affected right arm;
- Feeding a client who cannot feed himself or herself;
- Giving a client a modified bed bath (face and one arm, hand, and underarm);
- Making an occupied bed;
- Measuring and recording blood pressure;
- Performing passive range of motion for one knee and one ankle;
- Positioning a client on his or her side;
- Providing catheter care;
- Providing perineal care for an incontinent client; and
- Transferring a client from bed to wheelchair.

The examination costs $95 for both the written/oral and the skills portion. The written/oral portion alone costs $25. The skills portion alone costs $70.[76] These examination fees include the cost of certification: the Board does not charge any additional fees to applicants.

Candidates have two years to pass both portions of the examination. Failing candidates must pay a new examination fee each time they retake either portion of the examination. Candidates who fail either component of the examination more then three times must successfully complete a nurse aide training program before applying to retake the examination.[77]

[74] *Colorado Nursing Assistant Candidate Handbook*, Pearson-Vue (2008), p. 20.
[75] *Colorado Nursing Assistant Candidate Handbook*, Pearson-Vue (2008), pp. 24-39.
[76] *Colorado Nursing Assistant Candidate Handbook*, Pearson-Vue (2008), p. 6.
[77] *Colorado Nursing Assistant Candidate Handbook*, Pearson-Vue (2008), p. 40.

Table 6 illustrates, for the five fiscal years indicated, the number of written/oral examinations and skills evaluations administered to applicants seeking Colorado CNA certification, and the corresponding pass rates.

Table 6
Examinations for Colorado Applicants

Fiscal Year	Examinations Given	Pass Rate
02-03	4,646	73%
03-04	4,742	76%
04-05	4,692	70%
05-06	5,473	70%
06-07	5,858	61%

The pass rate dropped from fiscal year 05-06 to 06-07, which Board staff attributes to difficulty with the previous testing vendor. Since Pearson-Vue has taken over, the pass rate has increased and stabilized.

Although there is an examination for the medication aide authority (MAA), as of this writing, no MAA applicants have qualified to take the examination.

Inspections

The Board must conduct periodic inspections, or site visits, as part of the nurse aide education program approval process. The inspector is a member of the Board staff.

An inspector may survey a program at any time, but must do so at least every two years to ensure the program is still in compliance with the NAPA and Board rules. If the inspector identified deficiencies during a previous site visit, an additional visit may be necessary to determine whether the program has corrected the deficiencies.

During a site visit, the Board inspector might meet with the program's leadership, tour the program's facilities, interview students, review organizational materials and files, and do anything else that helps determine the program's compliance with the standards established in the laws and rules.

After the site visit, the inspector develops a detailed report and submits it for the Board's review at one of its quarterly full Board meetings.

Table 7 shows the number of inspections conducted by Board staff as part of the nurse aide education program approval process.

Table 7
Inspections

Fiscal Year	Number of Inspections
02-03	57
03-04	30
04-05	50
05-06	36
06-07	52

As stated above, the Board must conduct inspections of education programs every two years. The pattern in the number of inspections from year to year reflects that more programs come due for inspection in odd-numbered fiscal years.

As of July 2008, there were 103 nurse aide education programs that have full Board approval.

Complaints/Disciplinary Actions

Anyone—a hospital, staffing agency, physician, patient, or the Board itself—may file a complaint against a CNA. The Committee reviews complaints at its monthly meetings.

Table 8 shows the number of complaints received for the past five fiscal years.

Table 8
Complaints

Fiscal Year	Number of Complaints Received
02-03	177
03-04	159
04-05	197
05-06	381
06-07	158

The number of complaints increased dramatically in fiscal year 05-06, the year that the Division's Office of Investigations started comparing the Division's database against that of the Colorado Judicial Department on a routine basis. This effort revealed a number of CNAs with criminal convictions that had not been properly disclosed to the Board, and the Board filed complaints on the basis of these convictions. Most of these CNAs were identified with the first cross-check. Subsequent cross-checks revealed fewer cases requiring investigation, and the complaint numbers dropped down again.

Table 9 illustrates the nature of complaints filed with the Board for the five fiscal years indicated.

Table 9
Nature of Complaints

Nature of Complaints	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07
Standard of Practice	53	31	10	56	57
Criminal Offenses	32	25	81	101	46
Physical/Mental Disability	2	3	0	4	8
Substance Abuse	12	23	24	42	19
Discipline in Another State	5	0	3	3	1
Verbal/Physical/Sexual Abuse of Patient	54	36	56	81	69
Patient Neglect	12	27	14	37	29
Misappropriation of Property	6	1	11	25	10
Fraud/Misrepresentation on Application	1	4	5	6	5
Board Rule or Order Violation	0	11	3	29	8

Note: The number of the nature of complaints will not equal the total number of complaints reported elsewhere in this report because a complaint may have more than one allegation.

The most common types of allegations against CNAs involve standard of practice, criminal offenses, and verbal, physical, or sexual abuse.

After investigation, the Committee may find probable cause that a certificant violated the grounds for discipline and consequently pursue disciplinary action. Disciplinary settlement may be reached either internally via Board staff or via the Attorney General's Office (AGO).

Table 10 below illustrates the total number of final actions taken by the Board for the five fiscal years indicated.

Table 10
Final Agency Actions

Type of Action	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07
Revocation/Surrender of Certificate	45	44	45	55	29
Suspension	7	4	8	15	5
Letter of Admonition	15	12	5	7	7
Injunction/Other Actions*	1	0	1	0	1
Total Disciplinary Actions	**68**	**60**	**59**	**77**	**42**
Certificate Denied	--	3	10	2	1
Dismissed**	67	79	126	146	111

*Other actions include but are not limited to revocations held in abeyance or stayed, suspensions held in abeyance, and cease and desist orders.
**Dismissals include confidential letters of concern which may be issued by the Board when initiation of formal disciplinary action is not warranted. The Board did not have the authority to issue letters of concern to CNAs until July 1, 2006.

The rise in the number of dismissals reflects the increased number of complaints generated by the Office of Investigations' comparison of the Division's database against that of the Judicial Department. Many of these complaints, upon investigation, did not warrant further action.

Analysis and Recommendations

Recommendation 1 – Continue the regulation of certified nurse aides (CNAs) for 11 years, until 2020.

The statutes relating to nurse aide regulation are encompassed in Article 38.1 of Title 12, Colorado Revised Statutes (C.R.S.), and are collectively known as the Nurse Aide Practice Act (NAPA). Section 12-38.1-101, C.R.S., vests the Colorado Board of Nursing (Board) with the authority to regulate certified nurse aides (CNAs), and section 12-38.1-103(1), C.R.S., establishes that the primary regulatory duties of the Board include certifying qualified applicants, approving education programs preparing nurse aides for certification, and implementing the requirements of the federal Omnibus Budget Reconciliation Act (OBRA). Pursuant to section 12-38.1-110(1), C.R.S., the Board appoints a Nurse Aide Advisory Committee (Committee), to assist it in fulfilling its mandate.

Any discussion of the necessity of CNA regulation begins with OBRA, which mandates that nurse aides working in settings that receive funds from Medicare and/or Medicaid receive certain minimal training and testing. Each state is responsible for establishing a nurse aide registry that implements these requirements. Because of this federal requirement, total deregulation of CNAs is not an option. The question becomes whether the regulatory mechanisms Colorado has established to meet the federal requirement are effective.

Federal law requires the states to regulate CNAs working in long-term care as well as home health aides (HHAs), and establishes slightly different requirements for each setting. Colorado had the option of creating a distinct regulatory program for each setting. The General Assembly decided to create a single program instead. Reasons for this included administrative efficiency and the desire to develop a flexible CNA workforce able to work in either setting without seeking additional training or certifications.

However, representatives of the home health community, as well as some consumer groups, report that the current CNA education does not adequately prepare CNAs to provide home health services. Often, substantial additional training is required before the CNA can fully function in the HHA role.

The fact of the matter is, the federal requirements for CNAs and HHA training overlap significantly. It is unlikely that adopting separate standards for HHA training programs would have a measurable impact on the level of preparation of the CNA workforce.

Further, CNA practice varies tremendously from one home health agency to the next, and, for that matter, from one long-term care facility to the next. Almost every long-term care administrator interviewed for this report felt that new CNAs coming in to their facilities usually require extensive training, or re-training, before going out on the floor, unless the CNA received his or her initial training at that facility. The practice of CNAs largely depends on the expectations and established practices of specific employers: it is unlikely the need for sometimes lengthy orientations or reorientations would be eliminated by expanding the basic CNA training. The combined CNA program effectively assures a basic level of competency among the most commonly required nurse aide skills.

A greater issue lies in the question of whether HHAs need to be regulated at all. Several consumer groups noted that the federal requirements can interfere with consumers' ability to find—and pay for—the home care they truly need. So-called "private pay" consumers, who do not rely on Medicare/Medicaid reimbursement to defray health care costs, can, quite simply, hire whomever they wish, certified or not, and ask that person to perform whatever tasks or services are needed. Pursuant to OBRA, those who rely on Medicare/Medicaid must hire CNAs, who are held to a limited scope of practice that may hamper their ability to truly meet consumers' needs.

In a 2006 survey conducted by the American Association of Retired Persons (AARP), eight in ten Colorado members said that it is extremely (40 percent) or very (42 percent) important to have access to long-term care services in their homes. Almost half of those surveyed would prefer to receive nursing care at home (49 percent) rather than in assisted living (38 percent) or in a traditional nursing facility (2 percent).[78] According to nationwide surveys, adults with disabilities overwhelmingly prefer to stay in their own homes.[79] Not only do consumers clearly prefer home care, home care is significantly less expensive than care in a nursing facility: on average, Medicaid dollars can support nearly three people in home and community-based services for every person in a nursing home.[80]

Federal law allows the states considerable latitude in using Medicaid dollars to fund programs that provide an alternative to traditional institutional nursing care. These programs may be exempted from federal rules, including the HHA certification requirement. Although Colorado has taken some steps to promote home and community-based long-term care services, the state would do well to develop more options that increase consumer access to nursing care in home or community-based settings.

[78] *Colorado Long-Term Care: A Survey of AARP Members,* American Association of Retired Persons (2005), p. 4.
[79] *A Balancing Act: State Long-Term Care Reform*, AARP Public Policy Institute (2008), p. 1.
[80] *A Balancing Act: State Long-Term Care Reform*, AARP Public Policy Institute (2008), p. 6.

By and large, the single CNA certification program has been effective. By approving nurse aide training programs and maintaining a competency evaluation, the Board has a means of assuring CNA applicants meet standards of minimal competence. The Board has established an application process that identifies applicants with criminal histories or background that may disqualify them from placement on the CNA registry. The Board investigates complaints against CNAs and takes disciplinary action against those who violate the NAPA. Through these activities, the Board acts in the interest of the public.

With the CNA certification program, the Board certifies applicants meeting minimal standards, removes unsafe CNAs from practice, and meets the federal registry requirements established by OBRA. For these reasons, the Board's regulation of CNAs should be continued for 11 years, until 2020.

Recommendation 2 – Change the composition of the Committee to allow an LPN who supervises CNAs to serve on the Committee, and simplify the requirements for members representing the public.

Section 12-38.1-110(1), C.R.S., establishes the representation on the Committee.

Included among the Committee members is one licensed professional nurse who supervises certified nurse aides. Because many CNAs work in long-term care, where licensed practical nurses (LPNs) are as likely, or more likely, than registered nurses (RNs) to hold supervisory positions, this seat should be redefined to be a licensed professional or practical nurse who supervises CNAs. Regardless of the type of nursing license he or she holds, a supervisor of CNAs should have a firm grasp of CNA practice. Broadening the qualifications for the position would ease recruiting and retaining individuals for this position without compromising the expertise of the Committee.

Section 12-38.1-110(1), C.R.S., also requires that two consumer members serve on the Committee: a family member of a consumer who receives home health services or nursing facility services and a consumer of home health care or nursing facility services. Since these criteria were put in place as part of the 2002 sunset bill, the Board has had difficulty filling these positions, particularly the consumer of home health care or nursing facility services. Only one consumer member has been appointed to this position, and that person's health problems made regular participation on the Committee difficult. The frequent meeting schedule and heavy workload also make it difficult to recruit and retain Committee members representing the families of consumers, who are often busy caring for their loved ones.

The specificity of these criteria is unique among health care boards, which typically do not place any specific qualifications on their public members. The narrow criteria make it difficult to fill these positions. These two positions should be redefined simply as public members, with no additional qualifications.

However, because representation of consumers of health care or nursing facility services and their families on the Committee is highly desirable, the Board, in appointing Committee members, should make every reasonable effort to appoint representatives meeting these criteria.

Recommendation 3 – Authorize Committee members to receive $50 per diem for their service.

Section 12-38.1-110(1), C.R.S., expressly forbids Committee members from being compensated for the services, in other words, from collecting a per diem allowance. This provision does not take into account the heavy workload of the Committee, and its critical role in enforcing the NAPA.

The Committee acts for the Board in matters relating to CNA certification and enforcement. While the Committee must report its activities to the Board quarterly, it routinely makes independent certification and enforcement decisions. The Board does not review the Committee's decisions before they become final. The Committee meets monthly, and its workload is usually as heavy as that of the Board's inquiry panels. Members of the Board are permitted to collect $50 per diem. To recognize members of the Committee as enforcing the NAPA on the Board's behalf, they should be permitted to receive the standard $50 per diem allowance as established in section 24-34-102(13), C.R.S.

Recommendation 4 – Repeal the Medication Administration Advisory Committee.

Section 12-38.1-110.3, C.R.S., directed the Executive Director of DORA to establish an advisory committee to study medication administration by CNAs in nursing and home health facilities.

The final report of the Medication Administration Advisory Committee was published as part of the 2002 sunset review of the NAPA. Because the Committee has completed its task, this section should be repealed.

Recommendation 5 – Revise grounds for discipline to clarify grounds regarding drug use and establish as grounds for discipline failing to respond to the Board and failing to report criminal convictions.

Section 12-38.1-111, C.R.S., establishes the grounds upon which the Board may take disciplinary action against CNAs. Numerous small changes would clarify this section.

Section 12-38.1-111(1)(i), C.R.S., establishes the following as grounds for discipline:

> Has habitually abused or excessively used any habit-forming drug or any controlled substance as defined in section 18-18-102 (5), C.R.S.

The statute citation in this provision is outdated, and no mention is made of drug diversion. This should be rewritten as follows:

> Habitual intemperance or excessive use of any habit-forming drug or any controlled substance as defined in section 12-22-303(7), or other drugs having similar effects, or is diverting controlled substances, as defined in section 12-22-303(7), or other drugs having similar effects from the licensee's place of employment.

Two new provisions should also be added.

Currently, the Board cannot take action against a CNA who fails to respond to a 30-day letter, which is the letter the Board sends to a CNA asking for response after a complaint has been filed. A provision should be added that establishes failing to respond in a materially factual and timely manner to a complaint as grounds for discipline.

A second new provision should be added that allows the Board to take action against any CNA who fails to report criminal convictions within 45 days of conviction. This poses a clear threat to public safety, and the Board should be able to pursue disciplinary action against those who withhold this information from the Board.

Recommendation 6 – Consolidate language on unlicensed practice.

Currently, there is wording regarding unlicensed practice in several places throughout the NAPA. For the sake of clarity, all wording regarding unlicensed practice should be relocated to section 12-38.1-118, C.R.S.

Recommendation 7 – Revise the provisions regarding physical and mental examinations.

If the Board has cause to believe that a physical or mental condition may be interfering with a CNA's ability to practice safely, it can order the CNA to undergo a physical or mental examination. Two small changes would clarify this section.

The current statute states that such evaluations must be performed by a physician designated by the Board. Depending on the type of examination, a licensed psychologist, advanced practice nurse, or social worker might be equally qualified to conduct the evaluation. The provision should be reworded to clarify that such evaluations may be conducted by a physician or "other licensed health care provider."

Section 12-38.1-113(2)(b), C.R.S., establishes the consequences if a CNA fails to submit to a physical or mental examination. The current wording states:

> If such nurse aide fails to submit to such examination, absent a determination by the Board that there is good cause for such failure, the Board may summarily suspend such nurse aide's certification until such time as the nurse aide submits to the required examination.

This wording should be simplified to state:

> If a nurse aide fails to submit to such mental or physical examinations, the Board may suspend the nurse aide's certificate until the required examinations are conducted.

Recommendation 8 – Repeal the requirement that proceedings relating to complaints where formal charges were filed be subject to the Colorado Open Records Act.

Section 12-38-116.5(9), C.R.S., exempts disciplinary proceedings—including investigations, hearings, and meetings—from the Colorado Open Records Act (CORA). This exemption assures due process for the CNA undergoing disciplinary proceedings. There is, however, an exception to this exemption:

> Except when a decision to proceed with a disciplinary action has been agreed upon by a majority of an inquiry panel and a notice of formal complaint is drafted and served on the licensee by first-class mail[.]

In other words, meetings regarding disciplinary proceedings are closed, except for when the Board, through the Committee, has filed a formal complaint against a CNA via the Attorney General's Office (AGO).

This creates an unintended double standard. When CNAs agree to a settlement *before* a formal complaint is filed, the final disciplinary document becomes public, but all subsequent discussion of the case is held in closed session. When CNAs agree to a settlement *after* a formal complaint is filed, then all subsequent proceedings relating to the case must be conducted in accordance with CORA. In theory, this penalizes CNAs who exercise their right to due process.

In practice, the exception creates a considerable administrative burden for Board staff as well as the Committee. Since discussion of cases in which formal complaints were filed is subject to CORA, even long after the case has been settled, these cases must be conducted in open session. Board staff must sift through the 40 to 50 cases on a typical Committee agenda, determine which ones fall into this category, and place those cases on the open session agenda.

Requiring that all discussion of cases where formal complaints were filed be conducted in open session is unique to the NAPA and the Nurse Practice Act. Similar health care boards, namely the Board of Medical Examiners, the Board of Dental Examiners, the Podiatry Board, and the Board of Chiropractic Examiners,[81] carry no such exception: although formal complaints and final disciplinary documents are public, disciplinary proceedings may be conducted in closed session.

Removing the requirement that these cases be discussed in open session will in no way reduce the public's access to disciplinary information. Formal complaints prepared by the AGO and all final disciplinary documents would remain part of the public record.

Therefore, the requirement that cases where formal complaints were filed be subject to CORA should be eliminated. Doing so would bring the Board in line with other health care boards and would streamline the administration of Committee meetings without compromising public safety.

Recommendation 9 – Direct the Board to promulgate rules establishing the education requirements and scope of practice for CNAs with Medication Aide Authority.

Section 12-38.1-110.5, C.R.S., establishes medication aide authority (MAA) for CNAs. After the authority was created, the Division developed an application, selected a vendor to develop an examination, and prepared to process applications for the authority. As of this writing, the Division had received only a handful of applications. None of these applicants qualified to take the examination.

The MAA has been in place for three years, yet not a single CNA has procured it. The concept of medication aide authority is not a novel one. According to data from the National Council of State Boards of Nursing (NCSBN), 14 other state boards of nursing regulate medication aides. Why have so few Colorado CNAs applied for the authority, and why haven't any applicants qualified to take the examination?

The history of MAA in Colorado begins with the long-term care community. Representatives of this community reported difficulty in recruiting nurses, particularly in rural areas. They also pointed out that nurses working in long-term care were spending an inordinate amount of time administering routine medications rather than performing tasks requiring the advanced knowledge, skills, and judgment that nurses possess.

In response to these concerns, the General Assembly passed House Bill 02-1090, which created an advisory committee to study the administration of medication by CNAs. The initial recommendations of the Medication Administration Advisory Committee (MAAC) were included as Appendix C to DORA's 2002 sunset review of the CNA certification program.

[81] §§ 12-36-118(10), 12-35-129(7)(e), 12-32-108.3(12), and 12-33-119(10), C.R.S., respectively.

Based upon the MAAC's recommendations as well as a comprehensive review of the laws of other states, DORA made a two-pronged recommendation: 1) to pursue creating MAA, and 2) to empower the MAAC to develop the specific educational and experiential requirements and scope of practice for CNAs with MAA. This recommendation passed as part of Senate Bill 03-134.

Medication aide authority was finally established with the passage of Senate Bill 05-155.

The final requirements differed from the initial recommendations of the MAAC. The total number of hours of required training in the final law is close to the MAAC's recommendation: the MAAC recommended a minimum of 140 clock hours in specified content areas, whereas the final law requires 10 credit, or 150 clock, hours. However, one important difference lies in where the MAA training can be offered. The MAAC advised that such training could occur in nursing facilities, as well as in assisted living and board and care homes.[82] The new law required the training to be completed as part of a practical nursing or psychiatric technician program.[83] Requiring the education to occur in these settings automatically made it more difficult for those in rural areas—who were expected to benefit the most from the establishment of the MAA—to obtain the required education.

Another important change occurred in the scope of practice. The MAAC did recommend placing restrictions on the medications CNAs with MAA could administer, and on the administration routes that MAs could employ. The final law, however, went far beyond these recommendations by permitting MAs to administer medications orally only. With this change, the MAA became much less useful for employers.

The limitations on the scope of the MAA and the requirement that education be completed at a community college rendered the MAA simultaneously less useful and harder to achieve. With some retooling, however, the MAA could still fill an important niche in Colorado's health care system. Both consumers and employers would benefit from access to a greater number of health care providers trained to administer medications. They would further benefit from a nursing workforce able to focus on developing care plans and delivering skilled nursing services rather than administering medications. With thoughtful revision, the MAA could help expand access to health care services in Colorado.

Redesigning the MAA would also make it a viable option for Colorado facilities that currently hire licensed psychiatric technicians to administer medications. This concept is explored more thoroughly in Recommendation 1 of DORA's 2008 sunset review of the psychiatric technician licensure program.

[82] *Sunset Review of the Nurse Aide Certification Program*, Department of Regulatory Agencies (2002), p. 87.
[83] § 12-38.1-110.5(2)(a), C.R.S.

In keeping with the second sunset criterion,[84] the Board's primary objective in redesigning the MAA should be to establish the least restrictive form of regulation consistent with the public interest. The education and experiential requirements for MAA must be reasonable, and the scope of practice must be wide enough to accommodate the needs of the employers who helped bring about the MAA in the first place.

Since the establishment of MAA in Colorado, the nationwide trend toward developing such programs led the NCSBN to develop a model curriculum and scope of practice for MAA. The Board should take direction from the NCSBN model in redesigning the MAA. Further, the Board should consider at least the following in developing the new rules:

- Reducing the number of required hours of education;
- Expanding the allowable routes of administration;
- Reducing or eliminating the required hours of work experience; and
- Developing different scopes of practice depending on practice setting, if appropriate.

As a first step in redesigning the program, the General Assembly should remove from statute the specific language governing the MAA scope of practice and education, experience, and certification requirements. Instead, the General Assembly should empower the Board to promulgate rules addressing these areas. Establishing the requirements in rule allows the Board a measure of flexibility in fleshing out the new requirements, while still giving stakeholders the opportunity to be involved in crafting the new MAA via the public rulemaking process.

Recommendation 10 – Authorize the Board to require CNA training programs to include up to 25 percent more hours than the federal minimum.

Federal law requires nurse aide training programs to offer at least 75 clock hours of training.[85] According to a 2002 report from the Office of the Inspector General of the federal Department of Health and Human Services, half of the states have requirements exceeding the federal requirement, and one-third of all states require 100 hours or more of instruction. Twenty-three states surveyed require simply that training programs meet the 75-hour requirement, but permit such programs to provide any number of additional hours above that. [86]

[84] § 24-34-104(9)(b)(II), C.R.S.
[85] 42 C.F.R. § 483.152(a)(1).
[86] State Nurse Aide Training: Program Information and Data, Office of the Inspector General (2002), p. 5.

Colorado law essentially falls into the final category, but goes one step further. Rather than simply requiring that nurse aide training programs meet the federal minimum, section 12-38.1-108(6), C.R.S., states:

> Except as provided in this article, the board shall not require a nurse aide training program that substantially exceeds the requirements established in the federal "Omnibus Budget Reconciliation Act of 1987", as amended.

Historically, the Board has interpreted this provision as prohibiting it from requiring Colorado nurse aide training programs to provide more than 75 hours of training. The phrase “except as provided in this article” seems to permit the Board to do so within the NAPA, as long as the requirements do not “substantially exceed” the federal requirements. In other words, the Board *may* be able to increase the requirements, just not by too much, and what constitutes “too much” is open for debate.

This wording needs to be clearer, but the question remains whether the Board should be permitted to require more than the federal minimum of hours.

The primary duty of the Board is to protect the public. If the Board determines that Colorado CNAs are not sufficiently prepared when they enter the workforce, that 75 hours of training is not enough to assure minimal competence, the Board has a responsibility to determine whether CNA training needs to be expanded to protect the public. For example, almost every single long-term care and home health administrator interviewed for this report remarked that newly certified CNAs have insufficient training for dealing with clients with cognitive impairments and dementia. This lack of skills could endanger Colorado’s citizens. It is the Board’s responsibility to increase the training requirements in the interest of the public health, safety, and welfare.

Representatives of the long-term care community are, understandably, eager to train CNAs and get them to work as soon as possible. They may fear that any increase in the number of required hours might jeopardize their ability to coordinate care for residents. That said, long-term care facilities and their residents are the greatest beneficiaries of a well-trained CNA workforce. Well trained CNAs will likely make fewer errors, and be more prepared on their first day of work, which may help in retention of such employees.

Section 12-38.1-108(6), C.R.S., should be revised to authorize the Board to require Colorado nurse aide training programs to include up to 25 percent more hours than the minimum number established in the federal law. Any such increase must fall within the subject areas already required by federal law. This will allow the Board to protect the public without placing an undue burden on educators and employers of CNAs.

Recommendation 11 – Clarify that the four months nurse aides may work without being certified must be consecutive.

Federal law permits nurse aides to work full-time in a long-term care facility for up to four months without being certified.[87] This provision is intended to help long-term care facilities meet their workforce needs while nurse aides are pursuing CNA certification, without compromising patient safety. Pursuant to this federal requirement, section 12-38.1-117(1)(d), C.R.S., establishes that a nurse aide is exempt from the NAPA provided such person:

> … is directly employed by a medical facility while acting within the scope and course of such employment for the first four months of such person's employment at such medical facility if such person is pursuing initial certification as a nurse aide. A person may utilize this exclusion only once in any twelve-month period.

However, Board staff reports that some CNA applicants are using this four-month period inappropriately. For example, some applicants break up the four month period over an extended period of time (i.e., work for one month, take several off, work another month at a different facility, take a month off, etc). Others misinterpret the law, thinking it allows them to work as a nurse aide for four months of every year even if they have not taken or passed the certification examination. This is clearly not the intent of the federal or the state law.

Therefore, section 12-38.1-117(1)(d), C.R.S., should be reworded to state that the exemption to the NAPA applies only for the first four **consecutive** months of a person's employment in a medical facility.

Recommendation 12 – Extend the waiting period to two years for CNAs who have been denied certification, have had their certification revoked, or have surrendered their certification to avoid discipline.

Currently, CNAs who have been denied certification by the Board, who have had their certification revoked, or who have surrendered their certification in lieu of revocation, may reapply after a period of one year.[88]

Other health care professionals, including dentists, midwives, podiatrists, and pharmacists,[89] are required to wait two years. Given the severity of the violations that result in revocation or surrender of a certificate, and the amount of Division time and resources it takes to process revocations and surrenders, two years is a more appropriate waiting period. The waiting period for CNAs should be increased to two years.

[87] 42 C.F.R. § 483.75(e)(2).
[88] § 12-38.1-115(3), C.R.S.
[89] §§ 12-35-129(2), 12-37-103(4.5), 12-32-108.5(3), and 12-22-116(9), C.R.S., respectively.

Recommendation 13 – Repeal the section of the Colorado Nurse Practice Act regarding delegating the selection of medications.

Section 12-38-132, C.R.S., addresses the delegation of nursing tasks. Section 12-38-132(1), C.R.S., contains the following statement:

> In no event may a registered nurse delegate to another person the authority to select medications if such person is not, independent of such delegation, authorized by law to select medications.

The use of the word "select" in this context is confusing. It is unclear whether selecting is distinct from administering, and if so, how. Further, the statement is unnecessary, given that the rest of the section clearly delineates the circumstances under which a task may be delegated.

The sentence above also could be construed to restrict the ability of CNAs with MAA to administer medications. Removing this sentence will permit the Board to proceed with the revision of *Chapter XIII, Rules and Regulations Regarding the Delegation of Nursing Tasks* in order to accommodate the redesign of the MAA program, as laid out in Recommendation 9 above.